Policy Brief

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Improving Health Service Delivery through Community Participation in Kenya

Case for Kisumu County

– Daniel Asher

Introduction

Generally, governance is the manner in which the state and its various institutions consult and reconcile with people, markets and civil society, through laws, policies, regulation and finance. Today governance is overarching with many dimensions. It is not just about the effective management of economic resources but encompasses the realisation of citizens' right to demand accountability and the obligation of public actors to be accountable to its citizens.

The right to the highest attainable standard of health, including right to healthcare services, reproductive healthcare to every citizen is provided for under Chapter 43 (1)(a) of the Constitution of Kenya. Under chapter 56 of the constitution, the state has the responsibility of putting in place affirmative action programmes designed to ensure that minorities and marginalised groups have reasonable access to health services.

The Fourth schedule of the Constitution allocate responsibilities to county governments' over the county health facilities and pharmacies; ambulance services; promotion of primary healthcare; *et al* (excluding regulation of the profession).

The national development plan-Kenya Vision 2030 emphasises the need for community participation in order to meet national development objectives.

However, marginalised groups are yet to appreciate various platforms of participation provided for under the constitutions and other various legislations and policy documents owing to lack of capacity and awareness among them. As a result, many challenges have continued to bedevil the realization of the desired health outcomes in the country. In rural and remote communities, facilities are few and far apart. Even in urban areas, health facilities may exist, but are often under-funded or under-staffed, experience frequent shortages of medicines and supplies, and often located in areas that are inaccessible to the marginalised groups in the informal settlements. Often facilities are located in towns and cities, where transportation is too expensive for most poor families.

Why Focus on Marginalised Groups?

A critical factor of health-related initiatives in Kenya is the cultivation of the capacity and platforms for the effective participation of marginalised groups in social accountability aspects of healthcare services.

CUTS Nairobi has been implementing a project entitled 'Empowering Marginalised Community Groups for Inclusive Governance in Kenya's Health Service Delivery (EMACIGHES)' since July 2013 with the support from Akiba Uhaki Foundation. The project had two components comprising national health budget analysis and the Kisumu county level community training on social accountability tools and community monitoring process, baseline survey on users of public health services at the community level and the state of play in terms of physical structures, equipments and other infrastructure available within the public health facilities. Among outputs is the publication of key messages and recommended health service delivery model for Kisumu County.

Key Findings at National Level

- National health budgetary allocation though increasing is still way below Abuja declaration target of 15 percent of total expenditure. This deprives many public health facilities of basic essential infrastructures, equipments, prescription drugs and remunerations to health workers leading to frequent national strikes and general reluctance of public health workers.

- Actual national health expenditure is much lower than the approved expenditure; implying possible inefficiencies either in the financial system that hinders release of funds to the health programmes, or government not effectively implementing health programme work to ensure that all expenditures are exhausted.

- All 47 counties are below the country's targeted doctor's population ratio of 36 doctors per 100,000 populations. Kenya has a little more than 8,600 registered medical doctors – of a population of more than 40 million people – and only 4,500 of those doctors are currently working, according to the Medical Practitioners and Dentists Board.

- Most county health budgets lack on adequacy of data of actual community needs as they were drawn in record time just to facilitate allocation of funds without effective public consultations.

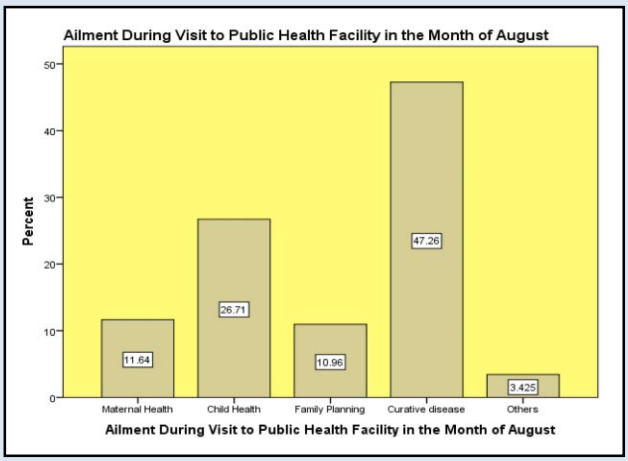
- Health service devolution to county governments was hasty without effective stakeholders' consultation and with disregard to the time frame stipulated in the constitution.

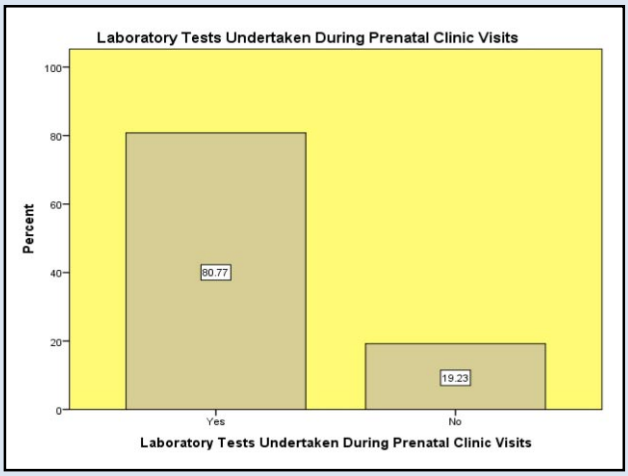
- Expectant women continue to receive cruel treatment by health service providers at public health facilities across the country.

Consumer Feedback on Health Service Provision

A. Citizen Report Card - Kisumu County

- The community members are over burdened by curative diseases at 47.26 percent followed by child health at 26.71 percent.





- Despite pre-natal clinic registration, only about 41 percent made substantive visits of between four to nine times to pre-natal clinics before delivery with majority of about 30 percent making only four visits.

- About 11 percent of the expectant women were not taking the supplements in spite of attending prenatal services.

- Despite attending the pre-natal clinic, 19.23 percent of women were not exposed to any laboratory check-up for blood or urine related tests regardless of its benefits in detection of possible infections including HIV and other medical complications, such as high sugar/ protein level and opportunity for earliest possible medical intervention.

- Over 19 percent of community members do not have the knowledge on membership of community health committees.

- Over 37 percent of community members reported absence of prescribed medication at facilities.

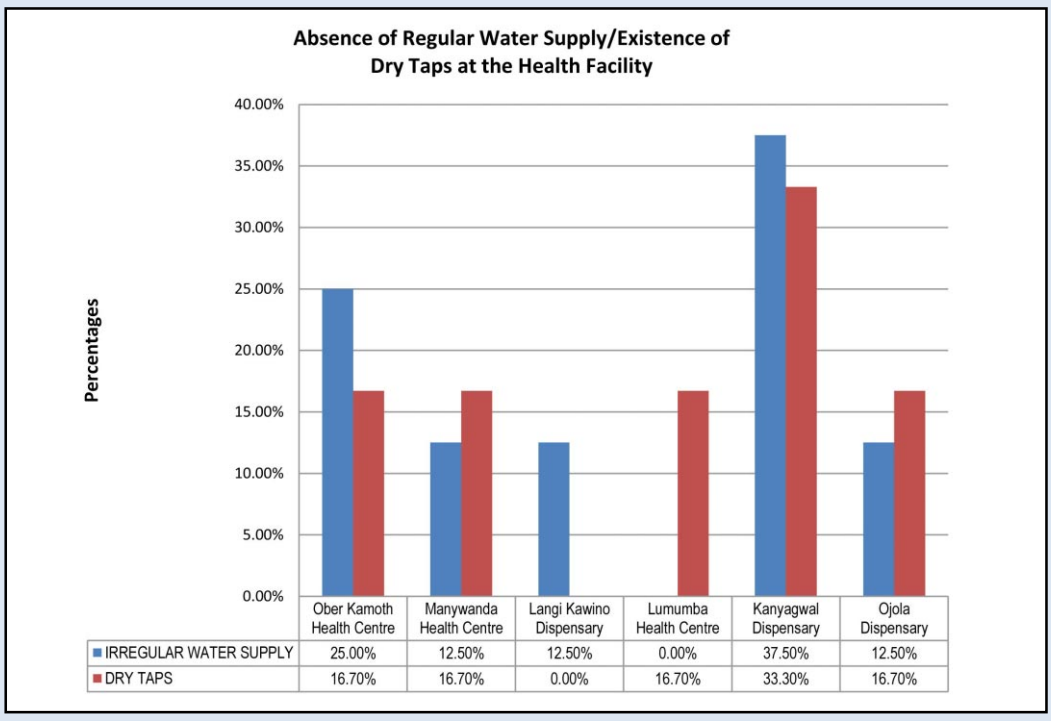
Bribe Payment	Demanded Bribe	Bribe paid (Kshs.)			
		100	200	500	50-450
7%	69%	33%	13%	20%	34%

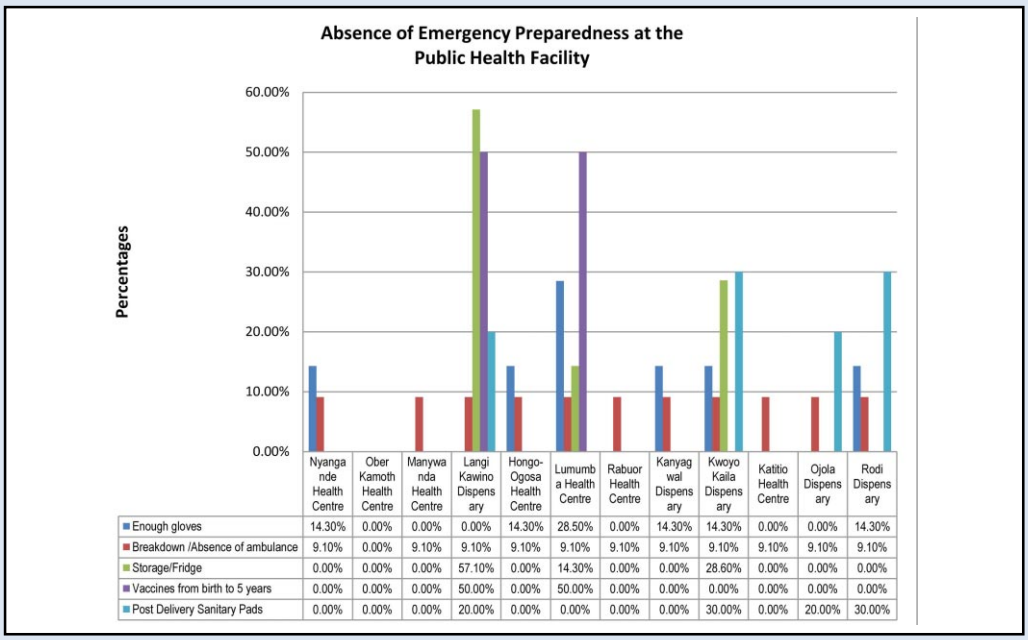
Delayed/None Response to Complaint	Preference To Public Health Facility	Inadequacy of Health Equipments
52%	94%	38%

- Over 47 percent of community members are either dissatisfied or partially satisfied with public health service delivery in Kisumu County.
- Over seven percent confirmed having engaged in payments of bribes to secure health services at the public health facility.
- About 69 percent of the bribe payment was demanded by health service providers while 31 percent were voluntary bribe to facilitate action by health service providers.
- Majority of respondents (over 33 percent) paid Kshs. 100 for bribe, 20 percent paid Kshs. 500 whereas over 13 percent paid Kshs. 200 for health services. The remaining component of respondents paid varied amount in the range of Kshs.50- 450 for the health services.
- General apathy by community members on the issue of complaints as majority (over 73 percent) have never complained about poor health services provision in the county. This general apathy may be attributed to lack of awareness or confidence by community members on existing institutions or systems of redress relating to health service issues.
- Delayed or no response (Over 52 percent) on complaints by the relevant health officers
- There is greater preference (94 percent) to public health facilities by community members as opposed to other alternatives (5.97 percent) in the neighbourhood.
- Over 38 percent of respondents held the feeling that medical equipments within public health facilities are either inadequate or not good enough to perform their functions.

B. Community Monitoring Report- Kisumu County

- Irregular water supply or existence of dry taps in most public health facilities in the county.
- Telecommunication system remains a challenge among many public health facilities at the county. Over 80 percent of health facilities either lacked the telecommunication equipments or were out of order or relied on personal mobile phones for health service providers.



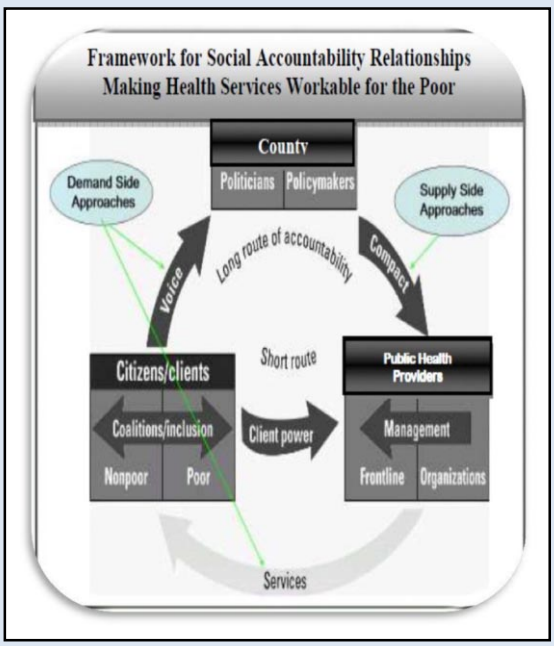


	Nyangande Health Centre	Ober Kamoth Health Centre	Manywanda Health Centre	Langi Kawino Dispensary	Hongo-Ogosa Health Centre	Lumumba Health Centre	Rabuor Health Centre	Kanyagwal Dispensary	Kwoyo Kaila Dispensary	Katitio Health Centre	Ojola Dispensary	Rodi Dispensary
Enough gloves	14.30%	0.00%	0.00%	0.00%	14.30%	28.50%	0.00%	14.30%	14.30%	0.00%	0.00%	14.30%
Breakdown /Absence of ambulance	9.10%	0.00%	9.10%	9.10%	9.10%	9.10%	9.10%	9.10%	9.10%	9.10%	9.10%	9.10%
Storage/Fridge	0.00%	0.00%	0.00%	57.10%	0.00%	14.30%	0.00%	0.00%	28.60%	0.00%	0.00%	0.00%
Vaccines from birth to 5 years	0.00%	0.00%	0.00%	50.00%	0.00%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Post Delivery Sanitary Pads	0.00%	0.00%	0.00%	20.00%	0.00%	0.00%	0.00%	0.00%	30.00%	0.00%	20.00%	30.00%

- Lack of emergency preparedness in most public health facilities and basic necessities including gloves, post-delivery sanitary pads, ambulance facility, under five years vaccine and their storage facility/fridges, lack of proper waste disposal mechanisms.
- Lack of basic requirements including sick bed, inpatient's beds, laboratory and its equipments and reagents.
- Absence of information display charts or insufficient to properly guide patients on services offered and where to get them at the facilities.
- Existing health service information charts lacked in the definition of the Ministry's, core functions, services offered, commitments, obligations, customer's rights and obligations, mechanisms for complaint and redress for any dissatisfied community member.
- The lack of properly trained and well compensated community health workers.
- Exorbitant user fees for tests, drugs, and medical procedures.
- Poverty as another major challenge to access of health services by majority of the population.

C. Proposed Public Health Service Delivery Model and Recommendations

New emerging approach in which citizens actively engages in holding service providers/ leadership accountable for their actions, decisions and behaviour is called Social Accountability (SAc). It is public accountability through civic engagement. Procedures of SAc can be initiated and supported by the county or national government, citizens or both, but very often they are demand-driven and operate from bottom-up.



What is Social Accountability?

Social accountability refers (SAc) to a broad range of actions and mechanisms that citizens, communities, CSOs and independent media can use to hold public servants and public and private service providers accountable.

SAc tools include participatory budgeting, public expenditure tracking, citizens' report cards (CRC), community score cards (CSC), social audits, citizens' charters, people's estimates, and so forth.

These mechanisms are being increasingly recognised world-wide as a means of enhancing democratic governance, improving service delivery and empowering poor.

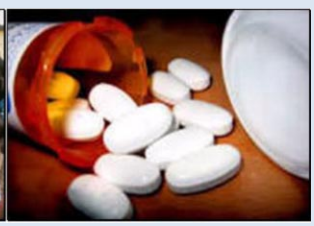
Recommendations

Therefore, in addressing the challenges in the health service delivery at both national and county government, the study recommends a raft of measures to be undertaken by both the national and county governments:

1. The county assembly need to prioritise community involvement in the process of health service delivery through the following actions:
   - County assembly need to develop programme for routine meeting with members of community to educate them on their health rights and responsibilities; gather their views in relation to quality of health service delivery, challenges and in addressing those issues to promote standards of public health service delivery; and to improve the general state of the health facilities.
   - County assembly to set aside minimal resource allocation by county government to facilitate capacity development on good governance and SAc tools to the community and routine implementation of community health report card and health facility monitoring report to keep on check the quality and level of absence of health service. This will provide a rigorous basis and a proactive agenda for communities, civil society organisations or local governments to engage in a dialogue with service providers to improve the delivery of public services.
   - County assembly to develop county-based health service delivery citizen reporting and community monitoring toolkits to help gather community views in relation to public health service delivery to be implemented through the village council and whose reports to be made public and handed directly to county representatives in a community baraza/ forum for appropriate action. This will, therefore, act to enhance performance by health service providers and action on lacking equipments or poor facilities within public health centres.

2. There are several institutions that play a key role in ensuring accountability in the health sector. These institutions are largely involved in providing legislative or operational framework that will ensure the interaction of stakeholders produce positive health outcomes. However, while this is the case, none of these institutions have the mandate to enforce accountability. There is need for the national government to develop a more accountable framework enforcement with mechanisms to ensure greater leaps towards achievement of health-related millennium development goals.

3. In the realisation of the Constitutional provision under Article 43(1)a (2) and (3) on (2) on the health standards' rights, emergency health service provision, and the need for state provision of appropriate social security to persons who are unable to support themselves and their dependants. The national government should undertake the establishment of emergency medical treatment fund to cater to the emergency health needs of the poor. This particular fund should be able to reimburse both the



public and private sector for the emergency health services rendered to the deserving poor.

4. In a bid to deal with the challenge of inaccessibility to quality health services resulting from disparities on income/poverty prevalence across the country, the government needs to undertake radical reform within the existing National Hospital Insurance Fund (NHIF) to become a universal coverage scheme (a single payer system) where population healthcare is publicly funded by national government with both private and public delivery mechanisms. In this case, the national government becomes the primary reimburse (payer) of healthcare services as the county governments take up the primary responsibility of managing, funding, and governing healthcare with funds from national government. The county governments can either serve as the main purchasers of care from providers, or devolve this responsibility to other entities. The national government will, therefore, use the national taxes to reimburse payments of health services through counties. The full medical cover under the proposed universal coverage scheme should prioritise the deserving vulnerable groups of women, children, youths, the old and people with disabilities. This new system will be able to grant the choice to patients visiting public institutions or private physician for health services at predefined cost limits for each individual over time period.

5. While there is increase in the amount of expenditure being allocated to the health sector, this amount is way below the Abuja Declaration target of 15 percent. There is need for a strong advocacy for increased budgetary allocation that meets the 15 percent target. The health sector allocation should match and even surpass the education sector budget. For this to happen there must be political will and commitment both at the county level and national level as has been seen in the education sector.

6. The health sector has a comprehensive budgetary process within the larger budgetary making process in Kenya. The sector allocations by programmes and detailed budget lines are undertaken at the sector working groups. There is need for effective stakeholders' engagement at the development stage of the health sector position paper to influence health sector allocation that positively affects women, children, disabled groups and people living with HIV/AIDs. The position paper presents an analysis of the context, sector performance, achievements and the resource requirements for the health sector.

7. In the health sector, budgetary allocation is highest in the curative and preventive and promotive health sub-programmes. These are the core programmes that deal with the health needs of women, children and PLWHAs. While the government has made tremendous efforts to prioritize the health needs of these groups, there is need to ensure child nutritional needs are catered for. This has not been well addressed in the current 2013/14 budget.

8. The country has moved to a devolved system of government, however, from the programme budget approach, it would be important to disaggregate the health sector budget to what is done by the national and county government. In this way it will be possible to hold the right institution accountable for health outcomes.

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 CUTS Nairobi, Yaya Court, Second Floor, Room No. 5, Ring Road, Kilimani, Nairobi, Kenya. Ph: +254-20-3862149. Fax: +254-20-3862149, E-mail: nairobi@cuts.org, Web: www.cuts-international.org/ARC/Nairobi