Citizen’s Engagement in Health Service Provision in Kenya

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Abstract
Kenya’s form of governance has moved gradually from centralized systems of the 1960s, 70s and 80s to more democratic and decentralized forms. However, challenges still remain for quality citizens’ participation. The participation of other stakeholders in health is recognized by Government in various policy documents. The Kenya Health Policy Framework of 1994, the National Health Sector Strategic Plan (2005-10) and other sector strategic plans for 2008 to 2012 call for strengthened partnerships, including the private sector, civil society organizations and communities. The national Kenya Vision 2030 also calls for strengthened public private partnerships in health provision. This approach is reinforced by the launch of the Community Strategy in health in 2006 that targets to reach about 40 per cent of the Kenyan households in the next four years with focus on the poor. As a result, structures are in place for actively engaging communities, civil society organizations and other stakeholders in health policy discourses. Civil society organizations, that are active in mobilizing communities for participation in development, are signatories to the Code of Conduct that commits them to working within joint sector plans as well as the sector-wide approach structures. The private not for profit and private for profit in Kenya also own and manage about half of all the health facilities and health workers. On the other hand, households contribute close to 40 per cent of the total health expenditure, mostly in the form of out of pocket expenditure – a factor that seriously hinders their access to health services. In order to improve efficiency in delivery of services, the Ministry of Health has developed structures to deliver financial resources direct to rural health
facilities and hospitals, whose management consists of both government, private sector, civil society organizations and community representatives as one mechanism of increasing access to quality and affordable health services. However, there are factors that still limit citizens’ participation in health provision, that include low awareness of their rights; limited decentralization in the management of health facilities; weak referral system within the health delivery system as well as the weak policy, legal and institutional frameworks for health services and commodities - resulting to high costs and inefficiencies in the system.

1. Introduction
The participation of citizens in health provision has been changing in line with socio-political changes that have taken place since independence. These changes have involved a shift from fairly centralized authoritarian systems of the 1960s, 70s and 80s to more democratic and decentralized forms of governance. The launch of the District Focus for Rural Development (DFRD) strategy in 1983 and revised in 1995 was a major attempt towards involving citizens in decision making. The strategy noted that “local people needed to be involved in the decision making, planning and implementation of projects in their areas to enable development to be a self-sustaining process”. This was in recognition that about 80 per cent of the population lives in the rural areas while many were unemployed. The strategy led to the establishment of structures up to lowest administrative unit through which development programmes were to be also planned and implemented. Whereas the intention was commendable, its implementation left a lot to be desired. The biggest weakness of the strategy was that it was not embedded in law. The strategy and its structures are currently under review.
The citizens’ participation in health can be seen in the context of three main avenues, namely: private sector; operations of the civil society organizations and the communities themselves. These segments of stakeholders currently own and manage about 48 per cent of all the health facilities in the country. There are many civil society organizations operating in the health sector in the rural areas but who not necessarily own health facilities but are involved in other forms of community capacity building, mobilization and advocacy.

2. Policy and Legal Framework
The participation of citizens in health provision is anchored in government national and sectoral policy documents and plans. The Kenya Health Policy Framework of 1994 called for an enabling environment to strengthen NGO, Local Authority, Private and Mission sector providers in health. The National Health Sector Strategic Plan I (NHSSP I) recognized the need to improve partnerships. This was followed by seconding of staff to non state actors and later, provision of health commodities to these facilities. This was later reinforced by the NHSSP II (2005-10). The Kenya Vision 2030, which is the current Government’s blue print for transforming the country into “an industrialized, middle income country with a high quality of life by 2030” recognizes the participation of the private sector and other stakeholders as key to meeting national development objectives. Consequently, the strengthening of the public private partnerships in health is identified as one of the priority activities to be undertaken during the period.

Recognizing the role that communities can play in supporting health interventions, more especially, preventive and promotive health services, the Ministry of Health in 1996 launched the Community Strategy. The main objectives of the strategy are to build the capacity of households not only to
demand services from all providers, but to know and progressively realize their rights to equitable, good quality health care. The strategy targets to reach about 40 per cent of the population in the medium term, with focus on the poor.

Faith Based and Civil Society Organizations also play a major in reaching the citizenry at the grassroots level. Therefore creating a conducive environment for their operation is crucial towards achieving the health goals and citizens participation. Towards this end, a Memorandum of Understanding (MoU) was signed in 2009 between the Government and the Faith Based Organizations in health. The MoU provides a framework for collaboration in sharing of resources, policy dialogue and improving access to quality healthcare.

The Ministry of Health is currently working with the private sector and Non-Governmental Organizations towards strengthening the collaboration within the framework of the public private partnerships (PPPs). Already, a number of workshops have been held to identify areas of collaboration, develop guidelines for the collaboration and the appropriate structures.

3. Institutional Framework
The District Focus for Rural Development strategy provides structures for participatory development up to the village level. The Village Health Committee is the lowest unit of involvement for communities at the grassroots. Although the practice of these units has not been uniform across the country, they have shown that they constitute a good mechanism for citizen’s participation. Where they have been effective, it has been observed that there is potential for building capacity to manage community-
based activities as long as they are well linked to other administrative structures; providing community-based information; dialogue based on information, health promotion, disease prevention and simple curative care, especially when community own resource persons (CORPS) are involved. However, the biggest challenge in this approach is the sustainability especially of the community own resource persons who may fall prey to development agents without due regard to community priorities. The issue of level of education and training of community health workers also presents another challenge to effective citizens’ participation in health provision.

Although the structures for Sub-Locational and Divisional Health Committees are provided for in the District for Rural Development strategy, they have not been very active in the health sector in Kenya. The most active structure that promotes citizens participation has been the District Health Stakeholders Forum. The District Health Stakeholders Forum brings together all development practitioners in health in the districts to jointly plan and review progress. They participate in the development and review of Annual Operation Plans with support from the District Health Management Teams (mainly from Government).

The advent of devolved funds in the 2000s has also re-activated citizens’ participation, though not directly related to health alone. These funds include, the Constituency Development Funds (CDF), Local Authorities Transfer Funds (LATF) and Constituency HIV/AIDS funds. The health sector has been receiving the largest proportion of these funds, given the high priority that communities give to health. For instance, over one thousand rural health facilities have been constructed over the last few years through
CDF alone. However, due to poor linkage with the District Health Management Teams, close to half of these facilities still remain unutilized due to lack of personnel to manage them. Efforts are currently underway to recruit additional staff as well as engage with the NGOs and private sector on how to put to use these facilities within the framework of PPPs in health.

At the national level, the structures for the Sector Wide Approach in health also take cognizance of the need to engage with all the stakeholders in policy dialogue, planning and sector review. In this regard, the NGOs, through the Health NGOs Network (Hennet) and the private sector through the Kenya Private Sector Alliance (KEPSA) and Private Hospitals Consortium (PHP) are members of the Health Sector Coordinating Committee (HSCC). The HSCC incorporates membership from all key development partners and government agencies, including Ministry of Finance. Hennet has a membership of 79 countrywide while the sector has almost 2000 NGOs working in the various areas of the health sector – some not active at all. This arrangement is further strengthened through establishment of various Inter-agency Coordinating Committees that report to HSCC, that have even wider involvement, being at technical level.

4. Health Commodities and Resources
The support by Government to health facilities managed by Faith Based Organizations (FBOs) has been going on within the framework of the Health Policy Framework of 1994 and National Health Sector Strategic Plan II, though not on a consistent basis. This is in recognition of the fact that FBOs have a better reach to the grassroots level and in the hard to reach areas. The rural faith based health facilities have been receiving medical kits as well as staff. The FBOs hospitals have also been receiving doctors and nurses and
other key health personnel to assist them reduce their operational costs and maintain efficiency in their services. About 43 per cent of the nurses, 57 per cent of the doctors, 55 per cent of the clinical officers and 74 per cent of the pharmacists and pharmaceutical technologist are found either in the private for profit or private not profit facilities. This demonstrates the important role that the private sector has towards reaching the citizenry in Kenya. With the MoU in place and the Sector Wide approach being implemented, the private sector and other non-state actors will continue to play a greater role in healthcare provision in future.

5. Healthcare Financing

Recent studies on healthcare financing show that out of pocket expenditure constitutes the highest proportion of the total health expenditure. The total out of pocket expenditure in health in Kenya stands at about 35.9 per cent while public expenditure as a proportion of total health expenditure is 29.1 per cent. About 30 per cent of the total health expenditure comes from the development partners. This kind of scenario makes access to health a big problem for the majority of the people below the poverty line that constitute about 45.9 per cent of the population. It has further been established that almost 40 per cent of the people who fall sick during the year do not seek medical care due to the high cost of healthcare. In response to this, Government is implementing a number of reforms geared towards increasing access. These measures include the establishment of the Health Sector Services Fund (HSSF) and Hospital Management Services Fund (HMSF). The main objective of HSSF is to deliver finances for operations direct to the point of use in the dispensaries and health centres. Prior to that, only about 50 per cent of targeted funds could reach these facilities. On the other hand, HMSF is meant to provide a framework for better
management of finances at the hospital level. The management of both of these initiatives includes community members and women representatives to take care of citizen interests. The overall objectives of these initiatives are to give autonomy to facilities to manage their own responsibilities and therefore respond adequately to citizen concerns.

Other measures also being taken include developing a financing strategy that ensures that the poor have access to quality healthcare through either the government providing free healthcare or a fund being created to manage prepaid schemes. The National Hospital Insurance Fund, a national health insurance scheme will play a greater role in this arrangement by receiving funds for covering the poor and other categories of the population either from the government or from the development partners.

At higher levels of public budget preparation, the Government organizes ‘public hearings’ forums through which the members of the public give feedback and propose priorities likely to create impact. These forums can be viewed as avenues through which citizens, Government Officials and other stakeholders come together to exchange information and opinions about budgets before they are finalized. However, the effectiveness of this approach is yet to be evaluated and documented.

6. Health Services Delivery
The effective service delivery for all citizens depends on a proper organization of the healthcare system. In Kenya, the health delivery system is organized in six levels. Level 1 is the Community Level. It consists of using Community-Owned Resource Persons (CORPs) and Community Health Extension Workers in health promotion as well as the household and the
village health committees. Level 2 and 3 consists of primary health services where health promotion and basic treatment services are provided. Only simple diagnostic and short term in-patient services are provided at this level such as maternity and short recuperative observations. Major treatments are offered in Levels 4 and 5 which comprise District and Provincial/Regional General Hospitals which also serve as referral centres for Levels 1, 2 and 3. Level 6 are the national referral and teaching hospitals.

However, given the weaknesses in governance system in Kenya in the 1980s and 90s, the number of facilities increased but which were not meeting the required level of care. This scenario significantly weakened the referral system to the extent that patients could just seek services from the higher levels of care without exhausting the services at lower levels. The result was a breakdown of the referral system with the consequent compromise of the quality of care at the referral levels due to excess demand. For example, Kenyatta National and Referral Hospital in Nairobi (capital city) receives only one per cent of patients on proper referral arrangements. The rest are brought in from around the city and other parts of the country without any prior arrangements. The consequence of this is that most of the patients brought in are those who are unable to pay for services or whose condition has already deteriorated. The quality of services at the hospital has also gone down. It is for this reason that strengthening the referral system is one of the reform areas that Government is focusing on.

7. Pharmaceutical Services
The pharmaceutical sector in Kenya is part of a specialized and highly globalized industry, in which pharmaceutical products, trade, personnel and
services are intrinsically linked in a complex and dynamic matrix of health, economic and political issues; each with national, regional and global dimensions. This multi-dimensional nature encompasses numerous externalities, often conflicting with public health principles for ensuring equitable access to essential medicines. Although the first national drug policy of 1994 realized some achievements, its implementation was constrained by lack of an enabling legal and institutional framework. Consequently, the policy and strategic direction for the pharmaceutical sector has remained weak, with low prioritization in health decision making and failure to address the rapid development and externalities of the sector. Pharmaceutical sector problems have manifested in public sector stock-outs of essential medicines, incidences of counterfeit and substandard medicines in the market, unauthorized dispensing and illegal medicines outlets; and inappropriate medicines utilization leading to resource wastage and poor health outcomes. These challenges hinder universal access to essential medicines to the citizenry. However, Government is currently in the process of developing a new pharmaceutical policy to address these weaknesses.

8. Health Services and Promotion

The efforts on health promotion among the citizenry by both government and other stakeholders have mainly targeted diseases that contribute most to the disease burden and mortality. These include malaria which contributes to almost 33 per cent of morbidity; other respiratory diseases that contribute about 29 per cent and diarrhea and skin diseases that make almost 13 per cent of the total. In this regard, health promotion has tended to target malaria, respiratory diseases, diarrheal and skin ailments, including HIV/AIDS. In particular, malaria and HIV/AIDS promotion have received the highest attention among the public. This can be demonstrated by the
amount of resources being channeled to these areas and the large number of Non-Governmental Organizations as well as Community Based Organizations involved. According to the National Health Accounts of 2005/06, HIV/AIDS spending as a proportion of total health expenditure was 17.4 per cent, with about 70 per cent of it from the development partners. The main focus of interventions has been on community campaigns through public education/meetings, media materials, distribution of condoms and Voluntary Counseling and Testing (VCT). However, for those already infected, the focus has been to improve access to anti-retroviral therapy. There are currently over 300,000 people on anti-retroviral therapy.

The provision of quality healthcare beyond the health facility has also become an important component in the provision of HIV/AIDS care and support. This entails the continuation of care from the health facility to the home level, while maintaining the required standard of care. The introduction of ART to the management of HIV positive patients further stresses the importance of Home Based Care to ensure adherence to therapy and close supervision for any adverse effects to treatment. The citizenry therefore ensures successful implementation of comprehensive management of HIV/AIDS cases. Peer education among the people has also played an important role in the control and spread of HIV/AIDS. This has been enhanced through greater awareness being created to provide the right information and remove the stigma often associated with the disease. In order to achieve this objective, the HIV/AIDS programmes have focused on school-based AIDS education for youth; education sex workers, injecting drug users and most other most at risk populations.

9. Conclusion
Major efforts have been made in Kenya to strengthen citizens’ participation in development, including health provision. This has been done through various policies, strategies and programmes. However, the results have been mixed with development interventions still fairly centralized. In particular, the District Focus for Rural Development failed to make a significant impact due to the politicization of its implementation and failure to anchor in the law. Recent approaches and strategies are slowly reversing this and increasing citizens’ participation. Devolved funds are some of these examples. The launch of Community Strategy, the facility based financing approaches (HSSF and HMSF) and broad stakeholders’ involvement in health provision are also improving citizens’ participation. Finally, it is clear that while decentralization of power and services is necessary to make citizen participation in local governance meaningful, it is not sufficient to ensure real participation or accountability. Decentralized administrations can be as bureaucratic as centralized administration.
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