Engaging communities: An approach to strengthen health systems in Kenya

Timona Chore[1]*

[1]*Strathmore University Law School, Nairobi, Kenya*

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Abstract

In traditional Africa, there were lower preventable burdens of diseases and mortality because health was viewed collectively by the community. Therefore, community members worked collaboratively to prevent and manage diseases. However, a large proportion of sub-Saharan countries today, including Kenya, bear one of the highest preventable burdens of diseases and mortality in the world. Community engagement initiatives can be used as an effective means for addressing the determinants of diseases and mortality. This is best achieved through people's active participation, especially at the community level. The aim of this paper is to stimulate debate on the significant role played by community engagement in strengthening health systems. The paper argues that communities should be an integral part of health systems and proposes that community engagement should be a subject of mainstream concern, a staple discussion in national and subnational government levels, academic forums and with policy makers. The paper will realize its objectives through literature review and a case study on the community engagement activities of the Maternal and New born Improvement project (MANI). Kenya has some of the highest rates of maternal and new born mortality in the world. Thus, the MANI project supported by the Department for International Development is working with the Bungoma county government to strengthen the local health system and increase survival of mothers and new borns in the county. Through the case study, the paper assesses the efficacy of community engagement in strengthening health systems by evaluating the impact of the projects' community engagement activities on the health system.

Introduction

Public health issues comprehensively include all manner of diseases such as: chronic diseases (for example: cancer, obesity and diabetes), communicable disease, maternal and neonatal health etcetera. These health issues in any community are influenced by the physical, social and economic environments in which people live.

Health systems are charged with the responsibility of promoting overall community health and well-being, by addressing the determinants of diseases and mortality. To achieve this, health systems need to work hand in hand with communities by involving and engaging communities when formulating and developing initiatives aimed at solving comprehensive health issues bedevilling people in a community.

The communities should not only be engaged in formulating the initiatives but also participate in the initiatives. Questions arise as to why this is important and how this can be achieved?

A ‘community’ includes individuals, groups, organizations and associations or informal networks that share common characteristics and interests based on place, issues, or identity-based factors. These communities often have similar concerns, which can be shared with the health facilities to help create more relevant and effective health programs. (Morgan & Lifshay, 2006).

A healthy community has well-connected, interdependent sectors that share responsibility for recognizing and resolving problems and enhancing its well-being. Successfully addressing a community’s complex problems requires integration, collaboration, and coordination of resources from all parts. (Thompson et al, 1990) From a systems perspective, then, collaboration is a logical approach to health improvement.

According to the CDC, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is moreover, a powerful vehicle for bringing about environmental and behavioural changes that will improve the health of the community and its members.

It often involves partnerships and coalitions between health service providers and communities , and serves as a catalyst for changing policies, programs, and practices. (CDC, 1997). In general, the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations (CDC, 1997; Shore, 2006; Wallerstein, 2002)

Community engagement involves dynamic relationships and dialogue between community members and health facility staff, with varying degrees of community and health department involvement, decision-making and control. (Morgan & Lifshay, 2006). In public health, community engagement refers to efforts that promote a mutual exchange of information, ideas and resources between community members and the health department.

While the health department shares its health expertise, services and other resources with the community through this process, the community can share its own knowlegde and experiences to help guide public health program efforts. (Morgan & Lifshay, 2006).

Renowned health organizations around the world, including the World Health Organization (WHO), have taken cognizance of the importance of community engagement in improving healthcare. This elucidates why WHO has conducted extensive research on community engagement and has moreover formulated a series of policies, strategies and frameworks on the same. (WHO, n.d.)

The Centers for Disease Control and Prevention (CDC) includes numerous community engagement activities as part of essential public health services. These community engage activities as noted from the essential public health services from the CDC include: Informing, educating and empowering people about health issues and mobilizing community partnerships and actions to identify and solve health problems. (CDC, n.d.)

Community engagement is not a new strategy in public health. It has played an important role in the field over the last century, originating in traditional public health practice and evolving in response to changing population health issues and the need to develop additional strategies to address them. (Morgan & Lifshay, 2006).

When chronic diseases emerged as the leading cause of death in the 1950s, public health experts recognized that social and environmental factors strongly influenced the development of these conditions. Health facilities then started to involve community stakeholders in developing broader solutions to address both behavioural and environmental risk factors associated with these diseases. (Morgan & Lifshay, 2006).

In the early 20th century, public health experts took the lead in determining the priority health issues and solutions. At that time, public health used community engagement strategies primarily to control communicable diseases by mobilizing people to participate in mass immunization, sanitation and hygiene programs. (Morgan & Lifshay, 2006).

There is evidence to show that community participation in health service delivery and health care leads to improved health outcomes within that community. For instance, in the United States of America (USA), specifically the state of California, after the passage of California's Proposition 99 Tobacco Tax in 1988, which provided funding for health departments to go further in their efforts, forming coalitions and mobilizing communities to organize and advocate for policies to prevent tobacco use.

These activities led to environmental and public health protective policies, changed community and social norms about smoking, and decreased smoking rates across the country. (Morgan & Lifshay, 2006).

In Kenya, Kakamega specifically, a small-scale subnational community health pilot programme was launched with community mobilisation being a key intervention. The local community was assisted by a Non-Governmental organization to identify their own problems, collect their own data, and implement their own solutions (Rosato et al., 2008).

The pilot programme was successful as it achieved improvements in primary health care, immunisation, water supplies, family planning, and malaria control. It also increased community support and self-reliance. (Rosato et al., 2008)

Though community engagement as established from international world health organizations and studies is essential in promoting healthcare. The Kenyan government even after formulating a community health policy and framework, has not made any effort to implement it.

The policy and framework is instead being implemented and used by Non-Governmental Organisation, as the government has not even set aside a budget for its implementation. The main objective of this paper it to show the importance of community engagement in improving healthcare with the aim of showing the need for the Kenyan government to budget for and implement its community health policy and framework.

Methodology: case study

Overview

While improvements have been made in recent years, maternal and infant mortality rates in Kenya remain unacceptably high; 362 maternal deaths out of every 100,000 live births, and 39 infant deaths out of every 1,000 live births (Kenya Demographic Health Survey, 2014). It is estimated that 7,700 Kenyan women die each year because of pregnancy related causes.

This translates to approximately 21 women every day and almost one Kenyan woman per hour. Bungoma County lies far behind the national average for the uptake of maternal and new born health services. Only 41 percent of births in Bungoma are conducted by a skilled attendant, compared to the national average of 62 percent. Bungoma is ranked 43rd out of the 47 counties in Kenya for skilled birth attendance (KDHS, 2014).

With support from the United Kingdom Department of International Development (UK AID), the Maternal and New-born Improvement (MANI) project is working with the Bungoma County Health Management Team (CHMT) to strengthen core health systems and increase survival of mothers and new-borns in the county.

Technical assistance is being provided across three core areas: strengthening health systems to manage and deliver quality Maternal and New-born Health (MNH) services, focusing on health planning, governance and leadership; working at the community level to increase demand for uptake of MNH services for mothers and new-borns and leading the County Innovation Challenge Fund (CHIF) to provide funding for innovative projects, which offer local solutions to local problems in reducing maternal and new-born mortality. (MANI, 2016)

The MANI project through a series of community health initiatives has reduced the maternal mortality rate in Bungoma county. The aim of the case study is to show the importance of such community initiatives in improving healthcare in communities and strengthening health systems.

Approach

There are various mechanisms of approaching community engagement. The foremost is outreach which is essentially a one-way communication channel where community members are basically informed on matters concerning healthcare. For example: community health education and sensitization.

The subsequent one is consultations which is a two-way communication channel whereby information flows to the community which in turn gives feedback based on the information availed. Involvement is also another mechanism of community engagement which is identical to consultations but encompasses more participation by the community on healthcare issues.

Collaboration is a mechanism of community engagement whereby communication is bidirectional and there is a multi-way dialogue between the community and health service providers. In this mechanism the community is involved in decision making and forms partnerships with health service providers with the aim of solving various health problems. The community is further involved in every step and aspect of the problem-solving process.

The community health initiatives used by the MANI project apply the above approaches to community engagement.

Community health initiatives

Community scorecard

In Bungoma county, Kenya, the percentage of women who deliver their babies in health facilities is lower than the national average. Reasons for this include long waiting times at health facilities, disrespect and abuse from health providers, shortage of staff, inadequate facilities, and fees for services which should be free.

MANI is using a Community Score Card (CSC) approach to improve relations between the diverse members of the community who are the service users and the health facility staff who are the service providers. This process reinforces and complements other strands of the MANI project, and provides a forum for service users and providers to talk about their experiences with health services. (MANI, 2017)

The CSC is a social accountability approach designed by CARE, and used to monitor the availability, access and quality of public services. The CSC process provides a framework for discussion and negotiation between community members, service providers, and local officials, who then develop specific actions to address identified concerns or issues.

The CSC consists of five phases: planning and preparation, conducting the score card with the community, conducting the score card with service providers, interface meeting and action planning, and implementation and monitoring. (CARE, 2013)

The first phase involves identification of the community targeted, mobilizing them for a meeting and sensitizing them on scorecard and what is all about. In the second phase the selected groups in the community are engaged in identifying issues in relation to the services offered through focused group discussions.

The several score cards generated from the focused group discussions are then consolidated to produce a single scorecard by the entire group. The issues identified are then used to develop indicators of which the community members score based on the services offered and reasons for scoring. The same process is also conducted with health service providers (nurses, doctors, clinical officers, facility in-charges etcetera). (CARE, 2013)

The fourth phase is a meeting which involves representation from the community and health service providers to discuss the scorecards generated from both the community and the health service providers and generate an action plan based on the indicators scored both at the community and health service provider level. In the last phase a task force is selected from both the community and health service providers to monitor and do follow ups on the various issues raised during previous phases. (CARE, 2013)

Below is a sample of the CSC in a health facility in Bungoma county.

Improving Accountability at Tongaren Model Health Centre

Tongaren Model Health Centre was among the first group of facilities to participate in the CSC process in 2016. The CSC is good opportunity to identify challenges that hinder service utilization by the community and service provision by health facility and finally come up with solutions to the challenges faced by both the facility and the community. The table shows the key issues that were raised by the community and the facility during the CSC process in 2016 and 2017. (MANI, 2017)

Theme[1]	Community score		Facility score	
	2016	2017	2016	2017
Low uptake of 4th ANC visit			3	4
Staff shortage	2	3	2	3
Lack of health education	2	5	4	5
Lack of male involvement			2	3
Delayed maternity reimbursement			1	2
Lack of lab equipment			2	4
Poor referral systems			1	5
Privacy	1	5		
Shortage of non-pharmaceutical items [2]	1	1	2	4
Attitude of health providers	1	3		
Long queues	2	3		
Charging for services that should be free	2	3		

Figure extracted from MANI learning series 2017 on the community scorecard.

Participants use a scale of 1-5, with 1 being very bad, and 5 being very good. The community and facility had some issues which were common, and some which were not. The interface meeting provides a unique space for a two-way dialogue.

It's beneficial for the community members as they get to hear the challenges the facility faces like delayed payments from the county government to the facility or delayed delivery of medicine by the Kenya Medical Supplies Authority. (MANI, 2017).

Below are images of charts used in the CSC.

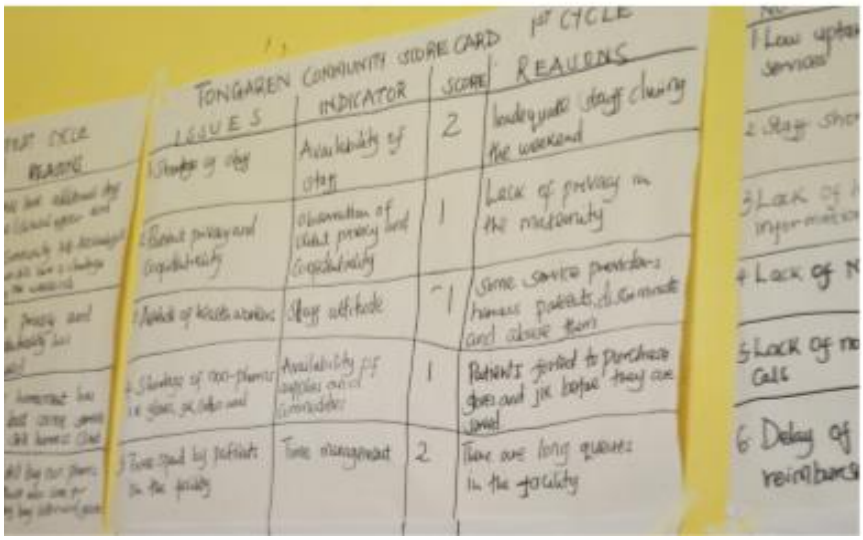

Figure extracted from MANI learning series 2017 on the community scorecard.

As a result of the CSC process, many concrete actions were taken in between the first and second cycles at the Tongaren Model Health Centre. Most notably:

1) New staff hired: staff shortage was a big problem discussed in the first round. The facility had only nine nurses, instead of the 20 required for such a big catchment area. Since the first CSC, they have hired one clinical officer and one lab technician. Shortage of staff is still a big challenge, but both the community and facility noted the progress.
2) Uptake of services has improved: The facility staff reported that more women are visiting the facility now that they have a new lab technician. This means lab tests can be done more promptly.
3) More health education sessions: prior to the first CSC there was a lack of community health education. Now health education sessions take place each morning for the community.
4) Improved emergency referrals: emergency ambulance services should be free for maternity patients, but due to poor ambulance coordination and fuel allocation sometimes patients are asked to pay. The Tongaren Model Health Centre now ensures that fuel is available so that no maternity patient has to pay for ambulance services in an emergency. Fees for other ambulance services are clearly displayed
5) Privacy: another area of improvement was on the issue of privacy. During the interface meeting in June 2017, community members and facility staff spoke positively about the changes that have taken place in the maternity ward since the first CSC meeting in 2016. Mothers described the lack of privacy they experienced in the old maternity ward. Everything was open, with no private space, and with male casuals passing through the labour room when women were labouring. (MANI, 2017)

The CSC is a great tool for the facility management and board to use to monitor progress and also to escalate issues with the Ministry of Health.

Birth companions

The term 'TBA' refers to traditional, independent, community-based providers of care during pregnancy, childbirth and post-natal period. TBAs generally use skills learned from relatives and friends and not based on any medical training. Across Bungoma County, pregnant women have typically enlisted the help of traditional birth attendants (TBAs) to deliver their babies at home instead of going to a health facility.

Women's reasons for using a TBA for home delivery, rather than going to a health facility, are varied. Some say TBAs are familiar, known to them and from their own communities. Others say TBAs are available and accessible at all times, whereas health facilities can be far away or closed at night. Other pregnant women, particularly teenage mothers-to-be, say health facility workers are unfriendly or rough with them. (MANI, 2017)

However, due to high maternal mortality rates, the government of Kenya actively discourages home births with unskilled providers and has even passed legislation criminalising such activities.

The dangers of home delivery in other words unskilled delivery include but are not limited to: exposing mothers and new-borns to infection of HIV&AIDS, it can lead to the death of the mother or new-born when the mother suffers from high blood pressure or due to excessive bleeding after birth.

There also some birth complications such as premature births and situations where the baby comes out from the wrong position which will need immediate operative care, which the TBAs cannot perform. Home hygiene is also not appropriate for delivery.

The MANI project has changed this by reorienting TBAs to become 'birth companions' by increasing their knowledge and skills through training, giving them a role in referring and accompanying women to nearby facilities, and providing pregnant women with a mix of the personal and professional care that they need and want. (MANI, 2017)

The MANI project has engaged and collaborated with TBAs, who are part of the local community, rather than marginalising them. MANI has reoriented 200 TBAs to become birth companions (BCs) who refer and accompany pregnant women to health facilities and provide MNH support and education before and after birth. The BC training covers:

1) The status of MNH (Maternal and Neonatal Health) in the local area - why mothers and babies will have better outcomes at health facilities with skilled providers
2) MNH services available and how BCs can link women to these services
3) How to promote household MNH practices such as good nutrition, supplementation and hygiene
4) Basic MNH skills such as: keeping the baby warm using Kangaroo baby care, instructing mothers to position and attach the baby on the breast, proper hand washing procedures and cord-cleaning.
5) Basic communication, advocacy and networking skills. (MANI, 2017)

Although BCs face a loss of income from home deliveries, they are mostly positive about the training they have received and their new role. Since delivering babies at home is discouraged, TBAs' services were in demand, but they had to hide what they were doing. Currently, the MANI project has provided branded shirts and identification for BCs, bringing them and their work out in the open.

Thanks to meetings between MANI, BCs and health facilities, there is now an understanding and acceptance of the role of BCs by the formal health system. MANI is also piloting a Village Savings and Loan (VSLA) model with BCs, a microfinance initiative developed 25 years ago by CARE and replicated across the world. With capacity-building from MANI, BCs will engage in group savings and loans, with a view to starting small business ventures to replace lost income from their work as TBAs. (MANI, 2017)

BCs have embraced their role and the MANI project is tracking the number of referrals made by BCs each quarter. In the first six months of 2016, BCs referred 1,738 women to health facilities to give birth. (MANI, 2017)

Community health volunteers

MANI is working throughout Bungoma county in western Kenya to educate communities and increase use of health services through strengthening community units, which increase women's awareness of their rights to access health services, such as free maternity care and the National Hospital Insurance Fund (NHIF).

The community health awareness is geared towards educating and promoting knowledge of danger signs in pregnancy and labour and encouraging women and their families to seek both routine and emergency maternal and new-born health care. Since July 2015 the project has trained 100 Community Health Extension Workers (CHEW) who in turn trained 520 Community Health Volunteers on Community Based Maternal and New-Born care (CBMNH). (MANI, 2016)

The CBMNH module equips the CHVs with knowledge and skills to create demand and use of maternal and new-born health services. MANI has also trained CHEWs and CHVs on social analysis and action, a method that opens up dialogue and supports communities in exploring the social and cultural barriers that prevent women accessing and using maternal and new-born health services.

These community health volunteers are reaching thousands of people across six sub-counties in Bungoma. Between October 2015 and January 2016, 6,000 people attended dialogues at 50 community units. The MANI project is also reaching out to communities by training participatory education theatre groups in maternal and new-born health. (MANI, 2016).

Transport subsidy

For millions of people across Africa, access to health care services remains a challenge. In a recent report by the World Bank and World Health Organization on tracking universal health coverage, it was estimated that at least 400 million people worldwide lack access to one of

seven essential services for Millennium Development Goal priority areas (WHO and World Bank, 2015).

Access is affected by factors such as shortages in health personnel or medicines. Large distances to health facilities, difficult terrain and lack of transportation. In Sub-Sahara Africa, over 70% of people live in rural areas, where roads are in most instances not in a good condition with most being dirt roads. (World Bank, 2015).

The problem of inadequate transport infrastructure is particularly burdensome to health systems in Sub-Sahara Africa as the delivery of healthcare in remote areas has become challenging. Many patients have to travel long distances and sometimes through difficult terrain, to access health services.

Moreover, due to high poverty levels, many households cannot afford the cost of transport to health facilities. Consequently, these has detrimental effects on pre-natal and maternal health. (Parkhurst & Ssengooba, 2009: Rutherford, Mulholland & Hill, 2010).

Many of the reasons for the high number of maternal and neonatal deaths are related to challenges in accessing facility-based services, such as women's lack of power in decision making, relatively high costs of transport to health facilities, and long distances to the nearest health facility.

Affordable transport has been identified as a key obstacle for poor women in Bungoma in accessing maternal and new-born services. In collaboration with the local communities in Bungoma county, the MANI project came up with a transport subsidy programme.

Where the local communities provide a means of transport and MANI provides support to those who cannot afford to raise their transport. This is achieved through a voucher scheme, in which pregnant women who would otherwise not afford transportation are given a transport voucher for facility delivery. (MANI, 2018)

With support of the MANI project, community health volunteers register local transport providers and identify poor women to receive a transport voucher. When they are due to deliver, the mother contacts a registered driver who takes her to the nearest health facility.

The health worker records the voucher and, once verified, MANI sends a mobile money payment to the transporter. The transporters are available 24 hours a day, seven days a week. In using local transport, such as boda bodas, communities are leveraging their own resources to save the lives of women and their babies. (MANI, 2018)

Findings

For countries to reach the goal of universal health coverage, it is essential to regularly assess health systems to identify and tackle existing capacity gaps that will enable stronger, more efficient and equitable service provision. Measuring systemic change in health systems can be challenging, and as such, can oftent be overlooked.

Building this into programming from the onset is key. Having a robust set of baseline data provides a snapshot of where the system is, and highlights where prioritisation should be given. (MANI, 2018)

The Maternal and Newborn Improvement (MANI) project uses an Organisational Capacity Assessment (OCA) to assess the capacity of the county and subcounty health management teams (CHMT & SCHMT) to manage and deliver high quality and accessible health services for all. An OCA is a method used to assess the capacity of an organisation.

Mannion Daniels designed and adapted an OCA for use in guiding health programming and planning in Bungoma County. The adapted OCA is an Excel-based tool and draws its framework from the six WHO building blocks. Utilised for the dual purpose of advocacy and planning, the OCA empowers decision makers and programme implementers to prioritise the most critical interventions necessary for improved service delivery.

Tracking progress over time also provides quantitative documentation of improvements in health system capacity**.** (MANI, 2018).

The figure below shows county level health system improvements across three years of the MANI project.

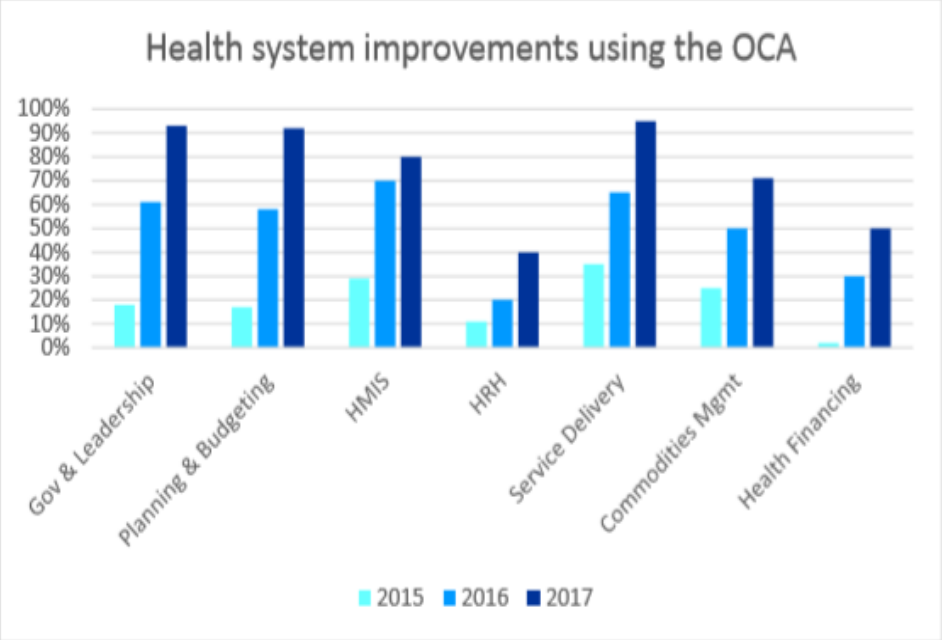

Figure extracted from MANI learning series 2017, on Measuring Health System Changes: Spotlight on Bungoma County.

It is evident from the above OCA assessment that there have been improvements in health service delivery over the 3 years. Moreover, it is also evident that health system is strengthened and becomes better from one year to another. This can be attributed to MANI's community health initiatives which have played a critical role in leading to the above results and are at the core of MANI's operations.

Conclusion

From the above case study, it can be concluded that community engagement can strengthen health systems and lead to improvements in healthcare delivery. Hence the government of Kenya should include a budget for community health initiatives and implement it existing community health policy and framework. This can go a long way in improving healthcare access especially in rural areas in Kenya.

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