PARTICIPATION IN RURAL HEALTH DEVELOPMENT: A CASE STUDY IN KENYA

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The London School of Economics and Political Science
University of London
as a thesis for the degree of
Doctor of Philosophy
in the Department of Social Policy and Administration
December 1996

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ACKNOWLEDGMENT

There are numerous institutions and individuals to thank for their support. The African Medical and Research Foundation (AMREF) provided financial sponsorship and leave of absence to undertake the fieldwork research. The Save the Children Fund (UK) allowed me the time to finalise the dissertation. The Maua Methodist Hospital allowed me access to research their community-based health care programme. Government of Kenya local administration officials in Igembe Division cooperated in every possible way.

It is not possible to name all the individuals who provided various forms of support and assistance over the period of this research study. However, I would be re-miss if I did not acknowledge the following people: the late Sir Michael Wood and Dr Christopher Wood of AMREF, Sr Margaret Bailey at the Community Health Department of the Maua Methodist Hospital, Charles Mwiti who assisted with translation, Nyambura Githagui, Eban Taban, Jared Onyango and David Njoroge, former colleagues at AMREF. A very special thanks goes to Dr Erik Nordberg and particularly Helena Dalton for their friendship and invaluable support in enabling me to finalise the dissertation, and to my three children - Tiffany, Teresa and Chania for their patience, love and understanding. I am greatly indebted to my advisor, the late Professor Brian Abel-Smith for the guidance and encouragement he gave me over the years. Finally I would like to thank the good people of Igembe Division who shared their views and opinions with me and made me feel welcomed in their remarkable land.

ABSTRACT

Achieving active participation of community members in community-based health care programmes (CBHC) is a challenging and complex task. It is also a criterion for successful programming and is promoted as a universal truth and requirement for primary health care development. Nevertheless, most CBHC programmes admit that more needs to be done to achieve satisfactory levels of community involvement. Thus, a better understanding is required as to why success in community involvement has been in most part, elusive.

The thesis uses a historical perspective to examine the emergence of participation in the period prior to and during the community development era in Africa and the post-independent period in Kenya. The emergence of participation and it's progression as an international health strategy in the 1980's and 1990's within WHO, a leading international organisation promoting community involvement in health is critically examined. At the community level, people's perception and understanding of community participation and an analysis of how they participated in the case study CBHC programme provided an operational assessment of community participation. A particular focus was community contributions as a mechanism of participation.

Thus, the primary aim of this thesis was to examine in rural Kenya the socio-economic and institutional support factors which can potentially enhance or limit participation of community members in rural community-based health development programmes. The main socio-economic factors examined were education, income, group membership and domestic factors such as harmony in the household and women's time. The roles of local structures and support personnel such as community health volunteers (CHVs), health committee members (HCMs) and local leaders in promoting participation were also analysed. The method used was interviews with a sample of these respondents.

Based on the case study research results, the thesis draws conclusions on the factors that appear to be most significant in relation to community participation. The importance of

education, group membership and regular monthly visits by CHVs were identified as particularly significant factors. A more informed understanding of these relationships will enable health planners in designing integrated programme strategies which can help promote broader community participation in health development programmes. An awareness of these factors and their inter-relationships by operational-level health staff will enable them to enhance community participation when developing and implementing community-based health care programmes.

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ABBREVIATIONS

CBHC	Community-Based Health Care
CHD	Community Health Department
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CIH	Community Involvement in Health
DDCs	District Development Committees
ECN	Enrolled Community Nurse
EPI	Expanded Program on Immunization
FAO	Food and Agricultural Organization
GOK	Government of Kenya
HCMs	Health Committee Members
HFA	Health For All
IHC	Igembe Health Council
ILO	International Labour Organization
IRH/FP	Integrated Rural Health/Family Planning
MCH/FP	Maternal and Child Health/Family Planning
NGO	Non-Government Organisation
PHC	Primary Health Care
RHTCs	Rural Health Training Centres
RHU	Rural Health Unit
SIDA	Swedish International Development Authority
SRDP	Special Rural Development Project

TBAs	Traditional Birth Attendants
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
VHWs	Volunteer Health Workers
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

The objective of the research is to examine the determinants of participation of community members in a rural community-based health care programme in Kenya. This is done in order to draw conclusions on the key factors which can be developed, strengthened, and addressed by community leaders, government and non-government health officials to enhance individual and community participation in such programmes in Kenya, and possibly elsewhere in Eastern Africa.

This study examined the nature and extent of participation in one of the long standing community-based health care (CBHC) programmes in Kenya and the factors that influenced it. The proposition is that community participation can only be enhanced and sustained if an integrated approach to development which addresses the key factors that influence the participation of community members in health development programmes, is taken. Moreover, it is essential that priority is given to addressing those key factors which help to solidly establish the basic levels of participation. These will form the building blocks for involvement in other programme activities such as evaluation and future planning, and address other issues such as sustainability.

Securing the participation of individuals in development activities and services which are being offered is a vital step in building a base for sustainable participation and establishing a framework for group and community participation. Individual participation in utilisation of services also means a change in health behaviour as a result of community health education, health advice and home visiting services provided by the community representatives of the CBHC programmes. Without utilisation of services and facilities which are provided, further participation is unlikely to occur (PAHO 1984, p.xi).

EARLY DEVELOPMENT OF CBHC IN KENYA

The CBHC approach strives for more delegation of responsibility for health promotion, better balance between curative and preventive health care, more voluntarist input into

the system, increased awareness and sensitization and better cross-disciplinary integration (Shaffer, 1983, p.i). Many of the CBHC programmes which were started in the late 1970's and early 1980's in Eastern Africa did not involve the communities in their design or in the programme planning process to any great extent. Programme design was undertaken primarily by planners within non-governmental organisations (NGOs) or by church mission health staff. They assumed that communities would be interested in the activities and services, mainly mobile maternal and child health/family planning (MCH/FP) clinics, being offered and in having one of their villagers trained as a community health volunteer (CHV). Many of the programmes were externally funded, there was therefore little need for cost-sharing with the concerned communities.

The evolution of many CBHC programmes in Kenya during the late 1970's and early 1980's, can be characterised in the following way:

i) The CBHC programme idea originated mainly with NGO or church mission health service staff based on the realisation that hospital-based curative care was having little impact on improving the health status of community members and as a result of the influence of the WHO/UNICEF-sponsored Alma Ata PHC Conference in 1978.
ii) Communities were selected by the respective programme staff for initiation of a CBHC programme and the idea was presented to local administration officials and local leaders, and then to the communities whose cooperation was sought to participate in the scheme.
iii) Participation consisted mainly of selecting community members as CHVs and health committee members (HCMs), utilising the mobile outreach MCH/FP services being provided, selective behavioural change mainly related to hygiene and sanitation and based on home visiting by CHVs, and, making contributions in labour and materials to the programme mainly for construction of simple health facilities and equipment.

The participation by community members in planning programmes and decisions regarding how the programme activities were to be provided was the exception rather than the rule. This level of participation, however, is the essence of what the World Health Organization described as community involvement in health (CIH), stated as, "..a process by which

partnership is established between government and local communities in the planning, implementation and utilization of health activities in order to increase benefit from self-reliance and social control over the health infrastructure, technology and process." (WHO 1985, p. 4).

Community participation in relation to planning and decision-making of CBHC programmes is an evolutionary process and has lagged behind the initial development of CBHC programmes in Africa. NGOs have elicited at best the cooperation of the communities when initiating the programmes in which the communities were to participate. Thus, programmes have too often been initiated for rather than with communities. This is not a criticism of NGOs or church mission organisations who have been at the forefront of the development of CBHC programmes in Eastern Africa. Usually, only few if any local structures were in place which the programme planners could have involved in planning the activities. Those that were, might not have been known to the health personnel who had little experience in dealing with communities. Little inter-sectoral collaboration existed so the experiences and knowledge of community development workers or other extension workers regarding local structures and community dynamics might not have been known to health workers.

Based on a comparative analysis of community participation in health programmes in Latin America, Ugalde (1985, p. 49-50) contends that local community participation programmes organised by private groups such as universities, churches or foundations could be effective as a means to decentralise, to resolve some immediate health problems, to improve the utilisation of services, and create social and political awareness. The CBHC programmes which emerged in Kenya during the late 1970's and early 1980's had the potential to effectively address these same issues. Based on a detailed and critical discussion of community-based health care in East Africa during the ten years since Alma Ata, Mburu (1989, p.1076) claimed however, that "Much ideal typical rhetoric is heard about the essence of community involvement and participation, but little evidence of sustained participation is found in most of the PHC projects which are spread out widely in Africa".

PARTICIPATION AS A DEVELOPMENT STRATEGY

Since the focus of this research study is participation by community members in rural health development, it is important to examine how community participation as a development strategy was perceived, understood and interpreted. Historically, during the 1970's, the participation of the poor in rural development became a major concern for UN agencies such as ILO, WHO, FAO, and UNICEF (Oakley and Marsden 1985). The United Nations Research Institute for Social Development (UNRISD) devoted a major branch of its research work to a Popular Participation Programme in the 1970's (Stifel and Pearse 1982; UNRISD 1983). In 1976 the ILO sponsored World Employment Conference identified the issue of "basic needs" and the crucial role of participation in such a strategy (Curtis et al 1978). ILO's assistance to rural workers' organisations to bring about effective participation has been an important programme for many years. The World Conference on Agrarian Reform and Rural Development (WCARRD), held at FAO Headquarters, Rome, in July 1979, highlighted people's participation in the institutions and systems which govern their lives as a basic human right (Ghonemy 1984). In 1978 the WHO/UNICEF Alma Ata Conference similarly stressed the importance of `participation' in extending primary health care (PHC) and Health for All (HFA) by the year 2000 (WHO/UNICEF 1978). A decade later the World Bank recognised the role of community participation in development planning and project management (Bamberger 1988). In the early 1980's, following the Alma Ata Conference, UNICEF was also promoting the concept of community participation (Mandl 1982). In the late 1980's, the World Bank also undertook a study of the experience of the World Bank projects with community participation in the urban housing, health and irrigation sectors (Paul 1987). Outside the UN agencies during the same period, the promotion of participation became a major plank for non-governmental organisations led by the Christian Medical Commission, the African Medical and Research Foundation, and International Institute for Rural Reconstruction, among others.

There is now a vast literature on the concept of participation in relation to rural and social development (Lele 1975; Cohen and Uphoff 1980; Korten and Alfonso 1983; Midgley

1989: Oakley 1989). Over the past decade it appears that consensus has evolved that participation is a necessary condition for the meaningful expansion of a people's ability to manage their affairs, control their environment and improve their welfare (Seeley et al 1992, p.1089).

In the context of rural development, participation is concerned with how to bring about some meaningful involvement in development on the part of those who live in rural areas and who depend upon the rural sector for their livelihood. In general terms, participation can be seen as,

> "...a means for the widening and redistribution of opportunities to take part in societal decision-making, in contributing to development and in benefitting from its fruits." (Oakley and Dillon 1985, p. 1).

Participation can also mean getting involved or being allowed to become involved in the delivery of a service or the evaluation of a service, or even to become one of a number of people consulted on an issue or a matter (Brownlea 1987, p. 605). Simply put, to participate is to be a party to or a part of some common venture (Shaffer, 1991, p. 73). But true participation is not a simple affair. For instance, Brownlea (1987, p. 607) warns that we must recognise that some people are not even interested in participating. They simply want to get on with living, or doing what they have been doing for a long time, and are much more accepting of things as they are and feel that they have already delegated the decision-making role to others and are quite happy to leave it to them.

Participation has been advocated not only because it facilitates social service delivery by lowering costs and smoothing implementation but because it fosters a sense of belonging and the integration of communities (Midgley 1986, p. 34). The objective of participation can range from economic and practical concerns associated with project efficiency, relevance and cost recovery to political aims of equality and empowerment (Asthana 1989, p. 13). Participation can be perceived also as an indicator of successful development.

In a attempt to bring some reality to the rhetoric over what participation actually means, various authors have focused on defining participation by how it occurs or operates in practice. Cohen and Uphoff (1980) stress that participation is not a single phenomenon, and outline four types of participation: (1) participation in decision-making; (2) participation in implementation; (3) participation in benefits and; (4) participation in evaluation (Winch et al 1992, p. 344). Rifkin (1988, p.933) stated that there are three characteristics of participation which are that it must be active, involve choice and must have the possibility of being effective. She contends that the mere receiving of services does not constitute participation. An important question is then whether utilisation of services and facilities has the same interpretation of participation as does receiving services. If so, it then appears that it does not even qualify as a first level of participation to some analysts.

A study undertaken for the UN Panel on People's Participation in 1982 reviewed the practice of participation in both the government and non-government sectors of rural development and suggested four different forms of participation:

(1) Participation as Collaboration or Cooperation: whereby rural people are informed of rural development programmes and projects and their collaboration and cooperation is sought. Participation, therefore, is in activities and on terms over which the people themselves have no direct control;

(2) Participation through Organization: whereby organisations are set up which ostensibly have the objective of facilitating participation. The equating of a lack of participation with a lack of organisation is a common argument and therefore, organisations are introduced to provide the vehicle for this participation;

(3) Participation in Community Development Activities: whereby the direct and active involvement of local people is sought to undertake and complete a whole range of physical improvements at the community level. In these tasks the local people have a meaningful say in their planning and execution, but the dynamic of participation is limited to the task at hand and is not normally concerned with building the means to sustain the dynamic after the completion of the physical improvements;

(4) Participation as a Process of Empowering: whereby a group of people who previously had no basis from which to intervene in or influence rural development activities, achieve this basis and use it for their continued involvement in these activities. The approach of this process is educational and the building up of the basis for participation is the objective of the process (Oakley and Dillon 1985, p. 8).

The difficulty with this type of categorisation is that it gives the impression that the forms or types of participation are mutually exclusive, when in fact they should be part of an integrated process. For instance, a means to sustain the dynamics of participation in community development activities is through organisation in working with communities to strengthen and develop viable local organisations and community-level groups.

Oakley (1989, p.9) claims that there is no single working interpretation of the concept of participation that has been universally accepted in development work. He cites three interpretations of participation which reflect quite different concepts of development:

(1) "Participation means.....in its broadest sense to sensitize people and thus to increase the receptivity and ability of people to respond to development programmes, as well as to encourage local initiatives."
(2) "With regard to development....participation includes people's involvement in decision-making processes, in implementing programmes...their sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes."
(3) "Participation involves....organized efforts to increase control over resources and regulative institutions in given social situations on the part of groups or movements of those hitherto excluded from such control." (Oakley 1989, p.9).

These three interpretations are reflected in the different forms of participation identified in the UN Panel on People's Participation Study. The first interpretation could be perceived as participation as collaboration or cooperation and through organisation, the second interpretation relates to participation in community development activities and the third interpretation as process of empowerment. Other ways of interpreting participation are to consider it as a means of achieving a set objective or goal and a way of using the economic and social resources of communities to achieve programme objectives, or as an end or process in itself which enables communities to become more directly involved in

rural development with the critical elements in the process being to enhance awareness and to build up local organisational capacity. In reality the participation process should incorporate the elements of being both a means to initiate involvement and an end to help sustain it.

According to Uphoff (1985, p. 477), who participates and how may be more crucial to project success than any purely quantitative expression of participation. He states, "Researchers can reasonably disagree about what is to be considered participation, but it should be possible to assess the results of different approaches, assumptions, and mechanisms." An objective of this research study is in fact to assess the results of approaches taken to involve community members in a rural health development programme and the mechanisms used to achieve it. This study focusses on participation at the community level.

Similar to participation there are numerous definitions of community in the literature. In the PHC literature community has been defined in various ways. One is that community is all the people in a geographically defined area within which every family knows every other family and wherein all feel united by common responsibilities, and known leadership (Shaffer 1991). Midgley (1986, p.24) suggests that community has had two meanings in the health and development literature. The first is that which defines community in geographic terms with community members sharing the same basic values and organisation. The second definition is that which says a community is a group of people sharing the same basic interests. The interests change from time to time with the consequence that the actual members of the community change from time to time. However, this definition still implies that communities are regarded as a homogeneous entity. Tumwine (1989) states that in real life a community is rather a heterogenous entity in which the members have different class interests and even the smallest of communities may reflect the social dynamics in a region or country. Moreover, it would be a highly naive health worker who neglected this simple fact.

The WHO Study Group on Community Involvement in Health (CIH) felt that the community is largely a geographical expression and that CIH should be based upon clearly identifiable socio-economic or cultural groups at the local level (WHO 1991). Oakley (1989, p.26) contends that current thinking on development is that the word community is inadequate as a means of indicating people who share common needs and problems. He believes there is a need to take into account economic and social differentiation in the community when health services are being provided at that level and particularly when an attempt is being made to involve the community in those services. Even deprived communities are differentiated in terms of status, income and power according to Midgley (1986). These differentiations within communities could also have a determining effect on the potential level of participation in health development.

When the health sector thinks of the community, it is usually in terms of the catchment area of health facilities or mobile clinics or segmented into at-risk groups (WHO, 1991). This definition is rooted in the epidemiological view of community. Rifkin (1988, p.933) claims that for primary health care, in terms of equity, effectiveness and efficiency, groups of people need to be identified so that resources can be allocated to take into account this aspect of health concerns in seeking a realistic definition of community.

To Hollnsteiner (1982, p.58) the equity principle of PHC militates that this group would be the poor majority who are most in need of better health care and should organise themselves for achieving it. She adds that there is general consensus that participation does not refer to everyone in a community since for instance local elites already have a strong say in decision-making. The challenge is how to elicit the participation of disadvantaged groups in health development programmes designed to help them achieve better health care status. Notwithstanding, the participation of local elites cannot be ignored in a CBHC programme. The issue is that they would no longer be the dominate group in decision making.

To Mburu (1989, p.1076) the power of the elite lies partly in their control of information and manipulation of the people through selective dissemination of such information to

ensure their hold on power. In this way power and authority do not change hands, an oligarchy gradually forms at the grass-roots level and is able to enshrine itself as indispensable. This was particularly the case in countries which have been dominated by a single political party like Kenya. There is little evidence to date that the emerging movements to multi-party democracy in Africa will alter greatly the dominance of elites at the community level.

It is important to know whether or not participation is simply a formal action with little meaning or an activity which allows the individual to gain greater control over situations that would alter his or her life (Cohen and Uphoff 1980, pps.224,225). Oakley and Marsden (1985, p.27) believe that it is the former rather than the latter interpretation which has been predominant. They state that the development literature is overburdened with the documentation of participation strategies which have failed in terms of giving the majority of rural people any meaningful say in those issues which affect their livelihood. They further contend that the concept of participation as empowering is a radical departure from years of more traditional practice. They admit that this interpretation of participation faces formidable barriers, and it is difficult to imagine governments and locally established structures offering other than powerful opposition.

A window of opportunity for broad-based, meaningful participation occurred just after the independence in Kenya. For a brief period, community members were able to play a major participatory role in decision-making on development issues. They were empowered through the "Harambee" movement to plan and undertake community-level development projects. This broader participation in Kenya changed the use and allocation of resources in rural societies. However, within a span of a few years, the Kenya Government reversed this policy and established strict bureaucratic procedures which in effect returned the control of rural development decision-making from the community level to more central levels within the government. This example of participation as empowerment in Kenya and the ensuing conflict is discussed in Chapter 3.

In relation to the health sector, Oakley (1989, p.72) believes for most writers CIH is a means of extending health service coverage and releasing massive human resources for health development. Such an interpretation of CIH is, however, inadequate and fails to recognise the legitimate demands for worthwhile participation. He contends that CIH cannot be regard as a mere means of technology transfer; it must imply some notion of the transfer of power and authority to local people to enable them to become effectively involved in health development.

If there are concerns that the word community is too general or broad to be meaningful in development terms, and if it is more relevant to be specific and identify groups of people within communities, it definitely undermines any attempt to try to define what is meant by community participation. For that reason, the title of this research study did not include the word community. Rather it is felt that individual, household and group participation is just as significant to health development as community participation. Rifkin (1988, p.933) had similar views regarding specificity when she proposed a definition of community participation as, " ...a social process whereby specific groups with shared needs living in a defined geographical area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs." The importance of decision-making in relation to community participation was stressed by Chand (1989, p.1114) who claims that decisions are taken by different levels in a community with the bulk of decision-making at the family level and at the level of distinct interest groups. Clear cut strategies are required to facilitate decision-making at each level which involves generating information, facilitating a forum for interaction, communication and dissemination.

Several studies have set forth the rationale for the importance of community involvement and the arguments for adopting it as a strategy for health development (MacCormack 1983; WHO 1983; PAHO 1984). Oakley (1989, p.5) has developed a composite list of those arguments from several sources:

"(i) CIH is a basic right, which all people should be able to enjoy. Involvement in the decisions and actions that affect people's health builds self-esteem and also encourages a

sense of responsibility. CIH as a principle is of intrinsic value in the development of communities in a wider sense and should be promoted as a basic approach to health development.

(ii) Many health services, particularly in developing countries, function on the basis of limited resources. CIH can be a means of making more resources available by drawing upon local knowledge and resources to complement what is provided by the formal health services. Furthermore, it can help to extend the coverage of health services and to lower their overall cost. CIH can also make health services more cost-effective and lead in the long run to an adequate return on funds invested in the health sector. It is not, however, a substitute for formal health services or a mechanism of double taxation.

(iii) CIH increases the possibility that health programmes and projects will be appropriate and successful in meeting health needs as defined by the health authorities. When health services take into account local perceptions of health needs and are managed with the support of local people, there will be a better chance of their programmes being successful.

(iv) CIH breaks the knot of dependence that characterizes much health development work and, on a wider front, makes local people aware that they could become usefully involved in development in general. Ultimately CIH can help to make people politically conscious and eager to make their voice heard in regard to development processes in their country or area."

Moreover, Mburu (1989, p.1084) states that community participation is a crucial element to achieve sustainable community development and that dialogue with the community is critical to the success of a truly community-based primary health care project. A centre-piece of primary health care is that people should participate in promotion of their own health. In fact people have the right to community involvement and this right is not a suddenly discovered feature of human society, but a renewed recognition of community involvement as a central value of all human activity (WHO 1985, p.12).

On the other hand criticisms of the notion of community participation relate to its lack of conceptual clarity; to the gap between the rhetoric, which calls for "authentic"

participation, and the reality of the approach where participation tends to take the form of cooperation in the implementation or utilisation of activities planned by external agencies; to the practical limitations in achieving participation and the ideological implications of the concept (Asthana, 1989, p.261). Stone (1989, p.207) adds an additional issue of cross-cultural applicability to the concept of community participation. She believes it may be creating an international arena for the expression of such Western cultural values as self-reliance, individualism, human equality and equity. Brownlea (1987, p.614) suggests that not all cultures place a high value on participatory approaches to health decision-making, and even among those that do, there is very uneven assistance given to enhance the capability for effective participation.

Midgley (1986, p.36) believes that a more critical issue is whether or not community participation can achieve real improvements in social conditions. Questions remain as to whether too many preconditions have been laid down for successful participation to ever occur and be sustained, such as demand for national policy commitments to community participation, re-allocation of resources and decentralisation and restructuring and reorientation of health services.

Both the terms "community participation" and "community involvement" are in common usage. The latter term is used by WHO who argue that it implies a more active engagement of the community in health issues, in which communities cooperate with health professionals, as well as initiating and taking responsibilities for health action in their own right. However, various forms of participation can also be interpreted likewise. WHO officially designated the term as Community Involvement in Health (WHO 1991, pp.5-6). Both terms are used interchangeably in this study.

If there is ambiguity and lack of clarity of what community participation means amongst academics and programme practitioners, one can imagine the confusion which exists at the grass roots operational level. Laleman and Annys (1989, p.251) report that an intensive debate among staff members and community health workers (CHWs) in the Philippines revealed a lack of clear understanding of the concept of community

participation Specifically, the absence of an instrument to assess the process of community participation resulted in a vague and unsatisfactory analysis of the situation.

Oakley (1989, p.16) states that there is a case for putting emphasis on practicing community involvement in health rather than on defining it. He recommends WHO should seek to promote and monitor the practice of CIH in different contexts in order to develop the understanding needed to support its practical application on a wider scale. A WHO Study Group on CIH (1991, p.8) suggested two main interpretations of the practice of community involvement in health (1991, p.8). The first was building up communities' awareness and understanding of the problems of health development and the causes of poor health as the basis for their continued and future active involvement in health development. The second interpretation was having access to specific information and knowledge about health service programmes as a pre-condition for becoming involved in health activities designed and directed by others. It is important to gain a more informed understanding of the role of participation in addressing these two important goals. The research study has focused particularly on studying these two issues of awareness and understanding and access to information and knowledge about health service activities.

Various definitions and interpretations of participation, community and community participation have been cited and discussed. They provide theoretical points of reference and targets for what might be achievable in reality at the community programme level. The conceptual framework for the research study was to examine participation in rural health development within a case study programme focusing on how and assessing why participation was occurring in practice and then comparing those results to the factors set out in the various theoretical interpretations of community participation. A premise put forward is that participation could be occurring in practice in spite of the absence of some, if not several, of the policy changes recommended to enhance participation proposed by agencies like the World Health Organisation. If so, then a re-assessment is needed to offer revised policy guidance on ways in which participation in health development can be most realistically achieved.

The various factors which were examined regarding their potential influence in enhancing or impeding the participation of community members in the Maua CBHC Programme were:

(i) Education: formal and non-formal

(ii) Local group membership

(iii) Household income

(iv) Socio-domestic issues: family size, women's time, and harmony in the household

(v) Local institutional support: community health volunteers, health committees, health committee members, local leaders.

These factors were selected based on a review of literature (WHO 1977; Stinson 1982; Ahmed 1982; WHO 1983; PAHO 1984; Bennett and Maneno 1986), discussions with Maua CBHC Programme managers, CBHC and primary health care development specialists in Kenya and on the health care development experience of the researcher.

The strategy pursued in addressing the research objective was to undertake an institutional analysis of the emergence of participation as international health policy within the World Health Organisation then focus at national level in Kenya by examining the historical perspective of how participation was perceived and practised as community development policy in the colonial period in Africa, and during the post-independent period in Kenya. This was done to ascertain the nature of participation which was traditionally practiced and types of strategies and forms of participation which were used and were developed prior to and during the community development period following independence in Kenya. A similar institutional analysis at national health policy level was done for the emergence of participation as national health policy in Kenya.

The second part of the study (Chapters 6-11) describes the research methodology, the case study programme, and examines the evolution, perception and attitudes towards participation in the case study programme area. The issues of people's perception and understanding of participation, how people participate and the influences of socio-

economic and institutional support factors on levels of participation are discussed. Community financing as a way of participation is also examined.

The final part of the study (Chapter 12) identifies policy issues from the first two parts of the study, particularly those factors which appeared to strongly enhance community participation in the case study Maua CBHC Programme. The policy recommendations to enhance greater participation in rural health development, directed at international health agencies, national health policy-makers, international and national non-government organisation health managers, which emerged from the research study can be summarised as follows:

(i) The promotion of primary education and self-help groups as development priorities;
(ii) The need to enhance the partnership relations at community level between the formal health service staff and the community members;
(iii) The need to strengthen inter-sectoral collaboration related to income generation;
(iv) Development of innovative ways to technically support community level CBHC programme workers;
(v) More awareness and appreciation of the impact of socio-economic-cultural factors on participation.

Even though there has been an impressive amount of research into CIH, in many instances it has failed to study the details of how it works in the field nor has it focused on the concept of CIH itself (Oakley 1989, p.66). This study represents an attempt to enhance the limited body of knowledge related to these two aspects of CIH. The particular contribution it makes is the historical review of participation, as community development policy in the colonial and post-independent periods in Africa and Kenya, along with its emergence as international health policy within the WHO and as national health policy in Kenya, and, then, how participation has occurred at grass roots level in the context of a community-based health care programme in Kenya.

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CHAPTER 2

PARTICIPATION AS INTERNATIONAL HEALTH POLICY

INTRODUCTION

One of the driving forces for the emergence and development of participation as a health policy at international level was the World Health Organization (WHO). The other main forces regarding policy development and advocacy of community participation in health development, particularly during the period of the 1970's and early 1980's, were UNICEF and non-governmental organisations, such as the Christian Medical Commission. In addition to these institutions, individual country experiences, such as that of China, were influential in the development of community participation and primary health care.

Instead of reviewing the development of community participation within each of these institutions, this study will focus on community participation within one of them. The World Health Organization was chosen because of its historical leadership role in health policy and its influence on health systems development. Moreover, it offered the opportunity of a longitudinal study of community participation which included experiences of Member State countries, thus, capturing the individual country study option as well.

The following section reviews the emergence of community participation as policy within WHO prior to the Alma-Ata Conference. The next section examines how community participation was perceived within the context of primary health care at the Alma-Ata Conference. This is followed by a section concerned mainly with the strategies WHO proposed for implementation of community participation in health development and how it was to be measured and assessed. Finally, the activities, experiences and policy influence of WHO during the period of 1981 - 1992 in the area of community participation in health development are examined.

THE EMERGENCE OF COMMUNITY PARTICIPATION AS POLICY WITHIN WHO

Primary health care as a priority programme initiative, with community participation as one of its key components, first emerged within WHO as a result of the debate on the

reasons for the failure of the malaria eradication programme during the 1971 and 1972 WHO Executive Board meetings. The technical managers in WHO claimed that the malaria eradication programme had not succeeded because there had been no national will or coherent national programmes or policies for the programme, and that there had been inadequate funding and incompetent programme and administrative support. During the course of the debate, attention shifted from the malaria eradication programme specifically to the basic health services strategy which was failing to provide adequate support and maintenance services for the malaria eradication programme.[1]

Focus on the development of basic health services within WHO dated back to 1951 at a time when many developing countries were concentrating their health efforts on specialised mass campaigns for the eradication of diseases such as malaria and smallpox. The Director-General of WHO in his 1951 annual report stated that these efforts would have only temporary results if they were not followed by the establishment of permanent health services in rural areas to deal with the day-to-day work in the control and prevention of disease and the promotion of health (Djukanovic and Mach 1975, p.7).

Reference to basic health services per se came during 1953 when the WHO Executive Board stated that assistance in the health field should be designed primarily to strengthen the basic health services of the country. It should also meet the most urgent problems affecting large sections of the population, with due regard to the stage of social or economic development of the country concerned (Djukanovic and Mach 1987, p.108). During the 10-year period from the early 1950's to the early 1960's progress remained slow for both specialised mass campaigns for the eradication of diseases and the development of basic health services (Williams 1988).

More integration of these two strategies was necessary as stated in 1962 at the Fifteenth World Health Assembly,

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[1]Personal interview with the late Professor Ken Newell, former Head of International Health Department, Liverpool School of Hygiene and Tropical Medicine on 11 March 1988. Professor Newell was a previous WHO Director of the Division of Strengthening of Health Services in Geneva.

> "...while it is normally necessary for a malaria eradication programme to be implemented by a specialized service, the active participation of the health service assumes considerable importance as the programme progresses towards its goal, becoming fundamental in the maintenance phase when vigilance against the re-establishment of the infection becomes the responsibility of health services" (Djukanovic and Mach 1987, p.108).

Participation was mentioned, not in the context of the consumer of the health services or the community, but rather the health service provider in relation to his or her participatory role in the vertically managed malaria eradication programme.

During the 1960's the issue of consumer involvement or community participation still had not arisen within WHO health policy. What was becoming clearer was the fact that neither the mass eradication campaigns nor the basic health services strategy were working satisfactorily. Judged by the fact that in many countries less than 15 percent of the rural population had access to health services, it could be said that in fact the relative emphasis on programmes to control specific diseases over the 25-year period of the early 1950's to the mid-1970's may have hindered the development of basic health services. It was recognised that it was unlikely that the resources needed to expand the basic health services would be easily forthcoming. Newell stated, "With such a conclusion, WHO was almost forced to look deeper into the distribution, form, and roles of basic health services."[2]

Following the debate on the malaria eradication programme and the basic health services in 1971 and 1972, the Executive Board of WHO recommended to the Twenty-fourth World Health Assembly that the next organisational study should be entitled, "Methods of Promoting the Development of Basic Health Services". The World Health Assembly (WHA) requested the Executive Board to report to the Twenty-sixth WHA on the progress of the study. At the forty-ninth session of the Executive Board in January 1972 a working paper was submitted for use in discussions on this subject and, subsequently, the Board appointed a working group to make a further study.

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[2] ibid.

The working group produced a report in 1973 called the "Organizational Study on Methods of Promoting the Development of Basic Health Services". The study aimed to address fundamental questions of philosophic principle, national priorities and political and economic structure in developing strategies to promote health service development. China and its barefoot doctor programme served as an example of ways to accelerate improvements in primary health care, specifically that, "coverage and utilisation would be improved and a greater return would result from their use." (WHO 1973, p.110).

The Organizational Study Report also addressed for the first time the role and influence of the consumer in health development,

> "In the Board's view, the differences between urban and rural societies, between different regional and ethnic groups, and between persons with different ways of living and values, make it essential that the interface between the consumer and the health service be influenced by the consumer and that the accepted pattern serve the needs of both the health services and the consumer" (WHO 1973, p.104)

Consumer approval was seen as a requirement for the operation of a health service and for its goals and priorities. No single measure of consumer approval, however, could be cited by the study. Under-utilisation and the development of parallel health service structures were offered as signifying disapproval or criticism, pointing to a re-examination of existing solutions.

During the early 1970's the WHO Board believed that a major crisis was on the point of developing, based on widespread dissatisfaction of populations over the inability of their health services to meet their expectations. One cause of this dissatisfaction related to the consumer was a feeling of helplessness that the health services were progressing along an uncontrollable path, which might be satisfying to the health professions, but which was not what was most wanted by the consumer (Newell 1976, p.181).

Besides consumer preference as an important factor for consideration in the development of health services, community participation was also given recognition by the Organizational Study,

> "..What is necessary now is to solicit community identification with, and participation in, the development of health services. This will require innovative approaches" (WHO 1973, p.107).

The significance of the Organizational Study was the admission by WHO that the development of basic health services had been unsatisfactory, and that the interests, participation and involvement of the consumer must be considered in the future development of health services. WHO appeared open to explore various options and methods to help change the existing development pattern of health services, and to address particularly the issue of coverage and utilisation of health services. Moreover, the development of health services became one of WHO's highest priorities.

Although the Organizational Study was proposing a strategy based on references to experiences from other programmes, no recommendation was made to the WHO Executive Committee that WHO should undertake its own research into consumer or community attitudes into how health services should be developed. The Organizational Study even stated that,

> "It could be said that the way in which such a service could be run is already known and that what is lacking is a national will and a manner of overcoming the entrenched opposition of organized medicine" (WHO 1973, p.110).

Nevertheless, the WHO Executive Board recognised that changes in social policies were equally important and relevant to complement structural changes in the health services. Since little documented information existed in relation to the question of change, the Board sought to collect such a body of knowledge so that the experiences could be made available and lessons learned could be used by others.

The Organizational Study was a critique of the delivery of basic health services and it identified the problems, but did not give solutions. Proposals were needed on how to solve the problems and determine what should be done. A priority mandate for WHO executives was to get moving on how to find these solutions. The matter was referred to the UNICEF/WHO Joint Committee on Health Policy to decide on how to proceed. According to Newell, there were two choices. The first was to carry out a management study on why the health services had failed if everything was as bad as stated in the Organizational Study; or, secondly, they should obtain information on health service strategies which were working since the Organizational Study did not say all methods of developing health services had failed. The first option was turned down because it was not consistent with the spirit of the Organizational Study which stated that some things were working, for instance, 'the barefoot doctor idea'[3].

As a result, a joint UNICEF/WHO study was commissioned and enquiries were sent out in the name of the Joint Committee on Health Policy to elicit information within the WHO and the UN network and from governmental and non-governmental health programme managers about successful health service development approaches. Various organisations and agencies such as the Christian Medical Commission were used as informants. The study was published in 1975 as a WHO publication and was entitled, "A Joint Study on Alternative Approaches to Meeting Basic Needs of Populations in Developing Countries." It was endorsed by the UNICEF Executive Board and approved at the 28th World Health Assembly (Djukanovic and Mach 1975, p.10).

One of the five problems of broad choices and approaches to be overcome highlighted in the Alternative Approaches Study was the lack of community involvement (Djukanovic and Mach 1975, p 16). The study placed emphasis on the need for the health measures which effected behavioural change. It also stressed that the communities must decide on the measures, help carry them out and evaluate them. The measures represented basic health care which could be given by ordinary people provided they have adequate education, training, and technical advice and supervision.

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[3]Ibid.

The advantages of community involvement, namely that adequate coverage and use of preventive and curative health services at village level would be achieved, local self-reliance enhanced through local contributions and the fact that health services would be more in line with needs, wants and priorities of the population they served were stated in the study. Community involvement meant people's participation in making decisions about their health services which helped guarantee acceptance and utilisation of services, besides providing information back to decision-makers on felt needs and aspirations. In other words, participation enabled communities to be more readily mobilised, increased their health awareness, and provided health authorities with the information they needed for a better and more sensitive administration. Obstacles to community participation were related to centralised political systems and government health services, competition between the traditional and modern health systems at local level and cultural belief systems at community level.

As in the Organizational Study, the Alternative Approaches Study stressed the importance of utilising untapped resources within the communities themselves. All the approaches from the case studies employed one or more methods of gaining the understanding, cooperation and support of the population as a prerequisite for their participation in the programme. These methods were mainly political, relying on party organisations and in mass mobilisation of the people. Some of the ways where community participation was evident were in systems created which enabled people to express their health needs, community-sharing of the cost of primary health care which involved community participation in the decision-making process on how resources would be raised, and locally recruited primary health workers supported by their communities forming the front line of the health system and the entry point into it for the population. Receiving health, nutrition and hygiene educational messages from primary health workers who belonged to the community, and, hence, enjoyed its confidence and shared the same views, aspirations and language were other ways community participation was taking place.

The Alternative Approaches Study recommended the need for far-reaching changes in the organisational structure and management practices of the health services to include a new

brand of health professional with a wider social outlook, and trained to respond to the actual requirements of the population. The basis and the strength of such services was to lie in a cadre of suitably trained primary health workers chosen by the people from among themselves and controlled by them, rather than in a reluctant, alienated, frustrated group of bureaucrats 'parachuted' into the community (Djukanovic and Mach 1975, p.104). The primary health care workers then became the saviours who would overcome the failings of the basic health services.

As stated earlier, the 20th session of the UNICEF/WHO Joint Committee on Health Policy adopted the principles of, and approach to primary health care as outlined in the joint UNICEF/WHO study. Although being convinced that people's participation in plans and programmes designed to improve their health status was a necessary condition for successful intervention, the joint UNICEF/WHO committee still felt that more knowledge was required of those instances in which successful community-based development activities had been stimulated and maintained (WHO 1977, p.4). For this reason an agreement was reached that the 21st UNICEF/WHO Joint Committee on Health Policy should review and analyse examples of community participation which were considered to have led to improved health and a rise in the general standards of living in different settings. A significant result then of the Alternative Approaches Study, besides being one of the basic documents which influenced the adoption of the primary health care strategy, was that it prompted further focus on community participation as a major component of PHC.

Another document which influenced the adoption of primary health care and community participation as a strategy for WHO was entitled, "Promotion of National Health Services", presented by the WHO Director General Dr Halfkan Mahler to the 28th World Health Assembly in April 1975 (WHO 1975). It was prepared as a response to the debate at the 27th WHA meeting which called on WHO to give priority to assisting governments in the rapid and effective development of the health delivery system for under-served populations. This was in effect another response by WHO to the realisation that the basic health services strategy was failing to reach the majority of the rural poor.

The WHO/UNICEF joint study on "Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries", and the WHO Director-General's "Promotion of National Health Services Report" were prepared basically in parallel during 1974 for presentation to their respective bodies in 1975. Both the joint study and the report recommended the adoption by the 28th WHA of the primary health care strategy as a policy for the future development of health services.

Mahler's Report basically re-stated the main thesis of the Organizational Study but further amplified it. For instance, regarding the role of the people and communities, Mahler's Report stated,

> "That the people have rarely been given the opportunity to play an active role in deciding the types of activities they want and have not participated in the actual services they receive. Community interest and resources have too often been inadequately expressed and activated because there has been a failure to recognize that people will be most interested in and responsive to activities related to their own priority concerns" (WHO 1975, p.3).

Consumer dissatisfaction was also mentioned and again mainly in relation to the utilisation of services. Lack of due consideration on the part of health personnel to community development programmes, which was not stressed as much in the Organizational Study, was highlighted by Mahler. Moreover, the Mahler Report provided insight into the difficulties at community level of past efforts at health development, namely, that services have reached the community only marginally with little impact. Elsewhere services have overlapped at the community level with the result that too many demands, sometimes conflicting, have been placed on the community itself. The end result of this situation, according to Mahler, was that communities had become confused or had been left with their major concerns unchanged, and passive acquiescence to the unacceptable situation that existed (WHO 1975, p.4).

The solution to the problems posed in the Organizational Study, the Alternative Approaches Study, and, again by Mahler in his Report to the Twenty-seventh Assembly, was primary health care. In Mahler's Report primary health care workers are described

for the first time as an outgrowth of the barefoot doctor idea. According to Mahler, the effective functioning of the primary health care worker depended upon community acceptability and one of the ways in which communities could participate was in the recruitment and selection of PHC workers with the participation of the community (WHO 1975, p.5). The report, however, was not more explicit in describing how communities could participate and become involved. Moreover, operational guidelines from WHO about how to elicit community participation in relation to the development of primary health care were not forthcoming at this particular point in time.

An important aspect of Mahler's Report was that it stressed the importance of community and social development, and community dynamics. In situations where a community development framework existed, primary health care should be implemented within this framework, and PHC should be linked with whatever social activity was most significant to the community at its given stage of development. Mahler also saw the development of PHC as being unique in each country which recognised the dynamic nature of community development.

Various features of how the PHC programme would be developed were offered, but the emphasis was on steps to follow in planning primary health care, rather than focusing on the process of consultation with the consumers or concerned communities.

One of the reasons why the PHC strategy, as presented in Mahler's Report, received such widespread support from the industrial world could have been the resource and financing issue. This was stated as,

> "...it should be noted that these advances (of community based services) make good economic sense; instead of promoting health structures which require an initial and continuous high level of investment, a maximum use is made of resources already available to the society" (WHO 1975, p.8).

Although the latter point was potentially true, the investment needed to give proper support to the health structures to maximise local resources and support PHC was totally underestimated.

While the Alternative Approaches Study and Mahler's Promotion of National Health Services Study attempted to set out some of the steps required to elicit community participation in health development, the studies failed to bring to life the dynamics of the process, even in the case study material. Therefore, another approach was used by WHO to review alternative approaches to the development of basic health services. It was to request a group of people who participated in some of these attempts at change to document what happened. The authors were asked to give special prominence to the process itself. What was wanted was a series of stories that would give life and colour to the sequence of events and decisions they considered important[4]. These accounts were collected and published by WHO under the title, "Health by the People" by Ken Newell and were an extension of the Alternative Approaches Study.

Newell's "Health by the People" became a standard reference text in the international health field in relation to the concepts and dynamics of the primary health care approach, and the ways communities were involved in the health development process. Its popularity stemmed from the fact that Newell attempted to provide the reader with the reality of life at village level particularly in relation to health, e.g., "ground-level view is still one of swollen-bellied children playing in the dust of the village square, of lines of women carrying water, and of the scratching of little patches of land with a stick as the desert creeps nearer" (Newell 1975, p. x).

From the case studies Newell attempted to see if there were some general principles that could be used to help other countries and communities improve their health care systems and health status. One point that was continually stressed was the fact that development was a process and the approach used to enhance development influenced the chances for improvement. This represented new thinking for health professionals.

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[4]Ibid.

Newell did not see the financing of PHC as a separate issue but part of the overall question of raising resources for community development in general. Though the case studies were not presented in such a way that they could be assessed in relation to potential self-sufficiency, an assumption could be made, according to Newell, that such services can be self-financing after a period of time, and when the development costs have been found. Newell concluded by saying that,

> "..in most countries health development as a part of rural development is possible if one goes about it in the acceptable ways. These ways include the quick evolution of a village-based development organization and a primary health care system designed for that country coupled with a parallel national effort to build such a peripheral expression into the national scene" (Newell 1975, p.201).

Curiously, no reference was made to "Health by the People" in any of the WHO reports and documents leading to the official adoption of the primary health care strategy; whereas, the Alternative Approaches Study was continually cited.

Further investigation by WHO and UNICEF into community involvement as a key element of primary health care continued after 1975, particularly in regard to obtaining a better understanding of the process involved. As mentioned previously, a detailed study on community involvement was done by WHO and UNICEF and presented to the 21st session of the UNICEF-WHO Joint Committee on Health Policy. It was called "Community Involvement in Primary Health Care: A Study of the Process of Community Motivation and Continued Participation" (WHO, 1977).

The objectives of the 1977 Community Involvement Study were to identify elements of individual and community motivation and organisation which have led to the initiation and continued implementation of community-based primary health activities, and characteristics of the communities themselves and the mobilisation and educational processes, which have influenced either positively or negatively community-based health activities. The Study was suppose to analyse and present this information in a format so that the socio-cultural, economic, motivational, organisational and other factors that

appear to be common to the experiences described can be taken into consideration and utilised by WHO and UNICEF in their collaborative efforts with countries in further development of community-based primary health activities.

Seven principles were listed of which three directly addressed the community. These were that communities need to be involved from the beginning in the planning and implementation of the national primary health care programme, as well as of local primary health activities, primary health care activities require full utilisation of available community resources, and health interventions should be undertaken at community level by appropriately trained workers who, when possible, should be selected by the community itself from amongst its own people (WHO 1977, p.8). The other principles addressed the importance of inter-sectoral collaboration, national will and resource allocation, the nature of the health care interventions, and health system support.

The 1977 Report defined community as a group of people who can be identified as living with and having a sense of belonging to a geographic area (WHO 1977, p.9). This definition of community is similar to that expressed in Chapter 7 by people in the research case study area. The 1977 Report perceived involvement of the community in terms of a broad spectrum, ranging on the lowest side of being passive recipients of benefits, which it related to participating, to the other extreme where the community is actively and meaningfully involved in its own development. The 1977 Report stated that the more prevalent situation is where members of the community share to a limited degree in decision-making and have marginal physical interaction with the decision-makers and where channels for communicating their opinions to the authorities may be reduced to the use of mass action.

The 1977 Report set out various features of community involvement but only after explaining that the degree of community involvement varied because of the uniqueness of the social dynamics at play and the influences of the factors of cultural settings, economic realities, and political structure, as well as national policies and practices. The 1977 Report stated that a community can be plotted on the spectrum of community

involvement. The indicators would be the national commitment to support and accept active community involvement, the degree to which national plans reflect local aspirations and needs, the extent of decentralisation of government bureaucracy, the degree of organisation at community level and ability to organise its own local resources, the sincerity and quality of local leadership, and the extent to which communication flows from the centre to the periphery and vice versa, and within the community itself.

Based on the case studies, factors which had enhanced community involvement, according to the 1977 Report, have been access to education, both formal and informal, readiness of communities to want and accept change based on improved communication in its broadest sense, better approach to people by external change agents than during the former community development programmes, better understanding and the development of methods to involve people in the planning process, and a change of emphasis in development policies from a concern for "economic growth" to a concern for quality of life and people's welfare. Nevertheless, according to the 1977 Report certain key factors were still not sufficiently understood and exploited, such as community involvement in the totality of the planning process, the importance of traditional decision-making structures, and the nature and extent of both national and international external support (WHO 1977, p.55).

The conclusions reached in the 1977 Report centred around the basic premise that meeting community needs was the basis for the design and implementation of primary health care. It called for the involvement of community members in all stages of planning and implementation of such activities and, in satisfying those needs, the confidence of the community for further involvement in the developmental activities would be promoted. The 1977 Report recommended that special emphasis should be placed on community participation by UNICEF and WHO as part of their efforts to intensity their collaboration with countries in further developing their national primary health care programmes. Dissemination of information to enhance the understanding of the principles of community participation was also stressed as a role for UNICEF and WHO along with developing methods for identifying community resources that can contribute to the development of

local primary health care activities. Thus, community participation can be said to have received the utmost importance as one of the vital elements of primary health care prior to the 1978 Alma Ata Conference and Declaration on Primary Health Care. How community participation fared in relation to that conference will now be discussed.

COMMUNITY PARTICIPATION IN RELATION TO THE PRIMARY HEALTH CARE STRATEGY AT THE ALMA-ATA CONFERENCE

Stemming from the results of the various studies undertaken by WHO and UNICEF on promoting health development, WHO management believed that the commitment of national governments to primary health care was essential to its success, and that a public relations effort on PHC in the form of an international conference was required to help achieve it[5]. Consequently, the International Conference on Primary Health Care sponsored by WHO and UNICEF was held from 6 to 12 September 1978 in Alma-Ata, capital of the Kazakh Soviet Socialist Republic.

The Declaration of Alma-Ata referred directly to community participation, stating that people have the right and duty to participate individually and collectively in the planning and implementation of their health care. The definition of primary health care also embodied the notion of community participation. It stated,

> "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process." (WHO 1978, pp.3-4).

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[5]Ibid.

In further defining PHC, the Declaration of Alma-Ata again incorporated community participation,

> "5. [Primary health care] requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate" (WHO 1978, p.4).

The Alma-Ata report made 22 recommendations of which one specifically addressed community participation and three others made reference to it. Throughout the report the dominant role of government in activating primary health care was stressed. This can even be seen regarding the recommendation for community participation, which stated,

> "The Conference, Considering that national and community self-reliance and social awareness are among the key factors in human development, and acknowledging that people have the right and duty to participate in the process for the improvement and maintenance of their health, RECOMMENDS that governments encourage and ensure full community participation through the effective propagation of relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and well being" (WHO 1978, p 23).

Participation also featured prominently in the description of the primary health care approach which incorporated social and developmental dimensions differentiating it from the former strategy of basic health services. The PHC goals would be attained in part by social means, such as acceptance of greater responsibility for health by communities and individuals and their active participation in attaining it, according to the Conference.

The Conference report set out various ways in which community participation could occur in primary health care. These were involvement in assessing the situation, defining the problems and setting priorities, cooperation in utilising the services as a result of responsibility for one's own health care, changing health behaviours and contributing in labour and financially to primary health care. Appropriate education enabling com-

munities to deal with their real health problems in the most suitable ways was also put forward as a way in which community participation could occur.

The perceptions of how community participation can be facilitated were mainly through assistance by local and external groups, such as local government agencies, local leaders, voluntary groups, youth and women's groups, consumers' groups, non-governmental organizations, as well as by accountability to the people. A main objective of community participation, according to the Conference report, was to enhance coordination of development activities at local level (WHO 1978, p.49).

The report made reference to the case studies on community participation conducted by the UNICEF/WHO Joint Committee on Health Policy claiming that these case studies helped clarify the role of community participation in primary health care. No particular reference was made to the other two WHO sanctioned studies, the "Alternative Approaches" study or "Health by the People".

A definition of community participation was put forward in the report,

> "Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development" (WHO 1978, p.50).

According to the Report, this process enabled individuals and families to know their own situation better and to become motivated to solve their common problems. They become agents of their own development instead of passive beneficiaries of development aid. These statements were somewhat patronising in that they assumed that people were not aware of their own situation and, when they became aware, as a result of community participation, they would be motivated to solve their common problems.

The Conference came close to endorsing empowerment and encouraging communities to challenge the existing health service system, by stating that communities should not be obliged to accept conventional solutions that are unsuitable but improvise and innovate

to find solutions that are suitable. The latter point was equally relevant to government health services.

The Conference implied that the government health system was still where the control and expertise and last word lies,

> "While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs" (WHO 1978, p.50).

Throughout the Report the need for national policies was stressed and the area of community participation was no exception. Here policy development was recommended to enhance community cohesion, foster coordination at local levels and to ensure community control over the funds the community invests in primary health care development, and the personnel it was providing to participate in it. Mutual support between government and the community was called for, but again the responsibility was on the government to stimulate it, to establish inter-sectoral coordinating mechanisms, pass legislation to support PHC and, wherever applicable, to provide sufficient human, material, technical and financial resources. Since the responsibility for major actions mainly was with government, the pace of PHC development, including the essential component of community participation, therefore, rested more heavily on the interests, commitment and initiative of a government rather than with community interests and priorities. It was up to the government to stimulate the community and provide the mechanisms of participation.

The Report stated that one of the fundamental principles of primary health care was the participation of the community at all stages. The strategy to elicit community participation included communities having easy access to the right kind of information concerning their health situation and how they themselves can help to improve it. The source and control of the information rested with the governments and the programme managers, and the Report stressed that the information given should be neither

oversophisticated nor condescending but should be in a language people can understand. The means of delivering the information stated in the Report represented the classic media approach utilised in traditional health education, for example, posters, community notice-boards.

The Alma Ata Conference also addressed the issue of financing primary health care (WHO 1978, p.72). A major theme was preferential allocation of resources to primary health care, starting from communities and progressing through the other levels. It consisted basically of the allocation to communities and to supporting services of financial ceilings which were to be used for the particular purposes defined in the primary health care programme. The Conference, nevertheless, did not recommend re-allocation of resources from the curative level, particularly the tertiary level, to primary health care. However, this was where national will and commitment to PHC was demonstrated in the case studies for the national level programmes of Tanzania, Cuba and China.

The Report stated that financing was likely to be a combined community and government effort, with the government in the final analysis having to ensure that it was adequate for the agreed upon programme. The various ways of financing primary health care were social insurance, cooperatives and all available resources at the local level, through the active involvement and participation of the communities. The Conference recognised the level of development a country had reached as a determining factor in relation to the capability of communities to shoulder part of the financial burden of health development.

Voluntarism was never a key aspect of the proceedings of the Conference. One of the few references to it was in relation to financing where an assumption was made that if people were properly motivated and trained, greater use could be made of voluntary service for various health actions, including the development of local water supplies or part-time service in the delivery of health care (WHO, 1978, p.73). The reason why the area of financing was an appropriate place to bring in the subject of voluntarism was that few governments had the resources to support community health workers, and, therefore they needed this type of cost-sharing of manpower with communities.

In Newell's opinion the results of the 1978 WHO/UNICEF International Conference on Primary Health Care did not reflect the themes and strategies stated in the WHO study reports and papers which led up to the conference, particularly the Organizational Study on Methods of Promoting the Development of Basic Health Services. The emphasis on the consumer was watered down and instead a list was drawn up on what PHC consisted of and what people were expected to do to achieve it. These became the eight elements of PHC which are a selective way of viewing PHC and stating what PHC should consist of, rather than the consumers deciding what services are best needed and how they should be provided and the processes needed to achieve them[6].

WHO STRATEGIES FOR IMPLEMENTATION OF COMMUNITY PARTICIPATION

In January 1979, in resolution EB63.R21, the Executive Board of WHO endorsed the report of the International Conference on Primary Health Care, including The Declaration of Alma-Ata (WHO 1979, p.7). WHO management then formulated strategies for Health for All by the Year 2000. The WHO Executive Board suggested to the Thirty-second World Health Assembly that Member States use these strategies as a framework for developing their national primary health care policies and plans. These strategies were formally presented in the WHO document published in 1979 called "Formulating Strategies for Health for All by the Year 2000".

In this document, community participation was presented basically as a management and information issue for governments,

> "Government will therefore have to devise appropriate ways of promoting such participation, supporting it, effectively propagating relevant information, and establishing or strengthening the necessary mechanisms" (WHO 1979, p.17).

The recommended mechanism to ensure participation was for government, institutions, agencies, to take measures to enlighten the public in health matters, and the major

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[6]Ibid.

responsibility for developing and managing the ways and means of promoting participation appeared to be with government.

The Thirty-fourth World Assembly adopted the "Global Strategy for Health for All by the Year 2000", as well as resolution 34/58 of the United Nations General Assembly, concerning health as an integral part of development (WHO 1981a, p.7). One of the main thrusts of the Global Strategy was specifying measures to be taken by individuals and families in their homes, by communities, by the health service at the primary and supporting levels, and by other sectors.

The Global Strategy report stated that ways will be devised of involving people and communities in decisions concerning the health system and in taking responsibilities for self-care as well as family and community care (WHO 1981a, p.41). It was up to the ministries of health to explore the delegation of responsibility and authority to communities to organise their own primary health care or selected elements of it, and to provide guidelines and practical support as necessary to the communities that will organise their own primary health care.

Social control by communities in primary health care development formed part of the Global Strategy and was an area in which policy development was called for to ensure that individuals and communities can participate actively in deciding on health policy and in guiding the planning, management and control of the health infrastructure and programmes it delivered. The use of existing mechanisms such as local organisations or creation of new ones were the ways social control was supposed to be achieved with information and guidance being provided by health personnel. Ten global targets were recommended in developing PHC, two of which involved community participation. These were that all people will be actively involved in caring for themselves and their families as far as they can and in community action for health, and communities throughout the world will share with governments responsibility for the health care of their members (WHO 1981a, p.53).

The Global Strategy stressed the importance of generating and mobilising human and financial and material resources. Community involvement was the main strategy in developing the human resources for PHC development. It was left to ministries of health to explore appropriate ways of involving people in deciding on the health system required and the health technology they found acceptable, and in delivering part of the national health programme through self-care and family care and involvement in community action for health.

Seven specific measures were recommended for consideration to promote community involvement in relation to generating and mobilising resources, and they represented basically three different strategies. They were delegation of authority to communities to establish and carry out components of PHC, creation of participatory mechanisms and membership on various health bodies by community members, and individual responsibility for self-care and family care, mainly centred around applying principles of nutrition and hygiene (WHO 1981a, pp 65-66).

Launching health educational activities aimed at enlightening the population on prevailing health problems was another strategy stated in the Global Strategy for ministries of health. Literacy was identified as being of major importance for health and community involvement. It was linked to community involvement from the standpoint that it enabled people to understand their health problems and ways of solving them, and facilitated their active involvement in community health activities. Literacy had not featured prominently up to this point in the various WHO PHC development documents, including the "Health for All" series, even with the priority given to the role of information in promoting individual, family and community participation.

In terms of monitoring and evaluation, the main indicator for community involvement was the number of countries in which mechanisms for involving people in the implementation of strategies had been formed or strengthened, and were actually functioning, and decision-making on health matters was adequately decentralised to the various administrative levels.

Indicators for monitoring the progress towards Health for All by the Year 2000 were developed by WHO. The degree of community involvement, mainly in relation to health decision-making and the existence of effective mechanisms for people to express demands and needs, was cited as one of five indicators of political commitment to PHC (WHO 1981b, pp.20-21). The involvement by political party representatives and community-organised groups were specifically mentioned.

The "Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000" report stated WHO's preference for using the term "community involvement" rather than "community participation", the rationale being that it is not sufficient merely to participate, which may be simply a passive response (WHO 1981b, p.21). There was not much consistency, however, within WHO documents in reference to involvement instead of participation. Thus, the terms have also been used interchangeably throughout this chapter.

The Development of Indicators report included two social factors, education and housing, as influencing progress towards Health for All. An indicator of the contribution of education to PHC development was the literacy rate, or specifically, health literacy, namely an elementary understanding of nutritional and health needs and of how to prevent or control common health problems (WHO 1981b, p.24). The Report admitted that no indicators existed for health literacy and that the only way to assess health literacy was to carry out community surveys. The Report nevertheless mentioned some indicators of the effectiveness of dissemination of information for the educational process of health literacy such as number of mass-media outlets (e.g. newspapers, radio programmes, television or film), and the extent to which health information was actually disseminated through them, e.g., number of hours per week of health radio programmes and the use of peak-times.

Related to these indicators was access to radio, television, and film. Curiously enough no mention was made of community health volunteers or other community-level individuals and techniques of health education, such as home visiting as indicators of

dissemination of information. Yet community health volunteers was one of the main manpower strategies for PHC development.

The utilisation of PHC services naturally was an indicator in relation to the provision of primary health care. However, it was not cited as an indicator of community involvement. The availability of and accessibility to PHC services influence utilisation, as do economic and cultural factors, among other factors, which will be discussed later. The reasons for some people not utilising PHC services, and, thus, not becoming involved, even in a passive way, is important to determine and represents a major aspect of this research study. The Development of Indicators study stated that information on non-users and the reasons for non-use can really only be obtained from community-based surveys (WHO 1981b, p.27). Such a survey was a research method used for this study. The extent of community contributions in time, kind or cash was not highlighted by WHO as an indicator of community involvement. Rather resource allocation of national health budgets to PHC was seen as the single most important indicator of political commitment.

WHO Experiences in Community Participation

After the World Health Assembly launched the Global Strategy for Health for All in 1979, WHO attempted during 1981 to ascertain lessons learned on the development of primary health care from some 70 Member States (WHO 1983, p.5). The WHO "Review of Primary Health Care Development" addressed both the role of community involvement and PHC financing.

Regional and national country examples of community involvement for PHC were cited. From the African region it was reported that active participation by the community took the form of construction of health centres, wells and latrines and the remuneration of village health workers (VHWs), while the effectiveness of this participation depended to a large extent on the political, social and administrative structures. In general, the participatory approach in the African region by 1981 had not yet become common practice at every level (WHO 1983, p.97).

The main ways community participation was being practised and promoted according to the 1981 PHC Review was through local groups and using community health agents and traditional birth attendants. Various trends were identified relating to community participation such as an increased emphasis on utilisation of existing, and, the introduction of new, local level manpower and infrastructure. Community involvement in planning for PHC was still the exception rather than the rule. A significant finding was that community involvement in PHC never began effective in reality prior to communities reaching a certain threshold in economic, social and educational development (WHO 1983, p.105). An overall observation was that a lack of understanding among health professionals, decision-makers and health planners concerning community involvement in PHC was evident.

Community participation was discussed as one of the principal strengths and supports of primary health care at the technical discussions held in 1981 during the Thirty-fourth World Health Assembly (Kleczkowski et al 1984). Considerable importance was placed on the issue of decentralisation of decision-making and power over resource allocation and its effect on community participation. Attention by individuals to personal hygiene, diet and self-care was described as a narrow type of participation but one that was highly important, concerned as it was with life-styles and human behaviour as well as with therapeutic measures. The Technical Discussion Report claimed that the educational effort needed to raise and maintain competence in relation to the aspect of self-care could prove costly (Kleczkowski et al 1984). This is possibly so for self-care, but health gains can occur through low-cost educational efforts by community health volunteers directed at preventive health measures and behavioral change.

The Report stated that physicians and community health supervisors should turn to the social sciences for a better understanding of the dynamics of community participation and with a minimum of formal knowledge in the social sciences, health personnel can do a great deal themselves, simply by, "getting out of their offices and into community centres and people's homes and workplace to learn about the real and perceived needs and demands" (Kleczkowski et al 1984, p.38).

In 1983, WHO produced a report called "Community Involvement in Health Systems for Primary Health Care". The significance of this Report was that specific guidance was offered and a framework suggested for health planners and managers in selecting and developing appropriate national strategies for community involvement. The issues developed related to who should be involved, for what activities, and how involvement can be mobilised and organised to produce self-reliance and social control of PHC infrastructure and technology (Fonaroff 1983, p.7). Who was involved depended on what kind of participation was envisaged or was occurring regarding specific PHC interventions. How to involve those who participate in different kinds of activities for PHC depended on local conditions that affected relationships among people in communities and in external agencies.

The WHO experience up to 1983 showed that whilst community involvement was embraced in principle, it had not led in many countries to the political action required to make it a reality in PHC. One of the most explicit accounts by WHO of the mechanisms of CIH was produced by the Pan American Health Organization (PAHO) in its 1984 publication entitled "Community Participation in Health and Development in the Americas". Community participation in sixteen rural and urban PHC programmes in the region were analysed to identify elements that would lead to a more refined concept of community participation and ascertain and classify the major variables involved. Three distinct levels of participation were identified. These were,

> "1. Utilisation of services and facilities provided. This is not considered by itself to qualify as true participation but is rather a precondition, for without utilisation, further participation is unlikely to occur.
> 2. Cooperation with initiatives planned by an outside agency. This can include contributing labour, money, and materials and helping to carry out projects and activities.
> 3. Involvement in planning and managing activities" (PAHO 1984, p. xi).

The conceptual framework utilised to facilitate comparisons was to analyse the case study information according to the various dimensions of community participation. Three main dimensions were used. The first dimension was the mechanism/mode for community participation, that is, channels or structures through which community participation

occurred and how it occurred. The second was the breadth of community participation or who participates and how often, while the third dimension was the areas of community participation, namely planning, implementation and evaluation.

Information on community characteristics and factors affecting community participation were compiled as part of this study. The main characteristics of communities which had developed a degree of cohesion sufficient to support community action on health were a common need for basic services, including health as a priority need, a history of success in achieving goals through community action and the existence of an organisational structure through which action can occur. Other favourable community characteristics were a relatively high level of education which facilitated communication and understanding, and spatial concentration of the community and adequate communication and transportation facilities, which helped people share information and ideas and meet together to discuss problems and solutions. The presence of dynamic, enthusiastic leadership and community consciousness of its rights and responsibilities with regard to development were other general characteristics. The distinguishing factor of the more-participatory communities, was their dynamism, that is, "a process got started, and if conditions are favourable, it can grow" (PAHO 1984, p.7).

Another attempt by WHO to review the progress of community involvement in health development was a WHO interregional meeting held in Brioni, Yugoslavia, on 9-14 June 1985. The researcher participated in the meeting as a NGO representative (WHO 1985). The general view of the success of CIH at country level was that the concept was too new to make a judgement, and, moreover, proven indices or criteria for judging the success of CIH were still lacking. Representatives of the Africa Region at the Brioni Meeting reported that from experiences of about twenty countries of the Region, CIH consisted mainly of discussions on health and development matters with technical and administrative staff, selection and remuneration of village health workers, and physical, material and partial financial contributions to build local health and social infrastructures and to purchase essential drugs and maintaining local health services. Very few cases were reported of identification (planning) and funding by the community of development

projects (Aziza 1985, pp.5-6). Some of the major constraints to CIH in the Africa Region were lack of a clear national policy on CIH, lack of inter-sectoral coordination and insufficient planning with communities.

In 1987 WHO produced the seventh report on the world health situation entitled "Evaluation of the Strategy for Health for All by Year 2000." Community or consumer participation was included in the review which stated that consumer participation in planning and decision-making was still very limited (WHO 1987, p.44). Most countries were still attempting to reach the right balance between centralisation and decentralisation, particularly during current economic constraints. With the current constraints on budgets, there appeared to be an even greater tendency than before to centralise decision-making on priorities and on allocation of resources. It was recognised, however, according to the Global Review Report, that decentralization permitted greater participation by communities, and was more responsive to local needs. The importance of adequate information and of responsible consumer participation for the mobilisation of resources was equally recognised.

Only a few countries reported difficulty in mobilising communities for participation in health activities. These difficulties were mainly due to excessive centralisation regarding decision-making and control of resources and lack of a clear policy for involving communities in health care. Other obstacles were poor education, tradition, customs or beliefs concerning the causes and nature of ill-health, and a long dependence on government for all action and resources, which created a passive attitude on the part of the population.

Where community involvement had progressed it had done so with the support of mechanisms, particularly at local level, which often reinforced traditional systems, established local and district level health committees, involved local leaders and groups such as women's groups who had promoted and mobilised community support and action. The emphasis of community support in most developing countries had been on providing resources for establishing or improving health and sanitary infrastructure or paying

community-based health workers. An important contribution made by communities, according to the Review, had been in the form of volunteer services, but many countries were finding it difficult to sustain such involvement over a longer period (WHO 1987, p.50).

In 1993 WHO produced the eighth report on the world health situation. The report claimed that a large majority of Member States considered community involvement not only a political necessity but also an important and effective mechanism for planning, implementing and evaluation health programmes. Ninety-four out of the 151 countries reporting stated that mechanisms were fully functioning or were being further developed (WHO 1993, p.52). Some countries reported that it is difficult to mobilise communities to participate in health activities, mainly because of excessive centralisation in the control of resources and decision-making and lack of clear ideas of what communities should be expected to do.

According to WHO, experience to date suggested that there are a number of basic principles which were the key to the successful establishment and functioning of mechanisms for enhancing community involvement. These included:

> "- a partnership between health services and their professionals and local community people;
> - individual and collective leadership at the community level; and
> - sustainable mechanisms at the community level" (WHO 1993, p.55).

Two important obstacles have emerged in achieving progress in community involvement according to WHO. These are the absence of clear national policies or strategies for the establishment of community health worker programmes and the lack of specific and regular budgetary support from governments to sustain training, supervision, logistics, and financial incentives. The most frequently mentioned problems in the least developed countries were the low level of general education, lack of knowledge about diseases, and the absence of clear mechanisms for involving people. A number of countries are gradually beginning to recognise the important role of non-governmental organisations in linking the community with the health system and other sectors. However, clear

political commitment and effective strategies are required to harness these resources according to WHO's Eighth Report on the World Health Situation (WHO 1993, p.52).

One of the main reasons for the success of Alma Ata was the strong leadership role in primary health care policy development played by WHO and UNICEF. Since the Alma Ata Declaration just under twenty years ago, however, the influence of the WHO in the international health policy arena has diminished (Walt 1993, 1994). Several of the obstacles and constraints for the lack of success in achieving progress in community involvement are related to the absence of clear national policies and strategies in strengthening and supporting primary health care. Some of these relate to structural issues such as excessive centralisation, while others are related to allocation of resources. International health policy can provide the framework and rationale for action at national level in addressing these obstacles, but the strength and influence of WHO in strongly advocating for and pushing through international health policies at national level such as primary health care is questionable.

The major realignment in the international health policy arena over the past two decades has involved the World Bank which assumed a more central role as a major financier and as an authoritative source for policy ideas. The 1993 World Bank "World Development Report: Investing in Health" set the scene for a shift in policy in health, based on economic principles of cost effectiveness. Walt (1994, p.122) states that,

> "In the straitened economic circumstances of most countries affected by global recession, governments were advised to consider developing only those packages of interventions which could be shown to be cost effective in terms of gains to health".

Moreover, in practice, lending for health services strengthened the World Bank's overall standing in the health sector and its increased project sponsorship and policy analysis enhanced its credibility as an influential actor. Based on its economic and financial orientation, the World Bank was particularly focusing on health financing issues at a time of global economic stringency. The World Bank report, "Financing Health Care: An Agenda for Reform", published in 1987, heralded a new and proactive stance to national

health policies. In essence it called for a diminished role for the state and increased reliance on the market to finance and deliver health care. Thus cost-effective approaches to health care and the financing of health services became the focus of much health policy debate and research.

This was occurring at a time when WHO was seeing its budget becoming more influenced by extra-budgetary sources for specialised programmes such as the Global Programme on Aids, Control of Diarrhoeal Diseases, and Essential Drugs. The implication here was how far policy development was being removed from WHO's governing bodies into the hands of those giving the extra-budgetary funds. By the early 1990's about 54 per cent (as opposed to 25 per cent in 1971) of WHO's budget came from extra-budgetary sources (Walt 1993, p.128). WHO's privileged position in defining and implementing health policy in the developing world was also being increasingly shared with academic institutions, private agencies and non-governmental organisations with support from their respective national donor agencies. Furthermore, in the 1980's climate of economic stringency, the bilateral agencies have turned less to the specialised agencies such as WHO for overall health policy guidance, and more to the World Bank and International Monetary Fund to construct the policy framework for global economic and social aid.

It has been argued that WHO has not responded rapidly enough to changes in the health sector in many developing countries; that the level of local medical skills has improved dramatically and what is needed from WHO now is not technical assistance in medical care, but in health management and capacity building (Walt 1993, p.140). Shrinking public health sectors are presenting new challenges to health planning. Moreover, there is a need to broaden technical competency within WHO for developing health policies which set health in the context of socio-economic development and which incorporate economic and health financing perspectives. This is particularly needed for primary health care programmes whose success depends on the overall general development of communities and the participation of community members in the development process.

CONCLUSION

Participation as health policy emerged with WHO during the 1970's in response to a recognition that specialised programmes such as the malaria eradication programme were not cost-effective strategies and that the interests and the involvement of the consumer must be taken into account if basic health services were ever going to address issues of access, equity and affordability. The WHO, with UNICEF played a strong leadership role in the 1970's in setting into motion actions such as operations research studies and health system reviews to come up with alternative health care delivery strategies. At this time the prominence of WHO with national ministries of health in developing countries was such that they were willing to join WHO in developing strategies to develop and improve their health care systems. Many of these countries were just coming off colonial rule and were under pressure from their people to come forward with health care approaches which reached the rural areas. Donor agencies were supportive of this process since the emphasis was on attempting to gain better utilisation of existing resources. However, the medical establishments within developing countries were reluctant to see resources diverted from tertiary, curative care facilities to rural health schemes.

Nevertheless, the result was the call for primary health care as presented and declared at the Alma Ata PHC Conference in 1978. Reference was made to the fact that health had to be seen in the context of socio-economic development and that it must incorporate partnership with and participation of communities. However, the strong role of government in health policy and controlling the process of community involvement was also expressed. No call at Alma Ata was made for a major reallocation of resources from tertiary, curative services to primary health care development which would have demonstrated a real political commitment to PHC.

The WHO did set out to identify ways and means of how community involvement could be achieved and it incorporated an assessment of community involvement when it undertook formal reviews of PHC in 1981, 1987 and 1993. Findings revealed that community involvement in health development was occurring in some developing countries where a partnership existed between peripheral health staff and communities,

and, within communities with effective local leadership and sustainable mechanisms and local structures to mobilise community involvement. Obstacles and contraints were related to an absence of clear political commitment and national policies in relation to PHC development and lack of budgetary support to PHC activities. These factors are crucial to sustain the government's partnership role in PHC development and to offer clear mechanisms for involving people.

The WHO did not seek any extra funding for PHC development in the 1980's but expected the national governments to seek PHC funding from donor agencies. This did occur to some extent from donors such as the Swedish International Development Authority (SIDA) and the United States Agency for International Development (USAID). However, the World Bank emerged as a major influence in international health policy development and programming mainly as a result of the influence of its funding mechanisms. The global recession which occurred during the 1980's meant that donor funds were not as forthcoming for PHC development as after Alma Ata, while at the same time the World Bank was proposing a lesser role for the state in the social service sectors and requiring it as part of its structural adjustment programmes.

Through a combination of factors, PHC development and community involvement have not lived up to the expectations envisaged in 1978 when Health for All by the Year 2000 was the global goal. One important factor has been that WHO does not have sufficient experience and expertise to advise or guide governments in the social and community development areas in order to bring health into the perspective of broader socio-economic development. This area is also vital in understanding the dynamics of community participation. Moreover, WHO does not have the leverage to influence donor agencies to also advocate for primary health care development nor the influence with national governments to re-allocate resources to PHC or re-structure their health systems to address the issues of excessive centralisation in decision-making. Moreover, WHO is becoming more dependent on extra-budgetary funding which focusses on specialised programmes. Ironically, it was the experience of the specialised programme for malaria

eradication which convinced WHO that such programmes cannot operate without a viable basic or primary health service system and the involvement of the consumer.

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CHAPTER 3

PARTICIPATION AS DEVELOPMENT POLICY IN COLONIAL AFRICA AND POST-INDEPENDENT KENYA

INTRODUCTION

Numerous current day approaches to rural development were proposed during the colonial era. Participation as a strategy to enhance rural development in Kenya was promoted as far back as the mid-1930's as part of colonial administration policy. These are identified and discussed in this chapter which also reviews the role of participation in post-independent Kenya, particularly the Harambee Self-Help Movement. In addition, participation as a governmental policy for rural and health development as reflected in Kenya's five national development plans, spanning the periods 1964-1993 is also reviewed.

PARTICIPATION AS POLICY DURING THE COLONIAL ERA IN AFRICA

The emergence of the concept of community development and participation emanated from experiences in the education sector during the colonial era and was reflected in the reports of the Advisory Committee on Education in the Colonies (Colonial Office 1935, 1943).

The Committee's 1935 report proposed that a broader view of education be adopted as an effort to improve the whole life of the community. They realised, however, that this would be a radical departure from the traditional, more scholastic conception of education. It would require, in the case of each community, the formulation of a comprehensive plan for the improvement of all aspects of its life. However, at this juncture, no mention was made of the participation of the community in this proposed planning effort.

An appreciation of at least passive participation of the African communities and cultural sensitivities nevertheless was recognised.

> "No policy of social advance can be successful that is not inspired by a desire on the part of African communities to improve the conditions of their own life. To achieve its aim it must take into account African thought and feeling and must encourage African initiative, self-help and responsibility" (Colonial Office 1935, p.3).

The Committee considered the responsibility for helping improve African communities as being a moral obligation resting on colonial governments in Africa, but the people must meet the cost of educational facilities. Since African communities would not be able to support educational improvements in line with Western standards, it was felt imprudent to introduce them until economic development occurred. The developmental issue of sustainability in relation to the provision of recurrent costs was thus introduced.

The Advisory Committee on Education in the Colonies felt that health conditions, more than any other single factor, had retarded the advancement of African people. Linkages between available curative services, a healthy home environment, and adult education in health were also recognised some fifty years ago.

> "...Health propaganda among the young will be to a large extent wasted effort unless it is linked up with a campaign conducted by the medical department among the adult members of the community, and very specially among the women" (Colonial Office 1935, p.7).

Besides expressing the need for adult education, the 1935 Memorandum advocated the need for extension agents and promotion of local groups to enhance development. The idea for the former was borrowed from what was found to have been successful in the "American Negro South". Their tasks were similar to what became some of the main activities of community development agents. These tasks were described as,

> "..organising the people in formal groups to carry out what they have individually realised to be desirable. Without this the influence is not likely to prove lasting..." (Colonial Office 1935, p.14).

The 1943 Advisory Committee report on "Mass Education in African Society" promoted the concept of mass community education and emphasised more firmly the importance of community participation and leadership. The report said,

> "Measures taken by authority must carry with them the active and understanding participation of the community itself... That understanding and that willingness to make and sustain an effort will be achieved only if the real co-operation of the people is secured. It can be secured through the leadership from among the people themselves..." (Colonial Office 1943, p.9).

Thus, one of the objectives of mass education, was that it was a movement of the community itself, involving their active support. Community awareness, participation and control leading to social and economic changes were advocated. The main strategy to achieve these changes was adult literacy through mass education programmes. Some fifty years later education through adult literacy programmes is still an important development strategy to enhance community awareness and involvement.

The use of community volunteers in the adult literacy programme for mass education was a manpower strategy proposed then, which is a current manpower strategy employed in community-based health care. However, the type of community member proposed was related more to the Western notion of voluntarism. The 1943 report stated,

> "...it is true that as yet the number in many communities is small of individuals who have the leisure, and the sense of civic responsibility, which sustained voluntary work implies." (Colonial Office 1943, p.22).

Leisure time is hardly a criterion of selection for present-day community health volunteers in the developing countries, but, civic responsibility certainly is. What is worth noting here is that as early as the 1940's, a volunteer cadre related to development activities was being proposed. Another principle put forward then was participation as an educational process as well as a means to achieve programme success. This was expressed in the 1943 report in relation to the training of voluntary workers, as,

> "In addition they (voluntary workers) should have understood... the methods to be employed in securing the community's participation in the project, and in making that participation an education process with permanent educational effect on the individual and the community." (Colonial Office 1943, p.23).

Another fundamental strategy in relation to rural development participation recommended in the 1943 report was identifying and working with local organisations, stated as,

> "We are of the opinion that these truly indigenous and popular societies should be given the fullest recognition in the organization of a mass education system." (Colonial Office 1943, p.28).

Between 1947 and 1960 eleven conferences on African Administration were held. The term community development was coined at the Second Session of the Summer Conference on African Administration at King's College, Cambridge in 1948 as an alternative and complementary term to mass education. Participation formed a major part of the definition of "mass education" (community development) at the 1948 Conference. It was defined as,

> "..a movement designed to promote better living for the whole community, with the active participation and, if possible, on the initiative of the community; but if this initiative is not forthcoming spontaneously, it should be aroused and stimulated by special techniques designed to secure the active and enthusiastic response of the community." (Colonial Office 1948, p.101).

Community participation was perceived as the new and vital factor of the community development strategy and was characterised as the enthusiasm of the people, which must either be stimulated or guided into fruitful channels by techniques which were evolved for that purpose.

The 1948 Conference, the theme of which was, "The Encouragement of Initiative in African Society", stressed the importance of today's rhetoric of bottom-up planning. It stated,

> "The community itself must be taught to realise and express its particular needs for development, and executive planning in the field must be based on these rather than on a programme laid down from a more remote source and therefore neither so truly representative of what is actually required by the community or so likely to evoke their enthusiasm or to secure their active participation." (Colonial Office 1948, p.103).

The main technique to elicit community participation proposed, was the indirect approach designed to stimulate a real interest among the people themselves by drawing them into the picture at every stage of the initial preparation and planning of any project. The main strategy of this approach was the use of informal meetings and discussion at village level in places not associated with officialdom, which is very consistent with current thinking on how to approach communities. The weakness of the indirect approach, according to the 1948 Conference, was that it required that communities had some knowledge, however scanty, of the topic which was being presented to them, a factor which is less relevant now than at that time. Improved public health was one of the immediate results anticipated from this proposed new development strategy, and improved hygiene and public health was expected to be one of the first consequences of a mass education campaign.

Another fundamental tenet of current development thinking voiced at the 1948 Conference was the crucial role of participation of women in development.

> "We cannot too strongly emphasise the importance of their (women's) support and participation at all levels of community development. Where it has not been possible to stimulate communal interest and active participation in past development plans, this has often been due to the absence of women from these spheres of effort and their exclusion from the organisations which draw up plans." (Colonial Office 1948, p.103).

The 1951 Conference (Colonial Office 1951) outlined two broad strategies to enhance women's role and participation in development. The first was to give priority to social service programmes which lightened the burden of women. Examples were water made available in the village, firewood grown close at hand, grinding machines made to replace the pestle and mortar, and less laborious but more productive agricultural methods. All

of these recommendations are still relevant and, unfortunately, as elusive today as they were over forty years ago.

The second general recommendation was knowledge and education for women and efforts to change the attitudes of men regarding the roles of women in development. A practical suggestion made at the 1948 Conference regarding provision of knowledge was the use of a district visitor who would live and move freely among the people and become their guide, philosopher and friend. The district visitor idea appears similar conceptually with the role of the community development officer and to some extent with the present day community health volunteer.

No recommendations were put forward at the 1951 Conference on how to change the attitudes of men to accept a more participatory role of women in development. Even today this is a major challenge for development planners. Informal education in the form of workshops and group discussions at village level targeted specifically at men are some of the strategies employed today. However, cultural constraints are still at play which have been difficult to break down even over a forty year period.

The 1948 Conference endorsed decentralisation for planning and execution of community development projects, and outlined the organisational mechanisms which form the basis of Kenya's District Focus for Rural Development Programme, (e.g., village, inter-mediate, district and provincial committees dealing with development issues). What was recommended regarding organisational structures at the 1948 Conference at village level such as village committees is the same strategy incorporated by most present-day community-based health care programmes. The functions of the village committee were seen as stimulating the village unit by example, co-operation and leadership and the consequent fostering of an enthusiasm for mass education.

The village committee membership recommended at the 1948 Conference included local farming, co-operative and trading groups, representatives of religious, social and youth organisations, members of the local government body, and members of the technical

services. It mirrors the membership that is generally recommended by CBHC programmes today.

Incorporating community-based health care programmes into existing local structures, another current fundamental rural development principle, also did not escape the proponents of the new community development approach in 1948. The Conference Report stated,

> "Mass education therefore should wherever possible introduce better social service by building and improving what exists in the community already. To set up a new institution without regard for those already functioning is uneconomic and also invites failure by setting up antagonism before the new institution has had time to establish itself." (Colonial Office 1948, p.37).

The 1948 Conference was straightforward regarding the area of community financing. It stated,

> "We emphasise the importance of inducing the people to pay for what they want. These better things are not to be had for nothing. Mass education must be at pains in every phase of a campaign to drive home the unpleasant truth that social betterment needs two commodities to be supplied by Africans, voluntary work and money" (Colonial Office 1948, p.37).

The implication is that these two relatively available Western commodities of voluntary work and money were equally available to Africans struggling under colonialism; and, that better social services are a privilege and not a right, a policy which was immediately reversed at independence.

A reciprocal policy in the form of provision of subsidised social services to replace the enormous human and material wealth extracted from colonial Africa was absent. That policy in the form of development aid had to wait until after independence when the new African governments were in a stronger bargaining position vis-a-vis the Eastern and Western block countries. Nevertheless, the 1948 Conference Report did qualify their harsh position on community-financing, stating,

> "...we do urge that the principle of paying for these things (social services) in some form, individually or communally, should only be abandoned when absolutely necessary and when the withholding of the particular service in default of payment would do more harm than good..." (Colonial Office 1948, p.38).

Ways in which community development could be fostered according to the 1951 Conference (Colonial Office 1951, p.103) included organising small ad hoc levies for particular projects, by giving grants, by providing technical assistance, and by co-ordinating the work of all community development agencies, including voluntary agencies and tribal welfare societies. The 1951 Conference envisaged community development as a major concern of local government, not to be left to outside agencies. From the community side, the Conference expected the local community to contribute a reasonable proportion in materials, communal labour or cash towards whatever was required.

Financing mechanisms for community level development projects is as topical today as in the early 1950's when community development was emerging as a development strategy. The 1951 Conference (Colonial Office 1951, p.104) offered various recommendations including a tax of 1 shilling for community development projects. They admitted that the total sum would be minimal, "but even small sums would act as `primers' and they could be augmented either by grants...or, if the people so desired, by local rates for specific purposes. In order to complete a scheme desired by them the people of an area might well contribute materials or communal labour." These recommendations were very similar to the present day arrangement for development projects, whereby communities must provide some matching financing, either in cash, kind or labour.

Communal labour seemed a natural and major form of community contribution to the colonial administrators. Without any reference to anthropological research, they rather boldly claimed in their 1951 Conference that,

> "It is indeed in full accord with African custom that the members of the community should perform free services for the good of the whole community... It was customary in most areas for the tribal authorities to organise such labour and ... for tribal leaders to have the support of the tribe in this." (Colonial Office 1951, p.106).

Forced communal labour apparently was practised, otherwise clarification would not have been necessary in relation to what was allowable under the Forced Labour Convention of 1930. The 1951 Conference cited a despatch dated 9th July, 1947 addressed to African Governors clarifying the fact that, "the extraction of work or services for soil conservation and other similar measures essential for the life and welfare of the community could be fully justified under the Convention..."(Colonial Office 1951, p.106). However, the 1951 Conference did not believe that legislative powers should be used to coerce reluctant community members to provide involuntary labour. The Conference felt that compulsion was contrary to the whole spirit of community development and whole schemes would be prejudiced and made unpopular if it was used.

According to Mbithi (1973, p.90) the most well-known approach to rural development for the period 1946-1960 for eastern Kenya was successive communal labour campaigns. Of the approximately ten campaigns recorded for this period, none had any lasting measure of success. Such campaigns as forced communal dam-making, pit latrine digging, communal terrace-making, and compulsory road construction tended to alienate the participating parties. The abuse of the convention, which no doubt occurred, coupled with the general oppressive environment of colonialism, surely affected community attitudes to communal labour as a form of community participation.

The similarities between development thinking and strategies for colonial Africa of the 1940s and 1950's and those expounded today are striking. For instance, the call for increased community participation and awareness through adult literacy, promotion of local groups for development, improved status for women, devolution of authority to the district level, cost-sharing and cost-recovery. On the other hand the divergence between rhetoric, reality and feasibility was wider then than today. Besides the effect of independence, a major reason is that present day development thinking is influenced by professionals who are either African nationals, or are individuals who can more easily relate to the national environment than the colonial administrators. For example, the latter described their task at the 1948 Cambridge Conference as,

> "From the intellectual atmosphere of one of the oldest and greatest of the world's universities and from the study of a considerable volume of specialist literature it is something of an effort to cast our minds back to the realities and limitations of our daily work amongst backward peoples, often under almost primitive conditions. We have, however, constantly tried to make that effort.... " (Colonial Office 1948, p.86).

How in touch colonial administrators were with the realities of community development in Africa was questioned by Gardiner (1982, p.16) who said, "The governors and their staffs had limited opportunities to discover the real needs and aspirations of the people. They were of a different race, a different culture, a different tradition... It is not surprising, therefore, that they developed the belief that they knew what was good for the people better than the people know themselves". This was hardly an attitude conducive to eliciting community participation.

In their defence Nyagah (1982, p.63) claims that it was impossible for colonial administrators to practice principles of democratic participation, liberty, equality and social justice without challenging the whole essence of colonial rule in the first place. He asserts, however, that there was a deliberate lack of economic and social policy designed to secure an improvement of the social conditions of the colonised people, and, that the colonial administration was a law and order, not a development agent. Holmquist (1984, p.75) in writing on self-help in Kenya, viewed the emphasis of community development in Kenya during the colonial era as, "a state counter-insurgency effort" to the independent schools movement among the powerful Kikuyu tribe in central Kenya, the main white settler area in the country. Ng'ethe (1984, p.75) claims that nationalist politicians were well aware of the political threat of state-led community development. Many viewed community development as an attempt to keep the countryside from dealing with nationalist issues.

Gertzel (1982, pp.188-189) recognised, nevertheless, the difficulty in distinguishing between social and economic rather than political development and admitted that some economic and social progress rather than political development did start to occur as a result of a development role of the colonial administration in the latter days of colonial rule. As the concept, strategy and policy of community development became more

established in the early 1950s, the colonial administration perceived the local authorities as playing the most significant collaborating role with communities in development efforts.

PARTICIPATION AS POLICY IN POST-INDEPENDENCE KENYA

It was a general feeling among Africans that the colonial service was primarily structured to serve the purpose of law-and-order maintenance. The aspirations of the governments of newly independent Africa were qualitatively different in that, at least in rhetoric, they were more directly committed to the objective of development through the use of government structures. Development was the new catch phase and re-organising the government to incorporate planning for development, it was believed, would give it a fresh outlook. The civil bureaucracy was no longer primarily a guardian of law and order but the leader in development (Hyden 1982, p.147-148). Theoretically, the planning process for development should involve community participation.

In Kenya community expectations were high at the time of independence for development initiatives from the new government. Therefore, some development strategies needed to be formulated. This was done in part at a conference on education, employment and rural development held at Kericho in 1966 (Heyer et al. 1971, pp.1-2). A series of initiatives stemming from the conference led in 1968 to the selection and survey of fourteen divisions in Kenya considered to be representative of small-farming and to a lesser degree pastoral conditions, for preparation in 1969 and 1970 of multi-sectoral and to some extent experimental development plans for six of them.

This project was known as the Special Rural Development Project (SRDP) (Mbithi 1982, pp.140-144), and, according to Chambers (1973, p.23), its experience helped highlight problems and possibilities of decentralised planning activities involving local-level staff and communities. The most important lesson to Chambers from the Kenya SRDP was that the ability to implement is the crux of a good plan. Moreover, effective implementation depends on competent local-level staff.

A conclusion of the Ndegwa Commission (Gertzel 1982, pp.187-190), established in 1970 to enquire into the structure of the public service, was that the Provincial Administration was not closely enough linked to the development process, and that it (Provincial Administration) "is a major organ of political authority in the countryside." This was symbolised by its responsibility for law and order, including control of public meetings, a major mechanism for community education, fund-raising and participation. The Ndegwa Commission proposed a division of labour within the Provincial Administration between officers concerned with general administration including law and order and tax collection, and officers responsible for development. The Ndegwa Report recognised this as a basic constraint on rural development.

Thus, administrative change in Kenya after independence, up to the early 1970's, did not represent any radical change or innovation towards the decentralisation of government, nor did it imply any enhanced role of community participation in the development planning process.

HARAMBEE SELF-HELP IN KENYA

Rural development in the East Africa context, according to Mbithi (1973, p.85), is an increase in the ability of the individual and of the community to increase its span of control over factors which effect it. Development, therefore, means improving the outcomes which people are able to elicit from their environment, so as to make achievements correspond to wants. Such improved control, of course, would necessitate a more complex society and technology. But if people are, in fact, to achieve control over their social as well as their physical environment, they must advance without undue government patronage, as equal partners in development.

Kenya's Harambee Self-Help Movement was an attempt to improve the community's control over its political and social, as well as its physical environment. Harambee involved the people as partners in development, as initiators as well as recipients of change. A basic principle behind the Harambee Movement was that government could not initiate and sustain all rural development activity and that economic and social

independence demanded hard work by all citizens (Thomas 1985, pp.7-8). The Harambee Self-Help Movement in Kenya exploited traditional kinship organisation and communal work patterns and hence tried to maximise social control, group discipline and individual participation. It was supposed to minimise governmental agency patronage and financial commitments (an important point with the Treasury). It also attempted to maximise individual participation on the same type of projects which were costly to the colonial government and which had failed to achieve lasting benefits due to non-participation and take-over by the rural people (Mbithi 1973, p.90).

The history of the Harambee Self-Help Movement dates back to Kenya's independence. When Kenya attained internal self-government on June 1, 1963, Jomo Kenyatta gave the rallying cry to the new nation, "harambee", which symbolised the need for self-reliance and community initiative in the development of the country (Mbithi 1977, p.14). With the current government of Daniel Arap Moi, the slogan of Nyayo reiterates this imperative of harambee made famous by Kenyatta by following Nyayo (in his footsteps). In many respects, the call for harambee was a plea for returning to traditionally practised systems of work, support and care. It involved the collective work like clearing, planting, and weeding gardens, building houses or roads, and the activity of constructing self-help (harambee) schools, community halls, dispensaries, and institutes of technology (Willms 1984, p. 20).

Initially, the new post-independent government promised to match the initiatives of rural, peasant communities with funds or professional services. For example, if a community felt that they needed a school in their location, and with great resourcefulness they organised the money and work to build the school, they would expect the Ministry of Education to provide a teacher. Alternatively, they might build a dispensary and expect the government to provide the drugs and community nurse. However, the post-independence response to the call for harambee was so immediate and dramatic, that the government was ill-prepared to match the initiatives of the hundreds of communities who attempted to develop themselves. As a result, there were hundreds of schools,

dispensaries and clinics that had been physically constructed, but were not in use (Hill 1975, p.646).

In the face of growing discontent in the rural areas, the government attempted to regain its bureaucratic control of development (harambee, self-help) activities initiated by rural-based, peasant communities. As a measure designed to limit the increasing expenditure of scarce resources, the move to control harambee was an administratively rational, restorative strategy. It presumed to curtail the repetition of already planned essential service programmes in areas such as health care, water, agriculture, and education. It also attempted to diminish the rising frustration of the average citizen involved in harambee projects.

The Harambee movement, nevertheless, was an important form of community participation. It became constrained by government because it was not able to coordinate Harambee initiatives, nor was the government able to match or meet its contribution as part of the partnership arrangement with communities. This experience then had a potential detrimental effect on other initiatives to enhance community participation.

PARTICIPATION AS POLICY IN KENYA NATIONAL DEVELOPMENT PLANS

Government development plans are generally set out in time periods of five to ten years. They represent a policy statement of the priority plans and strategies which government wishes to pursue. For a variety reasons such as periods of global recession and weak commodity export markets, hyper-inflation, drought, rapid population growth, and civil conflict, many of these noble intentions are sometimes not fulfilled. They do represent, however, one of the most important public statements of a country's development directions and policies. Thus, the reference to participation in national development plans is an indication of the importance and commitment which a government places on participation as a development and health policy.

The first development plan for Kenya covered the period 1964-1970. This period was when the community development movement was in full strength in developing countries.

Reference to participation and involvement in the 1964-1970 Development Plan was stated as,

> "The primary goal of community development in Kenya is to involve people in the planning of their own development....Such involvement is at the root of nation building and economic development, neither of which can move very far or fast without the general and energetic support of the country's citizens." (GOK 1964, p.113).

Self-help was to be the basis of community development, and it was felt that participation in self-help schemes would produce a general awakening of interest in self-improvement. The community development strategy was to establish voluntary, unpaid community development committees at local, regional and national levels to channel the enthusiasm for self-help in useful directions. External funds would be provided to these committees to assist self-help groups. A cadre of community development staff would stimulate and guide self-help in the field and serve the self-help committees. The 1964-1970 Development Plan described the community development structure through which community participation was supposed to flow, the main mechanism being self-help projects. This represented the classical community development model which dealt more with structure and order than process and development.

The supplemental 1966-1970 Development Plan (GOK 1966, p.56) stated that the reasons for stimulating participation extended beyond equity and justice. It was felt that by mobilising inherent talents and abilities of the population, the future scope for development in Kenya would be widened tremendously. Thus, participation as a political goal was seen as an important alternative strategy for development in general. The policies and programmes set out to achieve economic participation, in the form of training, education and improved skills, were also to enhance the prospects of people being prepared to participate in development efforts, including health development activities.

The significance of the supplemental 1966-1970 Development Plan in relation to health was the government's policy to provide an adequate level of free basic social services to all its citizens. Free medical services for out-patients and all children in 1965 were cited

as an important first step (GOK 1966, p.314). The government also decided to place strong emphasis on measures to promote family planning education. Participation of individuals or communities in health development, however, was not mentioned as a strategy or policy initiative.

The 1970-1974 Kenya Development Plan (GOK 1970, p.19) claimed that the grass-roots efforts of the people to improve their conditions of living by self-help effort had made a significant contribution to development during the 1964-1970 Plan period, and the government aimed to give greater assistance to these efforts during the new Plan. The basic principle that sound, self-generating economic and social growth arises from participation of the people mainly through self-help was again expounded in the community development and social services section of the 1970-1974 Plan.

Three major problems were cited which endangered sound planning of projects, but none referred to lack of community participation. Rather they were related to organisational and managerial constraints, such as lack of technical people to give advice, lack of control over some self-help groups who have developed projects where recurrent costs were not ensured and political considerations having influenced the initiation and location of projects.

Important new policy initiatives in relation to self-help projects were that local communities would meet the running costs of their own projects to a greater extent in future, and all local self-help projects will be subject to the clearance of the District Development Committees. Much stricter control, in particular, would be exercised over the building of Harambee schools, so that their locations are planned in accordance with overall education goals. Thus, both the concepts of community participation in contributing towards recurrent costs, as well as decentralisation, was introduced for the first time. The latter was more as a method of control rather than enhancing participation in decision-making and sharing of resources.

A significant policy issue in this Plan was the transfer of responsibility for health services from the county councils to the Ministry of Health (GOK 1970, p.488). It was debateable how much, if any, community participation occurred when health services were managed by the local authorities. Nevertheless, the policy to centralise responsibility for health services development further removed any prospect of community participation in the planning or decision-making processes about health services development.

One of main goals of district planning stated in the 1974-1978 Plan was to seek willing and active participation of local communities in the planning and implementation of development programmes (GOK 1974, p.111). No mechanisms were offered on how to facilitate this objective, but re-organised District Development Committees would be responsible for preparing the District Development Plans and a new District Development Officer cadre was being introduced to strengthen the committees, and to co-ordinate district planning work and the implementation of approved projects.

The 1974-1978 Development Plan was the first plan where community development failed to warrant a separate chapter, even when the major theme and thrust of the Plan was development of the rural areas. One reason could have been that community development was relegated from ministerial to division status in the government structure. The objective of community development was stated similarly to previous plans, that is, "to mobilize people to co-operate in nation-building for the benefit of individuals within the community and the nation as a whole" (GOK 1974, p.482). The reference to the self-help movement was revealing in its content, besides the fact that it was more abbreviated than in previous plans. The Plan stated,

> "In the immediate post-independence period, emphasis was placed on the stimulation of the self-help spirit among the people. The resulting responses and enthusiasm of the people throughout the country in some cases defied orderly planning and, unfortunately, led to wasteful use of scarce resources. Emphasis has, therefore, had to shift from motivation per se to planning" (GOK 1974, p.482).

No specific references were cited, however, where resources had been wasted as a result of self-help efforts. It appeared that the technocrats had gained the upper hand in insisting on a more structured and less spontaneous approach to development. A functional description of the Division of Community Development, then within the Ministry of Co-operatives and Social Services, was provided in the 1974-1978 Plan. It was stated as being concerned with the organisation of local effort aimed at ensuring that the people collaborate with each other and with Government to improve their own economic, social and cultural conditions. The curious use of the term, "ensuring that people collaborate" sounds somewhat authoritarian and top-down. The Plan explained that these efforts towards material improvements produce more intangible factors, as, the "people participating become more socially confident and more economically self-reliant" (GOK 1974, p.482).

The 1974-1978 Development Plan called for more emphasis on promotive and preventive programmes as the strategy to achieve its main health objectives (GOK 1974, p.449). Participation through increased utilisation of health services, behavioural change, community participation in planning, or in decision-making, or through contributions were not mentioned as strategies to achieve these objectives. Poor access to health services in the rural areas, inadequate resources and organisation, and shortage of paramedical staff were the three major constraints hindering achievement of health goals according to the Plan. Removal of these constraints was the main strategy for the 1974-1978 Plan.

The Government of Kenya's endorsement of primary health care and "Health For All by the Year 2000" was not referred to in the 1979-1983 Plan, even though the Government had been a signatory of the 1978 Alma-Ata PHC Declaration. Reference was made, however, to the plight of the consumer for the first time. The Plan said,

> "More and more people are demanding modern medicine and are prepared to travel long distances and queue for better treatment" (GOK 1979, p.125).

The 1979-1983 Plan was the first to make reference to promotion of community participation and involvement in health, specifically in relation to environmental health

projects, and family planning. The strategy was to involve and engage the families themselves in development activities through making them realise the benefits of family planning. This rather one-sided and top-down form of involvement was to be done through informing and educating families on the consequences of high rates of birth.

The plan of action to implement the community health education strategy was a traditional one. That is, training additional health education officers and increasing the use of mass media for spreading health information, as well as distribution of audio-visual education materials. No mention was made of the community's role or participation in health education or even a description of behaviour to be changed through community health education. The emphasis on communicable disease control and control of vector-borne diseases mainly involved the development of specialised vertical programmes such as the Expanded Programme on Immunisation (EPI) and establishment of vector-borne control units.

The theme of the 1979-1983 Development Plan was alleviation of poverty throughout the nation. Widespread participation was cited as one of four basic principles which defined the nature of the development process. The plan stated, "All Kenyans are expected to participate in the development process. Creating and dispersing opportunities for such participation is a major aim of development strategy" (GOK 1979, p.1). The strategies for alleviating poverty were cited as the creation of income-earning opportunities, the improvement of expenditure patterns, the provision of other basic needs, such as nutrition, health care, basic education, water and housing, and institution building. Rural development was considered one of three development efforts to address income-generation. An essential ingredient of successful rural development was increased participation in the decision-making process at the district level (GOK 1979, p.15). The emphasis was on increased participation of local level technical staff, elected representatives and members of target groups in programme decision-making.

A particular concern to the Government was the changing pattern of family expenditure to the detriment of development. Specifically, the mis-spending in both high and low

income families. In the former, the plan claimed that children suffer from inadequate diets, while in the later incomes are dissipated on "beer and chang'aa (local brew) while children lack food, medical attention and parental supervision" (GOK 1979, p.17). Ignorance was also cited as a reason for injudicious expenditure of incomes, particularly in relation to nutrition and child development. The Kenya Government's policy to address issues of socio-economic change was to strengthen the family as a social unit through its several community activities, its functional literacy programme, and its support for family-oriented activities of voluntary agencies.

The theme of the Fifth Development Plan (1984-1988) was mobilising domestic resources for equitable development. The Government saw this as its responsibility to enable Kenyans to help themselves individually and collectively, and to improve the quality and distribution of its services by sharing the cost of existing services with those who benefit. Thus, the notion of cost-sharing was raised, but rightfully qualifying the fact that quality and distribution of services must improve.

Increased access to essential services was the main rationale for introducing cost-sharing according to the 1984-1988 Plan,

> "...it is both necessary and equitable to expect those who are fortunate enough to benefit from Government services and infrastructure to bear a larger share of their cost so that similar services can be further extended to others" (GOK 1983, p.47).

In designing the systems of charges, equity was to be addressed through provision for the remission of fees made for those whose need could be demonstrated. Participation of the people, communities, cooperatives and voluntary agencies in provision of essential services was encouraged in the 1984-1988 Plan. Community organisations, cooperatives and other forms of collective effort were particularly encouraged to take responsibility for the management, operation and maintenance of many facilities they have helped to construct.

A major policy initiative for the 1984-1988 Plan was that responsibility for planning and implementing rural development was shifted from the headquarters to the districts as part of an organisational strategy called "District Focus for Rural Development" (GOK 1983, p.91). No mention was made of the provincial level which had held power for the first decade after independence. The objective of this decentralisation policy was,

> "...to broaden the base of rural development and encourage local initiatives that will complement the ministries' role in order to improve problem identification, resource mobilization, and project implementation at the local level" (GOK 1983, p.91).

The district-based development policy was seen as creating new opportunities for co-ordination of local self-help with ministry efforts. According to the Plan, "Self-help contributions of money, labour, and material can be substantial in the overall context of district-specific rural development, and District Development Committees (DDCs) should plan their use so that these local resources complement other resources" (GOK 1983, p.95). This assumed that local self-help representation occurred in the planning of district-specific rural development. The method for the participation in planning at the local level was a committee mechanism. The lowest level government development committee mentioned in the Plan was the Divisional Development Committee. The District Development Committee was supposed to meet four times per year to review ongoing progress, consider new proposals submitted by the Divisional Development Committees, establish priorities for future projects, and endorse the district's annual submission of project proposals to the ministries.

The membership of the District Development Committee was predominately government administrative staff but NGO representatives could be invited. The membership did not cater for any representation of community groups or local organisations. It may have been assumed that community level representation occurred within development committees at sub-locational and locational levels. But these levels were not mentioned in the 1984-1988 Plan. Decentralisation of decision-making to the local level and enhanced community participation can hardly exist through the policies and mechanisms

of the District Focus Strategy. They are as bureaucratic as the central or provincial levels, and, only marginally closer to the rural areas and the problems of rural development.

In the 1984-1988 Plan, reference to participation in relation to community development and self-help efforts was relegated to a short section under the Social Services heading of Social Development, stated as,

> "The main objective of this programme is to help local communities to become self-reliant and to involve them in the planning process so as to sustain self-help efforts directed especially to rural development" (GOK 1983, p.171).

The 1984-1988 Development Plan was unimaginative in relation to health policy. Public awareness and involvement in preventive health measures were to be increased again through the classical health education media-oriented programmes. *Barazas* (community meetings) were an additional approach to those cited in the previous plan. The 1984-1988 Plan also stated that community health workers and health committees at local level would be trained in selected rural health activities. How this was to be done was not elaborated upon.

The co-ordination of rural health services was to be done through a special programme called the Integrated Rural Health and Family Planning (IRH/FP) Programme, a World Bank initiative also aimed at improving donor agency coordination in the health sector. It can be argued that the creation of special health programmes, placed within the organisational structure of a central ministry, merely adds to the confusion which the specialised programme is intended to rectify. Reasons for this are that the units are usually donor controlled and linked to donor funding cycles. The long term ministerial commitment is usually lacking for such programmes.

Passing reference was made to community-based health care (CBHC) in the 1984-1988 Plan. The rationale for the CBHC approach was to reduce pressure on existing static health facilities which would be the centre of operation for CBHC programmes. One of the most significant developments in health policy within the 1984-1988 Plan was the

introduction of selective charges for hospital out-patient and in-patient medical services as an alternative financing mechanism, and, as a way to extend the Government's financial capacity to provide services (GOK 1983, p.154).

In the 1989-1993 Plan, neither social services nor community development were mentioned per se. Rather they were categorised broadly under the heading "Participatory Movements", and the emphasis was on the success of Harambee in terms of financial contributions and as a means of generating local level resources. Moreover, Harambee was not described as a strategy to enhance participation in any other form than financial contributions.

The role of non-governmental organisations was extensively highlighted in the 1989-1993 Plan (GOK 1989, p.260). The plan claimed that NGO involvement in developmental activities would be strengthened by the District Focus for Rural Development Strategy through which the NGOs, in collaboration with the DDCs, community groups and local authorities would enhance the process of local participation in the design, implementation, monitoring and evaluation of projects. However, the Plan called for greater control and scrutiny over NGOs by requiring NGOs to provide a complete description of their organisation as part of registration with the Kenya National Council of Social Services.

The theme of the 1989-1993 Plan was "Participation for Progress". The stated policy was that Kenyans must be actively involved in productive work as individuals and as communities in the improvement of their own welfare. This was the sure way to satisfy basic needs, enhance human dignity and raise national welfare (GOK 1989, p.229). The implication was that, besides the private sector and NGOs sharing in the provision of basic needs, individuals and communities were expected to do so as well. This represented a major re-orientation of policies and priorities from previous plans as a result in part to structural adjustment and budget rationalisation.

The 1989-1993 Plan re-emphasised the need for full participation by the entire population in the economic activities of the nation. The meaning of participation was stated as,

> "...the commitment and involvement of the Government, non-governmental Organisations (NGOs), co-operatives, private business and individuals in achieving progress for society (GOK 1989, p.38).

It appeared that the Kenya Government was widening its scope for partnership and participation from other sectors, communities and individuals in attempting to achieve its national goals. The rhetoric in the Plan was certainly apparent in terms of participation, and, therefore, theoretically the political will also. The trend, however, was an emphasis on participation in relation to resource sharing and responsibility for one's own welfare.

The health section of the 1989-1993 Development Plan was superior to that of previous plans in relation to its relevancy and decisiveness. This was the first plan where the Ministry for Planning and National Development, responsible for drafting the development plans, appeared to actually confer with the Ministry of Health. For instance, finally Kenya's commitment to Health for All by the Year 2000 was referred to, stated as,

> "Developments in the health sector during the Plan period will be geared toward contributing to the long-term objective of achieving "Health for All by the Year 2000" (GOK 1989, p.237).

Thus, it took over 10 years since the Alma-Ata PHC Conference for the political will on the part of the Kenya Government for PHC to be reflected in their own development plans.

Community participation was prominent in the National 1989-1993 Development Plan in relation to health (GOK 1989, p.237). Low community participation was cited as a reason for an inequitable spatial distribution of health services in some areas of the country. Possibly, this reference was in relation to contributions towards construction of health facilities through self-help projects. Another problem area in relation to individual participation and self-care was lack of proper public information and education which would guide the people to develop competence in meeting the basic requirements of good health.

Three principles were put forward to achieve the HFA 2000 objective. These were,

> "...(a) to achieve cost-effectiveness, the promotion of health awareness should lead to individuals and communities taking greater responsibility for their own health...; (b) the achievement of the above objective should not be viewed as largely a public sector concern; rather, consistent with structural reforms contained in Sessional Paper No. 1 of 1986, a greater role will have to be played by the private sector, self-help groups and NGOs; (c) the belief that responsibility rests purely with the Ministry of Health is untenable" (GOK 1989, p.237).

This statement epitomised the "Participation for Progress" theme of the 1989-1993 Development Plan. Participation was being sought from individuals and communities to take greater responsibility for their own health, and a greater role to facilitate this process was sought from the private sector, community groups and NGOs. This greater role was financially oriented in the form of raising additional resources through cost-sharing, the contribution of communities, church organisations and other NGOs and increased private sector participation. Regarding community financing in health, the 1989-1993 Plan said "... the expansion of basic needs services in education and health will be met through cost-sharing. Government will introduce user charges and fees at graduated levels for hospital in-patient care and provide drugs at cost in public facilities" (GOK 1989, p.238).

The Government did address the issue of equity by claiming to safeguard the condition of the genuinely poor and disadvantaged members of society who would continue to benefit from the provision of free health services. No estimate was made as to how much revenue would be forthcoming through user charges and fees, but for public sector funding, a target reduction from 50 per cent to 40 per cent of total health expenditures was readily stated (GOK 1989, p.239).

An abbreviated and aborted attempt to introduce user fees at rural health facilities and hospitals was made during 1989 and 1990 (Njoroge 1989, p.40). Public discontent in relation to the quality of services was so overwhelming that President Moi was forced to rescind the policy and return to the former system of free health services at government rural health facilities.

CONCLUSION

Many communities in the rural areas of developing countries in Africa which experienced British colonial rule had exposure to various indirect participatory approaches to rural development. Thus, the introduction of many of these approaches as strategies to develop primary health care and enhance community involvement in health in the post-independent period and in the 1970's was not a completely new phenomenon. What was new was the anticipation by communities that participation could lead to more meaningful development and partnership with government where communities could have some control over the direction of development plans and strategies.

In Kenya this took the form of the Harambee Self-Help Movement. Unfortunately, however, tension developed within the partnership relationship between communities and government. This was due to lack of any coordinated mechanisms between the two partners to channel the energies, efforts and resources which were forthcoming from communities to development activities which government would be able to sustain on a longer-term basis. The reaction from government was to establish various bureaucratic procedures to gain control of the self-help movement. This basically altered the partnership relationship between communities and government, neutralising the spirit of Harambee and undermining the enthusiasm of the self-help movement.

The Kenya Government has been reluctant to return to a more equal partnership arrangement with communities ever since, even though decentralisation of development planning to district level, with the objective of seeking active participation of local communities in planning and implementing programmes, was set out as the government's policy in the late 1970's. However, none of the development plans of the 1970's articulated how this was to be achieved.

Community participation as a strategy in national health plans did not appear until the early 1980's. However, the plans were not explicit as to how community participation could be enhanced, other than through classical health education media-oriented programmes and community meetings. Ironically, the theme for the 1989-1993 Plan was

"Participation for Progress", but more emphasis was placed on an enhanced role on participation of individuals and communities in the sharing of the costs of development than on government. This was a result in part to structural adjustment and budget rationalisation. Harambee was not described as a strategy to enhance participation in any other form than financial contributions.

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CHAPTER 4

PARTICIPATION AS NATIONAL HEALTH POLICY IN KENYA

INTRODUCTION

The policy guidelines on the role of community participation in relation to primary health care and health systems development were agreed at the Alma Ata PHC conference and documented in the WHO "Health for All" series. It was then left to the participant countries and signatories to the Alma Ata PHC conference to implement the policies. Kenya was a participant country and signed the PHC Declaration. How Kenya then set about developing strategies to develop PHC and attempt to promote participation are examined and discussed in this chapter. This is done through a historical review of the development of primary health care in the Kenya health service and the government PHC policy guidelines which were aimed at promoting and supporting community-based health care (CBHC) in the country.

The chapter focuses on those policy guidelines related to enhancing community participation, and the lessons learned during the 1980's from various NGO CBHC programmes in involving communities in health development activities. An in-depth examination and analysis of community participation in relation to health development in a case study of a CBHC programme then follows in the next part of this thesis.

THE KENYA HEALTH SERVICE

The history of health services in Kenya dates back to the establishment of religious missions in the latter half of the 19th century and the arrival of the Imperial British East Africa Company officials. Kenya officially became a British colony in 1920. In 1924 African Native Councils were given the responsibility of administering health centres. The first formal training of paramedical staff was started in 1927. In 1936 the British Medical Association was appointed to define a strategy for health centre development. The Troughton Report of 1946 spelt out the policy on health centres and the strategies for implementation. The 1950's represented the years of rapid development of health services in Kenya. A wide range of paramedical training programmes were started at the Kenyatta

National Hospital (then King George VI Hospital), and in 1952 private family planning services were started in Mombasa. In 1960 the formation occurred for the first time of a Ministry of Health, which was re-named the Ministry of Health and Housing in 1962. In 1965 free medical treatment in government facilities was introduced in-line with the guidelines of the KANU Manifesto (Bennett and Maneno 1986, p.2).

The increase of government health staff and rural health facilities since independence in the early 1960's has been significant. For instance, the increase of registered physicians increased from 811 in 1964 (GOK 1964, p.107) to 1,063 in 1990 (WHO 1994, p.c-12). At the time of independence there were 148 hospitals compared to 254 by 1987. Rural health centres had increased from 187 in 1973 to 282 in 1990, while dispensaries had increased from 416 to 872 during the period 1973 to 1982 (World Bank 1993, p.208). However, despite these increases, more than 50 percent of households in Kenya travelled four or more kilometres to obtain health services, and only about 30 percent of the population lived within easy reach (two kilometres or less) of a health facility. The NGOs in Kenya are responsible for about a quarter of all public health care, particularly in remote areas and through the development and support of community-based health programmes (Hogerzeil and Moore 1987, p.472; Mwabu 1986, p.319).

HEALTH STATUS OF THE POPULATION

Infant mortality is considered one of the best indicators of the health status of a population. Estimates of infant mortality in Kenya during the period 1960-1993 showed that infant mortality declined gradually from a level of over 120 per 1,000 live births in the 1960s to a level of 61 in 1993 (UNICEF 1995, p.66). In the past 30 years, life expectancy at birth has increased from 43 to about 59 years. The most common diseases during childhood in Kenya were diarrhoeal diseases, acute respiratory diseases (including pneumonia), measles and malaria which accounted for over 70 percent of all diseases in children (UNICEF 1984, p.33).

The decreasing mortality and the high fertility rates resulted in a dramatic growth in Kenya's population in the 1970's and 1980's. The total population was 8.3 million in 1960,

10.9 million in 1969, 15.3 million in 1979, and 25.3 million in 1992 (UNDP 1994, p.175). The annual population growth rate of 3.8 percent during the 1980's put Kenya among the world's most rapidly growing nations (World Bank 1993, p.288). About 52 percent of the population is below 16 years of age (UNICEF 1995, p.74). One of the reasons for the persistence of high fertility rates in Kenya (6.4 in 1992) was a low percentage of couples/individuals that used contraceptives. The 1978 Kenya Fertility Survey found that only 29 percent of Kenyan women had ever tried any method of contraception and only 11 percent had used a modern method. The main reason for these low-acceptance rates was the desire for a large number of children (GOK 1982, p.48).

PRIMARY HEALTH CARE DEVELOPMENT

In 1970's the central government took over the running of most of the services previously operated by local councils, including the rural health services. According to Were (1978, p.22), one of the main reasons for the central government takeover was the great variation in the services provided by the local authorities, discrepancies in management of these centres, and the general fact that it was difficult to achieve an equitable distribution of health facilities and benefits in the structure that then existed.

In 1971-1972, a Joint GOK/WHO mission formulated the "Proposal for the Improvement of Rural Health Services in Kenya and the Establishment of Six Rural Health Training Centres" (Bennett and Maneno 1982, p.41). The thrust of the proposal was the expansion of basic health services to increase coverage from 15-25 percent of the population in 1972 to 46 percent by 1984 (Were 1978, p.23). The strategy for improvement of the rural health services was the rural health unit (RHU) concept. The RHU was a geographically defined health administration unit within the district and in most cases it corresponded to the administrative boundaries of the administrative divisions. Each RHU had a health centre serving as the headquarters with 4-6 dispensaries.

Health centres and dispensaries constituted the first points of contact with the formal health system for the majority of the people. A typical dispensary was staffed by one enrolled community nurse and one or two ungraded staff. A health centre usually had up

to twelve beds for inpatients and provided a broad range of outpatient services. By 1984 there were 258 rural health units. On average the RHU served a population of 50,000-70,000 people, with a wide range of 10,000 in low density and 90,000 in the high density areas. In addition the health units served 30-40 schools and about the same number of day care centres (GOK 1982, p.41).

A major feature of the Improvement of Rural Health Services proposal was the development of six Rural Health Training Centres (RHTC), regionally distributed. These RHTCs were responsible for in-service training of health personnel in order to form health teams who were supposed to provide services at the RHTC, health centres, sub-health centres and dispensaries, as well as providing health services for the people in their areas of residence. The RHTCs played an important role in establishing the RHU concept while external funds were available. When the project ended in 1979, however, the RHTCs role in training, as well as its leadership role in community-based health care development, became minimal. In 1982, the Integrated Rural Health and Family Planning Project was launched. A Community-Based Health Care Unit within the Ministry of Health was subsequently set up as part of the project in 1984.

The RHU was to provide the support for the development of community-based health care activities, besides provision of health facility-based services. Mobile outreach clinics were also supposed to be carried out in outlying communities as a strategy to improve access to maternal and child health services, particularly immunisation for children under five years of age, and as a means of support and supervision of dispensaries by health centre teams. Expanding the role of mobile services was to be one of the strategies to enhance interaction and regular contact with communities. The costs, however, in operating mobile services became too restrictive for the government health centres.

The main problem facing the delivery of rural health services during the 1980's continued to be the standard of services provided at health facilities (Bennett and Maneno 1986, p.4). A major constraint was budgetary. The percentage of government expenditure spent on health during the 1970's and 1980's was in the order of 5.5-7 per cent dropping

to 4.3 in 1990 (Mwabu and Mwangi 1986, p.763; Lele and Meyers 1989, p.19; UNDP 1994, p.153). Funds allocated for drugs, supplies and fuel and the maintenance of equipment, building and vehicles were inadequate. While numbers and patterns of staffing had improved considerably since 1970, the Ministry was confronted with a situation where buildings and staff may lie idle because of lack of funds to run the facilities. This problem was aggravated by low morale of the staff resulting in a further deterioration of the quality of services required.

It was unlikely that the share of government resources spent on health would increase. According to the 1989-1993 Development Plan, "the lowering of overall growth of government expenditure especially in the fields of education and health will be used as a means of attaining the desired level of budget deficit" (GOK 1989, p.61) The government strategy was to reduce costs through enhancing the overall effectiveness and management performance of the health care system, while expanding the privatisation of health services, establishment of fee paying hospital wards and cost sharing.

The static level of government expenditure on health during the 1970's and 1980's was influenced in part from the general decline in the Kenyan economy and its impact on government revenue. There was a substantial and progressive drop in GDP growth from a high rate of 6.7 per cent in 1964-72 to only 3.1 per cent in 1975 (GOK 1989, p.4). The 1973-74 oil crisis was the first of a number of external shocks that affected the Kenya economy.

The second oil crisis in 1978-1979 resulted in a slackening of demand for imports from developing countries like Kenya and a general stagnation of world trade. This meant that Kenya's terms of trade and purchasing power remained very weak. The growth rate of GDP fell from 8.2 per cent during the coffee boom years to 3.9 per cent in 1980. A further shock to the Kenya economy came in 1984 when the country was hit by a severe and widespread drought. GDP only grew by 0.8 per cent that year but recovered to a level of 4.8 per cent in 1985 and 5.5 per cent in 1986 (GOK 1989, pp.4-9).

Kenya's debt situation also started to become a problem in the late 1970's. Total outstanding foreign debt rose from KSh 136.3 million in 1974 to KSh 859.3 million in 1982 on account of the second oil price shock and drought, both of which took place in 1979-1980. By 1987, the external component of the public debt had sky-rocketed to nearly KSh 2.3 billion, constituting 76 per cent of the total public debt.

Service charges in 1987 on external public and publicly guaranteed debt represented 37 per cent of total value of exports of goods and non-factor services. External debt servicing emerged as one of the most critical issues that needed to be addressed if the growth of the economy was to be stimulated and sustained. According to Humphreys and Underwood (1989, p.43), Kenya's total official bilateral, private-source and multilateral debt amounted to US$5.95 billion, ranking it fourth in Africa behind Zambia (US$6.4 billion), Zaire (US$8.63 billion) and Sudan (US$11.126 billion). World Bank (1993, p.278) figures show a doubling of the total external debt between 1980 (US$3.5 billion) and 1991 (US$7 billion).

Ideally, the percentage increase of government expenditure on health should at least equal annual inflation levels. Unfortunately, this was not the case where inflation rate increases were as turbulent as the economy. The rate of inflation rose from a mere 2.6 per cent in 1972, spiralling to 9.8 per cent in 1973, 15.3 per cent in 1974 and 15.6 per cent in 1975. Between 1976 and 1981, the inflation rate fluctuated between 10 per cent and 13 per cent with the exception of 1979 when it fell briefly to 8.4 per cent. The second oil crisis and the ensuing economic recession, compounded by a widening government budget deficit, raised the inflation rate to an unprecedented level of 22.3 per cent in 1982. Concerted government efforts assisted by low oil prices, wide availability of goods and lower world inflation led to a decline in inflation pressure during the mid 1980's and by 1986 the inflation rate was 5.7 per cent, but it climbed to 7.1 per cent in 1987 (GOK 1989, p.16).

A similar macroeconomic crisis, described above for Kenya, affected most developing countries shortly after Alma-Ata and was particularly felt in sub-Saharan Africa (Abel-Smith, 1986 p.2; Evlo and Carrin 1992, p.165; Ogbu and Gallagher 1992, p.615).

Persistent current account and government budget deficits led to an unprecedented high level of external debt and interest payments, and governments were forced to adopt financial stabilisation and adjustment programmes proposed by the International Monetary Fund and the World Bank to address the situation. This led to cuts in per capita domestically financed government expenditure in virtually all sectors, including that of health.

In per capita terms total Kenya government health expenditure in 1983/84 was around KSh 42[1] (Nordberg 1986, p.123). A considerable proportion was spent at central and provincial levels and in particular on the Kenyatta National Hospital (KNH). According to Mwabu and Mwangi (1986, p.763), government hospitals in Kenya absorb about 65 percent of the health budget. Estimates of recurrent expenditure for KNH for 1983/84 amounted to 12.43 percent of the total recurrent expenditure for health which was 3.97 percent more than the entire budget expenditure for rural health services (8.46 percent) (GOK 1984, pp.155-156). Nordberg (1986, p.123) cites one estimate which calculated urban expenditure at around KSh 330 per capita per year and in the rural areas KSh 5 per capita.

One cannot help wondering whether the belated interest in the community-based approach was a response to the recognition that as the MOH services became more under-financed they would have less health impact. The backing of the community-based approach could have been based on the hope that you could get health progress cheaply. However, community-based health care cannot operate in a vacuum and at least a minimum but effective level of health services are required within the formal health service for purposes of technical support and referral services. Many non-government organisations have been able to provide a level of resources which provide the necessary support to help establish CBHC programmes. The question remains how sustainable these models are in the absence of NGOs or government take-over. A specific example is the use of mobile outreach services. This mode of health delivery, which was an important method of developing and supporting community-based health care activities and enhancing

[1]At the time of the research, KSh 20 = £1

community participation, was only utilised by the non-governmental organisations. They were able to manage the recurrent costs mainly because of external funding. The alternative strategy adopted by the government was to establish more static health facilities. However, with their recurrent cost implications, it is debatable whether this was in fact a less costly option.

COMMUNITY PARTICIPATION AS PRIMARY HEALTH CARE POLICY IN KENYA

In 1976 a cadre of government health workers known as the Family Health Field Educators was started in Kenya which had similar functions to community health workers. However, since they were government employees, they were not community-based but community-oriented. Local health committees were formed as early as 1976 and community-based health care (CBHC) programmes were started by non-governmental organisations as early as 1977. In Eastern Africa the development of the philosophy of CBHC first occurred at Nangina Hospital in Kenya in the early 1970's (Shaffer 1983, p.4).

In 1977 the Kenya Government, with the financial support from UNICEF and WHO, launched a pilot project in Kakamega to assess the potential for community participation in health care delivery. According to Willms (1984, p.112), one of the most important issues the Ministry of Health was hoping to learn from the national pilot project was how to facilitate the process of community participation, and, in particular how to construct useful links between the government and the community in such a way that the relationship between the formal and informal health systems developed into a mutually supportive system.

As a result of the national pilot project it was concluded that community participation was a feasible approach. It took the form of involvement of communities in decision-making and priority-setting focusing on health promotion and disease prevention. The pilot project demonstrated that community participation could take place through an organisational framework and through established community structures. It was possible for a dialogue to be conducted between the community and health workers.

A community mobilisation mechanism used in the national pilot project was community meetings (*barazas*) to disseminate the concept of community-based health care. Community health committees were established which met regularly and formed a rallying point for action. A community financial account was set up for the pilot project maintained by household levies and a fee for service system for the curative services of community health workers (CHWs). Leadership training was also undertaken for community leaders and CHWs (Were 1978, p.107).

Recognising the health staffing constraints that Kenya was facing but building on the country's demonstrated spirit of self-help, the Ministry of Health in the early 1980's developed a policy to foster a system of community-based health care (CBHC), centred around a village volunteer - the community health worker. This person was expected to be selected and supported by his or her community while the government was responsible for his/her training, technical support and supervision. By the mid 1980's this model of CBHC was already in existence in over 30 projects throughout Kenya, (e.g., Kibwezi, Nangina, Saridid, Maua) operated by local communities with assistance coming from non-governmental organisations (see Mburu and Boerma 1989; Kaseje and Sempebwa 1989; Johnson et al.1989).

According to Shaffer (1983, p.i), community-based health care (CBHC) is seen as a practicable way to narrow the widening gap between health needs and the resources to meet those needs. The key elements are voluntarism, motivation and prevention. The CBHC approach strives for more delegation of responsibility for health promotion, better balance between cure and prevention, more voluntaristic input into the system, increased awareness and sensitisation and better cross-disciplinary integration.

The CBHC movement in Eastern Africa was the "beyond-the-dispensary" part of the spectrum of PHC (Shaffer 1983, p.3). It was to suppose to foster and implement those recommendations of Alma Ata that were practicable beyond the dispensary. It addressed itself to encouraging and facilitating the peoples' own efforts to convert the Alma Ata philosophy into practice right where they lived. CBHC represented the geographically

peripheral or outer half of PHC. It focused on community-initiated activism. This activism was catalyzed by community health workers. It was hoped that this programme of community activism should eventually be viable with or without outside influence or aid, whether from government or non-governmental organisations.

In order to evolve a sound policy on primary health care that was built on practical experiences, mainly from NGOs, the Kenya Ministry of Health with the help of UNICEF, WHO, and the Swedish International Development Authority (SIDA) organised a series of workshops during 1983 and 1984. These workshops had a wide spectrum of participants ranging from government, UN and non-government organisations. The researcher was also a participant. The recommendations which emanated out of those consultations provided the basis for developing the policy guidelines for implementation of primary health care in Kenya. In some international circles, Kenya was considered to be very slow off the mark in defining their PHC policy guidelines. The delay could have been because the Ministry of Health wanted to review the operational results of the various NGO CBHC pilot projects, including the national pilot project, as part of the process in developing its national policy guidelines.

Community participation was identified at these PHC workshops as one of the issues that needed special attention to achieve Health for All by the Year 2000. Intensifying community involvement through health awareness and strengthening existing community initiatives for health development were cited as the rational steps to achieve the PHC goals. Community participation was given a chapter in the National PHC Guidelines, although it was added after the first draft was completed.

The overall primary health care policy of the Ministry of Health set out in these guidelines was aimed at increasing the number of communities active in their own health care, encouraging more community participation, changing the attitudes of health personnel towards PHC and strengthening collaboration with the NGOs in the field of PHC (Bennett and Maneno 1986, p.10). To achieve those aims, the district medical officers in particular,

and the district health management teams in general, were charged with the responsibility of coordinating the PHC activities in the districts.

Community participation was defined in the PHC Guidelines as the process by which a community mobilised its resources, initiating and taking responsibility for its own development activities and sharing in decision-making and implementation of development programmes for overall improvement of its health status. Community involvement was considered to be that process by which active partnership was established between development programmes within the community and the community itself. It could lead to the creation of partnership between the establishment (government), other development agencies and the community. It thus would contribute to attainment of community responsibility and accountability over all development programmes. Participation and involvement could lead to development of self-reliance and help a community to develop social control over its own infrastructure. The level at which any community participated in its own development process would vary from place to place depending on the level of involvement.

It was felt that community awareness could be achieved through participation and involvement of the community in community diagnosis, through creating demands and by exposure through proximity to another community where development programmes have been successfully undertaken. In addition *barazas*, churches, schools and development groups were identified as playing key roles in promoting awareness.

The proposed methodology for creating awareness at the divisional level was through training of trainers by district health management teams, briefing divisional development committees, discussions in *barazas* or small groups through community elders and TBAs, women, church groups and mobile clinics. The plan was that all community members would be responsible for creating awareness through committees and follow-up by local leaders.

The PHC Guidelines noted that a number of factors could influence the degree of community involvement. These were a favourable political atmosphere, social and cultural factors, and the educational status of the community and literacy which might affect the rapidity by which full participation and involvement was achieved. The community infrastructure including the communication network, economic factors, the level of inter-sectoral coordination at the community level, and suppression of involvement and initiative by projects which created dependency were also identified as factors (Bennett and Maneno 1986, p.70).

Community participation could take place in the health services in various practical ways. Some of these were communities liaising with health workers to help in problem-solving, helping improve environmental sanitation and water supply for health units, helping with transport, for example, for patients or local mechanics to help repair health centre vehicles, visiting health facilities to assess what assistance they can provide, helping with shelter for waiting mothers, helping in collecting drugs and vaccines from district stores to health centres and dispensaries. These examples identified specific actions on how community participation could occur, which was an improvement on the WHO literature which tended to be very general in relation to actions community members could take in participating in health development programmes.

Village development committees and health sub-committees are usually the structures in which community participation takes visible form. The village health committees should help identify and prioritise problems at the village level, provide the structure for community participation and the implementation of programmes, provide a channel for external assistance to be continued where necessary, and provide a channel of communication with division and district levels. Community participation in PHC should involve interaction with extension workers from different sectors such as health workers, community development and agricultural extension workers.

The need for re-orientation of health workers to take more responsibility in promoting community participation was not stressed in the PHC guidelines. This was a major gap

according to a former Senior Deputy Director of Medical Services who stated, "The role of community participation as a partner in the general effort of improving the health status of families has not been fully appreciated by the majority of our health workers in our institutions ...a reorientation programme is necessary to inculcate into the minds of our health workers the need for them to actively seek community participation for their health care" (Willms 1984, pp.83-84).

Financing CBHC development was addressed by the Guidelines, but not in any great detail. It only amounted to identifying potential funding sources. Community resources were mainly Harambee funds, income-generating projects, direct contributions, communal work and fees for services. Government taxes and grants from the Ministry of Health were options. Other external sources were church-related NGOs and international agencies. No guidance was given on how community groups could access resources outside their communities or how they could effectively mobilise and manage the resources which they did have access to within their own communities.

At the time the PHC guidelines were being formulated in 1984 and 1985, government experience in supporting CBHC development was limited mainly to the national pilot project. The government's capability to be a valid partner in CBHC development was quickly being compromised by financial constraints, and its lack of commitment to reallocate more funding from curative, hospital-based services to preventive and promotive primary health care services. The relevancy of the PHC Guidelines, therefore, was an issue, particularly regarding the role of government. The vast experience in CBHC development and community participation at this stage was with the NGOs.

Lessons were being learned from existing NGO CBHC programmes in Nangina, Kibwezi and Saradidi, among others, and the following conditions had been identified as relevant to community participation:

i) The programmes were essentially initiated by the community (either a women's group or a local congregation) and not imposed from outside;

ii) The programme leadership was highly motivated and sincerely committed to community participation;

iii) Information was available to the community in a manner it could understand, interpret and use;

iv) The community made all the important decisions at community meetings, took action and were involved in evaluating their progress;

v) There was community-wide eligibility to vote and freedom to choose and participate in development activities without undue duress;

vi) In the church-related programmes, religious commitment bound the groups together and motivated the community health volunteers to work without monetary rewards;

vii) The programmes capitalised on the prevailing political mood in Kenya which emphasised self-help (Harambee) projects, and self reliance;

viii) The community was better at participating in well-defined activities that brought tangible results in the not too distant future (Kaseje and Sempebwa 1989; Mburu, 1989).

Specific actions of individual and group participation which was being reported within some of the main CBHC programmes (Nangina, Saradidi, Kibwezi) operating in the mid 1980's were:

i) Extensive health education coverage at community level was being achieved and the presence of CHVs led to increased knowledge in preventive and promotive health behaviour and nutrition;

ii) Success was occurring by CHVs in getting people to dig, use and maintain pit latrines and improvements in home and environmental cleanliness;

iii) Very low CHV drop-out rates were occurring in spite of the fact that their work was purely voluntary;

iv) Stimulation of the community into taking an interest in promoting their own health, through their own efforts and through maximal utilisation of the available health services such as MCH clinics was occurring and increased immunisation coverage,

especially with the help of mobile services and home deliveries handled by trained persons;

v) Voluntary group participation, mainly women and church groups who had initiated and undertaken many of the health promotive activities, were helping sustain the CBHC programmes (Kaseje and Sempebwa 1989; Willms 1984; Johnson et al. 1989).

Verification of these very positive CBHC programme results had not occurred, however, by any formal external evaluations. Moreover, there were programme strategies and activities which were not eliciting the degree of participation hoped for. These operational experiences and lessons learned were:

i) Village health committees in some programmes were failing to enhance community participation and were active only for short periods of time when they were carrying out a specific activity. They were unable to lead the villagers on an on-going indefinite basis;

ii Non-health income generating activities were failing to generate income sufficiently to finance health activities. Fee-for-service proved the only available mechanism of generating income for health activities (Kaseje and Sempebwa 1989).

The PHC Guidelines represented the ideal and optimum CBHC development strategy. Even though they were formulated with NGO involvement and were based in part on lessons learned from operational experience, it could be said that the PHC guidelines were still too theoretical and optimistic, and, thus not useful when compared to the operational strategies being developed by various NGO programmes. The target groups for the PHC guidelines were health sector staff and other related sector personnel. The overall coordination and leadership role for CBHC development rested with the district health management team.

CONCLUSION

Finding ways to sustain the CBHC programmes financially, other than through external resources, was problematic for most NGO CBHC programmes in Kenya. Overall, they demonstrated some success in increasing health awareness, getting people to undertake better health practices and utilise health services. The programmes were sustained programmatically through strong support by women and church groups, in some cases, more significantly than the village health committees.

In the late 1980's budgetary constraints in relation to recurrent cost coverage were identified as the main cause of the poor standard of services provided at government rural health facilities and district hospitals. This did not bode well for an active role by rural health staff in promoting community participation. The government did not intend to increase its budgetary allocation to either health or education. An abortive attempt was made during 1988 and 1989 to help address the issue of financing health services by introduction of user fees at rural health facility levels, which was rescinded after considerable public discontent over the poor services being offered.

An essential input from government in promoting community participation in rural health development is to offer a viable health service in rural areas for communities to utilise and support. An important element is a health facility team who are properly trained and motivated to elicit participation in the health service programme from the communities they serve. Due to various reasons including, financial constraints and low morale amongst health staff, this input appeared not to be happening within the formal health system in Kenya. The government health service did not seem to be in a position to be actively eliciting community participation. Funds were not forthcoming to provide the minimum level of resources, namely essential drugs and medical supplies and mobility for technical support and supervision, to operate a reliable service in the rural areas. This resulted in general under-utilisation of the formal health service. On the other hand, for some rural health services operated by non-government organisations, missions or pilot schemes, which were managing their services more effectively and were under less

financial pressure, more opportunities existed for communities to participate in the health care services and promotive health activities.

The Kenya PHC Guidelines was an attempt to put community participation into a conceptual framework by identifying its parameters including the mechanisms and structures which were necessary to enhance its development. It was perceived in the context of a developmental process and various steps and elements were identified as goals to try to achieve it. Although the Guidelines spelled out some practical ways community involvement could take place, they were stating the ideal rhetoric about the essence of community involvement and participation which depended on the government playing a key promotive and supportive role in CBHC development. However, apart from the areas which had experienced NGO CBHC programmes, there were very few communities and health service units which were in a position to undertake and implement seriously the recommended guidelines. Moreover, the question remained whether the formal health sector staff, particularly the district health management team, could fulfill the roles identified for them in the PHC Guidelines, and, replicate the gains being realised by NGOs in eliciting community participation as part of the process of CBHC development.

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CHAPTER 5

RESEARCH METHODOLOGY

THE RESEARCH STRATEGY

For this study, an integrated qualitative-quantitative research strategy combining case studies, a household survey, key informant interviews, focused group sessions, historical and documentary sources was used . This was done in an attempt to use a variety of methods to contribute to a deeper understanding of the issue by triangulating various approaches to the same problem. Mechanic (quoted in Yach 1992, p.605) particularly endorses combining the advantages of the survey (its scope and its sampling opportunities) with the intensity of observation of smaller qualitative study. The greatest single advantage of multiple data sources is that they permit the collection of critical data on one topic that are not available from other sources used in the same study. More creative possibilities of integration arise when the same topic is covered in the same study by two or more data sources. In this study, interview segments from different respondents but on the same topic were integrated, which is a research technique recommended by Yin (1982, p.60). Warwick (1983, p.289) points out that, "If both an extensive survey and a set of intensive village studies show a certain pattern, the findings will have a stronger empirical foundation than if the same pattern emerged from just one data source".

The use of qualitative and quantitative research offer different types of data, so that the validity of one type often cannot be fully tested by the other type, but in many cases the data from the two methods complement each other, giving more confidence in the research findings than if the study depended solely on a single method (Whyte and Alberti 1983). Warwick (1983, p.281) agrees, adding that a reason for combining data sources is to increase confidence in the accuracy of measurements or observations made on a given phenomenon.

Based on the nature of the research topic, the most appropriate research approach for examining how participation was occurring at community level was case study research.

According to Patton (1990, p.54) case studies are particularly useful where one needs to understand some special people, particular problem, or unique situation in great depth and where one can identify cases rich in information where a great deal can be learned from a few examples of the phenomenon in question. A case can be a person, an event, a programme, an organisation, a time period, a critical incident or a community. For this research study the case was a community-based health programme, specifically, the Maua CBHC Programme in Kenya.

The case study does not imply the use of a particular type of evidence. Case studies can be done by using either qualitative or quantitative evidence or a combination of these (Yin 1981, p.58). Hamel et al 1993, p.1) states that a case study can employ various methods which include interviews, participant observation and field studies. Thus, the case study is not a 'method', but an approach or frame determining the boundaries of information gathering. Within this frame one may survey, interview, observe, participate, read or visit archives (Platt 1984). What the case study does best is study process, and process is the very heart of an explanatory method (Becker 1966, quoted in Stoecker 1991, p.94). Moreover, the case should be chosen for its explanatory power rather than for its typicality (Mitchell 1983, pps. 203-204).

The case study strives to highlight the features of attributes of social life. This is true whether the latter is perceived as a set of interactions, as common behaviour patterns, or as structures (Hamel et al 1993). In this study those interactions and behaviour patterns of social life pertain to cooperation and participation of community members in relation to rural health development and the structures which are necessary to help enhance participation.

According to Stoecker (1991, p.91) critics of case study research charge that the case study does not accurately measure independent and dependent variables, and it relies on retrospective, and, therefore, biased reports and employs arbitrary interpretations. He adds, "In general, the charge is that the case study suffers from a lack of rigour and an excess of bias". However, the use of a number of research strategies or multiple methods

(triangulation) to inject greater scientific rigour into the case study and to increase the internal validity of case study research is one strategy to address these criticisms (Yin 1993; Bulmer 1982). The second problem is that the case study does not allow one to generalise the findings to other settings, thus, there is no way to measure external validity (Stoecker 1991). In response Stake (1995, p.8) believes that the real business of case study is particularisation, not generalisation, and, "We take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does". Feagin et al (1991, p.7) in a similar vein, claims the detailed and rich data offered by the well-designed case study permits the analyst to develop a solid empirical basis for specific concepts and generalisations. Eisner (quoted in Warwick 1983, p.105) proposed that one can generalize from case studies because 'of the belief that the general resides in the particular and because what one learns from a particular one applies to other situations subsequently encountered'.

This study makes policy recommendations based on the results of the qualitative and quantitative research methods used in the case study . They therefore must be considered in the context of findings from case study research. Nevertheless, the study incorporated other research methods such as historical and documentary sources with qualitative and quantitative methods which allowed the study to examine the practice of participation with the theory of participation. Therefore, it is felt there is scope for generalisation and conceptual analysis. Warwick (193, p.284) contends that a reason for combining research methods in a single study is to augment the possibilities of generalising the results to a broader population.

The main quantitative research method used in the study was a household survey. Four hundred and fifty seven households were interviewed in the study representing eight percent of the total number of households based on the 1979 census in the eight sample sub-programme areas of the Maua Programme. Nichols (1991, p.11) states even when a survey is useful, it is often best used together with other complementary research tools. A limitation of only using survey methods, according to Warwick (1983), is that they are ill-suited to the study of complex social relationships and intricate patterns of interaction.

Their contribution is also limited when the aim of the research is to obtain first-hand behavioural information on such processes as leadership and influence in small groups or to construct a qualitative picture of a certain situation or flow of events.

The qualitative research methods applied in the study were focus group sessions, interviews with key informants and case studies. A total of twenty-two focus group sessions were conducted, 129 key informants were interviewed and case studies undertaken for 45 households. Foster (1984, p.852) believes that the primary health care movement lends itself particularly well to qualitative and anthropological research since it is based on villages, and, for health personnel, the purpose of community participation research is to find the key that will induce communities to play the roles the PHC philosophy expects of them. Because anthropological methods provide data as well as identifying community systems which affect behaviour, Buzzard (1984, p.275) claims they are particularly appropriate in health projects in developing countries. Commenting on research methods in the health sector, Yach (1992, p.606) states, "Globally there is a growing recognition that research is needed to obtain information for decision makers in the public health sector and that the type of research needed includes both qualitative and quantitative components".

Historical and documentary sources were examined in order to compare the interpretation and meaning of community participation across time. These sources are also referred to as secondary sources or secondary research, and according to Stewart and Kamins (1993 p.4), ..."help define the agenda for subsequent primary research by suggesting which questions require answers that have not been obtained in previous research". Contemporary theories on the features of community participation were assessed against historical accounts of the role of participation in the emergence of community development during the colonial era and the post-independence period in Kenya. Historical and documentary sources were used as well as the data collection method of interviewing in examining the emergence and development of community participation as international health policy within the World Health Organisation, and likewise as national health policy in Kenya. Contemporary documents were examined to ascertain current

trends on how participation was occurring within selected CBHC programmes undertaken by non-government organisations in Kenya. Health service utilisation statistics for the Maua Hospital mobile clinic were reviewed to determine levels of participation in that community-level health service.

THE CASE STUDY PROGRAMME

At the time the study was undertaken in 1987, approximately twenty community-based health care programmes (CBHC) were in operation in Kenya, all of which involved either non-governmental organisations or church mission hospitals. No government health facilities were involved with community-based health care programmes at that time, so the choice of the case study programme could not include a government one.

The criteria used for the selection of the case study programme included the following factors:

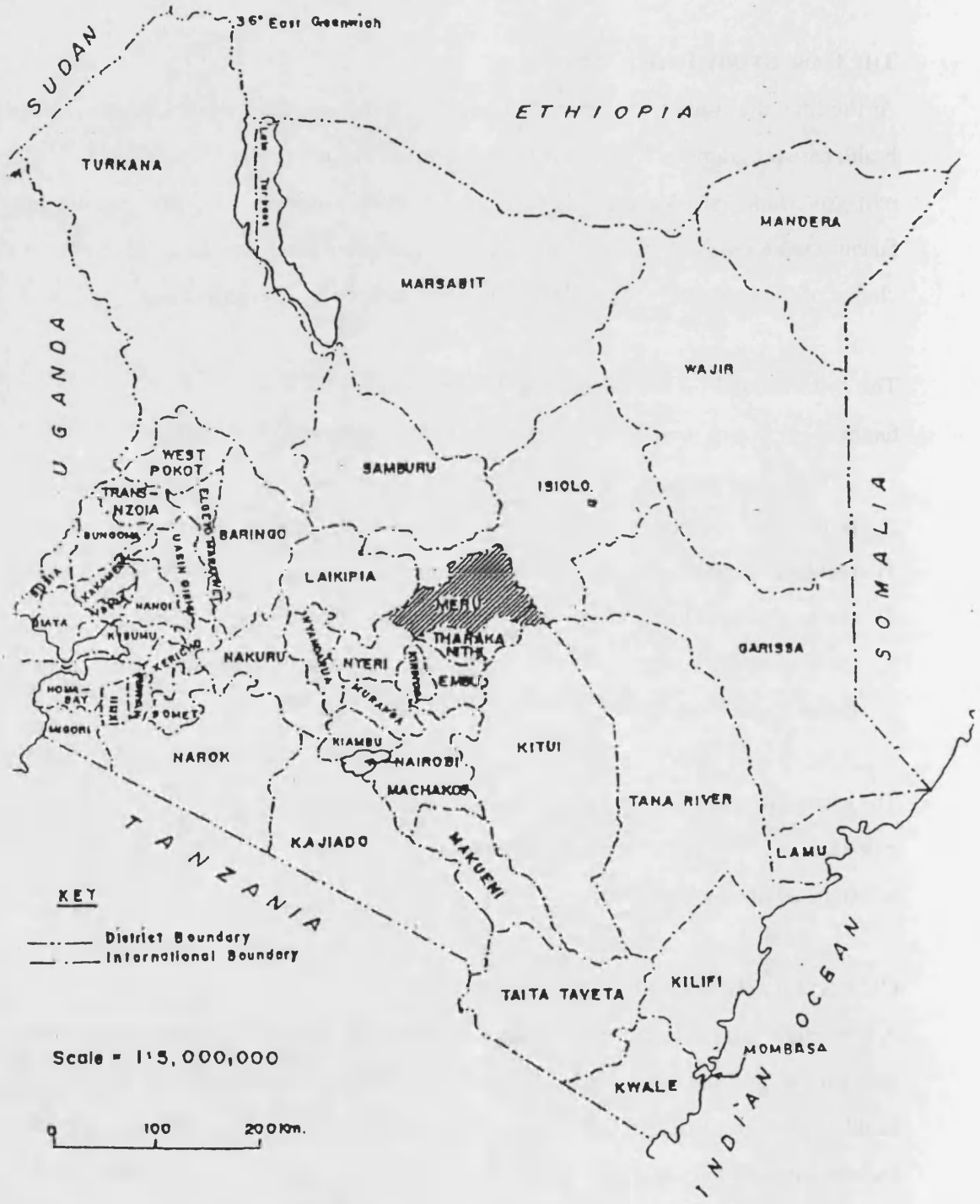
1) it had been operating for at least five years;
2) programme components included community health workers and health committees;
3) technical support was provided by a health facility;
4) the programme had not been studied extensively in the past;
5) the community leaders, local administration and programme managers were agreeable that a research study could be carried out on the programme.

The Maua Programme in Igembe Division in Meru District came closest to meeting these criteria, and, it was therefore chosen as the case study programme. The Maua Programme is described in Chapter 6.

CASE STUDY RESEARCH METHODS

A household survey and structured and unstructured interviews were carried out with individuals and groups directly involved in the Maua Programme such as community health volunteers, health committee members, local leaders and programme staff. Individuals indirectly involved in the Maua Programme such as chiefs, assistant chiefs, government extension agents, NGO workers, among others were also interviewed. Case

Figure 1: Location of Meru District in Kenya



Source: Meru District Development Plan, 1994-1996

study techniques involving selected households as well as comparison of sub-programme areas within the Maua Programme were other research strategies used. The fieldwork research was carried out over a period of 12 months during 1987 with the researcher based in Nairobi and spending several periods of one to two weeks in the field in the Maua CBHC Programme area.

Household Survey

Since the Maua Programme covered a large and diverse geographical area and catchment population, the survey research technique of a household survey was used in order to obtain a general opinion from community members on their views and attitudes in relation to the research objective. In support of making use of the household survey as a research technique, Cohen (1973 p.42) claims that, "...accurate information about the social life of a complex population are not likely to be obtained unless the research surveys the population". The greatest single advantage of a well-designed sample survey is that its results can be generalised to a larger population within known limits of error (Warwick (1973 p.197).

The household survey questionnaire was developed based on discussions with programme staff, community-based health care specialists, social scientists in Kenya and the researcher's fifteen years' experience in rural health development in Africa. The historical data and documentary sources which were reviewed for the study also influenced the nature of the questionnaire. Reference materials on community organisation and community financing and questionnaires used in other field studies were also consulted (Esman and Uphoff 1984; Goldsmith et. al. 1985; Russell and Reynolds 1985; Stinson 1982). The questions were a combination of open and closed-ended questions with some of the latter questions being pre-coded. A code book was developed for the open-ended questions after tabulating and analysing the responses. Nichols (1991, p.44) recommends that for large samples, questions with many possible answers, you may need to leave coding until later. Simple language and a spoken English style were guiding principles in developing the questionnaire. The household survey questionnaire was translated into the

local Kimeru dialect and administered in Kimeru. (See Appendix 1 for the English version of this questionnaire).

Regarding the strategy in determining the target population for the household survey, it was felt that it was not necessary to include each of the sixteen sub-programme areas encompassing the Maua Programme in the sample since some of the sub-programmes had similar characteristics. Therefore, it was important to select sub-programmes which were different in various ways. The criteria used to determine these differences included:

1) Agricultural potential, level of income and wealth of the area: classified as high, medium and low

Sources and levels of income and wealth were felt to be factors which might determine people's participation in health and other development projects, particularly regarding contributions in cash or in kind. Per capita figures are not officially published for districts and divisions in Kenya. Therefore agricultural potential was used as a proxy of income.

Sub-programmes operating in areas where cash crops were grown were rated as high potential areas. These sub-programmes are located at altitudes between 4,000 and 6,000 feet and in the rain forest ecological zone with the main cash crops being tea, coffee and miraa. The group of sub-programmes which were rated as medium potential are located at altitudes ranging between 3,000 and 4,000 feet. In the upper reaches of these areas, some cash crops were grown. These were, however, areas where mainly subsistence farming took place. The sub-programme areas which were rated as low potential had lower rainfall patterns and were located between 2,000 and 3,000 feet in the savannah ecological zone. A few cash crops like cotton and tobacco were grown in this zone. Main sources of income were from marketing horticultural crops on a seasonal basis.

2) Access to health facility: classified as easy, fair, poor

There were relatively few health facilities in Igembe Division and in 1987, they included a mission hospital, government health centre, a government dispensary and a mission dispensary. The optimum number of facilities for a division with the population of Igembe

Division according to the Ministry of Health standard, would be at least three health centres and fifteen dispensaries. In under served areas it is possible that people might be more willing to participate in health development projects.

Sub-programmes which were located within two to five kilometres of one of the existing health facilities along an all-weather road or within an hour's walk were scored as 'easy access'; 'fair access' amounted to 5-10 kilometres from a health facility, on roads impassable during the rainy seasons for the shorter distances, and on all-weather roads for sub-programmes closer to ten kilometres away. Sub-programme with poor access were areas beyond 10 kilometres and with no passable road during the rainy seasons.

3) Operational experience: classified as successful, fairly successful, less successful

Criteria for assessing the operational success of each sub-programmes area were mainly based on the opinion of the programme staff regarding the level of participation from the community members and local administration in relation to programme activities, and the level of activities of the community health volunteers (CHVs) and health committee members (HCMs) in carrying out their tasks. For instance the Kangeta sub-programme had few active CHVs or HCMs. In Kirindine the health committee was hardworking, but CHVs had not been trained, after having been selected some twelve months prior to the research study, due to a difficulty with the local administration.

4) Population density: classified as high (321-500 persons per square kilometre), medium (161-320), low (1-160)

Population density figures were based on the 1979 Kenya census[1]. Population density can be a reflection of the fertility of an area and its income potential and thus attraction for settlement. But it can also be a reflection of poverty if too many people are depending on a limited area of land, no matter how potentially productive the land is. Population density can reflect wealth and income and the potential for community contributions was therefore one of the reasons why it was selected as a criterion. The ratio of CHVs to

[1]This was the most recent comprehensive census available at the time the research was undertaken.

households and distances involved in carrying out home visiting were other considerations.

5) Remoteness and transport system: classified as not remote/good transport system, fairly remote/fair transport system, very remote/very poor transport system

Remoteness of an area and its transport system can be influencing factors on the level of wealth and income of an area since it affects the ease or difficulty in getting cash crops and horticulture products to markets. Remoteness can also influence the level of contact community members have with extension agents, project staff and communication and information in general with the outside world and their attitudes to change and new ideas.

6) Education and literacy: classified as good, fair, poor

Education is assumed to be an important factor in relation to people's receptiveness to ideas and, therefore, their willingness to cooperate in development projects. The level of development of educational facilities and non-formal educational opportunities was felt to be an important criterion for selection of the sub-programmes.

7) Geographical coverage

It was felt important that the sub-programmes selected should be from various parts of the division and not from just one or two areas to ensure geographical representation.

8) Number of years as a sub-programme area

An objective of the research was to ascertain knowledge and attitudes of community members towards the work of the community health volunteers and health committee members, particularly in relation to their willingness to financially support some of their work. This might depend on the number of years that the sub-programme had been operating in the area; therefore, another criterion was that the sub-programme must have been operating for at least three years.

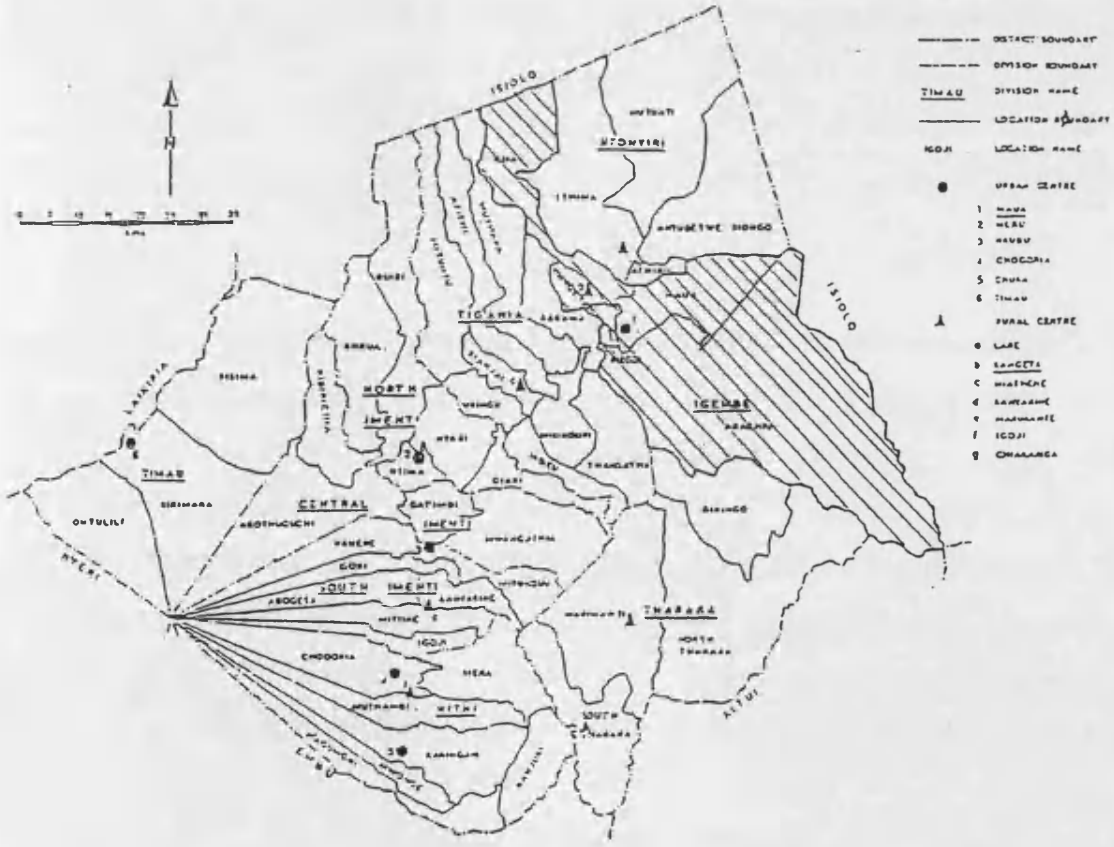
These criteria were developed in collaboration with the Maua CBHC programme staff. A simple scoring system was used for the above criteria based on three points for the first

classification, two points for the second and one point for the third. The sub-programmes selected from each of the three groups were as follows:

High Potential Group	Medium Potential Group	Low Potential Group
Auki	Athiru Gaiti	Ugoti
Kirindine	Kiengu	Kilili
Kanjoo		
Kangeta		

They represented eight of the 16 sub-programme areas.

Figure 2: Igembe Division within Meru District



Source: Meru District Development Plan, 1989-1993

Kangeta and Kilili were given special consideration. Kangeta was the only sub-programme collaborating with a government health facility, and the only sub-programme where the Maua Hospital mobile clinic did not operate. Kilili was included because it did not have its own health committee. That function was handled instead by the Athiru Gaiti health committee with representatives from the Kilili area.

Twelve enumerators were recruited to administer the household survey. They were Form IV leavers and were selected from a group of 30 who had been proposed by the chiefs from the various sub-programme areas. They were given an aptitude test and were interviewed by the researcher and a programme staff member. Four of the twelve enumerators selected were female and five had previous survey experience. A two-day training session was held for the group at the Community Health Department of the Maua Methodist Hospital. Each question was read out, explained and discussed conceptually with the enumerators. Pratt and Loizos (1992, p.43) recommend that if a questionnaire is to be used, then the trainer should take the team through it slowly, question by question, discussing the wording of each question. Role playing was used as a training method. An introduction was developed with the enumerators for describing to respondents the purpose of their interview. Since the enumerators were from Igembe Division and not from another area of Meru District, cooperation was not anticipated to be a problem.

The validity of the research data is a key consideration when making decisions on research methodology. Cohen (1973, p.42) asks, "How can valid quantitative information concerning human experience in Africa be generated?". He felt linguistic problems and constructing questions which related the research concept to local perspectives were the most obvious difficulties. Regarding the former difficulty, Cohen recommended the translation and back-translation technique which requires that questions originating in one culture be translated first into the target language and then, independently, back into the language of origin. This was done for the household survey questionnaire.

The initial translation of the questionnaire from English to Kimeru, the local dialect of the Meru people, had been done by a Form IV leaver from Maua recommended by the

programme coordinator. He had experience with another social science survey in Igembe Division. The questions were translated back from Kimeru to English by the survey team. Some modifications were made in the questionnaire prior to a one day pilot testing of the questionnaire in the Burieruri sub-programme area. Based on a review of completed questionnaires by the researcher and feedback from the enumerators, the number of questions was reduced and modifications were made to the questionnaire for purposes of clarification. A further day of training was carried out after the field test to discuss the enumerators' experience in administering the questionnaire.

The household survey was carried out during the period 21 March - 6 April 1987 starting with the Ugoti sub-programme. The timing of the survey was considered very favourable since the long rainy season did not start until one week after completion of the survey. Farmers had already planted their seeds in anticipation of the long rains so most heads of households were found at their homestead. One respondent per household was interviewed and the order of preference was head of household, wife if not head of household, or adult relative.

A systematic random sampling technique was used. A random start was identified and a sampling interval determined (Bernard 1988, p.85). Enumerators were dropped approximately 0.5 kilometres from each other starting from the health post or site where the Maua Programme mobile clinic was conducted. Households were selected on the basis of every 5th household back from a road. They were guided to the household by either a community health volunteer from the area or a Form 6-8 primary school student. The CHV's were instructed to excuse themselves during the interview. Households where either a community health volunteer or a health committee member resided were excluded. Since the nature of settlement in each of the surveyed areas was scattered households with individual plot-holders, this meant that the distance between households could be upwards of 500 metres. The average land per plot was approximately one half acre. Clusters of households are not the settlement pattern in Igembe Division. This sampling technique enabled the survey to incorporate households having some access to communication and contact with outsiders and those with potentially less opportunity for contact (10th and

15th household from a road). Enumerators were required to produce a sketch map of the households they had interviewed at the end of the day.

Each enumerator was instructed to carry out between two or three interviews per day. Spot checks were carried out by the researcher to ensure that each enumerator was adhering to the survey guidelines. An average of two days were required to interview the target number of households in each sub-programme which represented a minimum of 5 percent of the population for the respective area based on the 1979 census. The survey team returned to the Maua Hospital at the end of each day in the field. They were accommodated in the men's and women's dormitories at the Maua Methodist Hospital. Each day prior to proceeding to the field, a meeting was held with the enumerators to discuss the previous day's interview sessions and the plan for that day. Questions which were causing some difficulty in interpretation were also discussed. At least one completed questionnaire from each enumerator was reviewed daily by the researcher in order to judge how well the questionnaires were being completed. Important issues were then discussed at the group meeting and individual coaching sessions with enumerators were held as required.

Four hundred and fifty seven households were interviewed representing eight percent of the total number of households based on the 1979 census in the eight sub-programme areas. Zarkovich (1983, p.105) claims that there is a good deal of confusion involved in thinking of the size of the sample and the aimed-at precision in many surveys taken in developing countries, but the size of the sample is more a matter of convenience (such as 1 or 10 percent) or routine (3-5 percent) than of real justification. Bernard (1988, p.99) contends that a representative sample of 400 will be sufficient for most analyses, given a 5% confidence interval, in a large population of anything over 5,000. The more homogeneous a population, the more likely it is that a sample chosen from it will represent that population's parameters on the variables of interest. The cultural and social characteristics of the Igembe people in the Maua CBHC Programme will be discussed in the next chapter, but it can be said that they are fairly homogeneous population with a similar ethnic origin, cultural heritage and practices and a common tribal language.

In discussing survey research in relation to Western and less complex societies, Drake (1973) states that traditional communities are based on a kinship social network and are homogeneous with respect to a large number of social and cultural characteristics and that the individual is not an appropriate response unit in some communities of this type. He adds that "...a random sample of individuals may actually give us far less meaningful results - socially, scientifically, and politically - than we would have received by simply polling the leader of a particular community or cultural group" (Drake 1973, p 65). The communities in Igembe Division which were part of this research study were traditional horticultural societies and could be considered fairly homogeneous. Most of the communities incorporated between 2 to 5 major clans or kinship social networks.

In defense of utilising the household survey technique for research within a less complex society, it enabled the study to incorporate a much wider sample of community members within the Maua Programme area, and thus a broader-based range of views and opinions about a research topic where individuals are important. Even though traditional communities occupy very few social roles, each involves a vast range of activities, sentiments and interactions according to Drake (1973, p.64). Each village was headed by an elder and the research methodology included interviews with village elders (community headmen), consistent with what Drake believes is the most appropriate information source for traditional societies.

Regarding tabulation of the household survey results, as mentioned previously, a code book was developed for the responses to the open-ended questions. Tests of statistical significance are analysis techniques commonly used to determine whether to accept or reject a hypothesis (Adams and Schvaneveldt 1985, p.119). In the study two-variate cross-tabulation analysis was used for the factors of education, group membership and household visits by CHVs, identified as potentially influencing participation in community health projects.

Key Informant Interviews and Focus Group Sessions

An important research strategy was to ascertain the views and opinions on participation in health development from key informants in the communities such as community health volunteers, health committee members and local leaders who were directly involved in the Maua Programme. Also included in this group of respondents were local administration officials and government health workers responsible for or operating in the sub-programme areas. A third key group included in this phase of the research study were the programme staff responsible for the respective sub-programmes. Focus group sessions were held with groups of elders, local leaders, CHVs, HCMs, traditional birth attendants (TBAs), government extension officers, school teachers, women's self-help group members, youth group members. They numbered between 6-12 participants and on some occasions they were mixed groups.

Five of the eight sub-programmes areas were included for interviews with the above groups of respondents. These areas included Kirindine to represent the `high' potential area, Kiengu the `medium' potential area and Kilili the `low' potential area. Kangeta was again included for the same reason as described for the household survey and Athiru Gaiti since it was the oldest sub-programme area and because of its relationship to the Kilili sub-programme. The number of villages in each sub-programme varied from three in Kilili to eleven in Kiengu. At least 50 percent of the villages in each of the five sub-programmes were selected for key informant interviews and focus group discussions with local leaders. The villages were selected by non-random sampling. The pattern of selection was based mainly on getting a sample of villages which were spread throughout the respective sub-programme areas. The selection of local leaders was done by CHVs and HCMs along with a few pre-selected local leaders at a meeting with the researcher. They were asked to name three leading local leaders from each village, either male or female, who were involved in farming, the church or mosque, business, school, political party, or are officers in self-help groups, or elders or traditional birth attendants (TBAs). A total of forty eight local leaders were interviewed.

A total of sixty-nine CHVs and HCMs were interviewed in each of the five sub-programmes areas representing 66% of the total number of CHVs and HCMs operating in those sub-programme areas. Also interviewed were one chief, three assistant chiefs, three government enrolled community nurses (ECNs) and five Maua Programme staff representing or assigned to the five-programme areas in the survey. A questionnaire composed of open-ended questions was used for interviews with local leaders, CHVs and HCMs. The questionnaire included some questions which were specifically related to the respondent as a CHV, HCM or local leader. The questionnaire was developed in the same way as described above for the household survey. Some questions used in the household survey were included in these questionnaires for purposes of comparison. It was pre-tested in the field in the Ugoti, Kanjoo and Kirindine sub-programme areas. The chief, assistant chiefs, ECNs and programme staff were also interviewed utilising the questionnaire for local leaders.

A total of twenty-two focus group sessions were held in the sample villages of the five sub-programme areas. The discussion was focused on examining the history of the community, attitudes towards cooperation and voluntarism, factors influencing participation, assessment of the Maua Programme, role of local leaders, CHVs and HCMs. This research technique was used as a follow-up to the quantitative household survey. As stated by Khan et al (1991, p.145-146), focus groups are used to explain, expand and illuminate quantitative data, in order to gain some understanding about the reasons for certain findings. They provide a wealth of insight into motivation, attitudes, feelings and behaviour that cannot easily be obtained by quantitative methods along. This occurs because participants often feel more comfortable and secure in the company of people who share similar opinions, attitudes, and behaviour or simply because they become carried away by the discussions (Folcy-Lyon and Trost 1981, p.445). Feedback from the people on the research findings should be an important, integral part of the research process according to Ndagala (1985, p.24). The researcher used focus group sessions to also discuss some of the major findings from the household survey with mixed groups of community members in sample villages, along with seven larger community meetings. The number of participants for the community meetings ranged from seventeen

to forty. The interviews, focus group sessions and community meetings were conducted in English by the researcher with translation being done by a research assistant who had been a member of the household survey team.

Historical data, particularly in relation to how people cooperated with each other in the past and the tradition of voluntarism, was collected through recall of historical events or oral history from elders from the villages included in the survey. Two other questionnaires were used for the CHVs, HCMs and local leader respondents and administered simultaneously. They were:

i) a questionnaire to estimate the percentage of households that were participating in the Maua Programme mobile clinic and the factors which influenced or determined this participation;
ii) a questionnaire to obtain information on the homesteads of CHVs, HCMs and local leaders in relation to setting examples for community members to follow. The information covered such things as plot size, condition of the dwelling and cleanliness of the compound, sanitation and water storage facilities, crops grown including kitchen gardens.

Case Households

To carry out a more intensive and holistic investigation of the research topic, forty-five households were selected by CHVs and HCMs in the five sub-programme areas as case study households. Another reason for using the case method was to help verify the household survey findings, particularly those related to attitudes towards participation . Nichols (1991, p.37) advises exploring attitudes through in-depth case studies as well as structured interviews. He states, "Even well-designed questionnaires can only scratch the surface of what people really think, but longer informal discussions will fill out the picture" (Nichols 1991, p.37). Criteria for selecting the case households were the following:

1) households from the same villages which were identified for interviews with local leaders;
2) two households per village;

3) one household in the opinion of the CHV and HCM which was cooperating and participating in the Maua Programme by attending the mobile clinic and attempting to practice preventive and promotive health as a result of the home visiting by the CHV;
4) one household which was not cooperating or participating in the way described above.

These criteria are consistent with what Elder (1987, p.344) recommended for behaviour-analytic assessment, ..."to interview early adopters of pro-health practices to pinpoint both specific sources of motivation and influential actors in the health-related decision. Using a 'case-control' approach, similar interviews with non-adopters would further enrich this type of information."

Each of the forty-five case households were visited by the researcher and a structured interview using open-ended questions was conducted in Kimeru using the research assistant for translation. This visit was followed up by two or three more visits and a series of four questionnaires were completed. The questionnaires utilised for the household survey and the CHV, HCM and local leader groups were adapted for use for the case household interviews. The questionnaire to obtain information on the homestead described above was also used. An additional questionnaire was utilised to obtain the following information:

1) the way the household members were or were not participating in the Maua Programme;
2) the percentage of households in the village according to case household respondents that were not participating in the Maua Programme;
3) the factors which influenced or determined participation in the Maua Programme.

As a means of verification, information was obtained about the history of the household respondents' participation in the Maua Programme from the CHV or HCM who carried out home visiting for the respective case household. Also, the mobile clinic MCH cards

were examined for those households which claimed that they were utilising the mobile clinic services. The homesteads were scrutinised for various preventive and promotive health improvements such as latrines, dish racks, water storage containers, kitchen gardens and the general standard of living observed in relation to how well family members were clothed, condition of the dwelling, amount of furnishings, and cleanliness.

SOURCES OF BIAS

The potential sources of bias in this research study and the strategies used to overcome them are discussed in relation to the three stages of field research:

a) household survey
b) interviews with CHVs, HCMs, local leaders, local administration officials, extension agents and programme staff
c) case study households

Household Survey

The translation of the questionnaire from English into the vernacular language of Kimeru was a potential source of distortion and bias. The technique of translation and back-translation was used to help address this problem as discussed earlier. In administering the questionnaire the responses were translated back and recorded in English during the interview. The theoretical concepts of community participation were not particularly easy to translate, especially the concept of participation in decision-making and planning. As a way to monitor the quality and comprehensiveness of the recorded responses a sample of all completed questionnaires was checked by the researcher and group and individual discussions held with the enumerators.

Another potential source of bias was in relation to the sample size. Spot checks were done by the researcher to ensure that the enumerators were actually carrying out the interviews and according to the strategy of every fifth household back from the road.

The perception of community members of the household survey did offer potential bias. In order to carry out field research in Kenya approval must be obtained through the local

administration. In the case of this research, the District Officer for Igembe Division informed the chiefs in the respective locations who in turn informed their assistant chiefs about the research study. The assistant chiefs then either contacted village elders to inform them or announced at a community meeting (*baraza*) that a research survey was to take place.

Some of the community members in the Kilili sub-programme perceived the survey team to be health inspectors checking on latrine construction, based on the remarks made by the assistant chief about the survey at a baraza in Kilili. Apparently, there was a misunderstanding about the purpose of the survey on the part of the assistant chief based on a follow-up letter to him from a Maua Programme staff member. Construction of pit latrines was a health message which was communicated regularly to community members by local administration officials. Non-compliance can result in a fine imposed by the chief or assistant chief under the authority of the Chief's Act. Its enforcement, however, was not common.

During the field pilot test of the household questionnaire in the Burieruri sub-programme area, it was reported by enumerators that a few community members perceived them as debt collectors from Maua Methodist Hospital and refused to be interviewed. One household member insisted on an incentive to be interviewed. This latter problem however did not arise during the household survey.

Another potential source of bias was whether responses were truthful. A control used was multiple questions. A related form of this type of bias was respondents giving responses which they think the enumerator wanted to hear and which might result in development assistance coming to the area. The strategy to help overcome this was to ensure that through the introduction that respondents were aware of the purpose of the interview.

Key Informant Interviews

As a result of the methods used in selecting local leaders described above, it was felt that a representative cross-section of local leaders were identified and selected for interviews. The interviews were conducted by the researcher through translation by a research assistant who had been a member of the household survey team. Possible distortion through the translation was avoided by having the translation carried out by a research assistant familiar with the research subject. Seventy community health volunteers, health committee members and local leaders were interviewed separately by the researcher with the research assistant as translator.

Some interview sessions were conducted on a group basis to simulate the group dynamics of a committee meeting such as the health committee and to hear the views and opinions of as many selected local leaders as possible. The average number of people present at these sessions was between 10-20. A potential difficulty with group sessions is that a few people can dominate the discussion. To avoid this from happening an attempt was made to involve everyone during the course of the focus group discussions.

Case Households

The selection of case households offered potential bias as the selection of participating and non-participating households was primarily based on the recommendation of the CHV and/or HCM from the respective village. The criteria used for selecting case households regarding participation in the Maua Programme included whether the household utilised the mobile clinic or health facility services and took the advice of CHVs or HCMs regarding health behaviour change, mainly related to personal hygiene and sanitation practices. Before final selection the characteristics and practices of the household were discussed with the researcher.

The goal was to have an equal number of participating and non-participating households represented. Since some households were participating in some programme activities but

not others, the sample of case households included three instead of two categories, i.e., participating fully, participating partly, and not participating.

In discussing issues of social research in Africa, O'Barr (1973) stresses that investigators must be aware of the problems and avoid the hazards of applying survey research techniques outside the West. He also adds that attempts must be made to minimise bias and distortion, examples of which have been discussed above. O'Barr states finally that... "investigators must carefully catalogue which various techniques, both old and new, are workable. This will enable us to better understand the contexts in which different kinds of research procedures are useful and will permit future scholars to choose research strategies with a greater likelihood of success" (1973, p.18).

The rationale for the amplification and discussion of the research procedures in this study was in part to address O'Barr's last point. Even though more and more survey research is taking place in Africa, and specifically in Kenya, it is far less than takes place in the West. At the time the research was initiated, very little survey research had taken place in Igembe Division of Meru District. Lessons learned from survey research in Africa, such as this one, are valuable to future researchers regarding strategies, procedures and techniques, in addition to conclusions from the research findings themselves. Moreover, Rifkin (1990) states that it is essential to ascertain the views of community members on the value of community participation as an approach to health care. She claimed that few of the studies she had reviewed "....investigated with any thoroughness the view of members of the community. Moreover, few have asked the questions essential to understanding how effective community participation can be achieved" (1990, p.34). This then is one of the few field research studies to do just that.

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CHAPTER 6

THE MAUA METHODIST HOSPITAL COMMUNITY BASED HEALTH CARE PROGRAMME, KENYA

INTRODUCTION

> "If I were asked to pick the district of Kenya which excels above all others in beauty, variety and generosity of soil and climate, I think I might choose Meru, which runs from the high cedar forests of Mount Kenya, lost in mist and pinched with frost in the sharp starlit hours before dawn, down to the dry baking plains of the Northern Frontier" (Huxley 1960, p.217).

Meru District, in which more than 95 per cent of all Kenya Meru people live, was established in 1925. The Maua Methodist Hospital Community-based Health Care Programme operates in Igembe Division of Meru District which covers an area of 9,922 square kilometres on the eastern side of Mt. Kenya . According to the 1979 census, the district had a population of 830,179 people . Meru District, as well as Igembe Division, has all the climatic zones of the Republic of Kenya, ranging from the thick evergreen forests at the foothills of Mt. Kenya which include the Nyembeni Hills, to the semi-arid zones of the northeast and southeastern end of the district and the area bordering the Meru National Park in Igembe Division. Maps of Meru District in Kenya and Igembe Division within Meru District appear in Figures 1 and 2.

Igembe Division is one of the nine administrative divisions of Meru District. The division had a population of 171,597 (1979 census) and an area of 535 square kilometres (Meru District Development Plan 1989 - 1993, p.17). It is located some 50 kilometres east of Meru town and the Maua Methodist Hospital is situated at the administrative headquarters of Maua. Igembe Division has five administrative locations each headed by a chief who is a government civil servant and reports to the District Officer who is the head of administration in Igembe Division. There are also 12 administrative sub-locations which are headed by assistant chiefs, also appointed by the government. Each village has local leaders and clan elders who liaise with the assistant chiefs and the chiefs regarding security and development issues in their village areas.

The division is characterised by the Nyembeni Hills, an elongated, extruded volcanic feature which rises sharply above the surrounding plateau to a height of about 8,200 feet, then gently descends northward to 2,600 feet. Rainfall is plentiful on the southern and southeast facing mountain slopes which can expect 50-90 inches of rainfall annually. The eastern and northern lowlands receive amounts more within the range of 15-40 inches (Bernard 1972). These occur during two rainy seasons and the agricultural life throughout the entire district, including Igembe, revolves around this seasonal pattern.

The most significant and intensively used homestead area has been the highlands area of Igembe Division. Settlement preference for this area produced heavy population densities and definable villages. Yet on average settlement was dispersed rather than nucleated. The vast majority of Igembe is characterised by homesteads scattered over hillsides and ridges, and consisting of a several small cylindrical thatched houses and granaries grouped around a roughly circular animal compound. Occasionally, several related families would settle together, but these small clusters of homesteads were not nucleated or village settlements. If a dispute arose which the family head could not resolve, he or she would refer it to a clan elder.

While the homestead zone is used primarily for crop cultivation and secondarily for grazing, the lower zone is tilled for annual crops. Neither habitation nor livestock-keeping are suited to this lower zone because of Meru perception of its hazards of heat, aridity, and disease. Instead, women make daily trips from their homesteads to a number of small fields to prepare the ground, plant, weed, and harvest. The agricultural landscape of the lower zone is dominated by fields of millet, sorghum, pulses and grains. Most farms are dispersed over two to three ecologic zones, and according to Bernard (1972, p.61), the amount of land under cultivation would not exceed 5-7 acres per nuclear family.

The main cash crops for Meru District, including Igembe Division are coffee, tea and cotton. Horticultural crops like cabbages, carrots, potatoes and tomatoes are grown more extensively in the other divisions of Meru District, while the emphasis in Igembe Division is placed on growing food crops of maize and beans. But where there is fertile volcanic

soil, bananas, yams, sweet potatoes, and cassava are planted. In bottomlands, where irrigation occurs, sugar cane and taro are grown. One of the most important crops to the Meru is the banana which helps bridge food shortages between seasons.

The Meru people are a Bantu tribe and are comprised of nine sub-tribes: the Igembe, Tigania, Imenti, Miutini, Igoji, Mwimbi, Muthambi, Chuka, and Tharaka. They trace their histories back almost three hundred years, long before any of them were known as "Meru" (Fadiman 1993, p.5). Existing written records cover only the past ninety years, and these documents deal mainly with problems encountered by the various groups imposing colonial rule. Within all of these of records, according to Fadiman (1993, p.5), Africans play the role of shadows on the fringes of a European play. Nevertheless, some literature does exist regarding various aspects of Meru traditional and socio-cultural life and tribal heritage (Fadiman 1982; Bernardi 1988; M'Imanyara 1992).

The Igembe sub-tribe of the Meru live on the Nyambeni range in the north of the District where they have remained more or less isolated. For this reason they have clung doggedly to their traditional way of life which has been preserved more genuinely than by any other of the Meru sub-tribes (Bernardi 1959, p.3). Until recently, the immobility of the people of the Nyambeni range and their lack of interest in modern developments was regarded almost as one of their characteristics. A major development which had enhanced communication and provided greater exposure in Maua to other parts of the district, neighbouring provinces and Kenya in general was the tarmac road to Maua from Meru completed in 1981. The 50 kilometre section of the road south from Meru to Embu en route to Nairobi was completed in 1985.

Another characteristic of the Igembe is their clan age-class system in which the association of the *njuri* has been formed (Rimita 1988). The association with its full hold on social and political life still survives among the Igembe and the Tigania. Members of the *njuri* association are selected elders who have passed through a series of special initiation rites and paid the established fees. Generally, elders who have distinguished themselves by their brilliance and their wealth are selected since it is perceived that wealthy men wield

greater influence in the community and can afford to pay the exorbitant entrance fees (Bernardi 1959, p.25). The very high power possessed by the *njuri*, against which there is no possible appeal, makes their membership of privilege, open to abuses. It is a common experience to hear complaints levelled against the *njuri*. Many of these are related to land issues. Land in Meru is held under three headings: clan land; individual small-scale land holdings; and large-scale farms (Meru District Development Plan 1989-1993, p.8). Areas where much of the land has not be gazetted as adjudicated include Igembe Division where ownership of the land is vested in the clan (*Mwiriga*) and the clan distributes the land to its individual male members. Numerous meetings of clan elders and *njuri* members were observed during the field research and the researcher was informed that the meetings involved disputes over allocation of clan land.

One aspect of the culture particularly significant to the study is the use of miraa (*Catha edulis*) as a stimulant. Miraa is a cash crop unique to Igembe Division. Although only about 3,000 acres are grown, miraa is second to coffee in Meru as a revenue earner. It grows as a tree and the stems of the miraa leaves are harvested. When its shoots are chewed, they produce a stimulating effect on the body in much the same manner as caffeine. Constant chewing of miraa seems to be related to a demotivating condition where ambition, drive for progress and concern for others are lost (Bennett el al 1982, p.3). Traditionally it was mainly only chewed by elders, but an increasing number of teenagers and women were reported to be chewing miraa and involved in the picking, bundling and selling of the crop. Men are responsible for the management, protection and harvesting of miraa which is done frequently since the narcotic effect of the stem becomes impotent within 48-72 hours of picking.

Miraa is cultivated in small orchards (kiraa) in which a few trees are raised exclusively. As boys are better at climbing and frailing trees and youth can earn more money at this job than any job requiring education, school drop-out was a problem in the miraa growing areas. Many of these areas are ones involved in the Maua CBHC Programme such as Kangeta, Athiru Gaiti, Kirindine and Kiengu. However, Kangeta is the main miraa producing area. Because of a general reluctance to discuss miraa earnings, it was difficult,

to know just how profitable it was. Judging from the demand for miraa however, there was little doubt that profits are substantial.

PROGRAMME DESCRIPTION

The town of Maua dates back to 1912 when two Goans established shops in the area (Bernard 1972). A Methodist mission was established in 1928 and in the same year a hospital was built at the new Methodist outpost at Maua (Bennett et al 1982, p.3). By the early 1940's, missions were able to boast of increasing school enrollments and a gradual expansion of physical facilities and were perceived as agents of change. The Methodist mission at Maua has continued to play an active role in development up to the present, particularly in health care.

Established in 1977, the Maua Methodist Hospital CBHC Programme was one of the first CBHC programmes in Kenya and remained one of the few programmes where the technical support was provided by a hospital and its community health department. The Maua Methodist Hospital started in 1928 but it was only in 1974 that consideration was first given to its impact on the community (Bennett et al 1982, p.5). This was a similar pattern to other church mission hospitals in Kenya which had for many years followed the traditional approach to health care, tending to focus on the mainly curative hospital service 'reaching out' into a community that was not expected to take much active interest in the state and development of the health care it received (DeBoer and McNeil 1989, p.1007). In 1975 Maua Hospital senior management staff reviewed the records and found that there had been no change in the disease pattern since the hospital had started, except that more women attended for delivery. Simultaneously, requests were being received from Methodist Church women's groups in the more remote areas of Igembe Division for the hospital to established a mobile MCH service. It was then decided that there should be more concentration on community health and an outreach programme. A nurse was sent for training in public health and another public health nurse was recruited. Arrangements were made in 1976 to start an Enrolled Community Nurse (ECN) Training programme which by 1986 had 115 community nurse trainees. A Community Health Department (CHD) was established at this time to manage the ECN training programme and the

CBHC Programme. The Maua Methodist Hospital operated an active out-patient department averaging around 150-200 patients per day. There were 40 maternity beds out of a total of 130 beds in the hospitals and in the mid-1980's deliveries were averaging 4,000 per annum.

The Maua Programme covered 16 sub-programme areas, each consisting of between 3-10 villages. Nearly all of the people (98.5%) were from the Igembe sub-tribe. There were no major differences in tribal customs in any of the sub-programme areas. For instance the *njuri* appeared to be equally active in each sub-programme area. There also appeared to be close cooperation between village leaders and clan elders, the health committees and local administrative officers, particularly in relation to the Maua Programme and the operation of the mobile MCH/FP clinic. The majority of sub-chiefs were from the same administrative areas, even though they were appointed by government. However, their effectiveness in relation to development issues varied considerably and this is discussed later in this chapter. The tribal custom of miraa chewing was more prevalent in those areas where it was produced, and, thus, the social development and behavioural problems it caused were more confined to those sub-programme areas. Other variations within the sub-programmes were determined more by agricultural potential, remoteness of the area, the degree to which land had been adjudicated and the quality of local leadership than differences in social structures or tribal customs. Characteristics of five of the sub-programmes are described later in this chapter.

Each sub-programme area corresponded roughly to one of the twenty-two sub-locations in the division. The locations of the sub-programme areas had been based mainly on the groups that requested the mobile clinic services which to a great extent were church groups. There was no restriction on who could receive the mobile clinic services. The mobile clinic visits were carried out once per month to fifteen sub-programme areas within Igembe Division by the Community Health Department mobile MCH/FP team. Besides delivering maternal and child care and family planning services, these visits also enabled Maua Hospital Community Health staff to provide technical support to CHVs and health committee members (HCMs). The exception was to Kangeta where a government sub-

health centre operated. However, other technical support visits in the form of a monthly one-day visit by a community health nurse to work with the CHVs and HCMs in the Kangeta sub-programme area, did occur[1].

One of the main goals of the Maua CBHC Programme was to increase the participation and effectiveness of community involvement in health care. The main components of the programme included a mobile MCH/FP service and training and technical support to community health volunteers and health committees covering four of the five administrative locations. Overall programme management responsibility for the Maua CBHC Programme rested with the Igembe Health Council (IHC) which was established in 1982. It consisted of representatives from the Maua Hospital Community Health Department and from each sub-programme area. They included two members of the respective health committees and one CHV. The specific functions of the IHC were sharing of ideas and problems, liaison with local administration, promotion of education in the community, advising the health committees on new ideas, implementation of plans, fund-raising and strengthening the committees by means of training seminars. Each sub-programme was required to pay the IHC KSh 40 per month which was then paid to the Maua Hospital to cover the costs of the mobile clinic. Day-to-day management of the programme at sub-programme level was the responsibility of the local health committee. There was close collaboration between the health committees and the Maua Hospital Community Health Department (CHD) which was responsible for providing the mobile MCH/FP services and technical support to the programme. An enrolled community nurse at the CHD was assigned to each sub-programme for purposes of coordination and support.

As of December 1987 a total of 180 community health volunteers (CHVs) had been trained. The training consisted of an initial 2-week period followed by continuing education sessions which were carried out as part of the one-day technical support visits by one of the four enrolled community nurses assigned to each programme area. The ini-

[1]Interview with Margaret Bailey, Coordinator of Community Health Department, Maua Methodist Hospital, Maua, Kenya, 9 December 1986.

tial training was done at village level with the emphasis on preventive and promotive health activities.

The CHVs did not administer drugs and were basically health educators utilising home visiting as their main method of health education. They were supposed to devote two days a week to their tasks as community health volunteers. The number of CHVs selected to be trained was based on a ratio of one CHV to 100 households. Health information was collected by CHVs utilising a simple health information form called Health Happenings. The reward for CHVs was a gift presented at Christmas time by their respective health committee. The different gifts over the years had been items such as a washing basin, *jembe* (spade), pots and pans. The CHVs were selected by their villagers at a community meeting (*baraza)*. The major criterion was that the person be a respected member of the village who was willing to do voluntary work.

Each of the sixteen sub-programme areas had a health committee except for Kiegoi and Kilili. Their main task was to promote health development and health behavioural change through health education and to provide leadership, guidance and support to the CHVs in their area. The majority of health committees had received training from the programme staff on their tasks, with particular emphasis on community mobilisation and how to function as an effective local organisation. Health committee members were chosen by the villagers they were to represent.

The mobile MCH/FP clinic service was operated on a fee-for-service basis. A registration fee of KSh 25 was charged and then KSh 2 per visit. The funds were collected by the health committee during the clinic visit and kept in an account by the programme on behalf of the respective health committee. The average attendance for the mobile outreach clinic was 50-75 mothers. The majority of mothers were able to pay the KSh 2 clinic fee, meaning that an average of over KSh 100 was collected per monthly visit. The health committee had to remit KSh 40 per month to the IHC who in turn transferred the funds to the programme to cover the fuel cost of the mobile clinic vehicle. Funds were also used to purchase the Christmas gift for the CHVs. CHVs assisted the mobile clinic team with

patient registration, weighing of infants and health education. They received KSh 5 as a payment for lunch for that day from the fee income.

The Maua CBHC Programme was externally evaluated in October 1982 by a team with representation from UNICEF's regional office in Nairobi, University of Nairobi Community Health Department and a CBHC programme in Tanzania. The evaluation team claimed that the elements of the Maua Programme were all relevant and conformed to the Alma Ata concept of essential health care. The emphasis on community participation had been especially prominent (Bennett et al. 1982, p.42). One of their few criticisms was that the training of CHVs appeared to be very short in relation to the job they were expected to do and possibly more analysis of the behavioural causes of disease problems should be included in their training.

SUB-PROGRAMME AREAS

As mentioned in Chapter 5, five of the eight sub-programme areas which were included in the household survey were selected for more in-depth case study research utilising key informants, focus group discussions and case studies. The sub-programmes were Athiru Gaiti, Kilili, Kangeta, Kiengu and Kirindine. Figure 3 shows the location of these five sub-programmes and Auki, Kanjou and Ugoti sub-programmes which were also included in the household survey.

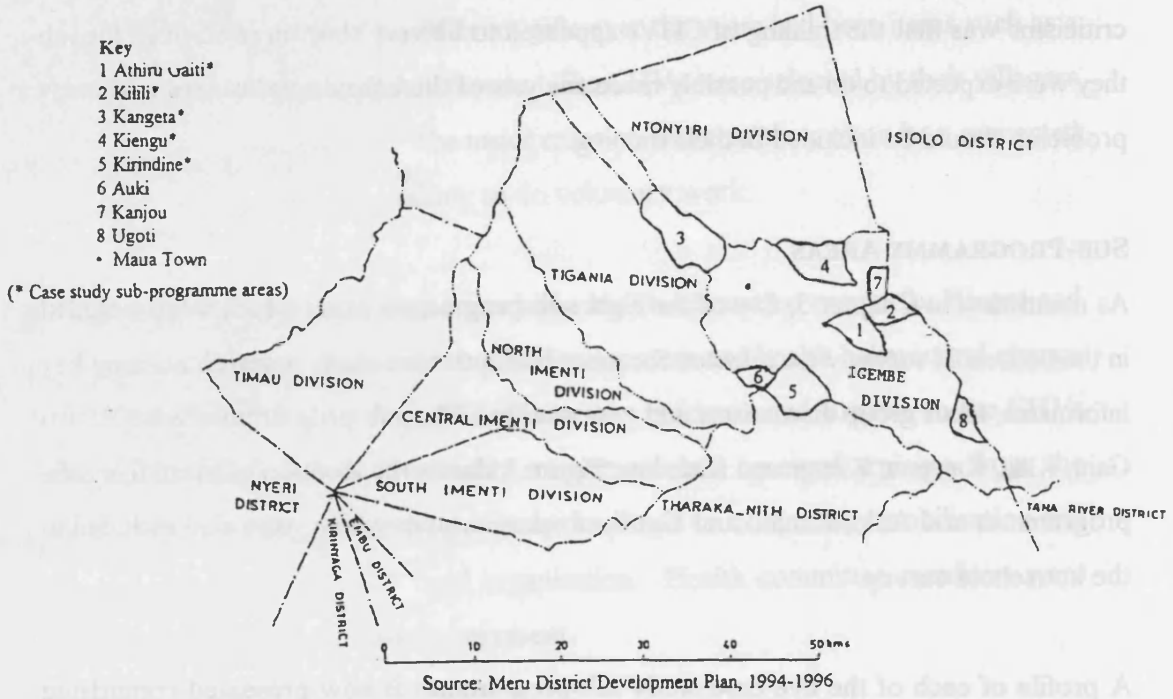
A profile of each of the five case study sub-programmes is now presented comprising demographic data, socio-economic characteristics, the situation regarding local leadership and local structures in the respective communities and the Maua Programme activities being undertaken. The influence of some of these factors and community characteristics in relationship to enhancing or impeding participation in the development activities in general and the Maua Programme in particular will be discussed in following chapters.

Athiru Gaiti

Athiru Gaiti was the one of the oldest sub-programme areas and was located nine kilometres from Maua in Thaciu Sub-location of Akachiu Location. It covered ten

villages which made up most of the sub-location which had a total of 1,476 households and population of 7,367 in a 32 square kilometre area, according to the 1979 census. The area was mostly inhabited by native people but some outsiders had settled there during the early 1980's.

Figure 3: Household Survey Sub-Programme Areas



Source: Meru District Development Plan, 1994-1996

The agricultural potential of the area was medium high to high. There were two, possibly three, ecological zones represented within the Athiru Gaiti sub-programme area as the land descended quite sharply over a distance of some 8 kilometres from about 5,000 feet where coffee and tea were grown, to a drier area at about 2,500 feet leading to the Kilili sub-programme area which is described later. The land had not yet been demarcated. Feeder roads existed and were passable except during the rainy season.

There were 12 active CHVs operating in the Athiru Gaiti sub-programme, six men and six women. Distribution of CHVs was one per village, except for three villages which had two CHVs. The health committee had 15 members. It had been chaired by a primary school teacher since it was formed in 1978.

The assistant chief for Thaicu Sub-location lived in Kirimene village, one of the ten villages covered by the programme. He was a Kikuyu who had been the assistant chief for over six years. His reputation as an effective leader was questionable. His over-riding interest seemed to be more personal than developmental. Being within Akachiu Location, the chief for this sub-programme was the same as for Kirindine.

The traditional elders' association, was very active. Land cases were settled by the elders, many of whom were members of the *njuri* association. People felt, therefore, that they would receive more favourable decisions if they were members of the same society as those judging their cases. Younger people in the community felt that the *njuri* association was not development-oriented; and, moreover, was excessive and wasteful of people's limited resources. Both the chief and assistant chief were members.

Numerous self-help groups had been established. The Methodist church was very strong in Athiru Gaiti. It was a church connection which initiated the programme in the first place when a women's group from Athiru Gaiti Methodist Church requested the hospital to provide mobile MCH services to the area.

Foster Plan International (FPI) had a field office in Athiru Gaiti village at the facility which was built as a health post for the hospital's mobile clinic services. KSh 20,000 was raised from local and outside contributions for its construction. Once the Kiraone dispensary was opened in 1985, which is located among the villages forming part of the sub-programme midway between Athiru Gaiti and Kilili, the mobile clinic service was shifted there. The previous location in Athiru Gaiti village, however, was more centrally located for the mothers than Kiraone.

The average level of education was reputed to be Standard 7, however, some local leaders felt that Standard 4-5 was more likely. Some adult education classes were being held but in Antubakui they have failed due to lack of interest, and subsequently, poor attendance.

A willingness to contribute to development projects had been demonstrated through the successful fund-raising efforts for construction of the mobile clinic health post at Athiru Gaiti village and contributions made towards the construction of the Kiraone dispensary. Nevertheless, bitter feelings existed about the Kiraone dispensary as community members felt that they were contributing to a government dispensary which would provide free medical services, particularly drugs. The Maua Methodist Church's contribution came mainly from a grant from the Kenya Ministry of Health as part of World Bank IRD/FP project. The dispensary was run by the Maua Methodist Hospital on a fee-for-service basis and was under-utilised. The nearest government health facility was Kanuni dispensary at the Chief's Camp, a distance of some five kilometres.

No major government programmes had been started in the Athiru Gaiti sub-programme area. The agricultural extension agent was active while the community development assistant was not considered so by local leaders. The government had not assisted the area in improving the road from Kilili to Kiraone to Athiru Gaiti. One private Landrover made the trip from Kilili to Maua each day, but no commercial transport service was available. Cases were common of people being transported to Maua Methodist Hospital by home made stretcher, the majority of whom were obstetric emergencies.

Kilili

The Kilili sub-programme was started in 1978 at the same time as the Athiru Gaiti sub-programme. Kilili was located some seven kilometres beyond Athiru Gaiti, but the road from Athiru Gaiti was very steep and rocky, making it difficult to reach, even by a four-wheel drive vehicle. Kilili was within Thaciu sub-location of Akachiu Location, and the sub-programme comprised three villages.

Because of its low rainfall, the Kilili area could be classified as a low potential area agriculturally. The main water source was a stream which separated the villages of Kilili and Kigoma. Kilili was located in the lower and drier part of the sub-location and no cash crops were grown except for some cotton and miraa in Kigoma village. The nearest market for women to sell their horticultural produce of maize, beans and bananas was Maua which was 17 kilometres away and uphill. Only one Landrover operated between Kilili, Athiru Gaiti and Maua.

The estimated number of households in the area was 350, with a total population of approximately 1,750 persons. The area incorporated about 18 square kilometres and was sparsely populated due to its low agricultural potential. It had become an area where newcomers from other parts of the district and Kenya had migrated. But it had also been settled for many years. For instance, the Kilili primary school was started in 1950, the first one in the sub-location. Land had yet to be demarcated here also.

The influx of people, particularly those from other tribes, had meant that new ideas on farming methods had been introduced which most people felt had been a positive development. The ideas for self-help groups had also come mainly from the outsiders who had moved to the area, or from NGOs like FPI. Nevertheless, some native people were resentful that land was going to other tribes. One outsider who had settled there, a Kikuyu from Miranga'a, said "I couldn't believe this was Kenya, or maybe Kenya before Uhuru (independence)."

Twelve CHVs had been trained for the Kilili sub-programme. Eight to ten CHVs were considered active by local leaders. The functions of the health committee of the Kilili sub-programme were covered by the Athiru Gaiti Health Committee whose membership included three representatives from the Kilili area. Local leaders and CHVs wanted Kilili to have its own separate health committee. This was tried in 1985 but those individuals selected in Athiru Gaiti met only once under the chairmanship of the senior elder from Kilili. The mobile clinic services were delivered from a health post which was constructed in 1983 through community contributions.

Formal leadership from the local administration and some senior elders was not considered strong, and a reason why the area had not progressed. Most of the time of senior elders was spent on settling land cases and domestic disputes. Few *barazas* were held in Kilili for instance. Informal local leaders, however, seemed keen to develop their area. Few local organisations existed other than churches and the KANU political party groups. Self-help groups were just starting to be organised, mainly as a result of the influence from new settlers and NGOs.

The level of education per household was considered lower than other sub-programme areas. No other primary school had been established in the area, and attendance was erratic at the Kilili Primary School according to the deputy principal. Children were pulled out of school by their parents to assist with planting, weeding and harvesting crops. There were only eight students in Standard 8 class, although the average number in Standard 1 was 40. Adult education classes were started in 1984 but failed. Women were not able to attend regularly because of heavy domestic duties. Early marriage was also felt to be a contributing factor to the low educational level of women in the area.

A women's self-help group was established in 1986 which raised funds through contract labour in order to assist its members financially. Another self-help group was formed in 1987 to address the dilemma of having to transport sick people by stretcher to Maua Methodist Hospital. Their goal was to raise enough funds to purchase a vehicle. The idea for the women's self-help group came from FPI and for the health-related group from the

Kikuyu from Muranga'a who was quoted earlier. A project committee associated with a FPI goat rearing project also had been formed, but it was experiencing difficulty in raising the KSh 50 contribution from members.

Community members seemed to have minimal cash income to contribute to development projects after meeting other commitments such as school fees, children's clothing, and food for their families. No government programmes had been started in the area. Extension workers from agriculture, livestock development and community development rarely if ever visited the area because of its remoteness.

Kangeta

Kangeta was the only programme area which operated within the immediate catchment area of a government health facility. The Kangeta sub-health centre was built as a harambee dispensary in the late 1970's. Consequently, it is also the only sub-programme area where the mobile clinic did not operate. This fact and the subsequent situation whereby the Kangeta Health Committee had no source of income from the mobile clinic fees had been a cause for the virtual collapse of the sub-programme in Kangeta.

The Kangeta sub-programme covered five major villages in the two sub-locations of Njia cia Mwendwa and Kangeta in Njia Location. The sub-programme area was located some 10 kilometres from Maua, bi-sected by the main tarmac road from Meru to Maua. Its centre was Kangeta town which was the second largest urban centre in the division. Kangeta town market operated three days a week. The area was mostly settled by native inhabitants, and the two sub-locations had a population of 15,348 in 1979 in an area of 91 square kilometres. The sub-programme covered approximately one half of this area.

Agriculturally, Kangeta was a high potential area spanning two ecological zones. Tea was the major cash crop and in near-by Kiegoi sub-location was located Igembe Division's largest tea factory. As mentioned earlier, Kangeta had the dubious distinction of being the miraa capital of Igembe Division, and, in fact, the whole of Kenya. The miraa trade had various adverse effects on community members. Continuous chewing can lead to

inertia and unruly behaviour resulting in quarrelling and disharmony within the household. Children are introduced to the miraa business at an early age since they are involved in picking the miraa shoots and at periods of the year which conflict with attending classes. The miraa business is also a disincentive for completing primary education since some school leavers can earn substantial sums of money through its trading.

The brewing and selling of local beer were not controlled in Kangeta as in other sub-locations, adding to the social problems of the area. According to a staff member at the Kangeta dispensary, besides brewing the beer, some women, including those who brought foodstuffs for sale at the Kangeta market, were becoming excessive consumers. Polygamy was practised widely, but few men were able to financially support multiple households. This meant that basic needs like food, clothing and shelter were even less adequately provided for, as well as fees for schooling.

In 1987, there were only five CHVs and a TBA who were still active in the Maua Programme out of the total of 15 CHVs who were trained in 1984. Only a few health committee members maintained their interest in the sub-programme. The virtual collapse of the Kangeta sub-programme was a major concern of both the Igembe Health Council and the Maua Programme staff. A major issue was the lack of a reward for CHVs since no funds were raised through a mobile clinic service. Besides the value of the Christmas gift itself, it represented a recognition of their work which was considered important to CHVs.

The vice-chairman of IHC met with the health committee and CHVs in February 1987 to ascertain what actions could be taken to revitalise the sub-programme. One recommendation was that a community meeting should be held to raise funds for the Christmas reward for CHVs and to propose that new CHVs and HCMs should be selected to replace those who had become inactive. The Maua programme representative for the sub-programme and the health committee chairman were supposed to liaise with the Chief of Njia Location to schedule the meeting. No meeting had taken place between these

concerned parties as of December 1987 and, consequently, no community meeting has been held.

The effectiveness of the local administration in supporting health programmes was questioned by staff members at Kangeta dispensary. The person in-charge of the facility cited the fact that no action had been taken by the chief to mobilise community labour and materials to build new latrines for the Kangeta dispensary staff houses. Since the health facility was a harambee dispensary, maintenance was the responsibility of the community and local administration.

Self-help groups existed and were active, as were church groups. FPI was starting to operate in the area, assisting in constructing new primary school classrooms at Kiolokia Muuti. No government projects had been undertaken but the community development assistant and agricultural extension officers were active in the communities. Kangeta dispensary staff were supportive of the sub-programme and in the past carried out joint home visiting with CHVs. CHVs used to assist in the dispensary's MCH clinic.

Kiengu

The Kiengu sub-programme was located in the sub-locations of Antubetwa Njoune and Amwathi in Maua Location which according to the 1979 census were inhabited by 19,880 persons in 3,503 households spread over a 41 square kilometre area. The programme area started 9 kilometres from Maua and comprised some 11 villages along a 10 kilometre stretch of road from Maua eastward towards the Meru National Park. The focal point of the sub-programme was the centrally located Kiengu village where the mobile clinic services were provided once a month.

Similar to Athiru Gaiti, the Kiengu sub-programme area was agriculturally a high to medium high potential area. The area sloped downwards from an altitude of about 4,000 feet where coffee, tea and miraa were the main cash crops to a middle part approximately 2,000 feet lower where some coffee, but mostly miraa was the major cash crop, then finally to a lower, drier area situated at about 1,000 feet. Here some cotton was grown

along with tobacco for the British American Tobacco Company. The main food crops throughout the sub-programme area were maize and beans. The area was, therefore, quite similar ecologically to Athiru Gaiti, but located to the east rather than the west of Maua. The land had been demarcated in the upper parts of the Maua Location, but this was yet to be done in the lower areas. The programme area had been settled mostly by the native people, but in the lower parts like Matiandui, newcomers were represented.

Feeder roads were being developed and communication was not considered a major problem, except for the lack of a road link between Matiandui and Kiengu which was a 7 kilometre uphill climb for mothers attending the mobile clinic at Kiengu.

The average level of education per household was cited as Standard 7 by local leaders, but some leaders felt this would be too high a level. Some adult education classes were being held, one being conducted at Amaku village by the chairman of the health committee, but another class at Kaurine, a fairly progressive village, had failed.

The Kiengu sub-programme was one of the newest sub-programmes having started in 1985. Twelve CHVs covered the area, one per village except for Kiengu village which had two CHVs. Health committee leadership was considered strong by local leaders and programme staff. The committee had 13 members, only two of whom were women. The mobile clinic programme was popular and on some occasions supplies of vaccines were exhausted as a result of high attendance.

Formal leadership was also considered strong as the chief for Maua Location was also the chairman of the Igembe Health Council. The assistant chief in the sub-programme area was also very supportive and during 1987 called 13 community meetings at which health was discussed along with other issues. The village elders were also committed to the sub-programme, along with other local leaders who assisted CHVs and HCMs with home visiting for instance.

The churches were active in promoting health. The number of self-help groups averaged about 1-3 per village and the number was increasing. However, some had failed due to poor management, weak leadership, and members expecting a quick return from their efforts. The KANU party structures were well organised with good leadership in this sub-programme.

The community members' willingness to contribute to development projects had been demonstrated by contributions to FPI projects, the Kiengu mobile clinic health post, the Kiengu clinic fund, besides contributions over the years for church and school projects. The level of contribution for the FPI water project, for instance, was KSh 200 for connection to one's homestead, less the cost of the pipes. The user fee amounted to KSh 5 a month thereafter.

No major government projects had been undertaken in the programme area. The agricultural extension agents did visit the area periodically, however the community development assistant was rarely seen. No government health facilities existed in the programme area.

Kirindine

The Kirindine sub-programme area, located in the Kirindine sub-location of Akachiu Location, some 14 kilometres from Maua, comprised five major villages covering part of the sub-location in a triangular area of roughly 35 square kilometres with an estimated population of 4,500 people in 750 households. The 1979 census for Kirindine sub-location recorded a population of 8,899 for 1,726 households in an area of 56 square kilometres. Population density for the sub-location was high at 157 people per square kilometre, but average in comparison to other similar high potential areas in Igembe Division. The land had not been demarcated in Kirindine sub-location. The villages in the Kirindine sub-programme area were all in the same ecological zone, situated at about 6,000 feet in the Nyambeni Hills. Kirindine sub-location was characterised by very steep slopes but extensive rainfall and many continuously flowing streams. The area was situated adjacent to the Nyambeni Forest Reserve.

Thirteen community health volunteers (CHVs), representing two CHVs per village, were selected for training in 1986. However, at the time of this research study in December 1987, they had not been trained. The main reason was that a *baraza* had not been called by the local administration, namely the chief or assistant chief, to raise funds for the costs of their two week training. The amount needed was approximately KSh 600 for accommodation and per diems for 12-15 CHVs and for two Maua Programme trainers. Training would be done locally.

An initial, small health committee was formed in the early 1970s. Committee members were mainly teachers and local leaders from Kailune village. New health committee members were selected at a *baraza* in 1985, including three members from the previous committee. The new health committee, which also included 2-3 representatives for each village, had 15 members, of which eight were actively involved in the programme. They regularly attended the health committee meetings, carried out home visiting and assisted the mobile clinic team. The health committee members were carrying out some of the tasks of CHVs, such as home visiting. The new committee was selected when the sight of the mobile clinic was shifted from Kailune to a new health post at Muthuria.

Mobile clinic visits from Maua Methodist Hospital to Kailune started in 1973. Rose, a health committee member, was instrumental in securing the mobile clinic service. She approached the Maua Hospital Medical Director in 1973 and stated that mothers from the Kailune area were not happy about travelling to Maua for maternal and child care services which then amounted to an arduous one day's journey. Based on this and similar requests from Athiru Gaiti, the hospital launched its mobile MCH/FP clinic outreach programme. The monthly mobile clinic services were shifted from Kailune to Muthuria in 1985 when a health post was constructed there on communal land through donations from the community. The facility was only used during the monthly mobile clinic visit. Local leaders had presented a proposal to the Kirindine sub-locational planning committee for a government dispensary to upgrade the health post.

The chief for Akachiu Location, a Kikuyu and not a Meru from Igembe Division, was considered active and development conscious. He organised a community fund-raising meeting (harambee) which raised KSh 7,000 for the construction of the mobile clinic health post, but he had failed to organise a harambee for training the CHVs. The assistant chief for Kirindine sub-location was killed by a poisoned arrow in 1985 over a dispute concerning land which he was adjudicating. A new assistant chief was named in July 1987. He was from Ugoti village where he had been chairman of the Ugoti Health Committee. Kirindine sub-location was a very large area making it difficult for one assistant chief to administer.

Informal leadership was not considered strong. During a focus group session with the health committee, the members complained of lack of interest from local leaders in the Maua Programme. On the other hand local leaders from Kailune village claimed that they did follow-up visits to check whether people were taking action on the recommendations of local administration officials and health committee members, particularly construction of pit latrines.

The churches were active in promoting health care by devoting time during Sunday services to preach on preventive health practices. Numerous self-help groups had been formed. Other local organisations such as the Kenya African National Union (KANU) Youth seemed well organised and led by respected young leaders.

The average education level per household according to local leaders was Standard 7. Adult education classes were taking place in only one village. The nearest health facility was the government dispensary at Kanuni at the Chief's Camp which was 10 kilometres from Kirindine towards Maua. No major government development programmes were being undertaken in the area. The livestock extension agent was active and provided technical advice mainly through home visiting. The Tea Authority workers were also felt to be providing effective services to the community. However, the community development assistant seldom visited the Kirindine sub-programme area. FPI had a field

office in the area and were carrying out various projects concerned with primary school building construction, water supply, and support to self-help groups.

Willingness to contribute to health projects had been demonstrated through the contribution of KSh 7,000 raised to construct the mobile clinic health post. Local leaders expressed a need for mobile clinic visits at different village locations. They also wanted the Maua programme nurse responsible for Kirindine to be visiting more villages during her one day a month technical support visits.

A summary comparison of the characteristics of each sub-programme is described in Table 1.

Table 1: Summary of Sub-Programme Areas

Characteristics	Sub-Programme Areas				
	Kirindine	Athiru Gaiti	Kiengu	Kangeta	Kilili
No. Villages	5	10	11	5	3
Approximate Population	4,500	7,367	19,880	7,674	1,750
Size of Area/sq.km.	35	32	41	45	18
No. Households	750	1476	3503	1279	350
Pop Density/ sq. km.	129	230	485	170	97
Agricultural Potential	high	medium	medium	high	low
Access to Health Facility	easy	fair	easy	easy	poor
Operational Experience	fairly successful	fairly successful	successful	less successful	fairly successful
Remoteness	not remote	fairly remote	not remote	not remote	remote
Education/Literacy Level	good	good	fair	fair	poor
No. Years as Sub-Prog.	15yrs	10yrs	3yrs	5yrs	10yrs
CHVs					
No. Trained	13 selected	20	12	15	12
No. Active	-	13	12	3	8
Health Committee					
No. Members	15	15	13	12	3
No. Active	8	10	13	5	1
Local Leaders	not active	active	active	not active	not active
Self-help Groups	many	many	many	some	some
Church Health Role	active	active	active	active	none
NGO Projects	yes	yes	yes	yes	yes
Govt Extension Agents	some	some	some	some	none
Community Development Officers	not active	not active	not active	not active	not active
Community Contributions for Health Projects	yes	yes	yes	limited	yes

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CHAPTER 7

PEOPLE'S PERCEPTION AND UNDERSTANDING OF PARTICIPATION

INTRODUCTION

This chapter examines people's perceptions and understanding of participation in the Maua Programme. This is done by reviewing the historical perspective of community participation, people's attitudes towards participation, their preference regarding project participation and who participated in the Maua Programme case study area. The following chapter then examines how people participated in the Maua Programme, namely, in the areas of planning, voluntarism, physical labour, contributions, utilising programme services, and behavioural change.

THE HISTORICAL PERSPECTIVE OF COMMUNITY PARTICIPATION IN THE MAUA PROGRAMME AREAS

People's perception of whether there was more or less participation by community members in affairs about health now than in the past was explored in order to provide some historical perspective to people's participation in the sub-programme areas. The majority of 457 household survey respondents (90%) stated that there was more participation by community members in affairs about health now than in the past (Table 2). Though not specifically stated, it was assumed that respondents were referring to the period prior to the establishment of the Maua CBHC Programme. Results differed slightly between sub-programme areas, ranging from 92 percent of household survey respondents in the Athiru Gaiti sub-programme area to 83 percent in Kangeta.

Table 2: Participation in Affairs about Health, Now in Comparison to the Past

	Overall	Athiru Gaiti	Kangeta	Kilili	Kiengu	Kirindine
No. of Respondents	*449*	*64*	*30*	*95*	*69*	*60*
1. More (%)	90	92	87	83	91	88
2. Less (%)	10	8	13	17	9	12
Total (%)	100	100	100	100	100	100

Respondents were asked to explain their answers. Sixty-five percent of the household survey respondents (N=354) said that more community members were participating due to education, understanding and enlightenment (Table 3). Other reasons were health education provided through community meetings and the work of the CHVs and HCMs (16%), development in general (11%), and finally, cooperation among community members (8%).

Table 3: Participation in Affairs About Health, Now in Comparison to the Past; Reasons Why More

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*354*	*48*	*23*	*74*	*53*	*38*
1. Understanding/education/ enlightenment (%)	65	58	52	72	62	48
2. Health Education (%)	16	15	18	20	30	16
3. Development (%)	11	25	13	3	2	18
4. Cooperation (%)	8	2	17	5	6	18
Total (%)	100	100	100	100	100	100

Health education as a reason for more participation was stated more frequently by respondents in Kiengu (30%) than in other sub-programme areas. The Kiengu sub-programme area had an active health committee and corps of CHVs, and an assistant chief who was particularly interested in health development. Only 15 percent of respondents from Athiru Gaiti cited health education, even though it was one of the oldest sub-programme areas. However, they did mention development in general (25%) as the second most important reason for more participation, compared to only 2 percent in Kiengu and 3 percent in Kangeta. This difference could be explained by the fact that Kiengu was a more recently settled area than Athiru Gaiti. The low response for Kangeta in relation to development was surprising since the new road linking Meru and Maua probably had more impact on Kangeta's general development than any other sub-programme area.

Willingness among community members to cooperate together was mentioned by Kilili (17%) and Kirindine (18%) respondents as a reason for more participation, more so than in the other sub-programme areas. A reason for the response from Kilili could be more

community cohesion and cooperation existed due to the harshness of the area. People are more dependent on one another in order to cope in low productive areas, even if they are from different ethnic groups. This would not apply however, to Kirindine which is a medium to high potential area. Moreover, the amount of community cohesion was questionable in Kirindine where the local administration and local leadership was weak, according to the Maua Programme staff member responsible for Kirindine.

The majority (94%) of CHVs, HCMs and local leaders respondents (N=34) also agreed that there was more participation now. Their reasons were similar to household respondents, for example, education, understanding and enlightenment (45%); cooperation among community members (11%). However, they placed a high value on community meetings and their own work (31%) in enhancing more participation now than in the past.

A case study respondent from Kiengu felt there was more participation now because people had attended public meetings organised by the assistant chief and had thus been educated about health matters. Another case study respondent from Kiengu stated, "People are knowing new things about health and these days people attend hospital but during the old days they were taking herbs instead." With regard to traditional ways, a case study respondent from Kirindine said, "There is more participation because old ideas are getting 'dead', like cooking in traditional pots and people are using things like *sufurias* (metal pots)."

A CHV from Athiru Gaiti felt that "[Community members] have realised the need to promote health in the community. This has come about through the efforts of CHVs." A Kiengu health committee member felt that most of the community members were aware of the programme activities of the Maua Programme which had enhanced the options on how people can participate in health affairs. This feeling was also expressed by a CHV from Kiengu who said, "There is more participation now because in the past there were no clinics."

For household survey respondents (N=64) who believed there was less participation now than in the past (Table 4), reluctance and/or lack of cooperation among community members was the main reason given (75%). No major differences existed between sub-programmes, except for Kangeta, where lack of information was also expressed more as a major reason for 'less' participation (27%) than in other sub-programme areas. Information about how people can participate in health promotion was one of the functions of the CHVs and HCMs, and, an important role of administration was calling community meetings to convey health information. As was discussed previously these elements were weak in the Kangeta sub-programme. Lack of understanding, plus poor leadership and lack of funds were the main reasons CHVs, HCMs and local leaders (N=24) felt that there had been less participation over the past 5-10 years.

Table 4: Participation in Affairs about Health, Now in Comparison to the Past, Reasons Why Less

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*64*	*9*	*3*	*18*	*19*	*10*
1. Reluctance/Lack of Cooperation (%)	75	89	100	55	79	70
2. Lack of Information (%)	9	11	0	27	5	0
3. Few Initiatives (%)	5	0	0	6	0	10
4. Lack of Funds (%)	5	0	0	6	0	10
5. Corruption (%)	3	0	0	6	16	10
Total (%)	100	100	100	100	100	100

Another perspective on participation was to examine if it was perceived as a factor which had influenced any improvement in the life of the people. Respondents were asked their opinions on whether they had seen any improvements over the years and, if so, what brought this change (Table 5). According to 95 percent of household survey respondents (N=454), improvements had occurred in the life of people over the years.

Table 5: Improvement Seen in Life of People Over Time

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*454*	*66*	*30*	*95*	*70*	*60*
1. Yes (%)	95	94	93	97	91	98
2. No (%)	5	6	7	3	9	2
Total (%)	100	100	100	100	100	100

The main reason cited for improvements in the lives of the people (Table 6) was education (27%). Except in Kilili which has limited agricultural potential, new farming methods (15%) was given as another important reason for improvement. Hard work (8%), the activities of non-government organisations (8%), population influx (6%) and improved communication (4%) were other reasons. None of the respondents cited increased participation and only 6 percent of household survey respondents cited cooperation among community members and contributions through the harambee fund-raising as influencing factors for improvements seen in the lives of people.

Population influx was particularly significant in Kilili (13%). Respondents in Kirindine felt communication systems was an important improvement (12%), but not so for Kilili respondents (0%). Community leadership/unity (2%) and help from the government (2%) were not felt to be significant reasons why improvements had occurred.

Table 6: Reasons for Improvements

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*451*	*62*	*30*	*92*	*70*	*60*
1. Education (%)	27	36	27	3	24	22
2. New farming methods (%)	15	12	7	17	20	10
3. NGOs (%)	8	11	3	8	12	5
4. Hard work (%)	8	5	7	5	7	15
5. Harambee/Cooperation (%)	6	5	7	2	7	8
6. Population influx (%)	6	3	13	9	4	2
7. Communications system (%)	4	2	0	5	4	12
8. Good leadership/unit (%)	2	3	3	2	4	0
9. Government's help (%)	2	2	3	0	0	3
10. Other (%)	16	15	17	15	9	20
11. N/A (%)	6	6	13	7	9	3
Total (%)	100	100	100	100	100	100

Thus, it seemed that as a result of education, people were more open to change, were adapting to new methods of farming and were receptive to outside influence which was represented by NGOs. New ideas were being brought in through population migration and improved communication. A basis for enhanced participation appeared to have been established.

Increased health facilities (26%), sanitation/clean water (25%) and the mobile clinics (16%) were the main ways that the health sector had improved, according household survey respondents (Table 7). Differences between sub-programmes reflected access to health care which existed in Athiru Gaiti (44%) and Kangeta (41%) but did not in the other sub programme areas. The Kilili sub-programme respondents valued particularly the mobile clinic visits as a health improvement (28%). However, 29% of household respondents believed that there had been no improvements in health.

Table 7: Improvements in Health

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*401*	*62*	*25*	*88*	*63*	*45*
1. No/little improv. (%)	29	16	20	20	38	44
2. Increased Facilities (%)	26	44	20	41	18	13
3. Sanitation/clean water (%)	25	24	24	32	21	22
4. Mobile Clinics/FP (%)	16	11	28	5	2	16
5. Other (%)	4	5	8	2	3	5
Total (%)	100	100	100	100	100	100

ATTITUDES TOWARDS PARTICIPATION

Examining whether participation was one of the actions being taken by community members, CHVs, HCMs and local leaders to help overcome their community health problems was explored as a way of obtaining a perspective on participation in the Maua Programme. First of all respondents were asked to identify their health problems (Table 8).

Table 8: Health Problems in the Community

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*451*	*66*	*25*	*94*	*69*	*59*
1.Water (%)	42	47	28	58	38	51
2.Inadequate facilities (%)	21	8	31	15	29	19
3.Communication (%)	14	18	17	4	0	8
4.Drugs (%)	6	9	7	10	2	7
5.Sanitation (%)	6	2	4	3	17	7
6.Outbreak of diseases (%)	5	8	14	3	1	3
7.Lack of knowledge (%)	2	2	0	3	0	3
8.Other (%)	4	6	0	4	13	2
Total (%)	100	100	100	100	100	100

The two main community health problems cited were lack of water supply (42%) and inadequate health facilities (21%). Communication (14%) was the other main problem associated with health. Surprisingly, availability of drugs was not given much significance as a community health problem (6%).

The order of priority for these problems was generally the same from sub-programme to sub-programme, but differences existed in their degree. For instance, problems with water ranged from 58 percent for Kangeta and 47 percent for Athiru Gaiti respondents to 38 percent for Kiengu and 28 percent for Kilili. Only 15 per cent of respondents from Kangeta and eight percent from Athiru Gaiti mentioned lack of health facilities as a problem, compared to 29 percent and 31 percent for Kiengu and Kilili respectively. These variations probably reflected the different levels of development in the water and health sectors for these areas. Kangeta had a government dispensary, but few water projects. Similarly, Athiru Gaiti had the Kiraone dispensary, and the NGO Foster Plan International (FPI) was starting to initiate water projects there. More sources of water, mainly streams, existed in Kiengu and Kilili where the FPI had also started water projects. In both these two sub-programme areas no health facilities were within easy access.

Communication was perceived as less of a problem by respondents from Kangeta (4%) and Kiengu (0%) which are located on main all-weather access roads. Sanitation was perceived as a major health problem in the Kiengu sub-programme area (17%), whereas overall it was only cited by 6 percent of household respondents.

The types of community problems cited by CHVs, HCMs and local leaders (Table 9) were similar to those problems named by household survey respondents.

Table 9: Health Problems in the Community as Perceived by CHVs, HCMs and Local Leaders

No. of Respondents (CHVs, HCMs, Local Leaders):	*27*
1. Inadequate facilities	27%
2. Water	22%
3. Sanitation	13%
4. Communication	11%
5. Family Planning	7%
6. Outbreak of Diseases	5%
7. Drugs	4%
8. Other	11%
Total	100%

To ascertain whether participation played a part in meeting perceived community problems, household survey respondents were asked what they were doing about solving their problems.

Table 10: What the Family Is Doing About Addressing Community Problems

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*432*	*64*	*26*	*93*	*62*	*57*
1. Nothing (%)	30	31	39	27	40	23
2. Contributions (%)	22	13	23	14	21	28
3. Initiating water projects (%)	18	17	15	31	18	21
4. Bldg latrines (%)	9	15	19	7	8	7
5. Cooperation (%)	6	5	0	7	5	14
6. Prayers (%)	2	2	0	5	2	2
7. Other (%)	13	17	4	9	6	5
Total (%)	100	100	100	100	100	100

The main response (30%) of the respondents was that they were doing 'nothing'. More positive responses, however, were contributing money, materials, labour (22%), participating in planning water and other development projects (18%), constructing latrines, maintaining cleanliness (9%) and cooperating in development activities (6%). The sub-programme areas exhibited interesting comparisons.

Actions by people in Kirindine to address their problems could be characterised as the most positive. The sub-programme had the lowest per cent of respondents doing "nothing" (23%) and the highest per cent making contributions (28%) and cooperating (14%). Kirindine also seemed to be active in participating in water projects (21%). It was only the area of building latrines and hygiene (7%) which was below the overall average (9%). The Kangeta and Athiru Gaiti sub-programmes had fewer respondents making contributions to address problems (14% and 13% respectively), but respondents in Kangeta were actively involved in water projects (31%) and in Athiru Gaiti with latrine construction (15%). Kiengu and Kilili had the highest per cent of respondents doing "nothing", 40% and 39% respectively. That response is easier understood for Kilili which is more isolated and less developed than Kiengu which is characterised by active community leadership. Respondents in Kilili cited latrine construction (19%) as a major action in comparison to other sub-programmes. In general, therefore, people's actions to address their problems did involve some form of participation, namely contributions, involvement in development projects, such as water supply, and behavioural change through latrine construction and improved hygiene.

CHVs, HCMs and local leaders (N=27) were asked what they were doing about these community health problems. Their responses were asking the assistant chief, chief and district officer to organise harambee fund-raising meetings to seek contributions for health facility construction, providing more health education through home visiting, as part of church services and at community meetings, and continuing to collaborate with FPI in water projects. Thus, strengthening cooperation with local administration and NGOs and non-formal education were the key strategies with the intended outcome of eliciting more participation and cooperation from community members.

PROJECT PREFERENCE

A mechanism utilised by communities, government, and NGOs to address community problems is through projects. A project is a set of organised activities designed to reach a specified objective and includes any effort on the part of a committee or a formal or informal group to achieve a specified objective, such as constructing a new classroom,

church or health post or feeder road for instance, or equipping a new or existing facility. The delivery of a specialised service such as family planning was perceived by community members as a project, and, was also included in this working definition.

Nearly three quarters (74%) of household respondents (N=381) stated that one of their household members had participated in a community health project (Table 11). Significant differences between sub-programmes were seen in Kilili (53%) and Kirindine (65%).

Table 11: Participation in Community Health Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*381*	*66*	*30*	*95*	*70*	*60*
1. Yes (%)	74	79	53	84	83	65
2. No (%)	26	21	47	16	17	35
Total (%)	100	100	100	100	100	100

The two reasons for not participating in any community health projects (Table 12) were that there were no health projects to participate in (41%) or lack of information (33%). Personal commitments (16%) was also cited. No health projects was a major reason cited in Kiengu (64%) and Kirindine (60%), whereas lack of information was a particular cause in Athiru Gaiti (50%) and Kilili (42%). Personal commitments featured prominently as a reason in Athiru Gaiti (30%). Lack of cooperation (4%) and, surprisingly, lack of funds (4%) were not perceived as major reasons restricting people from participating in community health projects.

Table 12: Reasons for Not Participating

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*105*	*10*	*12*	*14*	*11*	*20*
1. No health projects (%)	41	20	42	50	64	60
2. Lack of information (%)	33	50	42	36	9	25
3. Personal commitments (%)	16	30	16	0	9	15
4. Lack of cooperation (%)	4	0	0	0	18	0
5. Lack of funds (%)	4	0	0	14	0	0
6. Other (%)	2	0	0	0	0	0
Total (%)	100	100	100	100	100	100

Household respondents were asked to indicate which projects they had participated in (Table 13).

Table 13: Projects People Participated In

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*258*	*31*	*7*	*72*	*52*	*27*
1. Health facilities (%)	41	61	44	43	19	22
2. Water (%)	36	20	14	47	52	37
3. Mobile clinic (%)	10	3	14	2	17	11
4. Self-help groups (%)	6	13	14	3	8	15
5. Schools projets (%)	3	0	14	4	2	4
6. Other (%)	4	3	0	1	2	11
Total (%)	100	100	100	100	100	100

Health facility (41%) and water projects (36%) were the predominant types of community health projects household respondents had participated in. The exceptions amongst sub-programmes were Kiengu and Kirindine, where no health facility projects had been initiated, other than the health posts used for the monthly mobile clinic visits. No water projects had been started yet in Kilili (14%).

Projects associated with water (23%), education (22%), self-help groups (15%) and health (13%) projects were ones most preferred by community members (Table 14) according to CHVs, HCMs and local leaders (N=59).

Table 14: Projects People Most Interested in Participating In

No. of respondents (CHVs, HCMs, local leaders) : 59	
1. Water	23%
2. Education	22%
3. Self-help groups	15%
4. Health	13%
5. Church-related projects	9%
6. Agriculture	7%
7. NGO, well managed	5%
8. Other	6%
Total	100%

Lack of access to a health facility and lack of drugs were the main reasons why CHVs, HCMs and local leaders believed health was a preferred project area. The reason

expressed for interest in health projects by a former chief from Kiengu was, "Projects related to medical services are preferred because community members feel that these projects can help them afterwards." Participation appeared easier to achieve for water projects than for other projects. One CHV from Kiengu said, "Water is a major problem in this area and whenever called community members are eager to avail themselves." It would be difficult to find many communities in Kenya where water was not one of the top three community problems and priority areas for participation. Isely (1985, p.215) claimed that reports are too numerous to cite attesting to a strongly felt need among rural people for safe and abundant water. Moreover, Eng et al. (1990, p.1358) contend that as a consequence of participation in community-based water supply projects, communities have substantially higher rates of participation in other health programmes such as immunization. However, even though water projects were, on the one hand, a preferred project area, participation was difficult for some households in the Maua Programme area because they were not able to afford to join water schemes. One case household respondent from Kiengu said, "The water project is benefitting only a few individuals who have enough money."

According to a CHV from Kiengu, education projects were popular because community members realised the value and benefit of education, and, its relationship to future employment and potential financial assistance to the household.

Projects associated with the church were also preferred by some community members (9%). The reason was put rather nicely by a case household respondent from Nceeme in Kirindine who said, "Projects started by the church are always peaceful with no disturbances; there are no hassle with these types of projects." Preference for participating in projects reflecting a certain religious faith was a more church-specific reason for their participation according to CHVs, HCMs and local leaders respondents, as well as the desire to compete with other church denominations by participating in church-related projects. However, this phenomenon of people being mainly interested in joining church projects if they were from the same religious denomination or sect limits their potential

as local institutions for gaining broad-based cooperation and participation in community development projects and activities .

Projects which were well managed were also mentioned (5%). Good project management was associated with NGOs. The chairlady of a self-help group in Kiengu said, "FPI projects are preferred because of good management and people are interested in them. Their projects have committee officers who are regularly supervised by FPI." The financial resources of NGOs also was a reason for project preference. A case household respondent from Kilili stated that, "Self-help groups starting goat keeping and farming projects are assured by FPI that they can get some assistance through a loan."

For its importance, agriculture was a development sector where it was apparently difficult to generate participation (7%). The main reasons put forward by CHVs, HCMs and local leaders (N=21) for the community reluctance to participate in agricultural projects were:

i) Lack of understanding about the importance of such projects;
ii) Benefits are usually not quickly forthcoming which discourages members;
iii) People put personal interests and commitments before the group and their tasks;
iv) Men feel that farming is women's work;
v) Mismanagement and lack of leadership.

The challenge to the Maua Programme was to reduce the percentage of families who were doing nothing to combat their problems. Participation in a project-related development activity was one mechanism in which community members were becoming more involved in development.

PERCEPTION OF COMMUNITY PARTICIPATION

In examining how community participation was perceived at community level, CHVs, HCMs, and local leaders were asked to define both community and participation and then asked what they understood as community participation. The context of community participation was health since they were involved with the Maua CBHC Programme.

The definition of community ranged from simply 'people' to 'clan/tribe where people are living together' to 'group of people living together but cooperating when needed'. "Community is people" was how it was defined by 28% of CHVs, HCMS and local leaders (N=29). Other respondents (38%) expanded this definition further by saying, "Community is people living in a village or a group of people living together" . Other respondents (34%) brought together the concept of sharing and cooperation in their definition of community, expressed as, "Group of people who share things in common and help one another, experience the same problems, living together with a common goal." Linking cooperation with community was described by three Kirindine health committee members from Kailune village, who said, "Community means people in cooperation, without cooperation there is not a community."

Participation was perceived by CHVs, HCMS, and local leaders (N=37) as an act of cooperation. They defined participation as 'joining hands together', 'helping in doing some work together,' `working as a unit'. Similarly, a former chief from Kiengu saw participation as, "Ways and means of helping such as in self-help groups when contributing money for the members to uplift their living standards." Local leaders from Ambunju village in Kirindine defined participation as, "Attending clinic services, attending health meetings, digging pit latrines," which represented a perception of participation of either taking part (participating) as beneficiaries of services being provided by others or taking action on improving one's health status.

Community participation was conceptually understood by CHVs, HCMs, and local leaders (N=52) in basically four different ways (Table 15). These were involvement in health activities by taking some action related to health such as attending clinics or constructing latrines (69%), communities actively supporting health activities through their own initiatives or being assisted by outsiders (17%), doing what they were told to do (8%) and starting self-help groups (6%).

Table 15: Understanding of Community Participation

No. of respondents (CHVs, HCMs, local leaders) : 52	
1. Involvement in health activities	69%
2. Community action	17%
3. Doing what told to do	8%
4. Starting self-help groups	6%
Total	100%

The involvement referred to by respondents was mainly in reference to taking part in health-related activities or services, as said by one local leader from Athiru Gaiti, "[community participation] is the involvement of community members in the health activities such as health meetings and making any contributions wanted." A CHV from Kangeta stated it as, "Community involvement in health activities is attending mobile clinics, practising family planning and doing whatever is taught related to health."

The community initiative interpretation was also characterised as cooperating together. A CHV from Athiru Gaiti said, "Community participation is the way members of the community join hands in helping one another as concerns health matters," and a primary school headmistress from Kirindine defined it as, "Community participation is community members getting together in working towards the welfare of the community at large." One CHV from Kiengu said, "Community participation is members involvement in making decisions and carrying out health programmes."

Perceiving community participation as reacting to authority was described as, `by obeying health rules like digging latrines,' and `when they are told to build latrines, to keep their families clean they are getting involved as well as attending the clinic facility.' The interpretation of community participation as `starting self-help groups' was mainly from local leaders who were officers of self-help groups.

The understanding of community participation, therefore, appeared to mean community members being involved and cooperating in health activities, but mainly as recipients of services which already have been planned and that are being offered to them, or reacting to advice being provided by CHVs or HCMs or to rules on health given by local administrative officers. Because of their involvement and relationship to the Maua

Programme, the context for these interpretations of community participation by CHVs, HCMs and local leaders was health activities and health development.

WHO PARTICIPATES

By a 4 to 1 margin CHVs, HCMs, and local leaders (N=46) claimed that women participated more than men in development activities. Three reasons were put forward (Table 16).

Table 16: Why Women Participate More

No. of respondents (CHVs, HCMs, local leaders) : 46

1. Better understanding of importance of development programmes and value of group membership	57%
2. Women main target beneficiaries of development programmes	25%
3. Men preoccupied outside the household	18%
Total	100%

One reason was that women had a better understanding of the importance and benefits of programmes which can improve the welfare of the household because of their role and responsibility in managing the household (57%). At household level, activities such as water collection and storage, production and preparation of food, household cleanliness and hygiene, and care of children are considered the responsibility of women. Women therefore are dealing more than men with day to day domestic problems. "Women are at most times the ones left at home and participate in the development of the home and to a big extent the community at large," said a case household respondent from Kilili. "Women are more active and involved than men, know about domestic problems, while men are seldom around the family," according to another case household respondent from Athiru Gaiti.

Respondents believed that this better understanding of development programmes meant that women were more cooperative and willing to form and join self-help groups and participate in development programmes. Moreover, they followed advice easier than men. Put in a rather paternalistic way, one CHV from Athiru Gaiti stated that, "Women are more obedient than men and accept things easily. Women are more receptive to new

projects and ideas and are less suspicious than men." "Men ask too many questions, women go forward with things," according to another CHV from Kangeta.

In the Maua Programme self-help and church groups were generally reported to be active in development programmes and the majority of these groups were women's groups. Even though membership was not restricted to women only, men seemed reluctant to join, and, even more so, if their wives were members. One case household respondent from Athiru Gaiti felt, however, that families might feel that it was redundant if both the husband and wife were members of the same self-help group. The majority of self-help groups were involved with collective farming activities, particularly as a means of raising funds for their members. This type of farming activity did not appeal to men. Also, the practice of visiting the households of group members to give assistance as described earlier was not considered an appropriate activity for men to participate in. On the other hand men seemed reluctant to form their own self-help groups.

Another reason why respondents (25%) believed women participated more than men was that women were the main target beneficiaries of many development programmes, particularly maternal and child health and family planning services. A health committee member from Kiengu said, "Women are more active since they are the ones who take the children to the clinics and get most of the teaching from CHVs. They also attend meetings in a larger number than men."

The third reason why respondents (18%) believed women participated more than men was that men spend less time in the household and are preoccupied with activities outside the household such as attending meetings, miraa trading, resolving land cases or drinking local beer. An ex-chief from Kiengu said, "Women participate more since they are not engaged in as many things like drinking beer." One assistant chief from Kiengu felt that, "Women participate more because 90 percent of women have formed self-help groups. Most men don't understand the importance of the projects and are not bothered. Most men are lost in local brew taking places."

However, not all respondents (N=7) felt that women participated more than men. Some believed that men:

i) Provided the funds for contributions to development programmes and services including the mobile clinic fees;

ii) Participated more in community decision-making than women and specialised community affairs involving school and water projects and construction of feeder roads and buildings.

A chairlady of a self-help group from Kilili said, "Men contribute more in most harambees since they have enough money to contribute. Also for mothers who attend the mobile clinic, the fee is gotten through the efforts of the husband." A local leader from Kirindine added that, "Men participate more because women offer manual labour while men offer both finance and other things like land where projects can be installed."

The burden of manual labour by women was a reason why men felt obliged to participate according to a male case study respondent from Kirindine. He said, "Most of the time it is men who suffer. For instance they marry women from outside the community and they bring them to this place where there are problems like water. The men feel that it is their burden to try and solve these problems through contributions of money."

Men's role as decision-makers was expressed by a case household respondent from Kangeta as another reason by men participated more. He stated, "They (men) dominate in making decisions in the community." Relatedly, the sense of responsibility as head of household was felt to be why men participated more, according a local leader from Athiru Gaiti. He said, "Men are well aware that they are the heads of their households and their area's development is to a big extent upon them."

Some respondents (N=4) felt that both women and men participated equally in community development programmes. One case household respondent from Athiru Gaiti said, "...because sometimes men can represent their wives in meetings or women can do so likewise. If the wife attends that means that the husband was represented as he might be

left looking after the children, cattle or working in the *shamba*." Another case household respondent from Athiru Gaiti stressed the importance of equal understanding of the importance of participation. She said, "Those who understand both participate fully in school projects, in the church groups and even contributing materials (timbers, frames, iron sheets)." These responses reflected cooperation and harmony within households which is discussed in Chapter 9 as a factor influencing participation.

Conclusion

Participation in planning or decision-making was not the predominant view of community participation in the Maua Programme. Rather community participation meant mainly involvement in utilising services provided through projects and reacting to advice on behavioural change from CHVs and HCMs. A very high per cent (74%) of survey respondents claimed that they had participated in a community health project. Significantly, for those who did not it was mainly because there were no mechanisms or projects (41%) to participate in or because of lack of information (33%) about opportunities to participate in development activities, and not because of any lack of willingness to participate.

The activities in which respondents participated in were more focused on women and children and, hence, the perception that women were participating more than men. Additionally, it was felt women had a better understanding of the importance of development programmes and the value of group membership. Women were coming together more and more to form women's self-help groups in order to achieve more financial independence. This enabled women to cater more for their domestic needs and to make improvements at household level, for example, food, clothing, and cooking utensils, which affected health, and to pay for the mobile clinic registration card and follow on attendance fee. It also enabled women to join development projects concerning water supply for instance. Although women did have some control over these earnings, since men controlled cash crop income, they controlled the major source(s) of income for most households and the subsequent contributions to development programmes.

There was general consensus by communities that the standard of living had improved, not so much as a result of participation, but, relatedly, as a result of cooperation among community members and contributions which were made for health and development activities. External influences such as the presence of NGOs, influx of population which brought new ideas and improved communications played a part in improving the quality of life. These factors would have enhanced the quality of the participation and cooperation among community members.

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CHAPTER 8

HOW PEOPLE PARTICIPATED IN THE MAUA PROGRAMME

INTRODUCTION

This chapter examines the ways people participated in the Maua Programme. In considering participation as a process, cooperation is an important step and ingredient. In many communities, people are cooperating together and helping one another on an individual and group basis. Madan (1987, p.618) contends that the only viable concept of community involvement is that which takes an incremental view and seeks community cooperation in health schemes at the various stages of planning, implementation, and execution. The degree of cooperation is an indication of the extent of cohesion within communities. According to 91 percent of the household survey respondents (N= 456) in the Maua Programme, people do cooperate with one another in the areas covered by the programme (Table 17).

Table 17: Whether People Cooperate With One Another

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*456*	*67*	*30*	*95*	*70*	*60*
Yes (%)	91	93	90	98	86	85
No (%)	9	7	10	2	14	15
Total (%)	100	100	100	100	100	100

Responses from sub-programme areas varied little, except for the very high response from Kangeta. No specific reasons can be cited for this particular response. However, Kangeta is a high potential area agriculturally with many small-scale farms which offer opportunities for community members to assist one another with various agricultural tasks. The lower response from Kirindine could be due to the presence of the large Njuru Agricultural Estate where many communities members worked. Kiengu was a newly inhabited area and less densely populated.

According to household survey respondents (N=434), people helped one another mainly through physical labour, general communal work, self-help groups, contributing cash,

materials, and helping the sick (Table 18). These are discussed in the following sections along with variations within the sub-programme areas.

Table 18: Ways People Cooperate With One Another

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*434*	*67*	*30*	*93*	*62*	*58*
1. Physical Labour (%)	54	68	48	61	56	47
2. Communal work (%)	16	11	11	26	11	12
3. Self-help groups (%)	12	11	11	2	19	9
4. Contributing cash/materials (%)	5	5	11	0	3	7
5. Helping the sick (%)	5	0	11	1	2	12
6. Fundraising (%)	2	3	0	4	2	0
7. Home visiting (%)	1	0	0	4	2	0
8. NA (%)	5	2	8	2	7	13
Total (%)	100	100	100	100	100	100

COOPERATION RELATED TO PHYSICAL LABOUR

The most common way of cooperation through physical labour was helping either a neighbour, friend or relative at some stage of their agricultural work, such as ploughing, planting, weeding or harvesting, as well as either picking coffee and plucking tea. Another important way was through participating in communal labour activities such as constructing a house, school, church, feeder road, or in relation to some development project, for example, health post, cattle dip or goat rearing pen. A community tradition in Karurine village in Kiengu, for instance, was when a young man got married, community members joined hands and constructed a good room for the couple. General communal work appeared to be a very important way people cooperated together in Kangeta.

A third important form of cooperation related to contributions of physical labour, was to carry a sick person to a hospital, usually to the Maua Methodist Hospital. A group of 12 - 20 men are mobilised by the concerned family to carry the person, using a locally made stretcher. In many cases this was a woman with complications during childbirth. Two to three teams of four men would alternate carrying the stretcher, sometimes up to 15-20 kilometres over steep and rocky roads. It reflected the poor transport and communication system within some parts of Igembe Division, as well as poor access to health care

services. Although antenatal services were provided as part of the mobile clinics and training had been given to some TBAs in the sub-programme areas, pregnant women who had been advised to travel to Maua before delivery were reluctant to do so due to the costs of hospital care, difficulties encountered for the household in her absence, particularly regarding the care of children, and the long journey to Maua during this period of terminal pregnancy.

The above examples of participation through contributing physical labour involved informal groups. Sometimes these informal groups became institutionalised. For instance, a self-help group had been formed in Kilili whose main purpose was to address the problem of transporting sick people to Maua. The goal was to raise funds to purchase a vehicle which could transport people to Maua and also serve as an ambulance. Their goal was to raise Kenya Shillings 3,000 which they hoped could be matched by a donor organisation to purchase a vehicle. One common method of raising funds for this self-help group and others in the area was to undertake physical labour, usually connected with agriculture, on a contract basis. Sixty members joined the group which was registered as a self-help group with the Ministry of Culture and Social Services.

Other examples of physical labour as a form of participation in health were to assist a family with digging their pit latrine, and to fetch water and firewood for the family when the mother had fallen sick. Most of the health posts used for the mobile clinic services in the Maua Programme were constructed using local volunteer labour.

The factors which influenced the use of physical labour were the nature of the project, organisational efficiency and people's willingness to provide the labour. Regarding the latter, 99 percent of household survey respondents (N=445) stated that they would be willing to participate in community health projects through physical labour. Fifty four per cent of household respondents (N=428), however, indicated that they had never been asked to do so. Organising physical labour was mainly done through community meetings which were usually called by the assistant chief or chief. If either was inactive, then the

meetings did not take place, or if the work was not supervised or organised properly, enthusiasm waned after the initial start-up effort.

SELF-HELP GROUPS

Helping one another through self-help groups was another way people cooperated together and participated in community affairs (Table 18). Kangeta was the only sub-programme area where household survey respondents failed to identify self-help groups as an important form of cooperation. Assistance in promoting the establishment of self-help groups and providing technical support was the responsibility of community development assistants (CDAs) attached to the Ministry of Culture and Social Services. There were a total of five CDAs assigned to Igembe Division. Besides providing advice and guidance to groups on which activities and projects they might focus on, the CDA was responsible for registering the group with the Ministry of Culture and Social Services as a self-help group. This then allowed the self-help group to raise funds from community members for its activities. CHVs, HCMs, local leader respondents complained that the CDAs were rarely seen in their areas.

NGOs, such as Foster Plan International (FPI), had also promoted the establishment of self-help groups in Igembe Division, particularly for parents of the primary school children they sponsored. They also provided technical and financial assistance to existing self-help groups. The number of self-help groups in an area depended partly on how active the CDA was since in order to become registered they must be visited by the CDA. Another influencing factor was whether any NGOs were operating in the area.

Most self-help groups were established to address felt needs, such as the problem of getting sick people to hospital which was mentioned previously. Another example was a self-help group in Athiru Gaiti which was established by a women after experiencing great difficulty getting to hospital when she was suffering from a swollen leg. Her group was doing contract labour to earn funds to get members to hospital, to help pay hospital costs when needed and other expenses, such as school fees and sponsoring children at secondary school.

On average each village in the sub-programme areas had at least one or two self-help groups with a minimum of 15-20 members. The majority of the self-help groups were women's groups. One of their main functions was to help their members with agricultural work. They represented a group of people, mainly women, who were helping one another and cooperating together, and, thus are cited as an example of participation within the community. Church groups were also perceived in this way by household survey respondents.

In the previous chapter (Table 14) self-help groups were cited by CHVs, HCMs and local leaders as one of the main types of projects in which community members were interested in participating. However, almost the same proportion of CHVs, HCMs and local leaders felt the opposite. Their reasons for believing that community members were not interested in joining self-help groups were the following:

i) If the self-help group was not assisted by an outside agency, people were not interested in participating;
ii) Funds had been misappropriated by some self-help groups;
iii) Lack of cooperation among self-help group members;
iv) Lack of understanding between husband and wife, restricting her from joining and spending time on the group's activities;
v) Men did not like to join self-help groups which were mainly comprised of women members and were involved in farming activities which were considered the work of women;
vi) Lack of leadership by the officers of some self-help groups.

An example reported by CHVs from Athi village in Kirindine combined nearly all the above reasons in relation to self-help groups. They said, "Some times women are not cooperative; they join when the self-help group starts and then drop out. They come back if they hear that an outside agency like Foster Plan International (FPI) is coming in to sponsor. For instance, there was a problem within one particular group amongst its leaders. Money was received from a donor agency and misappropriated by the chairman, treasurer and secretary. Primary school teachers formed the group and then brought in

ignorant women and misled them. Employed people like teachers should not be chairman or treasurer, but only the secretary of self-help groups. They confuse uneducated women and sometimes misappropriate the money."

Nevertheless, in general self-help groups and church groups did provide organisational structures for participation to occur. Moreover, voluntary group participation is a resource which can help sustain a CBHC programme. For the Saradidi programme, most of this came from women and church groups who had initiated and undertaken many of the health promotion activities (Kaseje and Sempebwa 1989, p.1069).

COMMUNITY SERVICE AND VOLUNTARISM

Communal work was identified by household respondents (16%) as a way people cooperate with each other (Table 18). Becoming a member of a community committee such as the local primary school committee, church committee, water committee, health committee, or development committee was another form of participation in community affairs. Generally committees evolved in three ways:

i) As part of a local institution such as a primary school;
ii) Created by a local administration official or by government extension workers;
iii) Through the efforts of non-governmental organisations and as part of the projects and programmes they are sponsoring.

Committees for local institutions, such as primary schools and churches, existed in most communities. Committees created by the chief or assistant chief to help meet felt needs such as water and feeder roads also existed in most areas of Igembe Division. However, their existence depended on how effective local administrative officials were in organising them. Members of these types of committees were usually selected by community members at public meetings (*barazas*). Time commitment in relation to committee membership varied according to how well organised the programme was and how effective the committee leaders were. Committees associated with NGO projects and activities seemed to benefit from the technical guidance they received as well as other resource inputs, such as training of committee members in project management,

community mobilisation, bookkeeping, and leadership skills. As a result, these committees tended to be more organised and efficient than committees established through the local administration.

In the Maua Programme area, voluntarism occurred when an individual devoted a regular amount of time and effort to on-going tasks, requiring skills and knowledge acquired through training. However, voluntarism in a less formal sense was not a new phenomenon to the people of Igembe Division. It existed in the form of various duties undertaken by elders selected by community members. These duties mainly involved taking charge of guiding the youth, and settling domestic quarrels and land disputes. Clan houses existed where the elders would guide and advise young men on the traditions and values of the clan. The more traditional forms of voluntarism seemed to be waning, however, the duty of settling land disputes still existed particularly in areas where land had not been demarcated.

The usual reward for the village elder was tea or food, which was provided during the day when the matter was being resolved, or in some cases a "commission" of KSh 20 shared by both parties. Elders traditionally were the powerful people in the community who made decisions. "Times were changing and now people wanted to participate in decisions," according to one elder.

Prior to independence, chiefs and elders led campaigns for community members to leave aside traditions and customs which were harmful to health and development. They encouraged their people to discard skins for clothing, to stop using banana leaves for house construction and instead start using mud and cement, to build bigger houses, to stop defecating near their houses and to construct latrines. Special grazing and watering sites were selected for cattle and goats to control pollution of stream water.

Also, during this pre-independence period, according to a group of local leaders from Kiengu, elders chose one villager at a community meeting to inspect households. This person would see whether compounds were clean, compost pits and latrines were

constructed, water containers were kept clean, and if animals were watered at designated areas along streams. These village representatives would act as a team inspecting houses, and if people did not follow the rules, their houses could be destroyed. One group of local leaders from Kiengu claimed that these practices were organised and enforced by the colonial administrators. A second group said they were actions taken by chiefs and elders to improve the health and development status of their people, and that the practice disappeared when government public health technicians were introduced. Both groups, however, felt that CHVs are in fact a continuation of this earlier tradition of a villager being selected for health inspection.

Community health volunteers and health committee members are also examples of voluntarism and their roles will be discussed in Chapter 10. A related form of voluntarism was the practice of local leaders accompanying CHVs and HCMs when they were doing home visiting or doing follow up visits on their behalf to assess what health practices community members were taking. This service could amount to 4-5 days a month. Assistance to CHVs in the form of accompanying them during home visiting was also provided by some community members. However, only one percent of household survey respondents cited this action as a way people cooperate with one another (Table 18). The exceptions among sub-programmes were Kangeta and Kiengu. One respondent said that he attended a community meeting on health at Kiengu where it was announced that the CHVs needed help in carrying out their work. He decided to assist and now joins the CHV from his village when she does home visiting. He devoted between 1-2 days a month for this community service.

The services of traditional birth attendants (TBAs) are provided basically on a voluntary basis. Among the Meru in Igembe Division the reward for a TBA for delivering a child came much later when the child had grown. The practice was for the family to assist the TBA with her agricultural work. Presents were given, however, for complicated deliveries. In relation to the work of TBAs one local leader from Kangeta said, "God will reward those who volunteer," a sentiment which could be an underlying reason for the spirit of community service which was exhibited by those who do volunteer. This could

also be explained by the strong influence of the church in Igembe Division, particularly the Methodist Church. TBAs are respected members of the community. They are also active community members in that they are generally always members of a women's group. The number of TBAs in each sub-programme area ranged from 5 - 15. A few training programmes had been carried out for them by the Maua Programme and FPI.

CONTRIBUTIONS

According to household respondents, two other ways community members cooperated were contributing cash and materials (5%) and through fund-raising (2%) (Table 18). The former was particularly identified by respondents in Kilili (11%), a low potential area, as a form of cooperation, but the opposite in Kangeta (0%), which is a high potential area. However, the relationship of agricultural potential and fund-raising showed more consistency where respondents from Kangeta (4%) identified it as a way people cooperate, but respondents from Kilili (0%) did not.

Household survey respondents (N=320) identified financial contributions, manual labour, contributing materials and planning as the main ways they participated in health projects (Table 19).

Table 19: Ways People Participated in a Health Project

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*320*	*47*	*14*	*80*	*57*	*38*
1. Contributed money (%)	68	77	50	70	61	60
2. Manual labour (%)	18	11	29	21	28	13
3. Contributed materials (%)	6	8	7	1	4	11
4. Planning (%)	5	2	14	4	5	8
5. NA (%)	3	2	0	4	2	8
Total (%)	100	100	100	100	100	100

Responses on how people participated in health projects reflected in part, the economic potential of their sub-programme areas. Thus manual labour was mentioned by more people in Kilili (29%) and Kiengu (28%) than in other sub-programme area. Financial contributions was mentioned by less people in Kilili (50%) and Kiengu (61%) than in the other sub-programme areas. The exception here was Kirindine (60%) which was

considered a medium to high potential area. The relatively high per cent of respondents from Kilili (14%) who cited planning as how they participated could probably be attributed to the presence of the NGO FPI.

Financial contributions, were usually given during community meetings (harambees) which were called by either the chief or assistant chief in collaboration with the group or the family whose need was being addressed. Funds were raised at both the harambee meeting and afterwards on an individual donation basis. The types of need varied from construction of school classrooms, church buildings, health posts to training costs for CHVs, from secondary school fees for a child within the community to families which had experienced a tragedy. Self-help and church groups also aided their members through contributions. For instance, one group had a scheme whereby members paid KSh 23 as a membership fee and then they raised additional funds through contract labour. Every two weeks a vote was taken and the person most in need received what had been raised during that period. Another group concentrated its contributions on the needs of the infants of families within the group. This group was catering for 43 infants at the time and every two weeks a present was bought for one of the infants. Membership fee was KSh 10 for this self-help group and they also raised additional funds through contract labour. The idea for this scheme came from a local leader who had in turn heard of this method when he was working in Embu, a neighbouring district. Donating money or materials was the best way household respondents (N=433) (60%) believed they could participate in the future in community health projects. Community contributions and other methods of community financing are discussed further in Chapter 11.

PARTICIPATION IN PLANNING

Involving community members or various target groups in planning projects is a fundamental principle of primary health care (WHO 1978, p.51). In practice, however, outside agencies usually do the planning for local organisations, with the intention of leaving on-going decision-making to the organisation after initial decisions about priorities and programme support have been made (Young 1980). Numerous myths abound about planning. For instance, it may be thought that planning and goal-setting require a certain

level of sophistication on the part of leaders and community members. However, Esman and Uphoff (1984, pp.74-75) found no correlation at all between effectiveness in planning programme activities and levels of literacy or per capita income. Rather, in information gathering and consultation, local knowledge is needed more than formal training. Planning can be simplified and take the form of surveys, such as house-to-house interviews supplemented by group discussions to ascertain the most urgent needs of individuals and groups, what resources they control, and what they would be willing to contribute toward collective efforts. It provides the poorest members of the community with an opportunity to participate when restricted economically from other forms of participation like resource contributions. The planning function, well performed, can have the effect of educating the community or of drawing out effective new local leaders.

Besides providing opportunities for participation, planning activities strengthen the local organisation through shared knowledge of community needs and capabilities among committee members and a grounded consensus that could buoy the performance of other tasks. In this way, the process of planning and goal setting may be more important to the success of local organisations than the specific outputs of that process. Very little community participation however had taken place in the initial planning of the Maua Programme activities. Only five per cent of household survey respondents claimed that they had participated in this way (Table 19). Nevertheless, community members were involved in initiating the mobile clinic services to Athiru Gaiti and Kirindine through requests made by a church group from the Athiru Gaiti Methodist Church and a women's group from Kirindine for such an outreach service. Consultation then occurred between their local community groups and Maua Hospital staff as to the best location for the mobile clinic.

The NGO Foster Plan International (FPI) had involved community members in the project planning process for rural development projects in Igembe Division. This was done through general community meetings to:

i) Discuss and identify community needs;

ii) Prioritise and select projects to be implemented;

iii) Decide the types and levels of contributions for membership fees;

iv) Select project committee members to help manage implementation.

This process was used by FPI for a goat-rearing project in Kilili, and probably explains why a relatively high percentage of respondents for the Kilili sub-programme stated that they had participated in planning community projects (Table 19). Overall, 51 percent of household survey respondents (N=448) claimed that they had participated in planning community projects.

Table 20: Participation in Planning Community Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*448*	*65*	*30*	*95*	*68*	*60*
1. Yes (%)	51	54	63	41	50	48
2. No (%)	49	46	37	59	50	52
Total (%)	100	100	100	100	100	100

However, when asked how they had participated in planning (Table 21), the method most cited was contributions (49%). Thirty two percent said that they had been involved in making decisions about the project, and another 13 per cent said their involvement in planning was through sharing ideas. The Kilili response for involvement in decision-making (41%) probably reflected again the influence of the NGO FPI. Involvement in decision-making as a form of participation in planning was apparently not common in Kirindine (12%). Nevertheless, Kirindine respondents did cite sharing ideas as the highest form of participation in planning among sub-programmes (20%).

Table 21: Ways People Participated in Planning Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*204*	*31*	*17*	*34*	*31*	*25*
1. Contributions (%)	49	55	53	47	51	64
2. Involved in decision-making (%)	32	26	41	35	26	12
3. Sharing ideas (%)	13	6	6	18	16	20
4. Other (%)	6	13	0	0	7	4
Total (%)	100	100	100	100	100	100

Sixty per cent of household survey respondents (N=446) claimed that they had participated in planning or determining ways for funds to be raised for community projects (Table 22). This was particularly the case in Kiengu (67%).

Table 22: Participation in Determining the Ways Funds Are Raised for Community Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*446*	*65*	*29*	*94*	*70*	*59*
1. Yes (%)	60	55	55	56	67	58
2. No (%)	40	45	45	44	33	42
Total (%)	100	100	100	100	100	100

In describing how they had determined the way funds were to be raised (Table 23), the majority of respondents (N=198) identified the way they had contributed, e.g., personal contributions (56%) and where, for example at a harambee fund raising meeting (14%).

Table 23: Ways People Determined How Funds Were Raised

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*198*	*20*	*8*	*50*	*44*	*18*
1. Personal contributions (%)	56	75	87	50	52	83
2. Discussion at community meetings (%)	23	10	13	16	30	17
3. Harambee meeting (%)	14	0	0	30	11	0
4. Self-help groups (%)	7	15	0	4	7	0
Total (%)	100	100	100	100	100	100

The main way they were involved in planning how funds were to be raised was through community meetings or self-help groups. Discussion at community meetings was cited most by Kiengu respondents (30%). As noted previously, the sub-chief for Kiengu was very active in community health affairs. Respondents from Kangeta claimed that fund raising issues were addressed at harambee meetings, whereas in Athiru Gaiti, self-help groups played an important part in this process.

The main reasons given by household survey respondents (N=114) for not participating in planning were personal or domestic commitments, no self-help groups or projects to plan with or for and lack of information (Table 24).

Table 24: Reasons for Not Participating in Planning Community Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*114*	*17*	*3*	*33*	*20*	*19*
1. Personal commitments (%)	32	41	34	18	25	37
2. No self-help groups/projects (%)	25	6	33	28	50	16
3. Lack of information (%)	25	35	33	24	5	42
4. Lack of cooperation (%)	6	0	0	15	0	0
5. Illiteracy (%)	3	0	0	6	5	5
6. No reason (%)	9	18	0	9	15	0
Total (%)	100	100	100	100	100	100

Personal commitments was a major reason restricting participation in planning community projects in Athiru Gaiti (41%) compared to other sub-programmes (32%). Lack of cooperation was cited as a significant reason in Kangeta (15%). For Kiengu the lack of self-help groups or projects was an important factor (50%) whereas lack of information was not a hindrance compared to other sub-programmes. An indicator of effectiveness of the Maua Programme, and development in general, was good communication and adequate information. As stated previously, the Kiengu sub-programme had a development oriented sub-chief, committed health committee members and active CHVs. On the other hand, in Kirindine, which was characterised by having weak local leadership, lack of information (42%) was identified as the main reason why they had not participated in planning community projects.

PROGRAMME ACTIVITIES

Participation through utilisation of health services by community members in community-based health care activities is considered an important component of the participation process. Experience in this form of participation enables community members to be more informed to become involved in decisions on how services will be delivered and on how they can help support them. Involvement in decision-making can then occur through their respective health committee member or community health volunteer or at general community meetings. The major way on how community members were participating in the Maua Programme cited by CHVs, HCMs and local leaders was in regard to the mobile clinic services. However, participation in the mobile clinic programme was not perceived by household survey respondents as an example of a community health project in which they had participated (Table 19).

In the Maua Programme, activities which community members could participate in were the mobile clinic services and receiving health education from CHVs and HCMs, mainly through home visiting. These two activities are discussed in the next two sections.

Mobile Clinic Services

When the field research was being conducted, the Maua Programme mobile clinic services was visiting fifteen sub-programme areas monthly. This number was basically the maximum number of areas which could be covered by one mobile clinic during one month.

CHVs and HCMs played an important role in the mobile clinic service programme. Their tasks were to inform community members of the forthcoming dates of the monthly visits, and to assist the Maua Programme mobile clinic team by registering clients, weighing children and collecting clinic fees.

The extent of participation by community members in the mobile clinic service was examined through a review of mobile clinic attendance figures in relation to the population census data from the sub-programme areas - Athiru Gaiti, Kilili, Kiengu and Kirindine. No Maua Programme mobile clinic service operated in Kangeta since the government-

operated Kangeta Sub-Health Centre was located there. The sub-programme areas did not always coincide with administrative sub-location areas. This made determining the catchment population per sub-programme area more difficult. However, the household survey respondents specified which sub-location they resided in which helped to estimate the catchment population. The Government of Kenya Central Bureau of Statistics had estimated the 1988 population for Igembe Division. The estimated population increase over the period 1979-1988 was 4.45%. (GOK 1989, p.15)

The Maua Programme mobile clinic service catered mainly for mothers in their reproductive ages and children under five years of age. According to the 1979 Census, 39.4 per cent of the population in Meru District was between the ages 15-44, 48.7 per cent was under 15 years of age and 19.4 per cent was under five years of age. The Kenya Central Bureau of Statistics was projecting by 1988 that these percentages would be 38.8 per cent, 50.9 per cent and 20.6 per cent respectively (GOK 1989, p.18). Age population data was not dis-aggregated for 0-1 year of age, but the usual demographic pattern for sub-Sahara African countries is 5 per cent of the population to be under one year of age. Based on the 1979 census data and the 1988 population projections, the percentages used to estimate the total catchment population for the four Maua sub-programme areas were 39 per cent for the age group 15-44, 50 per cent for under fifteen years of age, 20 per cent for under five years of age and 5 per cent for under one year of age. Kilili and Athiru Gaiti are in the same administrative areas, thus census data included both sub-programme areas.

An objective of the Maua Programme mobile clinic service was immunisation of new born children. First and return visit health information data was recorded by the programme for the child welfare, ante-natal and family planning clinics. At the child welfare clinic it was assumed that the majority of first visits were children under one year of age. Therefore, based on the population data, it was possible to get an approximate percentage of children under one year of age who were attending the child welfare clinic, and, subsequently, an indication of the degree of participation in the programme. The percentage

of children under one year of age who attended the child welfare clinics at Kirindine, Kiengu, Athiru Gaiti and Kilili during the period 1977-1987 is shown in Table 25.

Table 25: Percentage of Children Under One Year of Age Attending Child Welfare Clinics

Sub-Programme Area: Kirindine

Period	No. 1st Visits	Estimated New-borns	%Attending child welfare clinics
1987	146	494	30
1986	154	474	32
1985	195	455	43
1984	227	437	52
1983	299	420	71
1982	299	403	74
1981	(only eight months recorded)		
1979-80	(no records found)		
1978	128	356	36
1977	143	342	42

Sub-Programme Area: Kiengu

Period	No. 1st Visits	Estimated New-borns	% Attending child welfare clinics
1987	249	416	60
1986	398*	400	99.5

Sub-Programme Areas: Athiru Gaiti (AG), Kilili (K)

Period	No. 1st Visits			Estimated New-borns	% Attending child welfare clinics
	AG	K	Total		
1987	191	85	276	409	67
1986	252	82	334	393	85
1985	207	45	252	377	67
1984	195	54	249	362	39
1983	318*	66	384	347	111
1982	355*	67	422	333	127

*First year of mobile clinic service to Kiengu and first two years in Athiru Gaiti and Kilili. One can assume, therefore, that first visits included other children under five years, besides new borns.

According to Table 25, there was an overall decline in attendance figures in 1984. According to Maua programme staff, this was due mainly to the severe drought and food shortage which occurred throughout the central highlands of Kenya at that time.

A steady decline in the number of first visits to the child welfare clinic in the Kirindine sub-programme area from 1984 through 1987 could be due to poor local leadership and

lack of information about the mobile clinic visits. As mentioned previously, there had been a high turnover of sub-chiefs in Kirindine who appeared not to be committed to health development. For instance, the training of selected CHVs was awaiting a general community meeting to raise contributions for the residential costs of their training. The Maua Programme Coordinator also rarely did home visiting with HCMs who have complained about her lack of commitment. Local leaders were also not actively involved in supporting the work of the HCMs.

It is not possible to determine the percentage of children under five years of age who had attended the child welfare clinic, since the figures for return visits do not specify the number of return visits per client. However, the total population under five can be estimated from the census data and some assumptions can be made in order to estimate how many children under five years of age were attending. An earlier assumption for first visit child welfare clinic figures was that these were generally children up to the age of one or 5% of the population. A second assumption was that the age of most return visit child welfare clinic clients was between ages 2-4 or 15% of the population. A third assumption was that the average number of times a woman would bring a child for immunisation in this age bracket would be a maximum of three times, and most likely twice a year. Therefore, the latter frequency has been used for this rough calculation of assessing the percentage of children between 2-4 years who were attending the mobile child welfare clinics. These percentages are shown in Table 26.

Table 26: Percentage of Children Between Two and Four Years of Age Attending Child Welfare Clinics

Sub-Programme Area: Kirindine

Period	Return Visits	No. of Children	Estimated Population (2-4 yrs)	%Attending child welfare clinics
1987	955	479	1,851	26
1986	739	370	1,777	21
1985	959	480	1,706	28
1984	1,244	622	1,638	38
1983	2,142	1,071	1,572	68
1982	1,327	664	1,509	44
1981	420	210	1,281	16
1979-80	518	259	1,230	21

Sub-Programme Area - Kiengu

1987	1504	752	1560	48
1986	1502	751	1498	50

Sub-Programme Areas: Athiru Gaiti (AG) and Kilili (K)

	AG	K	Total			
1987	1295	461	1,756	878	1,532	57
1986	1026	372	1,398	699	1,471	48
1985	1020	345	1,365	683	1,412	48
1984	856	285	1,141	571	1,355	42
1983	1860	394	2,254	1,127	1,301	87
1982	1101	187	1,288	644	1,249	52

It appears from Table 26 that approximately 50 per cent of children between the years 2-4 years were attending the mobile child welfare clinics, except for the Kirindine sub-programme area. The declining attendance pattern for Kirindine for child welfare clinic return visits, in relation to population increases, was similar to that seen for first visit clinic attendance. The reasons cited previously for the decline for first visits would also pertain to trends for return visits.

An analysis of ante natal and family planning clinic attendance was another indicator of participation in the Maua Programme. As stated previously, approximately 39% of the population was between the years 15-44 and, according to the Kenya Bureau of Statistics, 51.5% of the population in Igembe Division was female. The national fertility rate for Kenya was estimated to be 8.6 during the mid-1980s. Thus, it is assumed that a woman would require ante natal services once every third year during the reproductive years of 15-44. First visit returns at the monthly mobile ante natal clinics were examined in

relation to the population data to assess the level of participation in this service component. These figures are shown in Table 27.

Table 27: Ante Natal Attendance at Mobile Clinics

Sub-Programme Area: Kirindine

Period	Females 15-44 yrs	Estimated No. Pregnant	1st Visit	%Attending mobile clinics
1987	2,479	826	83	10
1986	2,379	793	99	12
1985	2,284	761	69	9
1984	2,193	731	120	16
1983	2,105	702	198	28
1982	2,020	673	181	27

Sub-Programme Area - Kiengu

1987	2,089	696	136	20
1986	2,005	668	138	21

Sub-Programme Areas: Athiru Gaiti (AG) and Kilili (K)

			AG	K	Total	
1987	2,052	684	139	61	200	29
1986	1,969	656	160	55	215	33
1985	1,891	630	119	37	156	25
1984	1,815	605	105	18	123	20
1983	1,742	581	159	40	199	34
1982	1,673	558	256	32	288	52

A decline in first visit ante natal clinic attendance occurred in Kirindine similarly to that cited for first visits to the child welfare clinic. Possibly, the explanations stated for the latter would also apply to the downward trend for ante natal clinic visits. The severe food shortages experienced in 1984 appeared also to have adversely affected first visit ante natal attendance. The Athiru Gaiti and Kilili sub-programme areas seemed to be slowly approaching the pre-1984 levels of attendance in 1986 and 1987. The clinic site in Athiru Gaiti village was changed to Kiraone dispensary in 1985 which could also explain the lower attendance figures for both the first visit child welfare clinic and the ante natal clinic. The Kiraone dispensary was between Kilili and Athiru Gaiti and was less centrally located to the villages in the Athiru Gaiti sub-programme.

The number of females in the reproductive age group was similar in the Kirindine, Kiengu and Athiru Gaiti/Kilili sub-programme areas. The number of women participating in the mobile clinic family planning programme in those areas is shown in Table 28.

Table 28: Family Planning Attendances, Combined First and Return Visits

Period	Kirindine	Kiengu	Athiru Gaiti	Kilili
1987	21	199	220	5
1986	30	178	167	2
1985	82	**	217	*
1984	28		188	24
1983	*		216	26
1982			102	11

* No records were available.
** This programme only started in 1986.

Kirindine had substantially fewer women participating in the family planning clinic programme than in Athiru Gaiti and Kiengu. The Kilili sub-programme falls within the population census data for Athiru Gaiti, but it appeared that a very small percentage of women were practising family planning in Kilili. It was not possible to know the number of family planning acceptors in relation to the population since the number of return visits did not specify the number of separate acceptors. The Kiengu sub-programme was the only one which appeared to be accelerating. The family planning programme for Athiru Gaiti appeared to have become static since 1985. No apparent reason can be cited. A more dramatic drop had occurred in Kilili. Poor local leadership could account for the lack of recovery in Kilili. The drop off in Kirindine was consistent with the declining number of child welfare and ante natal visits. Lack of leadership from both local leaders, local administration, health committee members and programme staff could be a cause, along with the fact that no trained CHVs were operating in that sub-programme.

Because mobile clinic attendance depended on a variety of factors, besides CHVs and HCMs advising mothers to utilise the service, it is difficult to judge their impact on enhancing participation in the mobile clinic services. All sub-programmes visited by the mobile clinic had CHVs and HCMs so there was no sub-programme which could be assessed as a "control sub-programme". Nevertheless, CHVs and HCMs could have an important indirect impact by making the mobile clinic service more efficient and effective.

This would be by communicating the dates of the next mobile clinic visit to households during home visits and assisting with the service itself, e.g., recording attendances, collecting fees, weighing babies.

Health Behaviour Change

One of the most important outcomes of participation in health development programmes is changing or modifying behaviour which is detrimental to health and adopting behaviour which promotes better health. Elder (1987, p.335), states that ..."behaviour modification is based on the assumption that behaviour is a `function' of environmental events which precede and/or follow the behaviour." Harkness and Super (1994, p.217) claim that a critical ingredient for success in programmes to promote health development appears to be the incorporation of new attitudes, beliefs and behaviours in individuals and families, and there is a need for approaches that facilitate systematic consideration of environmental influences operating at the household level. Berman et al (1994, p.206), state that, ..."household processes are becoming more critical as determinants of impact as health interventions increasingly rely on behaviour changes to produce benefits." Elder (1987, p.347) believes that, "Behaviour modification holds considerable potential for enhancing the public health of the developing world."

An important role of community health volunteers, health committee members and local leaders associated with community-based health care programmes is to enhance health-related behavioural change among community members. This is also an objective of local administration, as well as staff which represent technical ministries at community level. Community health volunteers, health committee members and local leaders (N=56) associated with the Maua Programme were asked if they had observed any health behavioural change by community members as a result of their work (Table 29).

Table 29: Health Behavioural Change Occurring According to CHVs, HCMs and Local Leaders

No. Of Respondents: 56

1. Construction of pit latrines	32%
2. Taking children to the clinic for immunisation	26%
3. Improved household cleanliness	11%
4. Balanced diets	6%
5. Taking sick children to the hospital	5%
6. Practicing family planning	5%
7. Other	15%
Total	100%

The two changes cited most were construction of pit latrines (32%) and taking children to clinic for immunisation (26%). A variety of other ways were identified, among them improved household and personal cleanliness (11%), balanced diets (6%), taking sick children to hospital (5%), and practising family planning (5%). In Kibwezi, in Kenya,, CHWs also reported success in having families build pit latrines (90% of CHWs), as well as in having the community keep cleaner compounds (48% of CHWs), digging rubbish pits (45% of CHWs) and cutting grass and clearing bush around the compounds (27% of CHWs) (Johnson et al. 1989, p.1045). In the Kenyan Saradidi Programme, the presence of village helpers towards health (VHHs) supposedly led to improvements in home and environmental cleanliness and knowledge in preventive and promotive health behaviour (Kaseje and Sempebwa 1989, p.1069).

A health committee member from Kirindine said, "Latrines have been constructed by many community members, mothers are attending clinic at a higher rate, and some have accepted family planning." Regarding the latter behavioural change, a CHV from Kiengu claimed, "The family planning programme has been very successful, about 35 members have accepted the idea as a result of our efforts." A health committee member from Kilili added that, "Most mothers attend clinic now. Most boil water for drinking and take salt water mixed with sugar. Also they have now accepted the idea of washing children's eyes according to our teachings." On the contrary, a CHV also from Kilili stated emphatically that, "There has been no or very little change. Very few have taken our teachings seriously. Few have proper latrines for instance." A focus group session of over 20 local leaders at Antubaakui villagers in the Athiru Gaiti programme area claimed that villagers

refused CHV advice. An example cited was that over 75% of households in Antubaakui do not have proper latrines. The reasons stated were the abundance of bush which people still can use and lack of income to construct a latrine. On the other hand, over three-quarters (78%) of household survey respondents (N=432) claimed that they had followed advice given by CHVs or HCMs and changed their behaviour (Table 30).

Table 30: Health Advice Followed

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*432*	*66*	*30*	*92*	*64*	*56*
1. Yes (%)	78	82	80	78	75	71
2. No (%)	22	18	20	22	25	29
Total (%)	100	100	100	100	100	100

The main reasons cited by household survey respondents (N=66) for not adhering to the advice given by CHVs or HCMs regarding health behavioural change was that either no advice had been given (48%) or no home visits had occurred (23%) (Table 31).

Table 31: Reasons for Not Acting on Health Advice Given

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*66*	*8*	*3*	*17*	*12*	*12*
1. No advice (%)	48	50	34	47	50	58
2. No home visits (%)	23	25	33	18	17	34
3. Ignorance (%)	14	0	0	18	17	0
4. No CHVs (%)	9	0	0	17	8	0
5. No money (%)	6	25	33	0	8	8
Total(%)	100	100	100	100	100	100

The Kirindine sub-programme appeared to have had the least amount of health promotion by the fact it had the highest per cent of respondents claiming neither no advice was given (58%) nor were there any home visits (34%). Ignorance of how to put the advice into practice was stated by 14% of respondents, mainly from Kangeta and Kiengu. Lack of money was not a major reason cited for not following the advice, except for respondents from the low potential area of Kilili (33%), but also in the neighbouring sub-programme area of Athiru Gaiti. Not having CHVs was not a problem overall (9%), except for Kangeta (17%) where the CHV component of the programme had collapsed.

The most valued advice given by CHVs or HCMs according to the household respondents (N=385) was constructing pit latrines (45%) (Table 32), but less so by Kangeta respondents (34%). Other advice was of lesser importance such as benefits of cleanliness and personal hygiene (10%), family planning (9%), child care and immunisation (5%), nutrition and balanced diets (5%), boiling drinking water (3%) and taking children and sick family members to clinic or hospital (3%). Seventeen per cent of respondents felt that none of the advice was useful. There was wide variation amongst sub-programmes with respondents from Kiengu (30%) and Kangeta (24%) registering the strongest negative feelings and respondents from Kirindine (8%) and Kilili (9%) expressing less dissatisfaction. The most surprising result is from Kiengu whose sub-programme was considered one of the most well organised and active.

Table 32: Most Valued Advice

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*385*	*59*	*23*	*92*	*60*	*49*
1. Constructing Latrine (%)	45	54	48	34	52	55
2. None (%)	17	12	9	24	30	8
3. Cleanliness (%)	10	7	13	14	7	2
4. Family planning (%)	9	5	13	10	3	14
5. Child care (%)	5	5	4	7	2	8
6. Balanced diet (%)	5	8	9	3	0	0
7. Boiling water (%)	3	2	0	3	5	2
8. Attending clinic (%)	3	5	4	1	0	4
9. Health education (%)	1	0	0	3	0	4
10. Other (%)	2	2	0	1	1	3
Total (%)	100	100	100	100	100	100

The main way in which household respondents (N=334) claimed they changed their health-related behaviour was digging and maintaining pit latrines (36%)) (Table 33). Four other ways were mentioned. These were boiling drinking water (15%), preparing balanced diets (14%), practising family planning (13%), and keeping one's compound clean and practising improved personal hygiene (12%). Child care related behavioural changes such as attending mobile clinics (5%) and caring for children (2%) were minimal.

Table 33: Types of Behavioural Changes

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*334*	*53*	*23*	*73*	*49*	*41*
1. Built latrine (%)	36	49	35	40	31	39
2. Boil drinking water (%)	15	13	17	11	20	17
3. Balanced diet (%)	14	15	9	8	6	12
4.Family planning (%)	13	0	17	12	23	15
5.Clean compound (%)	7	6	9	10	6	7
6. Attend mobile clinic (%)	5	8	0	7	8	3
7. Hygiene (%)	5	0	4	9	6	3
8. Child care (%)	2	4	0	0	0	2
9. Agricultural advice (%)	1	2	0	3	0	2
10. Other (%)	2	3	9	0	0	0
Total (%)	100	100	100	100	100	100

A major sub-programme variation was for Athiru Gaiti where respondents cited more change related to pit latrine construction (49%) than other areas, while indicating no change in relation to family planning. The high per cent of respondents from Kilili (17%) and Kirindine (15%) claiming to have changed behaviour in relation to family planning is not reflected in the statistics for family planning acceptors for those two sub-programmes (Table 15). On the other hand, this relation is more consistent for Kiengu (23%).

A factor which should influence the extent and magnitude of health-related behavioural change was the frequency of household visits by a CHV or HCM. Over half (54%) of household respondents (N=420) claimed that they were visited by CHVs at least monthly, while about a third (32%) stated that they were either not visited (23%) or not very often (9%) (Table 34).

Table 34: Frequency of Household Visits by CHVs or HCMs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*420*	*65*	*29*	*91*	*61*	*52*
1. Monthly (%)	54	60	64	43	51	56
2. None (%)	23	26	14	21	38	21
3. Not Often (%)	20	13	17	32	10	16
4. Other (%)	3	1	5	4	1	7
Total (%)	100	100	100	100	100	100

Predictably, fewer respondents from Kangeta (43%) than any other sub-programme area stated that they were visited monthly. Most CHVs from Kilili and Athiru Gaiti appeared to be carrying out regular home visits, according to respondents (64% and 60% respectively). Surprisingly, the sub-programme area indicating the highest per cent of household survey respondents not visited (38%) or not often (10%) was Kiengu. Possibly this was because it was still a relatively new sub-programme area at the time of the study.

The influence of number of visits by CHVs on the participation of respondents in community health projects and activities was analysed through cross tabulation analysis (Table 35). Frequency of visits was classified as not at all, once annually, and monthly. Some respondents could not give any of the above responses and these were classified as `others'. Overall 418 responses were analysed. Respondents were also categorised as either participating (N=315) or not participating in community health projects or activities (N=103). More respondents had participated who had not received any visits by CHVs (N=68) than those who were visited annually(N=28). However, in the three categories of 'none at all', 'monthly' and 'annually', the highest number of 'no participation' respondents (N=30) were those who had not been visited at all. Nevertheless, it would appear that annual visits have very little impact on participate. The highest number of respondents who had claimed to participate in a community health project or activity (N=97) were those who had been visited monthly. For respondents who were visited monthly participation was five times greater compared to those who were visited but did not participate. Regular monthly visits therefore appeared to be a significant influence on participation.

Table 35: Frequency of CHV Visits and Influence on Participation in Community Health Projects and Activities

Frequency of CHV Visit	Participation	No Participation	Total
None at all	68	30	98
Monthly	97	18	115
Annually	28	8	36
Others	122	47	169
Totals	315	103	418

Chi square = 7.91. p-value = 0.0478

The majority (86%) of CHV, HCMs and local leaders (N=46) interviewed strongly believed that home visiting did influence participation in the Maua Programme. Respondents stated that home visiting reminded household members of what they had been told either at clinic sessions or community meetings about health improvements and it increased the speed at which they undertook health improvements.

Home visiting was also a means of checking to see if households were taking advice. They believed that the levels of improvements were related to the frequency of regular visits. Household members appeared to be more motivated to effect changes when they were visited. They also feared being questioned by CHVs on why they had not done what was advised and did not like to be found at the same stage they were at the last visit. An assistant chief from Athiru Gaiti claimed that, "When the household is being visited regularly, it cannot fail to participate in one way or the other."

Nevertheless, according to a chairlady of a self-help group in Athiru Gaiti, resentment towards the CHV as a change agent was sometimes evident. She added that, "Some community members feel that the CHVs are lording over them, saying it is easy for you to recommend a measure such as boiling drinking water since you are better off then we are, you have had the advantage of training, and so on."

CONCLUSION

Community cohesiveness is a characteristic which can favourably affect participation. In the the Maua Programme sub-programme areas over 90% of respondents claimed that people cooperate with one another, mainly through sharing physical labour and undertaking communal work. However, this participatory resource was not being tapped by the Maua Programme as over half of respondents indicated that they had never been asked to contribute physical labour for any health projects or activities.

On the whole, the Maua Programme activities were established for the community and the nature of participation had been in the implementation of the programme rather than in its planning. The major community involvement in planning was determining how funds were

to be raised and the level of contribution sought. Contributing money was the predominant way household respondents claimed they had participated in a health project, while the major reason for not participating in planning community projects was because of personal commitments. It would be important to determine what these personal commitments were related to.

The introduction of CHVs and HCMs to the sub-programme areas did not appear to have any significant impact on increased mobile clinic attendance. The impact of CHVs and HCMs was probably more indirect, for example by helping to make the mobile service more efficient and effective through communicating the dates of mobile clinic visits and assisting with some of the administrative tasks of the service. Attendance figures had basically remained at the 1984 levels in the Maua CBHC Programme with some modest increases except for Kirindine, a sub-programme marked by poor local leadership, high turn-over of local administration officers and weak programme support.

The influence of CHVs and HCMs was more significant regarding health behavioural change. Over three-quarters of household survey respondents claimed that they were adopting promotive health practices such as pit latrine construction, boiling drinking water and balanced diets following the advice of CHVs. This was influenced by how regularly household respondents were visited by CHVs. Regular monthly visits had a significant influence on participation.

In general, community members in the Maua Programme area appeared to be participating in the ways being offered to them to do so. The main reasons for lack of participation in activities, such as planning or health promotion, were not related to any reluctance on the part of community members, but rather, due to no participatory mechanisms, such as self-help groups or health project; organisatonal weaknesses such as lack of information, no advice or no home visits by CHVs; or individual issues like personal commitments. More participation would be possible if these constraints were addressed.

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CHAPTER 9

SOCIO-ECONOMIC FACTORS INFLUENCING PARTICIPATION

INTRODUCTION

This chapter examines socio-economic factors in relation to participation in the Maua Programme. The main factors examined are education, income, and group membership. In addition, domestic factors such as family size, women's time, and harmony within the household are discussed. Institutional factors which influence participation are discussed in the next chapter.

The chapter reviews relevant findings from the household survey, and related responses from the CHVs, HCMs and local leaders. The latter group comprised a total of one hundred and seventeen respondents. As stated in Chapter 5 on Research Methodology, this number represented 66% percent of CHVs and HCMs involved in the Maua Programme in the five sub-programmes in Athiru Gaiti, Kilili, Kangeta, Kiengu and Kirindine. Not all of the one hundred and seventeen respondents provided responses, but the number which did are cited in the tables.

Cross tabulation analysis is also presented regarding the influence of various socio-economic factors on the nature and extent of participation by household survey respondents in community health affairs in the Maua Programme. Additionally, selected case study households are discussed in relation to their attitudes and practices regarding participation in community health affairs.

SOCIO-ECONOMIC FACTORS

Education

Education was considered an important factor in relation to participation in health development activities. Formal education, that is, primary, secondary and/or adult education was examined separately from non-formal education. The latter was defined by CHVs, HCMs and local leaders as obtaining knowledge and information from others.

Formal Education

Formal education levels of household survey respondents (N=454) was ascertained and is presented in Table 36.

Table 36: Levels of Education Amongst Household Survey Respondents

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*454*	*66*	*30*	*94*	*70*	*60*
1. Primary (%)	41	47	50	32	48	40
2. No Education (%)	41	27	40	54	40	45
3. Adult Education (%)	9	18	7	6	9	7
4. Secondary (%)	8	8	3	8	3	8
5. Other (%)	1	0	0	0	0	0
Total (%)	100	100	100	100	100	100

Overall, the proportion of household respondents with some primary school education (41%) was the same as those claiming to have had no education (41%). Wide variances existed between sub-programmes, particularly in Athiru Gaiti where only 27 percent of respondents had no education and Kangeta where 54 percent said they had none. Athiru Gaiti was an older, established settlement area with a strong Methodist church tradition. Kangeta was the most commercial-oriented sub-programme area in the Maua Programme where a major source of income is miraa. Possibly, therefore, the incentive to attend and to complete some primary school education is less in Kangeta. Children play an important role in the miraa trade by helping to pick the miraa leaves. Local leaders in Kangeta claimed that this was one of the reasons for the drop out rates in primary school in Kangeta.

Athiru Gaiti also has the highest proportion of community members with adult education. Adult education classes are usually taught by primary school teachers. This relatively high level of adult education beneficiaries in relation to other sub-programme areas is a good reflection on the primary school system in Athiru Gaiti. The encouragement by church leaders for members to attend adult education classes could also have been an explanation.

CHVs, HCMs and local leaders respondents (N=59) believed formal education was a potential factor which influenced participation by community members in community

affairs and health development activities. Five reasons were mentioned as to why this was so. Community members with some formal education:

i) appeared more likely to participate, to take health advice and were quicker in understanding health messages;
ii) were more aware of what to do in order to stay healthy;
iii) had already received some health education through the formal education process;
iv) were more likely to set good examples and to influence others since they had some health knowledge; and,
v) needed less teaching from CHVs or HCMs allowing them more time to concentrate their efforts on more problematic households.

These reasons are consistent to how Caldwell (1993 p.131) described the impact of education on health behaviour. He stated that, "Modern education does not merely provide knowledge but it teaches that one should implement knowledge learnt both in the school and also later from other reliable-or modern-sources. It teaches that modern health instruction should be sought, listened to, and followed..." Mosley and Chen (1984, 35) contend that educational levels can affect child survival by increasing women's skills in health care practices related to contraception, nutrition, hygiene, preventive care, and disease treatment. Cleland and van Ginneken (1988 p.1357) claimed that, "...schooling introduces children to totally new ideas of personal hygiene and cleanliness. For many it may be the first experience of latrines or of hand-washing before meals...."

Nevertheless, some respondents (N=7) did not feel that formal education was an important factor. They believed that people without formal education were participating as actively in the Maua Programme as those with formal education. The secretary of one of the health committees implied that people with no formal education take health advice more obediently. He said, "[Formal education] has a negative influence because those who have never gone to school obey the information easily."

The influence of education on participation of respondents in community health projects and activities was analysed through cross tabulation analysis. Two categories of

educational status were used. One group was for respondents who claimed not to have had any formal education and the second group was respondents with some formal education. Overall 333 responses were analysed. Respondents were also categorised as either participating or not participating in community health projects or activities. Among those who participated in community health projects and activities, 62 percent had some formal education as compared to 38 percent who had no formal education. The influence of formal education on participation was found, therefore, to be of significant value (Table 37).

Table 37: Levels of Education and Influence on Participation in Community Health Projects and Activities

	Participation	No Participation	Total
No formal Education	128 38.4%	60 50.4%	188 41.6%
Formal Education	205 61.6%	59 49.6%	264 58.4%
Total	333 100%	119 100%	452 100%

Chi square = 4.69, with Yates correction. p-value = 0.03017.

A potential outcome of the impact of education on participation in health development activities can be child survival. In fact, Caldwell (1993 p.128) claims that the chief stimulus to health programmes which are attempting to enhance behavioural change has been the demonstration of major differentials in the survival of children by the education of their mothers. Bicego and Boerma (1993) found significantly elevated risks of child mortality throughout the first two years of life associated with low levels of mother's education in a comparative study of survey data from 17 countries. They also reported that non-use of antenatal care was enormously sensitive to the effects of maternal education. According to Ojanuga and Gilbert (1992, p.616), health related activities such as family planning may be more influenced by education than any other single factor. A major review of research on the effects of education on health edited by Cochrane (1980) indicated that maternal education is closely related to child health whether measured by nutritional status or infant and child mortality. However, Caldwell (1993, p.128) also points out the impact of maternal education has tended to obscure the fact that father's education, even when controlled for income, also strongly influences child survival.

The estimated effects of changes in educational level of women on child mortality in Kenya was examined by Mosley (1985, p.274) who claimed that 86 percent of the decline in childhood mortality in Kenya between 1962 and 1979 may be explained by the increase in maternal education. On the other hand, Patel et al. (1988, p.1277), who carried out a study of reasoning about the cause and treatment of childhood diarrhoea by Maasai schooled and unschooled mothers in Kenya, found that schooled mothers' representation of the disease resulted in conceptual structures with unconnected facts and thus lacked coherence. Patel et al. (1988, p.1286) recommended that in order for the school-learned knowledge to be remembered over a period of time, efforts had to be made to teach the underlying causal mechanisms of the disease, that is, some understanding of why a phenomenon occurs is necessary. One way that can be done is through non-formal education.

Non-Formal Education

Non-formal education was perceived as information or knowledge gained at community meetings, through self-help and church groups and home visiting by extension agents or CHVs and HCMs. Responses from CHVs, HCMS and local leaders (N=65) for why they believed non-formal education was a potential factor influencing participation can be summarised as follows. Non-formal education:

i) helped those with no education to understand new ideas, especially older people;
ii) was a useful method of information exchange at public meetings where all kinds of people gather;
iii) could enhance the prospects of participation through home visiting and with groups.

According to a CHV from Kirindine, health information and knowledge acquired through non-formal education can result in community members undertaking health measures. He said, "Passing information from one person to another helps some community members go and try the ideas given, such as digging a latrine." Following on from this observation, a health committee member from the same sub-programme area stated, "People who do things through getting information from others feel proud after seeing the good worth of their actions." Individual-to-individual information exchange and knowledge was felt to

be an important mechanism for people who were not able to attend public or group meetings. A female health committee member from Athiru Gaiti observed that, "Getting knowledge through non-formal education helps older women in that, when they go home, they inform their daughters who then attend the mobile clinic services." MacCormack (1992, p.831) claims that when women acquire new health skills such as oral rehydration therapy, protecting water sources, making energy-dense weaning foods or detecting anaemia in pregnancy, they pass them on in their caring roles, and in the quiet conversations they have with others.

Income

A second socio-economic factor which was examined as potentially influencing participation was income. To get some general idea of household income levels, household survey respondents (N=439) were asked how much income they earned in a month (Table 38).

Table 38: Monthly Household Income

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*439*	*66*	*31*	*95*	*70*	*52*
1. 0-100 KSh (%)	42	33	65	28	41	48
2. 101-200 KSh (%)	17	12	16	23	20	11
3. 201-300 KSh (%)	13	14	6	15	9	13
4. 301-500 KSh (%)	12	18	10	12	14	12
5. 501-1,000 KSh (%)	10	14	3	17	10	8
6. 1,000 + KSh (%)	6	9	0	5	6	8
Total (%)	100	100	100	100	100	100

Forty two per cent of household respondents claimed that they only earn up to KSh 100 per month . Kilili, which is a low potential agricultural area due to low rainfall, had the highest percentage (65%) within this income level.

Just over 70 percent of household respondents earn between KSh 0 - 300 per month. For Kilili this is the highest overall at 87 percent, while for Kangeta it is lowest at 66 percent. Besides the miraa trade, Kangeta is a tea and coffee growing area. The sub-programme area with the highest per cent of household members (41%) claiming to earn over KSh

300 per month was Athiru Gaiti. Kangeta was the next highest (34%). Athiru Gaiti is also an agricultural area with miraa, coffee and tea production, besides being a well established community area.

Since the predominant source of income is through subsistence agriculture and cash crops, the flow of income tends to be seasonal particularly in relation to subsistence agriculture. Thus, the amounts indicated in Table 38 should take this factor in mind, meaning that the amounts stated by respondents might tend to exclude the income realised at time of harvest. The household survey was carried out just after the planting season prior to the long rainy season. The cash crops of tea and miraa tended to provide a steady monthly income.

Table 39: Sources of Monthly Household Income

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*450*	*67*	*29*	*94*	*70*	*60*
1. Farming (%)	66	58	72	45	51	88
2. Miraa (%)	14	24	10	21	26	0
3. Outside employment (%)	8	12	7	5	10	5
4. Other self-employment (%)	5	5	0	16	4	0
5. General labour (%)	3	0	7	5	3	2
6. Sale of livestock (%)	2	0	0	6	4	2
7. Other (%)	2	1	4	2	2	3
Total (%)	100	100	100	100	100	100

Not surprisingly, farming was cited by 66 percent of the participants as the main source of income (Table 39). Considerable variations existed, however, between sub-programme areas. There were three main reasons for the sub-programme differences. The first reason was whether the area was a miraa growing area, the second was the opportunity for employment, and the third was the existence of any commercial or small-scale trading activities. Farming was cited by more respondents in Kirindine (88%) and Kilili (72%) than in other sub-programme areas. In both these sub-programme areas, miraa growing, outside employment and other self-employment were not significant ways of earning income. Income from the miraa trade was considered important by respondents in Kiengu (26%), Athiru Gaiti (14%) and Kangeta (21%). Outside employment was cited most by residents in Athiru Gaiti (24%) and Kiengu (10%). Athiru Gaiti is near Maua and Kiengu

is near the Meru National Park. Kangeta is a thriving commercial centre with numerous small-scale businesses or shops. This could explain the high number of respondents (16%) who claimed that other self-employment was a source of income.

Obtaining accurate data on income levels is always problematic. Cleland and Van Ginneken (1988, p.1359) claim that few demographic enquiries have made a thorough effort to collect detailed household income on expenditure due to the complexities of measuring income or wealth in subsistence agricultural settings. The value of the data presented in Table 38 is that it provides a general idea of the income levels in the Maua Programme and its sub-programme areas. The income data was felt to be too unreliable, however, to do cross tabulation analysis.

In order to obtain some idea of household expenditure patterns, household survey respondents (N=450) were asked how they spent their income (Table 40).

Table 40: How Household Income Was Expended

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*450*	*67*	*30*	*95*	*70*	*59*
1. Food (%)	43	51	27	34	43	47
2. Clothes (%)	23	22	40	18	29	22
3. Paying fees (%)	22	19	7	30	14	24
4. General domestic use (%)	10	6	23	18	10	5
5. Medical costs (%)	1	2	3	0	0	2
6. Other (%)	1	0	0	0	4	0
Total (%)	100	100	100	100	100	100

Not surprisingly, 66 percent of respondents claimed to have spent their income on the basic needs of food (43%) and clothing (23%). Kangeta (52%) was the exception, where respondents cited paying fees (30%) as a significant expenditure outlay in comparison to other sub-programme areas. The fees could have been for primary school or NGO projects such as the water project which FPI was implementing in Kangeta. General domestic use was cited by respondents in Kilili (23%) and also in Kangeta (18%). This expenditure could have been for household items, transport costs or even electronic

goods. Medical costs were not cited by respondents (1%) as a main category of expenditure.

The reasons why CHVs, HCMs and local leader respondents (N=69) believed income was an influencing factor in relation to participation in health development activities were that community members with little income were not in a position to:

i) contribute to development projects;
ii) join self-help groups;
iii) make improvements to their households to promote better health and,
iv) provide themselves with basic needs such as food or clothing.

Moreover, the search for income sources restricts community members from being able to participate actively in community meetings, self-help group activities, or even attend mobile clinic services and be available when CHVs or HCMs do home visiting.

A relationship between income and cash crops was the theme of several responses from CHVs, HCMs and local leaders. A CHV from Kilili felt that, "Economically the community is not stable, there is little income for contributions due to no cash crops." A local leader from Kilili felt that households depending on subsistence agriculture rather than cash crops participate less in development and health programmes. He said, "There is very little income from selling food crops like maize and beans. There is no surplus to fetch enough money and the majority of community members in this situation participate less in the programme." A local leader from Kangeta felt that, "The problem is that the income from cash crops, such as from miraa, is spent on luxury items and little remains for contributions to development projects."

In relation to health development activities, a CHV from Athiru Gaiti said, "Lack of money restricts participation, for instance, a person can not build a good latrine without money or buy good clothes, and when asked for contributions, some bring but some say they will bring later, but don't due to lack of finance." A CHV from Kiengu said similarly, "If there is no source of income things like latrines can't be dug because money is needed.

Households which have no latrines claim that they can't afford to build one due to lack of income." Health committee members from Kirindine felt that "... people with limited income had little time or motivation to participate. For example, if they cannot even afford to buy food to feed themselves or soap to keep clean, would they be willing to participate." The relationship between income and health development was put simply by a female CHV from Kiengu who said, "No income, no development in health matters at home."

Another way income influenced participation was stated by a local leader from Athiru Gaiti who said, "Some women do not attend the clinic services due to torn clothes." Similarly, a case household respondent from Athiru Gaiti admitted that she not did attend community meetings or the mobile clinic because she was ashamed of her appearance and that of her children. However, two local leaders from Kiengu said that income does not affect participation since there are some people with money who do not take their children to clinics.

CHVs, HCMs and local leaders (N=69) believed generally that households which had a source of income maintained a higher standard of living and family members were healthier. This was judged by the health of the children, pit latrine ownership, ability to contribute and being more motivated to participate in health improvement activities. Households with no regular source of income were characterised by respondents as not being able to take sick household members to hospital, not having a pit latrine, possessing poor housing and insufficient food and not being able properly to maintain their children. Poor household members were constantly looking for work or having to work long hours which meant they did not have time to attend any meetings where health and development education was offered. A HCM from Athiru Gaiti said, "If there is no food they have no room for other matters, except going to see where they can get it."

Group Membership

Self-help Groups

Membership in local groups such as women's self-help groups played an important part in influencing participation according to CHVs, HCMs and local leader respondents (N=67). Membership in local groups offered an opportunity for members to:

i) meet and come together, to develop themselves, and to exchange ideas;
ii) be exposed to outside ideas since seminars and workshops were sometimes organised for local groups by external agencies;
iii) provide help and assistance to each other, which enabled members to practice what was being taught for health improvement, such as construction of latrines, general cleanliness, and to aid members when sick family members needed to be taken to hospital;
iv) provide a forum for CHVs and HCMs to present health messages and information;
v) provide a mechanism to receive information from NGOs and government sources.

Peer pressure was another way local group membership enhanced participation in relation to health behavioural change. This was achieved, according to respondents, through periodic visits made to individual member's households which encourage them to keep their families and compounds clean. Moreover, members saw good examples being set in health by other members which they tried to copy and then practice themselves for others to follow. Because CHVs and HCMs are volunteers and have limited time to devote to health promotion, having the opportunity to reach community members through local groups is an effective way to manage their time.

According to MacCormack (1992, p.834), women's groups are a forum for health education, for learning a range of self-care skills, and improved health and hygiene habits, which can be reinforced within a supportive group. She adds that these groups can improve the sustainability of a programme, but they do require back-up services through the primary health care system. Streatfield and Singarimbun (1988, p. 1241), in analysing social factors affecting the use of immunisation in Indonesia, stated that children of mothers who are members of local social organisations are more likely to be immunized

than children of mothers who are not members of any social organisation. One reason was that communication of information about immunization may be an important factor in motivating and encouraging mothers to seek immunization for their children. An important source of this information could be local social organisations.

To determine the extent of local group self-help membership in the Maua Programme area, household survey respondents were asked if they or a member of their household was a member of any self-help group. Fifty-nine per cent of household survey respondents (N=450) claimed that either they or a family member are a member of a local self-help group (Table 41).

Table 41: Self-Help Group Membership

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*450*	*67*	*30*	*92*	*70*	*59*
1. Yes (%)	59	69	60	55	51	54
2. No (%)	41	31	40	45	59	46
Total (%)	100	100	100	100	100	100

Nearly 70 percent of respondents from Athiru Gaiti claimed that a household member was a member of a self-help group, while this was so for only 51 percent of respondents from Kiengu. The settlement history of these two sub-programmes could be one explanation for the variance. Athiru Gaiti was one of the first settlement areas in Igembe Division, while Kiengu has just been settled within the past 5-10 years. Other reasons could be the influence of the church in promoting self-help membership and the fact that Athiru Gaiti with its higher population density is an easier area for community development officers who have responsibility for registering self-help groups to operate. Moreover, Athiru Gaiti is near to Maua, the division headquarters where community development officers are based. Kirindine (54%) and Kangeta (55%) were also two other sub-programme areas with relatively fewer households members being self-help members. The reportedly weak local leadership and infrequent visits from community development officers in both Kangeta and Kirindine could have been factors.

The rationale for joining a self-help group was also ascertained from household survey respondents (Table 42).

Table 42: Reasons for Joining Self-Help Group

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*248*	*44*	*12*	*50*	*35*	*30*
1. Helpful/benefits (%)	50	59	67	42	49	73
2. Development interest (%)	19	16	25	16	11	17
3. Desire to cooperate (%)	17	18	8	10	26	10
4. Project interest/water(%)	11	2	0	28	6	0
5. Promote health (%)	1	0	0	2	3	0
6. Other (%)	2	5	0	2	5	0
Total (%)	100	100	100	100	100	100

Fifty per cent of household survey respondents cited the reason for self-help membership as that it is helpful and provided them with some benefits. This was particularly so for Kilili (67%) and Kirindine (73%) respondents. Nevertheless, more respondents in Kilili (25%) than any other sub-programme cited an interest in development as the reason for their membership or that of the household member. In Kiengu respondents (26%) mentioned the desire to cooperate as an important reason for joining a self-help group. This was significantly more so than in any other sub-programme, except for Athiru Gaiti (18%). The reason for the high per cent of respondents in Kangeta citing project interest (28%) as a reason could have been the influence of the FPI water development project in that area.

Household survey respondents (N=168) who were not members of a self-help group were asked to explain why this was so (Table 43).

Table 43: Reasons for Not Joining Any Self-Help Group

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*168*	*20*	*12*	*40*	*32*	*25*
1. None to join (%)	26	10	0	55	25	20
2. Domestic duties (%)	26	30	58	15	13	44
3. Other commitments (%)	23	45	17	13	22	20
4. No information (%)	7	5	8	3	9	4
5.No money for membership (%)	6	0	0	10	13	4
6. Membership limited (%)	5	0	16	0	9	8
7. Lack of leadership (%)	2	5	0	3	3	0
8. Misappropriation of funds (%)	1	5	0	0	6	0
9. Other (%)	4	0	0	1	0	0
Total (%)	100	100	100	100	100	100

Three main reasons were cited by household survey respondents. A basic one was that there were no self-help groups to join in the first place (26%). This was so especially in Kangeta (55%) but not the case in Kilili (0%). Domestic duties was another major reason cited by over half of respondents in Kilili (58%) and by 44 percent of respondents in Kirindine. The third main reason was the obligation of other commitments which was cited by 23 percent of respondents, in particular by Athiru Gaiti respondents (45%). Neither lack of information (7%) nor money for the membership fee (6%) were cited as major reasons for not joining self-help groups, except in Kiengu (13%) and in Kangeta (10%) where money was considered a factor. In both sub-programmes water projects exist for self-help group membership, but a fee is required to join them.

The influence of self-help group membership on participation in community health projects or activities was analysed through cross tabulation analysis (Table 44). Two groups were categorised. One group was for respondents where a household member was a member of a self-help group while the second group was for respondents where no household member was a member of any self-help group. Respondents were also categorised as either participating or not participating in community health projects or activities. Overall 330 responses were analysed. Among those who participated, 67 percent were members of various self-help groups as compared to only 33 percent per cent who were non-members. Thus, it can be said that being a member of a self-help group was a strong factor in influencing participation in a community health project or activity in the Maua Programme.

Table 44: Self-Help Group Membership and Participation in Community Health Projects and Activities

	Participation	No Participation	Total
Group member	221 67.0 (%)	44 37.3 (%)	265 59.2 (%)
Non-member	109 33.0 (%)	74 62.7 (%)	183 40.8 (%)
Total	330 100 (%)	118 100 (%)	448 100 (%)

Chi square = 30.5 with Yates correction. p-value <0.0001.

Church Membership

CHVs, HCMs and local leaders (N=68) were asked to comment on the relationship between church membership and participation in health development activities. Their responses can be summarised as:

i) community members who attended church services and church functions can potentially benefit from the health and health-related advice given by church leaders, such as cleanliness and solving family problems;

ii) churches offered a place for people to meet regularly, making it easier to advise them on health issues;

iii) most community health volunteers and health committee members were church goers and were able to teach health education to members;

iv) church goers seemed to take advice easier and appeared more aware of personal hygiene, like wearing clean clothes;

v) members appeared better motivated through the church to set good examples in health promotion;

vi) church leaders helped households obey health directives and practices, and devoted followers obeyed what they are told by church leaders in health matters.

Schiller and Levin (1988, pp.1375-1376), in examining religion as a factor in health care utilisation, claimed that, ..." even if religious orientation does not directly determine the use of health care, it may still be a critical factor insofar as it contributes to the willingness of individuals to engage in certain health-related practices (e.g. self-care, hygienic regimens) or hold certain health-related beliefs or attitudes which are causally antecedent to utilization." A case household respondent from Kiengu said, "People are more

receptive to accepting new ideas from the church. Churches are teaching a lot of things on development, like latrine construction and personal hygiene."

Domestic Factors

Three factors which could be categorised as domestic factors which potentially could have an influence on participation were examined. These are household size, women's time and harmony within the household.

Household Size

The average number of household members for those households surveyed (N=452) was 6.56. CHVs, HCMs and local leaders (N=66) were asked to describe the relationship between household size and participation. Their responses can be summarised as follows. Families with many children:

i) did not have time to participate because it was difficult to organise and manage their households;
ii) were reluctant to participate in the clinic programme for fear of being questioned on why they had so many children;
iii) tended to have more demands which they were unable to meet financially such as food, clothing, shelter, educational fees and money for children's hospital care. This is particularly the case for polygamist families.

Respondents observed that families with few children seemed to cater for them better, to follow advice, to accept new ideas, and to set good examples.

Women's Time

Women are the household members responsible for child care and the general management of the household. According to Raikes (1989, p.454), "Child health is a woman's responsibility and in certain areas where infant mortality levels are high, one can speculate that the amount of time women spend on child care and seeking health care options must be considerable". Women's domestic household duties are numerous ranging from collection of water and firewood and cooking to washing of clothes and cleaning the

compound. They also play an important role in agricultural production and marketing. Lado (1992, p.789) claims that the traditional agricultural division of labour in Africa assigns definite roles to women, characterised as rising before dawn to fetch water, cook, then walking to the fields for planting, weeding and harvesting, and returning home in the evening with a load of wood gathered on the way.

Research studies on time and energy costs of distance to pursue basic and routine requirements of the household in Sub-Saharan Africa are scarce. One such study carried out by Mehretu and Mutambirwa (1992, p.23) in rural Zimbabwe found that these activities require about 25% of the daily time and energy budgets for each household member. The highest burden are domestic tasks to fetch water and firewood and to graze and water livestock, and these are mostly carried out by women who also have the responsibility for the nutritional and health status of other members of the household. A similar pattern probably holds true for other rural areas in Sub-Saharan Africa. Thus, their time is very limited to indulge in many social or group activities, or for that matter, even to attend promotive health activities such as maternal and child care services. In order to participate in any maternal and child care, self-help group or development activity time is involved. Thus, time as a factor influencing participation was examined.

CHVs, HCMs and local leaders (N=67) were asked what they felt was the relationship between women's time and participation. They claimed that most women's time was spent earning an income through farming or marketing or collecting water, and therefore, women had little or no time to participate in development programmes. This was observed in the responses from household respondents (Table 43), who cited domestic duties (26%) and other commitments (23%) as reasons why they were not members of any self-help group. Moreover, personal or domestic commitments was the major reason given by household respondents (32%) for not participating in planning community projects (Table 24, Chapter 8). It was also one of the main reasons cited by household respondents (16%) for not having participated in any community health project (Table 12, Chapter 7).

Moreover, according to respondents, even when the Maua Programme mobile clinic or a public meeting on development issues was timed to coincide with the traditional market days, the market women were still generally too busy to attend. The scenario described by respondents was that the household was usually in disarray, with plates not cleaned, no food prepared, and breastfeeding not done if younger children were part of the household. Accidents were reported to occur when mothers were away throughout the day. Thus, they claimed that children were not cared for properly.

Harmony within the Household

Harmony within the household was also a factor which was examined in relation to how it influenced participation. Harmony was defined as cooperation between household members as well as a peaceful home environment. Disharmony was the opposite and was usually caused by substance abuse by a household member, the most common being miraa and/or alcohol. Raikes (1989, p.454) contends that drinking is nearly always accompanied by both physical and verbal abuse towards women and children. Moreover, according to Lado (1992, p.798), men's social activities in Kenya, particularly the consumption of alcohol, were frequently reported by women to be a serious drain on the household income and resources. Other factors which can cause stress and disharmony within households are family size, low income and polygamy.

CHVs, HCMs and local leaders (N=68) were asked to describe how harmony in the household could be a factor which influenced participation. Their responses can be summarised as follows:

i) if there was no harmony in the household, usually there was no development. Problems were not addressed and children suffer from neglect, for instance not being taken for immunisations;

ii) male heads of households who were heavy drinkers and/or excessive miraa chewers rarely took CHVs or HCMs advice and could be disruptive in general.

Respondents claimed that when there was harmony, children were catered for, attention was paid to family demands, children were immunised and taken to hospital when sick, and money was not squandered.

FACTORS RESTRICTING HOUSEHOLD MEMBERS FROM PARTICIPATING IN HEALTH DEVELOPMENT ACTIVITIES

Household survey respondents (N=443) were asked to identify factors which restrict community members from participating in community health activities (Table 45).

Table 45: Factors Restricting Participation According to Household Survey Respondents

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*443*	*64*	*28*	*95*	*70*	*56*
1. Lack of cooperation /understanding (%)	49	55	50	45	50	64
2. Lack of income (%)	16	11	18	24	13	5
3. Lack of leadership (%)	9	14	7	7	13	7
4. Personal commitments (%)	5	2	0	2	4	4
5. Poor communication (%)	4	3	4	2	1	0
6. Lack of education (%)	3	2	4	3	6	5
7. Poverty (%)	2	3	4	2	0	2
8. Lack of information (%)	2	5	0	0	3	2
9. Sickness (%)	2	0	0	6	1	2
10. Corruption (%)	1	0	0	2	0	4
11. Ignorance (%)	1	2	4	0	0	2
12. Politics (%)	1	0	0	0	1	0
13. Inadeq health facilities (%)	1	0	4	0	0	0
14. Other (%)	4	3	5	7	8	3
Total (%)	100	100	100	100	100	100

The predominant factor restricting community members from participating in community health activities according to household respondents was lack of cooperation and understanding (49%). This was particularly so for respondents in Kirindine (64%), an area where community cohesion and leadership was reportedly lacking. Lack of cooperation could be defined as unwillingness to participate such as not attending community meetings. Lack of understanding could be perceived as not appreciating the benefits from participation and, thus, not participating in such services as antenatal check-ups, immunisation, family planning or pit latrine construction. This could be due to lack of education, information or poor communication. However, these factors were only

mentioned by 2-4 percent of respondents as factors restricting participation. Thus, it appeared household respondents were focusing more on the effects of non-participation (lack of cooperation and understanding) rather than on some of the root causes (lack of education and information, poor communication).

Lack of income (16%) was cited as the second most important factor. Surprisingly, this was especially the case in Kangeta (24%) where income levels are among the highest of the sub-programme areas. The water project which FPI is implementing in Kangeta could be a reason for this response from Kangeta. Some respondents might not have been able to afford the initial membership fee, and, therefore, rightfully cited lack of income as a personal and community constraint to participation.

Corruption (1%) was mentioned by respondents in Kirindine (4%) more so than by other sub-programmes. This reinforces the explanation for the high percent of lack of cooperation and understanding cited by Kirindine respondents. On the other hand, lack of leadership (9% overall) was not a major reason identified by Kirindine respondents (7%), whereas surprisingly, it was more so by Athiru Gaiti (14%) and Kiengu respondents (13%), sub-programme areas which had active HCMs and in the case of Kiengu, a very health oriented sub-chief. Lack of an adequate health facility (1%) was only cited by respondents in Kilili (4%).

CHVs, HCMs and local leaders (N=67) were also asked to identify which factors they felt most severely restricted community members from participating in health development activities (Table 46).

Table 46: Factors Restricting Participation According to CHVs, HCMs and Local Leaders

No. of CHVs, HCMs and local leaders: 67

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
1. Lack of income (%)	48	44	82	33	33	56
2. Lack of education (%)	31	44	6	28	37	28
3. Too few CHVs (%)	5	0	22	0	0	0
4. Not group member (%)	3	6	0	5	4	0
5. Lack of information (%)	3	6	0	9	4	0
6. Family size (%)	3	0	0	12	0	4
7. Lack of cooperation /understanding (%)	3	0	0	15	0	4
8. Lack of leadership (%)	1	0	0	0	0	0
9. Not church goer (%)	1	0	0	5	0	0
Total (%)	100	100	100	100	100	100

The responses between household respondents (Table 47) and CHVs, HCMs and local leaders (Table 46) appear to be quite diverse. Lack of income was perceived by CHVs, HCMs and local leaders (48%) as a major factor restricting participation compared to only 16 percent of household respondents. CHVs, HCMs, and local leaders from Kilili (82%) saw it as the overwhelming constraint. The reasons why income is an influencing factor were discussed in the above section. However, a health committee member from Athiru Gaiti offered another interesting view stated as, "Lack of money makes many people have negative feelings toward community programmes since they feel inferior to others." Another explanation was provided by one of the community nurses at Kangeta government dispensary who said, "Lack of income makes the poor not turn up when donations are asked." A health committee member from Kirindine believed that lack of income influences the nature of participation as well in that ...."those people with no money can't contribute any money, except labour to meet the amount they are expected to contribute."

CHVs, HCMs and local leaders identified lack of education (31%) much more prominently as a constraining factor than did household participants (3%). Whereas, CHVs, HCMs and local leaders identified lack of cooperation and understanding far less as a factor (3%) than did household respondents (49%). These differences could be a matter of perception, in that, the CHVs, HCMs and local leaders could have merged their

interpretation of the relationship between education, understanding, cooperation, while household respondents focussed as mentioned on the behavioural factors (lack of cooperation and understanding) and not on one of the causal factors (lack of education). This relationship was stated by a local leader from Kirindine who claims, "Lack of education is the biggest trouble because if one understands the value of the programmes (health) the person can do some basic things in health without using money or very little." This relationship between education and income was cited by the Assistant Chief from Athiru Gaiti who said, "Lack of education is the key problem because some activities don't need much money to participate, such as taking children to the clinic."

Not having a sufficient number of CHVs as health educators was a factor identified by CHVs, HCMs and local leaders (5%), but not by household respondents. However, even among sub-programmes, it was only CHVs, HCMs and local leaders from Kiengu (22%) who identified this dilemma as a factor restricting participation. It was stated by the Assistant Chief for Kiengu who said, "...lack of proper educators (CHVs). They are very few and they can't meet the demand of the community since the area is so large." The chairman of the Kiengu health committee saw this factor as inhibiting his committee's ability to "...influence the community members to do what is expected."

Not being a member of any self-help group (3%) and family size (3%) were also identified by CHVs, HCMs and local leaders as factors, but not as major ones in comparison to income and education. Neither were self-help group member nor family size identified by household respondents as factors restricting participation. This could have been because for self-help group membership, it can be perceived more as a way or method of how community members can participate in community and health development activities rather than a reason restricting them from doing so. Personal commitments was not identified as a factor, however it was cited by five percent of household respondents.

CASE STUDY ANALYSIS

Forty-three households were selected as case studies in the Kilili, Athiru Gaiti, Kangeta, Kirindine and Kiengu sub-programme areas. CHVs and HCMs from the respective sub-

programmes were requested to select two households from each village area as case study households. The criteria for selection was for one of the two households to be participating in the Maua Programme and the other not to be. Since each sub-programme had a varying number of major villages, the number of case study households differed for each sub-programme area.

The purpose of the case study methodology was to examine further the factors which influence household participation in the Maua Programme, and to gain additional insight into the reasons why some households are participating and some are not participating. Attitudes towards participation and willingness to participate were also explored. When analysing the household responses it became apparent that participation had to be classified in three different ways. Those were households which were either participating, partly participating or not participating in community development affairs or in the Maua Programme activities.

The main socio-economic and institutional support factors which each case study describes are education, income, group membership, family size, and contact with CHVs. Case study respondents also discuss what they perceived as the factors which influence participation in health activities. Four case studies have been selected for discussion which covered the three different ways of participation.

Case Study Households Participating in the Maua Programme

The first case study depicts a community member who was participating in the Maua Programme health activities. The case study was a woman with no formal education, minimal income, but was a member of a self-help group and was visited regularly by a CHV.

Case Study 1: Margaret, Karunune Village, Athiru Gaiti

Margaret was in her early thirties, married with six children, aged 14 to 8 months, with no formal education. Her oldest child Jerusha was in class 5, as a result of sponsorship by FPI. She was not able financially to send Martha age 11 and Salome age 9 to school.

Jacob age 6 was in nursery school. The sources of family income, approximately KSh 150 a month, were from burning charcoal at a shamba in Kilili, loaned by a friend, and from selling maize and beans. The homestead belonged to her husband's family. It was only a quarter acre and was shared with her husband's cousin. Her family house was mud-cement with thatch roof. The household compound was clean and had a functioning pit latrine. The water source was a stream one kilometre away.

Margaret was visited monthly by a female CHV who lived near Karurune village which was about 20 minutes walking distance away. She claimed that her health knowledge was learned mainly through the home visits from her female CHV. She related the relationship between water and health, the reasons for boiling drinking water and for storing it properly in a container with a lid. Margaret correctly described how to prepare oral rehydration solution for treatment of diarrhoea. She mentioned the value of keeping her children clean, having them immunised and taking them to hospital if a problem arose. She regularly attended the mobile clinic with her youngest child and was practising family planning. Margaret claimed that the KSh 2 clinic fee was not a problem for her.

According to Margaret, most mothers knew the advantage of taking children to the clinic. However, digging a latrine and keeping children clean was a problem. People are either too lazy or they had no income. Over 75 percent do not have cash crops on their shambas in this area. She had to leave her small children all day to go to burn charcoal in Kilili to earn some income.

Margaret was a member of a self-help group supported by FPI. There were 30 members, both men and women. To be eligible you had to have a child attending school who was being sponsored by FPI. The group managed farm projects and worked on them every Friday. The produce was sold. Every Thursday a member was visited by the group. They are given KSh 15 from each member, of which KSh 11 was a contribution to the member and KSh 4 was a contribution for the food which was served by the beneficiary. The money donated could be used as needed by the members. Her priority was clothing for her children including school uniforms. Follow up visits were made by the group

members to see how the member had utilised the contribution. The group encouraged the members to purchase a goat, chickens or cow which represented a productive asset. The FPI community health technician held meetings with the group from time to time.

Margaret claimed that family planning was a popular project because families wanted to limit their children since they were finding them a financial burden. Women were eager to join self-help groups since members are assisted by other members when in need. However, lack of income limited some women from joining because they could not afford to contribute when they were visiting other members.

Margaret claimed that the number of visits by CHVs was an important factor in promoting better health. A household member became concerned because she knew the CHV would expect to see something done since the last visit. She felt that the church had a health-related influence in that community members who attended Sunday services looked like they took care of their personal hygiene. Also, the church taught one, "To bear with ones' problems and served as a cooling system for coping with difficulties," according to Margaret.

This case study demonstrated how the combination of the factors such as regular home visiting by a dedicated CHV and self-help group membership, appear to help overcome the constraints of no formal education and very limited financial resources in relation to participation in health-related activities. An important additional factor, however, was the input of an external NGO in facilitating the formation of and support to the self-help group.

Case Study Households Partly Participating in the Maua Programme

Two case studies describe households which were partly participating in the Maua Programme. The first case study was a woman with no formal education, not a member of any self-help group and disharmony within the household, but with average income and who was visited regularly by a CHV. The second case study was a man who was not a

member of any self-help group nor his wife, whose income was minimal, but he has had some formal education and was also visited regularly by a CHV.

Case Study 2: Joyce, Muthangene Village, Kiengu

Joyce was 35 years old with six children, three of whom were in primary school and three others were below primary school age. She had no formal education, but she had attended adult education classes. She earned income from the sale of agricultural produce and coffee per season which amounted to about KSh 500 per month. Joyce was not a member of a self-help group because of no time to attend the group activities. She contributed money to the government Lare Health Centre and KSh 5 to the Kiengu clinic. She attended meetings where health issues were discussed. The last one had been two months ago, and the people were advised that children should be taken to clinics for immunisation. She attended church regularly.

Joyce claimed community members were involved in planning community projects through having an opportunity to ask questions at community meetings. According to Joyce, people are willing to give ideas on how to implement projects, but project committees usually plan project activities for community members, and then they propose what people should contribute. They then only ask the people if they were agreeable. She felt men participate more since they control the funds for contributions.

Joyce said lack of education leading to a lack of understanding about the importance of development projects was one of the reasons why some people did not participate. Community seminars and meetings on development needs could help overcome this. More CHVs were needed to be trained, and Maua programme staff should be visiting more people as well. Some people ignored the advice of CHVs. She was visited twice per month by her CHV who lived near-by. The previous visit had been two weeks ago, and she was asked if she was attending the mobile clinic. The CHV advised Joyce to take her children to hospital if measles was suspected.

Joyce's farm was two acres and she grew coffee, miraa, bananas, maize and beans. She kept some livestock. Because of lack of water she had no kitchen garden. Her house was mud cement with thatch and was not well built. Her compound was not well kept. She had no functioning latrine, rubbish pit or dish rack. Her husband was in the miraa business and provided about KSh 200 a month to her. She made extra money from two milk cows. She was able to maintain three of her children in school. She attended the mobile clinic regularly. She was not well clothed nor were her children. She was not practising family planning.

Joyce felt that formal education offered a special source of health knowledge while non-formal education did not help much. People usually did not respond to health improvements except when ordered to do so by the local administration. Income was vital regarding participation since it is required to help a family promote good health like buying soap for washing clothes. Also it meant that some women did not attend clinics due to lack of clothes. Many children place great demands on households. Visits from CHVs can mean changes through new ideas. Distance was not a serious factor in attending the mobile clinic. Those who did not attend the mobile clinic were just lazy, according to Joyce.

According to the CHV who visited Joyce, she is not fully participating in the Maua Programme activities. She accepted some advice but refused others. For example, she did not attend antenatal classes and has refused to participate in family planning services. She had not built a latrine fully, only the pit. On the other hand she has had her children immunised. This case study represented a household where the entire burden of promoting health in this large household has fallen entirely on the wife. Apparently her priority for health promotion was having her children immunised and not environmental sanitation improvements. The demands of her household meant that she had not been able to seek support through self-help group membership. She had little support from her husband, but she was visited regularly by the CHV. The household income was above average.

Case Study 3: Julius, Matiandui Village, Kiengu

Julius is a 37 year old farmer who had completed primary education. He was a Methodist but attended church irregularly. His family included his wife and six children, ages 2 - 15. Three children attended primary school. His wife was not a member of any self-help group because of domestic duties and working in the farm. Julius did contribute to the Kiengu clinic construction and school projects. Julius earned about KSh 100 per month from miraa trading and seasonal income from growing maize and beans.

His farm was seven acres where he grew miraa, mangoes, maize and beans. He kept numerous livestock. During the rainy season his family cultivated a vegetable garden. Their water source is one kilometre away. Their dwelling was mud cement with thatch roof. The compound was fairly clean with a pit latrine dug by himself three years ago and a granary. His wife did not attend the mobile clinic regularly nor practice family planning according to the local CHV. Distance was stated by Julius as a factor restricting women from attending the mobile clinic.

He attended community meetings and the last one stressed pit latrine construction. Julius was aware of the health committee and their role. He said that, "The health committee should make sure that sick people hiding in the villages attend hospital for treatment." Julius participated in the selection of his CHV who visited once per month. During the last visit two weeks prior to the interview he asked if all the children were immunised. He had found advice on immunisation most useful because his children now do not suffer when there are outbreaks of diseases. Boiling water during rainy season had been one way he had changed his health behaviour.

Lack of understanding due to ignorance, poor communication and lack of income were the main factors restricting participation according to Julius. He believed the introduction of cash crops like cotton and tobacco and the arrival of the non-governmental agency Plan International were factors enhancing more participation as well as the arrival of newcomers within the area and teachings at community meetings. Women's self-help groups passed on messages to other members to promote health programmes, and Plan

International held meetings to teach basic rules on health like how to keep children clean and healthy claimed Julius. More community meetings are needed and the number of volunteers should be increased since the area was large.

Women participated more than men since more projects are directed towards women than men like farming. People who do not participate are basically lazy. Lack of cooperation and understanding were the reasons, claimed Julius. They should be visited by those who do participate to encourage them and let them know the importance of participation.

Attending the mobile clinic at Kiengu Market had been the most successful activity of the Maua Programme because the facility is now nearer compared to Maua Hospital. However, Kiengu Market is over five kilometres away and distance was still a factor as mentioned above. According to Julius, digging pit latrines and not polluting streams by washing clothes were the least successful health promotive activities.

As stated, Julius's CHV reported that his children are taken to the clinic but not regularly. He has refused to join the family planning service of the mobile clinic. He did not always take advice seriously from the CHV. His children were not well catered for regarding food according to the CHV. Julius was very involved in politics and land cases to the neglect of his family. He had not fully completed construction of his pit latrine.

This case study represented a household where the head of household was educated and seemed quite conversant with health promotion activities. However, he was not putting his knowledge into practice such as participation in family planning and ensuring that his wife attended the mobile clinic regularly. His monthly income was average for his sub-programme area and he was visited regularly by a CHV.

Case Study Households Not Participating in the Maua Programme

The case study of a household not participating in the Maua Programme was a woman with no formal education, not a member of any self-help group, minimal income, not visited regularly by any CHV and was not living with her husband.

Case Study 4: Karuki, Karurune Village, Athiru Gaiti

Karuki was 31 years of age and had no education. She was member of the PCEA church, but she did not attend regularly. Karuki was the mother of four children, all girls, aged 13, 8, 4, and 1 and a half years old. Her husband was presently living with another woman. He had essentially abandoned Karuki and her children. She could not afford to pay school fees. The children were very poorly clothed. She did not attend the mobile clinic nor practice family planning. Only one child had been immunised at Maua Hospital when the child had been admitted suffering from measles and malnutrition.

When first visited, the researcher found both the mother and one of her children extremely ill and malnourished. The mother was reluctant to go to hospital because another child had not been discharged because of an unpaid bill. The researcher took the sick child and mother to Maua Hospital where they were both admitted. The mother was diagnosed for pneumonia and the child had measles and was malnourished. They both recovered after a three week stay.

Karuki's homestead was approximately three quarters of a acre in size and located about 300 metres from the village centre. She grew maize, beans and bananas. Miraa was grown and there were a few mango trees on the property. The family had two other farms. One was half an acre in Karurune which had approximately 100 coffee trees and another one was in Kilili. The monthly income from the farm was about KSh 200, mainly from miraa. Income earned from the other shambas was consumed by the husband on beer and keeping another woman, according to Karuki.

The hut where the family slept was a very primitive structure constructed from a few wooden polls and banana leaves. The compound was overgrown, unfenced and unkept with a lot of rubbish about. There was no latrine. The family collected water from a stand pipe built by FPI, located only 200 metres away at the Karurune Primary School.

Karuki was aware of self-help groups but she was not a member. She claimed she had no time to spend due to her children. She also did not have the necessary money to donate

as a group member. Another difficulty she expressed was that she had no clothes to wear when the groups were visiting members. This was also a reason given by her for not attending the mobile clinic or any community meetings. Karuki was not aware of any health committee or CHV in her area. According to her she had never been visited by either. This was refuted by the health committee member in her area, but he did admit she was not visited regularly.

Her household was considered a particularly difficult and impoverished one by the health committee. The local CHV and HCM appear to have given up attempting to assist Karuki because of her impoverishment. Nevertheless, it would seem that more could have been done to help her have access to the clinic services or self-help group membership. This could have been through exemption of the clinic fee, having a self-help group donate some funds to help clothe Karuki and her children, or approach the FPI to see if they could sponsor one or two of her children in school. FPI also support self-help groups of parents of children they are sponsoring.

The case study demonstrated the adverse impact on health development when there is friction within the household and no access to income by the wife of the household head. The meagre amount of income which the wife earned was not sufficient to operate a household with four young children. The income from coffee produced at a second shamba apparently was not used by the husband to support Karuki or their children. She appeared to be overwhelmed by her impoverished state. She was not able to protect the health of her children by utilising the clinic services, and, when illness occurs, she was not able to seek assistance. She did not have access to any support mechanisms like a self-help group. She was not being supported either by the Maua Programme volunteers in her area.

CONCLUSION

Education and self-help group membership were the most important socio-economic factors influencing participation in health development activities of the Maua Programme. The formal education process provided some health knowledge, and health messages were more easily understood by community members who had some education, thus reducing the time and amount of contact required through home visiting. Community members with some formal education acted as role models for other community members and influenced others to also participate in development activities.

Self-help groups served as mechanisms for community members to participate in development activities. Nearly 60 percent of household survey respondents claimed that a household member was a member of some self-help group. These groups were mainly organised for income generation purposes and financial and moral support to fellow members. They enabled members to meet, to exchange and receive ideas and to provide the opportunity for mutual support. Reasons for not joining were similar to the reasons given by respondents as to why they had not participate in planning health projects, namely, because no groups existed or because of the lack of time due to domestic duties or other commitments.

The main impact of lack of income as a major factor influencing participation was restricting community members from contributing to development projects, joining self-help groups and making health-related improvements at household level such as construction of pit latrines. Another negative impact of lack of income was related to people's time for participation. Priorities for poorer households were to seek income opportunities rather than using that time to participate in community activities.

Domestic issues such as family size, women's time and harmony within the household were inter-related factors influencing participation. Large families demand more time from women to address domestic duties and have higher financial demands which potentially can cause more stress within the household. Survival issues come more into play with impoverished households thus restricting the amount of time available for self-

help group membership and health promotion and prevention practices. Excessive alcohol consumption and substance abuse (miraa) were behavioural practices which were contributory factors to disharmony in the household.

No clear relationships between the socio-economic factors, local institutional support and participation can be ascertained from the case study households. However, it appeared that group membership was an important variable to influence participation coupled with regular visits from CHVs or HCMs. For instance, the case study named Margaret from Karurune village had no formal education and little income, but she participated fully in Maua Programme. She was a member of a self-help group and was visited regularly by a CHV. On the other hand, the combination of formal education and regular CHV visits did not result in any significant level of participation with the case study named Julius. Disharmony in the household, mainly friction between the husband and wife, appeared to be a common characteristic found with case study households where participation was either only partly occurring or not at all. This was so for the case study Joyce who received very little support in managing her homestead from her husband who was actively involved in the miraa trade.

What is more certain however, is that participation is difficult to achieve when the main socio-economic factors are negative and no support occurs from local structures. This characterised the case study named Karuki also from Karurune village who had no formal education, little income, was neglected by her husband, was not a member of any self-help group and was not visited by either a CHV or HCM.

An awareness and understanding of the inter-relationships and impact of various socio-economic factors, such as education, group membership, income, domestic issues, on participation in health development is essential. These factors represent key aspects of community and social development, community dynamics and inter-sectoral collaboration recognised by WHO as essential to the development of primary health care. However, as evidenced by the research findings, they are complex and require some formal training or orientation to fully understand their impacts on health programmes. The effectiveness of

of health staff in enhancing participation in health development programmes will depend on how well they comprehend these socio-economic relationships and are able to plan and programme their activities to address them.

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CHAPTER 10

LOCAL STRUCTURES FOR ORGANISING AND SUSTAINING PARTICIPATION

INTRODUCTION

An important function of a health system based on primary health care is the establishment and nurturing of close relations between communities and the health services, so that community members can become fully involved in protecting and promoting their own health. It is claimed that one of the most effective means of achieving people's participation in their own development is through institutionalised channels such as local organisations (Esman and Uphoff 1984, pp. 22-23). Moreover, the fact that organisation for socioeconomic development must be carried out at the village level has gradually been accepted by most governments of developing countries as well as by the majority of technical assistance agencies (Isely and Martin 1977, p. 307).

Although the 1978 conference of the World Health Organization at Alma Ata described the need for local institutions for PHC (WHO 1978, p.56), it did not indicate how external agencies and government ministries might attempt to introduce the requisite changes and adaptations in institutions at the local level, let alone how communities themselves could do so. These changes and adaptations referred to both the process involved in getting communities organised to participate in health-promoting activities and the structure and functional nature of the local organisations.

Few clear answers are available on precisely how such organisations should function in order to overcome existing constraints and successfully stimulate community members to participate in organised health improvement activities. Despite the large number of primary health care projects in which local organisational activities have been attempted, there are still relatively few in which they have succeeded, or in which success has been sustained over time. Thus, to a large extent, the benefits of local or community organisations in primary health care remain largely theoretical (Goldsmith et al. 1985, p.13). The literature on community organisation in the general development context is

vast (Esman and Uphoff 1984; Chambers 1974; Korten ,1980; Gow et al. 1979; Leonard and Marshall 1982) but it is limited in relation to primary health care, particularly regarding Africa.

Community organisation in the context of primary health care refers to the specific ways in which participation in health care activities is actually organised in a particular community (Pillsbury and Goldsmith 1983, p.2). It is important for primary health care because of its value in maximising community participation. For instance, a community or local organisation actively involved in selection and support of community health workers can contribute to the effective performance of those workers. It can legitimise health-promotion activities that might cause resistance if they appeared to be imposed from outside (Goldsmith et al. 1985, p.10; Marquez et al. 1987, p.26).

Community organisations can help build community support for the goals of primary health care to help assure that achievements will be sustained. More generally they can build community skills and self-confidence in undertaking new activities that promote socio-economic development which contributes in turn to improved health (Isely and Martin 1977, p.307). An effective community organisation can also play an important role in securing community financial contributions for various health activities, a point discussed in the next chapter on community financing.

Within primary health care, one of the main types of community organisations is the health committee (APHA 1983, p.41). Since community health volunteers are usually accountable to the health committee and through them to the community, CHVs will be included together with the health committee as a community organisation. In addition to the health committee and community health volunteers, other important groups at community level, which can directly influence participation in health and other rural development, are local leaders, local administration, and local groups such as self-help groups.

Community organisations and self-help groups are supported in their efforts to undertake development projects or activities by technical government ministry staff who operate at community level. Examples are community development assistants, extension officers for the agricultural and animal husbandry sectors, and community nurses and public health technicians for primary health care. The health system in the case study was represented primarily by a church organisation in the form of the Maua Methodist Hospital which provided the health services and technical support to the health-related local organisations and community-level groups.

While recognising the important roles played by local administration, government extension agents and health staff in promoting and supporting community participation, this chapter will focus primarily on the local structures and groups represented by CHVs, HCMs and local leaders and their roles in organising and sustaining participation, along with the support and assistance they needed in these endeavors.

COMMUNITY ORGANISATIONS

Community organisations form a framework through which community participation can take place. The outputs of these organisations should result in increased participation and are the functions or tasks of community organisations. The tasks of community organisations related to community participation examined in this study are planning, resource mobilisation and provision, management and coordination of services. Planning was discussed in Chapter 8, while resource mobilisation will be discussed in the next chapter. This chapter then will address issues of management and coordination of services and participation, and the role community organisations played in their effectiveness.

For local organisations like health committees, various management tasks are important activities and have a direct bearing on their effectiveness. Among these management functions are the selection of community health volunteers, and monitoring and supervision of their performance, serving as a link between the community and accountability to sponsoring agencies for resource inputs, and between the community and local administration in organising community health promotive activities.

SELECTION OF HEALTH COMMITTEE MEMBERS AND COMMUNITY HEALTH VOLUNTEERS

One major way community members participate in community-based health care programmes is through selection of health committee members and community health volunteers. The American Public Health Association (APHA 1982, p.49) found that of 52 PHC projects assisted by USAID, community health workers (CHWs) were selected by their communities in approximately three-fourths of the projects. Either a general community assembly nominated candidates or, more commonly, the village health committee selected CHWs who fit certain fixed criteria. In the APHA study no reference was made to how health committee members were selected.

In Kenya the usual procedure was for the community to select the health committee after it had an opportunity to learn about the objectives of the programme at a community meeting (*baraza*). Discussion was encouraged by those organising the *baraza*, usually the assistant chief and the programme support staff. Once selected the health committee then screened, interviewed and selected community health workers in most programmes. This was usually done in collaboration with the programme staff (Kaseje et al. 1987, p.57; Willms 1984, p.139; Johnson et al. 1989, p.1045).

In some cases, like the Maua Programme, the community health volunteers were then confirmed by the community at a *baraza*. Confirmation by the community was consistent with the Kenya Ministry of Health PHC Guidelines which stated,

> "...Preferably several candidates should be selected and then trainers and community committees can interview them. While the final choice rests with the community, it must be an informed choice..." (Bennett and Maneno 1986, p.63).

Health Committee Selection

The credibility of health committee members and community health volunteers is based in part on how democratic the selection process was. The selection procedure for health committee members in the Maua Programme involved a community meeting called by the area chief or assistant chief at the request of the Maua Programme staff. The programme,

its objectives and the role of the health committee were presented to the community by the Maua Programme representatives. Community approval was sought for the programme and a request then was made for volunteers to join the health committee. Each village was to be represented by one or two committee members. In reality the process was more confirmation of those volunteering than a vote among several candidates who wanted to serve as health committee members.

Awareness by community members of the HCM selection process was sought as part of the household survey. Twenty-four per cent of household respondents (N=407) were aware that the selection of health committee members involved a community meeting or *baraza* (Table 47). Another twenty per cent indicated that the process involved voting, and eight per cent said that the community participated in the process. Twenty-nine percent of respondents claimed that they were not aware of how HCMs were chosen. Other respondents thought selection was done by village representatives (7%), local administration (4%), or CHVs (3%). Three percent of respondents said qualifications was a part of the selection process.

Table 47: Health Committee Selection Process

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*407*	*60*	*24*	*86*	*63*	*57*
1. Not aware(%)	29	27	45	31	24	37
2. Baraza (%)	24	17	13	19	43	19
3. Votes (%)	20	30	13	8	14	14
4. Community (%)	8	12	4	11	6	11
5. Village representatives (%)	7	7	4	13	2	5
6. Local administration (%)	4	0	13	14	0	7
7. CHVs (%)	3	0	8	4	6	4
8. Qualifications (%)	3	5	0	0	2	0
9. Other (%)	2	2	0	0	3	3
Total (%)	100	100	100	100	100	100

From Table 47 one could say that fifty per cent of household respondents could identify some aspect of the HCM selection process. Respondents from Kilili were least aware of the process however. This could be because their sub-programme is managed by the Athiru Gaiti Health Committee and the selection took place in Athiru Gaiti. Respondents

from Kiengu appeared to be most aware of the selection process for HCMs, a sub-programme area with active local administration.

Community Health Volunteers Selection

The selection of community health volunteers in the Maua Programme was a responsibility of the health committee. As stated earlier, they screened and selected candidates who are later confirmed at a community meeting. Selection criteria included literacy, age, trustworthiness, acceptability in the community and willingness to serve the community. These criteria for CHV selection are consistent with other similar programmes in Kenya (Kaseje et al. 1987, p.57; Willms 1984, p.262), and selection criteria recommended in the National Guidelines for the Implementation of Primary Health Care in Kenya (Bennett and Maneno 1986, pp.63-64).

The APHA study (1982, p.49) found that criteria for selection of CHWs were usually established by the project staff rather than the communities or the local health committees. The important factor is not so much who established the criteria, but if they were discussed and agreed upon by the community. The National Guidelines recommended that the criteria should be discussed prior to the selection. In the case of Maua Programme, the criteria were recommended by the project team and agreed by the health committees and the communities.

Sixty-three per cent of household respondents (N=414) correctly identified some aspect of the selection process for CHVs, e.g., *barazas*, voting, community, qualifications (Table 48). However, twenty six per cent said they were not aware of the selection process. Some respondents felt that CHVs were selected by the health committee (4%), local administration (3%), other CHVs (2%), the church (1%) or Maua Hospital (1%). Respondents from Kangeta and Kirindine were least aware of the selection process for CHVs.

Table 48: Knowledge of CHV Selection Process

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*414*	*59*	*28*	*93*	*66*	*55*
1. Baraza (%)	28	25	25	19	36	29
2. Not aware (%)	26	25	18	33	20	33
3. Votes (%)	17	25	10	9	18	11
4. Community (%)	15	10	14	26	14	16
5. Health Committee (%)	4	0	4	2	6	3
6. Qualifications (%)	3	2	14	0	0	2
7. Local administration (%)	3	2	0	9	0	2
8. CHVs (%)	2	3	4	2	3	2
9. Church (%)	1	3	4	0	2	2
10. Maua Hospital (%)	1	3	7	0	1	0
Total (%)	100	100	100	100	100	100

Participation in the Selection Process

One very important opportunity for community members to participate in CBHC programmes is in the selection of community health workers. In the Maua Programme just under half (46%) of household respondents (N=444) stated they had participated in the CHV selection process (Table 49).

Table 49: Participation in CHV Selection Process

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*444*	*66*	*29*	*93*	*67*	*58*
1. No (%)	5	52	48	54	52	59
2. Yes (%)	46	48	52	46	48	41
Total (%)	100	100	100	100	100	100

No major variations appeared between sub-programmes. The Kirindine sub-programme showed the lowest level of community participation in the CHV selection process. This sub-programme was characterised by inactive local administration and received limited support from the Maua programme staff.

Apparently more community members would have participated if they had known it was taking place. According to household respondents (N=212), the main reason they did not participate (33%) was lack of information or awareness that the selection process was taking place (Table 50).

Table 50: Reasons for Not Participating in CHV Selection Process

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*221*	*29*	*11*	*50*	*32*	*33*
1. Lack of information	66	66	64	68	60	67
2. Not available	14	3	9	12	19	12
3. Domestic duties	7	17	18	0	9	12
4. Leaders responsibility	7	7	9	14	6	3
5. Working or illness	6	7	0	6	6	6
Total	100	100	100	100	100	100

Other reasons were that they were not available (14%), domestic duties (7%), responsibility of other leaders (7%), or they were working or were sick (6%). Lack of information was a consistent reason among all sub-programmes. More respondents from Kiengu (19%) than other sub-programmes claimed they were not available to participate, while this was the case in Athiru Gaiti (17%) and Kilili (18%) because of domestic duties. More respondents in Kangeta (14%) believed that the selection of CHVs was the responsibility of local leaders than in other sub-programmes.

Household survey respondents (79%) (N=370) generally thought that the present selection process for community health volunteers was a good way to select CHVs (Table 51). This then should have a positive effect on enhancing community members to cooperate and participate in the Maua Programme activities.

Table 51: Opinion on CHV Selection Process

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*370*	*59*	*22*	*79*	*58*	*45*
1. Good way (%)	79	73	86	71	78	84
2. Not a good way (%)	21	27	14	29	22	16
Total (%)	100	100	100	100	100	100

Respondents from Kilili (86%) and Kirindine (84%) were more positive about the selection process than those from Kangeta (71%). The reasons why household survey respondents (N=181) believed that the selection process was good was because it was fair (64%) and less corrupt or politically influenced (16%) (Table 52).

Table 52: Reasons Why CHV Selection Process Was Considered a Good Way

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*181*	*19*	*6*	*52*	*37*	*13*
1. It was fair (%)	64	42	33	65	52	77
2. Promoted voluntarism (%)	20	21	17	16	5	0
3. Minimised corruption (%)	16	37	50	19	43	23
Total (%)	100	100	100	100	100	100

Respondents from Kilili were more interested that it minimised corruption (50%), while respondents from Athiru Gaiti were particularly pleased that it promoted voluntarism (21%). Fifty-eight per cent of household respondents (N=48) believed that interviews would be a better way to select CHVs (Table 53).

Table 53: Better Ways to Select CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*40*	*6*	*1*	*12*	*11*	*3*
1. Interview (%)	58	100	0	50	36	33
2. By advertising (%)	25	0	0	25	36	67
3. CHV's select (%)	10	0	0	8	27	0
4. Special council (%)	7	0	100	17	0	0
Total (%)	100	100	100	100	100	100

Other ways to select CHVs proposed by respondents were by advertising (25%), having CHVs select the new CHVs (10%) or selection by a special council (7%).

There was widespread agreement in both the APHA study (1982, p.49) and a PRICOR study (Marquez et al. 1987, pp.26-27) that the choice of selection criteria was important to the CHVs' performance, length of service and impact in relation to enhancing community participation.

Credibility

A selection criterion for community health volunteers and health committee members in the Maua Programme was that the person must be a respected member of the community. This is a standard criterion for most CBHC programmes. One determinant of respect and credibility could be the degree of involvement in community affairs of community health

volunteers and health committee members. This would be an indication of their overall commitment to development. In the Maua Programme over ninety per cent of the community health volunteers and health committee members interviewed (N=70) were active in other community-related activities such as school and church committees, self-help groups, planning committees and the political party.

However, the situation can arise whereby villagers in leadership positions are over-extended by involvement in too many project-related committees and self-help groups. It is difficult to quantify being over-extended. Nevertheless, fifty-five per cent of CHV and HCM respondents (N=70) were members of at least two other committees or groups within the community. This could restrict the amount of time they could devote to their health promotion roles.

In many traditional societies, age commands respect and credibility. Selection criteria for many programmes do carry a minimum age limit. The Kenya Ministry of Health PHC guidelines did not recommend any age limits but related age to suitability of training and the tasks to be carried out. Health committees within the Maua Programme used 18 years of age as the minimum age requirement. The average age of eleven male CHVs interviewed was 32 years, and for the thirteen female respondents, 29 years.

Nepotism or political influence can undermine credibility, but this did not appear to be an issue in the Maua Programme. Politics and corruption were only mentioned by two per cent of household respondents as a general constraint in relation to participation in the health development activities (Table 45, Chapter 9). On the other hand, being chairman of a health committee can be advantageous politically. Three chairmen of health committees in the Maua Programme have become assistant chiefs and one became a chief.

Gender

Approximately one-half of the projects in the APHA study (1982, p.50) had mostly male CHWs. The study claimed that it was more difficult for males to deliver services to women and children as the sex of the health worker strongly influenced both who would

seek health care and what kinds of tasks the CHV would undertake. Some principal factors which appear to be important in determining whether male or female CHVs are most appropriate in a given culture are compensation, mobility and effectiveness.

The amount of compensation provided to CHVs may influence whether the community chooses men or women to be health workers. In societies where there is widespread unemployment, paid jobs usually are given to men. Conversely, where CHWs receive no compensation, the project staff in the APHA study observed that women were more likely than men to continue work as health providers in a purely voluntary capacity. However, this was not true for the Maua Programme where the gender balance for active CHVs (N=51) in the five sub-programme study area was fifty one per cent male and forty nine per cent female. However, the gender balance for HCMs (N=44) was more male dominated (68%).

Most CBHC programmes in Kenya do not compensate their CHVs in the form of a regular salary since they are volunteers working on a part-time basis. The Kenya Ministry of Health PHC guidelines encouraged communities to provide some reward or allowance to CHWs, but not a salary. The guidelines pointed out that,

> "...If external funds are used for payment of salary of CHWs or for other recurrent expenditure, this will reduce self-reliance and negate the concept and philosophy of community-based health care." (Bennett and Maneno 1986, p.65).

The Maua Programme system for compensating or rewarding CHVs was an annual gift at Christmas. It was funded from the income collected from the mobile clinic fees. The annual gift was presented at a community meeting which further enhanced the image of the CHV by providing public recognition of the community service role which the CHVs were carrying out.

For the majority (56%) of household respondents (N=450) in the Maua Programme Study, gender was not an issue. The exception was Athiru Gaiti which indicated a stronger preference for female CHVs (44%) than other sub-programmes (Table 54).

Table 54: Gender Preference for CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*450*	*66*	*30*	*95*	*69*	*60*
1. No preference (%)	56	49	63	62	55	57
2. Female (%)	34	44	33	27	38	30
3. Male (%)	10	8	4	11	7	13
Total (%)	100	100	100	100	100	100

The main reason why household respondents (N=210) did not feel that gender was an issue was because they believed that men and women served the same purpose as CHVs (72%). This was particularly the view among respondents from Kiengu (88%) (Table 55).

Table 55: Reasons for No Gender Preference for CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*210*	*24*	*13*	*38*	*29*	*17*
1. Serve same purpose (%)	72	67	72	72	88	68
2. Same capability (%)	15	12	17	19	6	16
3. Trained same (%)	13	21	11	9	6	16
Total (%)	100	100	100	100	100	100

Over one third of respondents, however, specified that they preferred a female CHV (Table 56). The main reason expressed by household respondents (N=146) was that female CHVs were more open and frank (Table 56).

Table 56: Reasons for Preference for Female CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*146*	*33*	*9*	*24*	*27*	*14*
1. More open/frank (%)	45	34	78	50	41	64
2. More capable (%)	27	21	0	33	41	22
3. More advice (%)	17	30	11	4	11	7
4. Better knowledge FP (%)	6	3	11	13	7	7
5. More committed (%)	5	12	0	0	0	0
Total (%)	100	100	100	100	100	100

Respondents from Kilili (78%) felt strongly about the issue of frankness and openness in relation to female CHVs, while respondents from Kiengu (41%) preferred female CHVs because they were considered more capable and knowledgable. It is assumed that female

community members feel more open discussing family planning and maternal and child health issues with female CHVs. Better knowledge of family planning was in fact a reason cited by six per cent of respondents for preference for a female CHV. Respondents from Athiru Gaiti believed female CHVs provided more advice (30%) and were more committed to their work than male CHVs (12%). The latter point however, was not cited by any other sub-programmes.

The main reason why male CHVs were preferred by household respondents (N=32) was also because they were considered more open and frank (Table 57).

Table 57: Reasons for Preference for Male CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*32*	*4*	*1*	*7*	*3*	*4*
1. More open/frank (%)	44	50	100	72	35	100
2. More capable (%)	34	25	0	14	0	0
3. More advice (%)	16	0	0	0	67	0
4. Better knowledge FP (%)	3	0	0	14	0	0
5. More committed (%)	3	25	0	0	0	0
Total (%)	100	100	100	100	100	100

Since the overall gender balance of the household respondents (N=456) was 57% female and 42% male, it is assumed that the respondents who preferred male CHVs were probably also male respondents. Respondents from Athiu Gaiti who indicated a preference for male CHVs believed they were more capable and knowledgeable than female CHVs. They were possibly referring to environmental health areas such as latrine construction. Respondents from Kiengu (67%) felt that male CHVs offered more advice than female CHVs.

HEALTH COMMITTEE

Background information on the health committees in the five sub-programme areas of the Maua Programme was presented in Chapter 6. What follows is an examination of the findings from the case study area in relation to how health committees members (HCMs) influenced participation, community perceptions of their role and performance, and the support and assistance needed by HCMs to promote participation.

Role and Tasks

In the Maua Programme the main motivating factor for HCMs (N=12) to continue their work after selection was a sense of community service in promoting health. Other reasons were:

a) Seeing health improvements stemming from the programme activities;

b) Exposure to outside ideas;

c) Cooperation from CHVs, and

d) Training received as a health committee member.

Health committee members interviewed (N=8) in the Maua Programme perceived their role as primarily promoting the health programme activities and motivating community members to participate in the programme. Other specific tasks mentioned were:

a) Educating community members mainly through home visiting;

b) Supervising the work of CHVs;

c) Planning and organising community meetings in coordination with local leaders;

d) Managing programme activities such as the mobile clinic;

e) Seeing that advice given is being followed;

f) Raising funds for programme activities.

As discussed earlier, determining community needs offers an opportunity for the community to participate in the planning process. However, according to health committee respondents (N=8), community needs had been determined by programme planners based on past operational experience. On-going planning however, was done, through community meetings, internal health committee discussions and from information gained through home visiting, particularly identifying those community members who were not attending the mobile clinics.

The main ways by which the health committee were attempting to enhance participation and health behavioural change, according to HCMs (N=6) were:

a) Advising and encouraging community members to accept the ideas being put forward by CHVs;
b) Creating awareness of the programme within the community through home visiting;
c) Providing health education at public meetings in collaboration with chiefs and assistant chiefs;
d) Encouraging community members to contribute to health activities.

Performance Assessment

Eighty seven per cent of household respondents (N=454) were aware that a health committee existed (Table 58).

Table 58: Awareness of Health Committee

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*454*	*67*	*30*	*95*	*70*	*60*
1. Yes (%)	87	94	80	82	79	88
2. No (%)	13	6	20	16	21	12
Total (%)	100	100	100	100	100	100

This ranged from a high of 94 percent for Athiru Gaiti where the health committee had been established since the inception of the programme in 1977 to a low of 79 percent for Kiengu which had one of the newest health committees, established in 1985.

Providing health education (29%), followed by home visiting (20%), were mentioned by household respondents (N=420) as the roles they perceived for HCMs (Table 59).

Table 59: Perception of the Role of HCMs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*420*	*62*	*25*	*93*	*66*	*55*
1. Health education (%)	29	34	36	24	26	35
2. Home visits (%)	20	21	20	17	20	20
3. Don't know (%)	12	8	12	16	20	9
4. Health promotion (%)	10	11	12	10	2	11
5. Planning health projs (%)	9	8	0	10	9	6
6. Organise barazas (%)	9	11	8	9	9	11
7. Identify health probs (%)	6	3	8	10	6	2
8. Provide medical asst (%)	3	0	4	1	5	6
9. Monitor CHVs (%)	1	0	0	2	2	0
10 Other (%)	1	4	0	1	1	0
Total (%)	100	100	100	100	100	100

Twelve per cent of the overall respondents claimed that they did know what the role of the health committee was. This was so for twenty per cent of respondents from Kiengu, where only two per cent of household respondents cited health promotion compared to ten per cent of household respondents overall who saw this as one of the HCM roles. Some respondents were able to be more specific in identifying HCM roles, for instance, planning health projects (9%), identifying health problems (6%), providing medical assistance (3%) and monitoring CHVs (1%). There were no major variations among sub-programmes, except in Kilili where planning was not perceived as a role (0%), and in Kirindine (2%) and in Athiru Gaiti (3%) where the same held true for identifying health problems. It was surprising that monitoring CHVs was perceived by so few respondents (1%) as a role for HCMs. Enhancing or promoting community participation was not perceived as a role *per se*.

A large percentage (89%) of household respondents (N=411) felt that the health committee was doing a "good" job (Table 60).

Table 60: Opinion of HCM Effectiveness

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*411*	*65*	*23*	*85*	*59*	*53*
1. Doing a good job (%)	89	89	96	82	88	94
2. Not doing good job (%)	11	11	4	18	12	6
Total (%)	100	100	100	100	100	100

Health education (30%) was the main reason given by household respondents (N=354) for the favourable response to the HCM effectiveness (Table 61). These findings differed from experiences in Saradidi where Kaseje et al. (1987, p.65) claimed that village health committees have not been effective except for occasional activities such as needs assessment and selection of CHWs. The concept of Village Health/Village Development Committees, serving as a link between communities and the CHWs has not been a viable one in the Kibwezi CBHC programmes either, according to Johnson et al. (1989, p.1051). The favourable assessment of HCMs in the Maua Programme pertains more to their health education role than to their relationship with CHWs as only one percent of household respondents cited supervising CHVs as the reason for the HCM effectiveness.

Table 61: Reasons for HCM Effectiveness

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*354*	*52*	*21*	*70*	*51*	*45*
1. Health education (%)	30	29	5	46	29	28
2. Promoting cleanliness (%)	13	23	5	6	14	16
3. Promoting health service (%)	13	12	28	3	12	16
4. Assisting needy people (%)	12	8	10	14	12	13
5. Good advice (%)	11	5	14	17	0	16
6. Latrine construction (%)	7	5	24	4	8	7
7. Organising barazas (%)	5	5	10	4	4	0
8. Development (%)	4	12	4	3	5	2
9. Family planning (%)	3	0	0	1	2	2
10. Supervising CHVs (%)	1	0	0	1	0	0
11. Other (%)	1	1	0	1	0	0
Total (%)	100	100	100	100	100	100

Promoting health services (13%) and cleanliness (13%) were two other health promotion activities which household survey respondents cited. The former particularly so by Kilili respondents (28%) and the latter by respondents from Athiru Gaiti (23%). Only three per cent of Kangeta household survey respondents mentioned promoting health services which

could indicate a weak relationship between Kangeta HCMs and the government health staff.

Assisting needy people was a reason mentioned by twelve per cent of respondents for HCM effectiveness. The advice given by HCM was also cited by respondents in Kangeta (17%) and Kirindine (16%), but not significantly in Athiru Gaiti (5%). The HCM role in latrine construction was mentioned as a reason why HCMs were doing a good job by twenty-four per cent of respondents in Kilili. However, this role did not have the same impression with other sub-programmes (7%). Thus, there was considerable variation among sub-programmes in their perception of why they felt HCMs were doing a good job.

Similar to the responses on the perception of the role of HCMs, some respondents were able to identify specific areas of HCM activity which made a favourable impression on them. These were their role in organising meetings (5%), development in general (4%) felt particularly strongly in Athiru Gaiti (12%), family planning (3%) and supervising CHVs (1%). However, these specific roles were mentioned by very few respondents.

Twenty-eight percent of household respondents (N=359) stated that they would like to see the health committee doing more home visiting (Table 62), particularly respondents from Athiru Gaiti (46%) and Kilili (42%). This represented again a more hands-on role for HCMs.

Table 62: Other Activities for HCMs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*359*	*50*	*19*	*84*	*60*	*42*
1. More home visiting (%)	28	46	42	23	23	26
2.Organising seminars (%)	13	14	11	14	18	17
3. Promoting health facility construction (%)	11	2	5	7	17	5
4. Health education (%)	8	6	5	13	2	10
5. Continuation of good work (%)	7	0	0	8	12	5
6. Promoting water projects (%)	6	6	16	5	5	7
7. Nothing more (%)	4	6	5	6	5	0
8. Promoting latrine construction (%)	3	2	0	5	5	5
9. More commitment (%)	3	0	5	0	2	12
10. Provide agric. advice (%)	3	2	5	5	5	0
11. Provide drugs (%)	3	4	0	4	0	5
12. Promoting FP (%)	3	4	0	1	0	5
13. Supervising CHVs (%)	3	0	0	6	3	0
14. Promoting nutrition (%)	2	2	0	1	2	2
15. Other (%)	3	6	6	2	1	1
Total (%)	100	100	100	100	100	100

A second group of activities according to priority was organising seminars (13%) and promoting construction of health facilities (11%). The latter activity was a higher priority for household respondents from Kiengu (18%) and Kirindine (17%) where access to health facilities was an issue. More efforts in health education were called for by respondents from Kangeta (13%). Kiengu respondents confirmed the good work of HCMs by calling for its continuation (12%), unlike respondents from Athiru Gaiti (0%) and Kilili (0%). Twelve per cent of respondents from Kirindine wanted to see HCMs being more committed compared to three per cent overall. Supervision of CHVs was only cited by three percent of respondents overall, and not at all by Athiru Gaiti, Kilili or Kirindine respondents. This activity was perceived in Kangeta as being more of a priority (6%).

Health committee respondents (N=9) believed that community members would like them:

a) Doing more regular home visiting;
b) Paying for those who cannot afford the clinic fees and hospital bills;
c) Taking sick community members to hospital;
d) Holding more health education meetings at village level;
e) Getting a health facility established in their area.

These perceptions, for example more home visiting and securing health facilities, were similar to what community members also wanted to see (Table 62). The main difference was in relation to what HCMs characterised as assisting needy people (Table 61), e.g., paying for poor patients, taking the sick to hospital. This role was not stated by household respondents as an activity they would wish to see HCMs addressing (Table 62). However, 12% of household respondents (Table 61) cited assisting needy people as a reason for HCM effectiveness.

Fifty-three per cent of CHVs, HCMs and local leaders respondents (N=43) believed incentives or rewards, including a salary to be provided through community contributions, would make health committee members more active. Other ways to motivate HCMs were:

a) Training;
b) Encouragement from the programme planners, support from local administration and CHVs;
c) Seeing more community members carrying out their health advice;
d) Meeting regularly with programme planners.

Support and Assistance

In order for a health committee to be effective in health promotion and in enhancing participation, it requires support and assistance from a variety of sources. These can be from within the community and from community health volunteers, or it can be from outside the community, such as from the programme support staff. Doan et al. (1984, p.8) claim that the latter form of support is needed more in health than in some other aspects of rural development. Health committee respondents (N=23) identified the following ways in which the community participated in supporting them:

a) Contributing funds for training and the annual reward for the CHVs;
b) Setting good examples by participating in the programme, e.g.,paying the fee for the mobile clinic, accepting the health education advice, and teaching and influencing other community members to participate;

c) Informing them of health problems in the community and which community members are not adhering to advice or attending the mobile clinic;
d) Providing community labour for their shambas or those operated by the health committee;
e) Following the advice being given and practicing what is taught;
f) Helping transport sick members to hospital;
g) Contributing land.

The project team and health committee relationship is vital. It represents the interface between the outside supporting agency and the local institution responsible for effective operation of the community-based programme. According to HCMs respondents (N=7), for the Maua Programme, the types of support and assistance needed by the health committee from the project staff were:

a) Advice and ideas on solving the problems they faced in getting community members to participate in the programme;
b) More training for themselves and training of additional CHVs;
c) Financial support and good overall management of the programme.

The most urgent and difficult problems facing the health committee, according to HCM respondents (N=21) were:

a) Lack of understanding and ignorance from community members about health promotion;
b) Specific health-related problems, such as reluctance over latrine construction, poor family planning acceptance, poor clinic attendance;
c) Lack of funds to run the programme fully and securing contributions from the community;
d) Helping sick people identified by CHVs;
e) Getting a health facility established in their areas;
f) Lack of trained CHVs;
g) Lack of cooperation from local leaders;
h) Coping with all the activities of the programme.

Regarding difficulties in securing community financial contributions, the problem was described by a health committee member who said, "The most urgent problem is encouraging people to pay the money needed to foster health projects. In most cases where money is wanted, people have nothing to contribute."

COMMUNITY HEALTH VOLUNTEERS

Community health volunteers (CHVs) are a major feature of the many community-based health care programmes. Numerous authors have reviewed the use of community health workers in national programmes (Ofosu-Amaah 1983; Walt 1988) and joined the debate on the effectiveness of CHVs (Kaseje and Sempebwa 1989; Johnson et al.1989) or their shortcomings (Walt 1988; Jancloes 1984; Skeet 1984). The latter view pertains mainly, however, to experiences of governments with large systems of community health workers (CHWs). In Burkina Faso, for instance, health system utilization of CHWs was found to be insufficient and a possible reason for failure was lack of community participation (Sauerborn et al. 1989, p.1168).

The review by Berman et al. (Berman et al 1987, pp.456-457) of six large-scale community-based worker programmes found "... no substantive evidence of large-scale health impact of CHW programs as yet." Nevertheless, the review stated that many of the potential benefits of CHW activities are indirect and that CHWs have spearheaded a fundamental change of emphasis in the rural health system, from clinic-focus to community-focus, with special attention to the needs of those previously under-served.

More success has occurred with smaller, NGO-supported CBHC programmes in Africa. Johnson et al. (1989 p.1045) cited the request from leaders in adjoining areas to set up similar programmes as a significant indicator of success for the Kibwezi CBHC programme in Kenya. The Saridid community in Kenya reported they have benefited from easy accessibility of health services at the village level through the CHVs (Kaseje and Sempebwa 1989, p.1069). Mburu and Boerma (1989, p.1006) state that rural hospitals appear to be an effective basis for the development of CBHC in East Africa, if approached properly. Nevertheless, Walt (1988, p.5) notes that several evaluations of CHV

programmes have been carried out, but little can be concluded from their findings about the effectiveness of CHVs. This was also true for the external evaluation of the Maua CBHC Programme which was carried out in 1982. It claimed that there has been steady expansion and progress, but the report did not comment per se on the effectiveness of CHVs (Bennett el al. 1982). In the Maua CBHC Programme CHVs play an important role in enhancing community participation, and the section which follows examines their training, roles and tasks, what type of support and assistance they are receiving and how their performance is perceived by the community.

Training

The main ways CHVs in the Maua Programme are trying to bring about participation are utilisation of mobile clinic services and promotion of health-related behavioural changes at household level. The CHV must present a convincing case to community members before they are willing to change their traditional ways or participate in programme activities. This requires both good communication skills and solid practical knowledge. The latter enables them to back up their advice with how-to-do-it instructional skills. Increased cooperation with government technical staff in the fields of agriculture, water and sanitation would also strengthen their technical capability.

Community health volunteers in the Maua Programme are trained in groups of about 15 men and women by 2-3 enrolled community nurses. The training curriculum covered an initial two week period. A variety of teaching methods was used, such as visits to Maua Hospital, working in the mobile clinic, handouts, home visiting, and traditional forms of communication - role plays, stories, songs. Training sessions were carried out at community level and at the Community Health Department at Maua Hospital. After initial training, volunteers had a one day's training each month from the Maua Programme community nurse who was assigned responsibility for the area. A relationship was thus built up between volunteers, the community and a community nurse. The initial and in-service training period was between 3-4 weeks over a one year period.

Over 50 percent of the programmes reviewed in the APHA study (1982, p.49) had training periods between 5-12 weeks, which included initial and in-service training. This was also the pattern for CBHC programmes in Kenya (Nangina, Kibwezi, Saridid) with the initial training lasting between 2-6 weeks then followed by one-day sessions each month and an annual refresher training course every 1-2 years (Willms 1984, p. 265; Johnson et al. 1989, p.1044; Kaseje et al.1987, p.68). Regularly supervised on-the-job training was a feature of the Maua Programme and most other Kenyan CBHC programmes. However, the APHA study stated that on-the-job training does not take place systematically in many of the programmes because of lack of resources and the pressing need to train new workers. Supervised in-service training usually occurred in most Kenya programmes because resources were available through the non-governmental agencies or church organisation sponsors.

Role and Tasks

The motivating factor to become a CHV, according to CHVs interviewed (N=16), was to promote health by educating fellow community members on health matters. The motivating factors for continuing to serve were:

a) Sense of duty to continue to serve the community;
b) Satisfaction from seeing people adhere to one's advice and thus improving their health status;
c) Knowledge acquired through training;
d) Support and encouragement from the Maua programme staff;
e) Personal benefits it represented.

These motivating factors were very similar to those expressed by village health helpers in Saradidi, e.g., desire to help people, enjoy the work, personal development (Kaseje and Sempebwa 1989, p.1068).

The most important tasks of community health volunteers, as perceived by CHV respondents (N=9), were:

a) Educating and advising community members on health matters;

b) Carrying out home visiting;
c) Promoting utilisation of health services;
d) Identifying health problems within the community;
e) Seeing that the programme is doing well.

A female CHV from Kangeta described her role by saying it was to "...to visit people in the villages, teach health education and identify health problems the people have in their homes." A Kirindine CHV was more explicit regarding the health educational role, stating it as ... "teaching community members the importance of having a latrine at their homes, taking a sick person to hospital, boiling water before drinking, and taking children to clinic for immunisation against disease." Kaseje et al. (1987, p.60) also found in the Saridiidi CBHC Programme that CHWs considered home visiting and disease prevention activities as their most important activities.

The CHVs tasks were meant to enhance participation in the Maua programme activities. They entailed getting community members to take advantage of the programme activities, such as the mobile clinic services, and influencing change or modification in their health behaviour. According to CHV respondents (N=12), the specific types of participation or behavioural change they were trying to influence were:

a) Personal hygiene and keeping households clean;
b) Pit latrine construction;
c) Joining self-help groups;
d) Practicing family planning;
e) Attending mobile clinics and health facilities for MCH services;
f) Taking the sick to hospital;
g) Getting community members to make contributions to the Maua programme, for instance to buy equipment for the mobile clinic.

According to CHVs respondents (N=12), they enhanced participation by:

a) Teaching community members the importance of participating in the programme;
b) Home visiting;

c) Discussion sessions with local groups such as women's self-help groups, church groups;

d) Participating in public meetings when health issues were discussed.

Home visiting was the main CHV task identified by forty-two per cent of household respondents (N=434, Table 63).

Table 63: Perceptions of CHV Role

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*434*	*67*	*30*	*94*	*67*	*52*
1. Home visiting (%)	42	51	40	32	42	46
2. Health education (%)	23	21	30	25	24	21
3. Promoting hygiene (%)	16	13	13	20	18	17
4. Don't know (%)	7	4	0	13	10	2
5. Train community (%)	2	0	0	4	0	2
6. Assist at mobile clinics (%)	2	5	10	11	0	6
7. Pit latrine construction (%)	2	0	3	1	1	2
8. Promote FP (%)	1	0	0	1	3	0
9. Promote better nutrition (%)	1	0	0	1	0	2
10. Treatment (%)	1	4	0	0	1	0
11. Other (%)	3	2	4	2	1	2
Total (%)	100	100	100	100	100	100

From the responses, it appeared that CHVs in Athiru Gaiti (51%) could be carrying out more home visiting than in the other sub-programmes, with the opposite happening in Kangeta (32%), where significant attrition of CHVs had occurred. The other two main tasks which household respondents believed CHVs were supposed to carry out were health education (23%) and, specifically, promoting general cleanliness and hygiene (16%). Other specific health promotion activities mentioned by some household respondents were pit latrine construction (2%), promoting family planning (1%) and better nutrition (1%).

Only seven per cent of respondents claimed that they did not know what CHVs were supposed to do, but for Kangeta it was nearly twice that (13%). How household respondents perceived the role of CHVs was generally consistent with how CHVs also described their role.

Community health volunteers are supposed to devote two days per week to the Maua programme. Sixty-eight percent of CHV respondents (N=13) claimed they spent between 1-2 days on CHV activities. This amount of time was very similar to that reported for similar CBHC programmes in Kenya, e.g., VHHs in Saradidi spent an average of 5-10 days each month (Kaseje and Sempebwa 1989, p.1067), CHWs in Kibwezi spent 12-14 hours per week in community health activities (Johnson et al. 1989, p.1045), CHWs in Nangina work one to four afternoons per week (Willms 1984, p.268).

Nearly all CHVs (N=13) (93%) felt that they were not giving enough time for their community health work. The main reasons were:

a) Domestic duties, which mainly applied to female CHVs;
b) Need to cover a large area;
c) No reward.

Fifty-four percent of household survey respondents (N=421) also felt that CHVs were not spending enough time on community health work (Table 64).

Table 64: Assessment of Time Spent as CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*421*	*64*	*29*	*88*	*62*	*54*
1. Not enough time (%)	54	52	55	55	61	57
2. Enough time (%)	46	48	45	45	39	43
Total (%)	100	100	100	100	100	100

Respondents from Kiengu (61%) felt the strongest about CHVs not spending enough time on their CHV duties. Kiengu and Kilili are less densely populated and households are spread over a larger geographical area than the other sub-programmes. Thus, the reason cited by CHVs of needing to cover a large area could explain this variance for Kiengu. Sixty-five percent of household respondents (N=375) would like to see CHVs spend more time in general (30%) and, specifically, doing more home visiting (35%) (Table 65).

Table 65: Future Role of CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*375*	*53*	*25*	*82*	*60*	*46*
1. More home visiting (%)	35	30	36	45	32	35
2. Spend more time as CHV (%)	30	28	36	23	37	39
3. Continuation of good work (%)	13	11	12	15	15	4
4. More determination (%)	9	8	4	6	5	15
5. Hold more community meetings (%)	3	9	12	1	0	2
6. Be more innovative (%)	2	0	0	2	2	2
7. Promote cleanliness (%)	2	2	0	5	5	0
8. Disease control (%)	1	2	0	1	0	0
9. Promote mobile clinic (%)	1	6	0	0	0	0
10. Promote child care (%)	1	2	0	1	3	2
11. Other (%)	2	2	0	0	1	1
Total (%)	100	100	100	100	100	100

More determination from CHVs was called for by Kirindine respondents (15%). This response probably referred equally to Kirindine HCMs since CHVs had not yet been trained in Kirindine. A general response which could be considered as approval of their current role was, "continuation of good work" cited by thirteen per cent of household respondents, but only by four per cent in Kirindine. A group of other activities were recommended such as holding more community meetings (3%) and being more innovative (2%), besides, health promotive tasks like promoting cleanliness (2%), disease control (1%), and promoting the mobile clinic (1%) and child care (1%). Promoting greater participation in the programme activities was not cited *per se*.

Support and Assistance

CHVs respondents (N=5) stated that community members provided support and assistance to them by:

a) Practicing what was taught regarding health promotion and behavioural change;
b) Educating other community members on health practices and passing information to community members about various programme activities taking place, such as the date of the next mobile clinic visit;
c) Providing moral support.

The most important forms of support provided by the health committee according to CHVs (N=6) were:

a) Organising meetings with the community to discuss health matters;
b) Raising funds;
c) Assisting in doing home visiting.

CHVs respondents (N=8) would like to see more support and assistance from HCMs, stated as:

a) Better cooperation and dedication from HCMs;
b) Organising regular meetings to discuss their work;
c) Helping with community members not participating in the programme;
d) Providing funds when needed;
e) Organising lunches when doing home visiting;
f) Providing more technical advice for latrine construction.

In Saradidi (Kaseje et al. 1987, p.65) the major support for CHWs came from programme centre staff and committees, however, village health committees have not provided adequate support to CHWs. Apparently, a strong central programme staff and committees fulfilled this need.

CHVs respondents (N=16) in the Maua Programme felt that they needed resources to carry out their work effectively. They cited the following:

a) Food allowances when doing home visiting;
b) Transport in the form of a bicycle or a transport allowance;
c) Increased knowledge through training, manuals, guidebooks;
d) Uniforms, badges;
e) Salary;
f) Someone to accompany them during home visiting.

Sixty-two per cent of CHVs respondents (N=12) agreed that the community should provide the funds for these resources, in collaboration with the assistant chief and the

health committee. The other CHV respondents (38%) believed that it should be the Maua Programme in collaboration with the health committees. The assistant chief should organise fund-raising meetings and the health committee should liaise with the project staff to purchase the bicycles and provide the training.

Performance Assessment

The PRICOR-funded studies (1987, pp.34-35) on how to increase community participation in CHW components of PHC programmes found that in general, communities are willing to use and support CHWs if they believe that the services that CHWs provide have some benefit. In the Maua Programme, eighty-four per cent of household respondents (N=296) claimed that CHVs were doing "a good job" (Table 66). Respondents from Kilili (94%) gave a higher performance rating to CHVs than any other sub-programme area. Respondents from Kiengu (76%) gave the lowest, even though, other aspects of this sub-programme were rated high, e.g., HCM effectiveness (Table 60). Nevertheless, the overall rating means that at least three out of every four respondents from Kiengu felt CHVs were doing a good job.

Table 66: Performance Rating of CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*296*	*42*	*16*	*85*	*51*	*19*
1. Doing a good job (%)	84	88	94	81	76	79
2. Not doing good job (%)	16	12	6	19	23	21
Total (%)	100	100	100	100	100	100

The main reason stated was their work in health promotion (42%) (Table 67), and this was particularly so in Kangeta (53%). Health advice was cited as a significant reason in Athiru Gaiti (54%), while in Kangeta household respondents rated this function much lower (17%). On the other hand, Kangeta respondents rated CHV health knowledge (9%) much higher than other sub-programmes (2%). Uplifting living standards (11%) and enhancing health awareness (9%) were other reasons.

Table 67: Reasons for Good Performance Rating of CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*218*	*24*	*7*	*70*	*37*	*11*
1. Health promotion (%)	42	33	43	53	44	36
2. Health advice (%)	33	54	29	17	32	46
3. Uplifting living standards (%)	11	9	14	10	8	9
4. Enhancing awareness (%)	9	4	0	11	11	9
5. Health knowledge (%)	2	0	0	9	0	0
6. Sacrifice being made (%)	2	0	0	0	5	0
7. Nutrition (%)	1	0	14	0	0	0
Total (%)	100	100	100	100	100	100

The reasons given by a few household respondents (N=18) on why they felt CHVs were not doing a good job were that they did not do home visiting (56%), were lazy and reluctant to do their work (39%) and were teaching irrelevant topics (5%) (Table 68).

Table 68: Reasons for Poor Performance Rating of CHVs

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*18*	*3*	*0*	*4*	*6*	*2*
1. Did not do home visiting (%)	56	67	0	0	67	50
2. Lazy (%)	39	33	0	100	17	50
3. Teaching irrelevant topics (%)	5	0	0	0	16	0
Total (%)	100	100	0	100	100	100

The sole reason cited in Kangeta was laziness, which also could have been related to what respondents in other sub-programmes cited as "not doing home visiting".

LOCAL LEADERS

Local leaders are a key community group in relation to promoting development activities in any community and in enhancing community participation. They play a vital role in promoting preventive health behaviour at village level (Streatfield and Singarimbun 1988, p.1244). The level of support and backing they provide development initiatives is usually a factor in their success or failure. The role local leaders played in the Maua Programme is examined as well as the nature of support and assistance they provided the programme. How well CHVs and HCMs perceived that role is also discussed.

Role and Tasks

Local leader respondents (N=21) active in the Maua Programme saw their role in relation to enhancing community participation as:

a) Motivating and mobilising community members;
b) Setting good examples for other community members to emulate, such as making financial contributions at funding-raising meetings;
c) Assisting CHVs with home visiting and gaining access to remote areas;
d) Ensuring that health messages of local administration officials are followed;
e) Educating community members in public meetings, self-help groups and in churches;
f) Raising funds for various programme activities;
g) Planning, organising programme activities, seeing they are managed well.

The responses from local leaders respondents (N=21) on how they attempted to enhance participation were similar to those expressed above by health committee respondents. For local leaders the ways were:

a) Educating community members in public meetings, at self-help group and church meetings;
b) Setting good examples and making contributions;
c) Encouraging community members to play an active role in the Maua Programme;
d) Organising community meetings to discuss health issues;
e) Enforcing the directives on health promotion given by local administration.

However, their views differed in so far as they felt they ought to be role modelling and enforcing rules pertaining to health in collaboration with chiefs and assistant chiefs, mainly pertaining to latrine construction. The latter way of enforcing rules would hardly meet the standard interpretation of participation.

The specific health-related ways local leaders (N=21) were trying to enhance community participation in the Maua Programme for community members were to:

a) Take children to the mobile clinic and attend antenatal clinics;
b) Construct pit latrines;

c) Maintain clean homesteads;
d) Take the sick to hospital;
e) Improve family diets;
f) Practice family planning;
g) Join self-help groups.

Support and Assistance

Local leaders also need support to play a more active role in health promotion. The main types of general support expressed by local leader respondents (N=16) were:

a) Regular seminars and training on the importance of community participation in health activities;
b) Rewards and incentives;
c) Encouragement and support from programme staff and local administration.

Performance Assessment

Community health volunteers and health committee members respondents (N=16) were asked if they believed local leaders were carrying out their role in health promotion and in enhancing community participation. Only thirty nine per cent believed that they were. Indicators of an effective role for local leaders cited by CHVs and HCMs respondents (N=16) were:

a) Presiding over projects when asked to do so;
b) Being available when required by project promoters;
c) Educating community members during meetings;
d) Setting good examples;
e) Seeing that people follow the recommendations they give for health promotion and behaviour change.

The reasons cited by sixty-one per cent of CHVs and HCMs respondents (N=16) why local leaders have not carried out their role very well were that local leaders were:

a) Not taking their role seriously and were not being motivated by local administration;
b) Lacking understanding as to what their role was;

c) Inadequately trained on the value of health promotion and community participation;
d) Tending to leave the work for health workers;
e) Lacking incentives.

CONCLUSION

Community organisations are pivotal to the success of community-based health care programmes. They offer mechanisms for mobilising and coordinating community support. They also represent an important way in which participation can be enhanced at community level. Involvement of local organisations can ensure that some form of community control exists in CBHC programmes.

An important catalyst to enhance participation are CHVs, HCMs and local leaders. The degree to which this occurs however, depends on how motivated and committed they are as volunteers and how effective they are in carrying out their tasks. This is determined to a large extent by the local support they are getting from community members and the technical support provided through the programmes or services they are associated with. CHVs, HCMs and local leaders must gain the respect of community members for the role they are undertaking in order to maximise participation.

The roles of health committee members most recognised by community members were providing health education and doing home visits. This broad health education role was deemed beneficial enough for eighty-nine per cent of community members to view favourably the work of their health committee. Many of the health education messages concerned environmental health and utilising health services, each of which was also stated as reasons for HCM effectiveness. More managerial-type activities like supervising CHVs, organising community meetings and generally enhancing community participation, were secondary to the more action-oriented role of health promotion and assisting community members.

Eliciting participation from reluctant households was an important issue. CHVs felt they could be more effective with more assistance from HCMs, especially with households

which were not participating. In turn more advice and ideas on promoting participation were needed from programme staff, as part of their vital support role. This should be done as part of basic or on-going training. The majority of CHVs had not received enough training on how to promote community participation. The main area of support needed by local leaders was for training in community participation methodologies.

Another important issue related to effectiveness and participation is level of resources and incentives. Selected inputs for CHVs to enhance their effectiveness could be food allowances and expenses for transport which should be provided by the community. Although CHV effectiveness appeared positive in the Maua Programme, measured by eighty-four per cent of household respondents stating that CHVs were doing a "good job" - promoting health, providing health advice, uplifting living standards, enhancing health - more time devoted to this role was recommended by over half of household respondents, particularly in the form of home visiting. The majority of CHVs indicated that they were spending already between one and two days a week carrying out CHV duties. Therefore, their willingness to devote more time was questionable without some form of material support.

The challenge to CBHC programmes is gaining the right balance between resources needed to achieve effectiveness and to sustain the programme, which can be generated within the community; the degree of voluntarism and commitment of community members to the programme; and the inputs required externally, in the form of technical support. For both CHVs and HCMs, an important form of community support was for community members to just practice what was being promoted. The satisfaction from seeing people adhere to one's advice and thus improving their health status was a major motivating factor for both CHVs and HCMs. On the other hand, only a third of CHVs and HCMs felt that local leaders were fulfilling any meaningful role in the programme because of lack of commitment and lack of motivation from the local administration. Community attitudes regarding material support to CHVs is a community-financing issue discussed in the next chapter.

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CHAPTER 11

COMMUNITY FINANCING

INTRODUCTION

Contributions from community members is one of the most common and important ways community members can participate in CBHC programmes. Contributions can take the form of physical labour, in-kind contributions or financial contributions. In the Maua Programme, 68 percent of household respondents cited contributing money as the main way they had participated in a health project (Table 19, Chapter 8). These actions also represent how communities help finance community-based health activities.

The Alma-Ata PHC Conference addressed the issue of financing primary health care, including the concept of community-financing. A major theme was preferential allocation of resources to primary health care, starting from communities and progressing through the other levels. One of the 22 recommendations from the Alma-Ata Conference specifically dealt with mobilising resources for primary health care which included those at the local level through community participation. That recommendation stated,

> "*17. Resources for primary health care*
> The Conference, Recognizing that the implementation of primary health care requires the effective mobilization of resources bearing on health, RECOMMENDS that, as an expression of their political determination to promote the primary health care approach, governments, in progressively increasing the funds allocated for health, should give first priority to the extension of primary health care to underserved communities; encourage and support various ways of financing primary health care, including, where appropriate, such means as social insurance, cooperatives, and all available resources at the local level, through the active involvement and participation of communities; and take measures to maximize the efficiency and effectiveness of health-related activities in all sectors" (WHO 1978, p.30).

The conference report stated that financing was likely to be a combined community and government effort, with the government in the final analysis having to ensure that it was adequate for the programme agreed on, and for communities to shoulder part of the financial burden of health development. The only reference to the concept of

community-financing in WHO's document, "Formulating Strategies for Health for All by the Year 2000", was that maximum use should be made of local energy, materials and resources through local community solutions (WHO 1979, p.18). No guidelines were offered as to how this was to take place or what types of solutions should be explored.

The WHO produced reports on the financing of primary health care (WHO 1978; Mach and Abel-Smith 1983; WHO 1984) and organised inter-regional conferences on community participation (WHO 1985) where community-financing had been discussed. However few WHO sponsored workshops on community-financing have been organised to assist national policy makers, ministry of health planners or district health management teams facilitate its development. Possibly, the WHO felt that community-financing of primary health care was being addressed adequately by its PHC financing studies or by other agencies such as the World Bank (World Bank 1987; Mwabu 1990) and UNICEF (UNICEF 1988; Kanji 1989; McPake et al. 1993) in the context of user fees, community pharmacies, revolving drug funds and the Bamako Initiative.

Stinson, who carried out a comprehensive review of community-based financing mechanisms of over one hundred USAID supported projects, defined community-financing as, "..contributions by beneficiary individuals and groups to support part of the cost of public health care services" (Stinson 1982, p.13). It was also defined by Russell and Reynolds as, "..the mobilization of resources by a community to support, in part or in full, basic preventive and curative health services for its members" (Russell and Reynolds 1985, p.8). Community-financing, according to Carrin (1988 p.601), involved the direct financing of health care by households in villages or distinct urban communities.

Because of the ambiguities created by these various definitions, Abel-Smith and Dua (1988), attempted to clarify the concept of community-financing. They pointed out that Stinson's definition could, theoretically speaking, include contributions through taxation or formal national social security schemes, but added that these types of contributions have never been discussed as methods of community-financing. A more important clarification was to exclude individual household spending on medical care, through or-

dinary free market purchases of services and drugs, as community-financing of health care. Their rationale was to emphasize the meaning of community in their interpretation of community-financing, that is, "...some form of local social organization getting together and undertaking collective action - a concerted action for the benefit of people who share a common interest or purpose. Self-help on a mutual basis is the cornerstone of community action" (Abel-Smith and Dua 1988, p.96).

The distinction between public health sector financing and community-financing can also be made in relation to how funds are utilised. If they are associated with the overall community-based programme activities and are either retained by service providers such as CHVs, or used to maintain or improve the provision of services or for replenishing commodities such as drugs as part of revolving funds, then they are a form of community-financing. In other words, community-financing refers to what might be called the inter-community cycle of resources, that is, resources changing hands only within the community for activities which are part of a community-oriented programme. However, if they are not retained within the primary health care system at the community level and are used to offset the costs of providing public-oriented health care services in general, they would not quality as a type of community-financing. As decentralisation policies are implemented and government primary health care facilities are able to retain the revenues they raise to help improve the quality of services for the communities they serve, the greater the likelihood of them being involved in community-financing.

Arguments have been advanced which suggest the need for caution in the approach to community-financing. These are that community-financing does little to promote equity and can place too great a burden on the poor and the sick. Resources can rarely be raised on a sustained basis through voluntary labour, while many of the resources generated are not easily used to meet the full range of health needs. It tends to favour the creation of those kinds of health facilities for which there is a high local demand rather than meeting professionally perceived needs. A high degree of external support is needed to mobilise and sustain community efforts. Indeed, some have argued that part of the emphasis placed on community-financing amounts to diversionary activity by governments which

lack the political will to generate new resources or to reallocate existing ones. Health care is a public good and should, therefore, be nationally financed. Moreover, community-financing is largely untested. (Abel-Smith and Dua 1988; Stinson 1984).

The most common objectives of community-financing schemes based on Stinson's review (1982 p.19) were restocking basic drugs and paying health workers. About a third of the projects used community-financing at least partly for general revenue. Community labour and contributions were widely used for constructing and maintaining health posts and sanitation facilities.

The community-financing methods discussed in this chapter are the ones utilised and others possibly appropriate in the case study area and other similar CBHC programmes. They are personal service fees, communal labour, provision of services by volunteers, ad hoc contributions and pre-payment schemes. The main study objective in regard to community-financing was to examine community-financing as a significant form of community participation and to gather information about the willingness of communities in the case study programme to participate in community-financing methods which would help promote and sustain the various CBHC activities.

PARTICIPATION IN FINANCIAL PLANNING

Community-financing offers the community the right to ensure that services are acceptable and responsive to priorities, as judged by the community, and is a tangible demonstration of community participation. The WHO Study Group on Financing of Health Services emphasised this point. It stated,

> "The contributions of the local people gives them both the right and incentive to participate in the running of the programme. Such participation is an important base upon which to build health awareness in its widest sense and generate those changes in personal behaviour which can contribute to raising health standards..." (WHO 1977, p.11)

Djukanovic and Mach (1975, p.99) also saw financing as a way for communities to gain more control over their health affairs:

"Financing and decision-making are complementary functions that reinforce each other; they place the community in a position of authority as it shoulders responsibility for its own services.."

An opportunity for participation within community-financing is deciding how funds are to be raised for community health activities or the methods of community-financing and what amounts are reasonable and appropriate as contributions. This opportunity usually did not occur in many CBHC programmes since the initial design was pre-determined with little or no involvement by community members. Nevertheless, participation during the implementation period takes on added meaning and importance in making CBHC programmes truly community-oriented. Various operational needs requiring financing offer opportunities for participation in financial decision making by community members. These can be for improving services such as purchasing weighing scales, or a cold box for transporting vaccines or a set of tools for environmental health work or to maintain existing services such as the maintenance of the building serving as the health post. Other decisions could be to reward the volunteers who are working for the community. When taken during the implementation rather the planning stage, it offers community members the opportunity to base their decision on appraisal of the work of the community health volunteers and the health committee members.

Sixty percent of household respondents (N=446) in the Maua Programme claimed they helped decide in which way funds were to be raised for health projects (Table 69).

Table 69: Participation in Financial Planning

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*446*	*65*	*29*	*94*	*70*	*59*
1. No (%)	60	55	55	56	67	58
2. Yes (%)	40	45	45	44	32	42
Total (%)	100	100	100	100	100	100

However, when asked how, 55 percent of household respondents (N=205) said they participated in financial planning by personal contributions and another 13 percent said by harambee fund-raising (Table 70).

Table 70: How Respondents Participated in Financial Planning

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	205	23	8	51	45	19
1. Personal contribution (%)	55	65	88	49	51	79
2. Meeting, discussion (%)	22	9	12	16	29	16
3. Fund-raising/harambee (%)	13	0	0	29	11	0
4. Self-help groups (%)	7	13	0	4	7	0
5. Foodstuffs (%)	3	13	0	2	2	5
Total (%)	100	100	100	100	100	100

These responses in fact indicated more how they participated. Nevertheless, 22 percent of household respondents said that the way they participated in financial planning was through discussion at committee meetings or *barazas*. In the Kiengu sub-programme, health care promotion was a priority programme of the local administration. This involved numerous community meetings (*barazas*), and it was not surprising, therefore, that more respondents from Kiengu (29%) indicated that they had participated in financial planning than any other sub-programmes.

Eighty-six percent of CHVs, health committee members and local leaders respondents (N=34) claimed that community members helped decide the ways in which funds were to be raised for health projects and the main mechanism was through community meetings (*barazas*).

For the forty percent of household respondents (N=99) who claimed that they did not help decide how funds were to be raised for community health projects, the two main reasons cited were that this was either the responsibility of local leaders and the health committee (52%), or that they were not aware that such matters were being decided due to lack of information (27%) or cooperation by local leaders or the health committee (9%) (Table 71).

Table 71: Reasons for Not Participating in Financial Planning

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*99*	*11*	*3*	*37*	*14*	*9*
1. Responsibility of leaders (%)	52	55	33	67	43	11
2. Lack of information (%)	27	9	67	16	29	78
3. Lack of cooperation (%)	9	0	0	14	14	0
4. Responsibility of HCMs (%)	8	27	0	3	7	0
5. Personal commitments (%)	3	9	0	0	0	11
6. Other (%)	1	0	0	0	7	0
Total (%)	100	100	100	100	100	100

Lack of information that financial planning issues were being discussed was cited especially by Kirindine (78%) and Kilili (67%) respondents. The responsibility for informing community members resided mainly with the local administration. Lack of information was not seen as a problem in Athiru Gaiti (9%), but rather, 27 percent of respondents believed that financial planning was the responsibility of the health committee.

WILLINGNESS TO CONTRIBUTE

Nearly all household survey respondents (N=453) in the Maua Study (99%) claimed that they were willing to contribute to health projects which would improve their family's health. This very positive response was consistent with other similar surveys. In the Philippines, a majority (89%) of household heads expressed their willingness to participate in health financing schemes and had generally positive attitudes toward participation. In Honduras, a 1983 Ministry of Health household survey found that 93% of the households interviewed expressed willingness to pay a small fee for services and medications (PRICOR 1987, pp.24-25).

Personal benefit and welfare (47%) were the main reasons Maua Programme household survey respondents (N=415) gave on why they would be willing to contribute to health projects (Table 72).

Table 72: Reasons for Willingness to Contribute to Health Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*415*	*60*	*26*	*94*	*66*	*49*
1. Personal benefit/welfare (%)	47	38	42	47	39	53
2. Health promotion/development (%)	43	48	38	48	52	41
3. Provision of medical services (%)	7	3	19	5	9	6
4. Water (%)	2	10	0	0	0	0
6. Other (%)	1	1	1	0	0	0
Total	100	100	100	100	100	100

Forty-three percent of respondents cited health promotion and development as the reason for their willingness to contribute. Some respondents (9%) identified the types of the health benefits they would like to receive, such as provision of medical services (7%), water (2%). Provision of medical services was a strong reason cited by Kilili respondents (19%) compared to other sub-programmes (7%). Kilili is the most remote of the sub-programmes. In Athiru Gaiti, respondents were particularly willing to contribute financially for projects related to water (10%), in comparison to other sub-programmes (2%).

Abel-Smith and Dua (1988, p.98) stated that people's willingness to pay is in part dependent on who received the benefits from the services created. If they benefited the community more than the individual, there may be some reluctance to participate in such a community financed project. Nevertheless, the health promotion and development benefits, cited by respondents (43%) as their reason to contribute, could be addressed by projects which also had a broader community benefit.

ABILITY TO CONTRIBUTE

The strength of consumer demand for health care must be a crucial consideration in deciding what activities are appropriate for community-financing and how much revenue is likely to be generated. Demand reflects both people's willingness to pay a specified sum for certain goods and services and their ability to pay, measured by their ready cash or other resources. Demand expressed by individual action may differ from community demand.

Ability factors likely to affect demand include total community resources, the distribution of resources between and within households, seasonality of production, and the requisite form of payment. The major types of community resources for community-based health care programmes are:

- money: individual household earnings from cash crops or food produce, income from self-help group activities, self-employed shopkeepers, businessmen and businesswomen, and financial contributions from local groups;
- assets such as materials, livestock and land;
- individual and communal *labour and time.*

Only a small number of community-based health care projects have formally assessed the community's ability to pay for CBHC services before their inception (Stinson 1982, p.16). The Maua Programme case study was not one of them. The decision on the level of the registration and service fee for the mobile MCH clinic was made by the programme planners and the Igembe Health Council.

No satisfactory method has been developed to predict the potential resources of a poor community, but to improve their health conditions, all people, even poor, have some available resources, according to Jancloes et al. (1982, p.1). Carrin (1988, p.602) agreed, claiming that the lack of resources at household level is often given as a reason against community- financing. However, despite low purchasing power, there is generally a certain ability and willingness to pay for medical care. A PRICOR Study (1987, p.23) on community- financing concluded that study communities had considerable ability to pay for health care, at least in the aggregate. Russell (1995, p.220) cautions, nevertheless, that willingness to pay for health care is not synonymous with ability to pay, "because health expenditures may impose considerable costs on household consumption and investment patterns, and may start a process of asset depletion and impoverishment". Russell (1995, p.229) cites surveys which found that over half of rural households in Sierra Leone (56%) and Kenya (59%) and a third of rural households in Tanzania (32%) did not have cash available for care.

In the Maua Programme community resources and household income were discussed in previous chapters, along with the seasonality of production. The remainder of this chapter focusses on the form of payment in relation to the various types of community-resources and community-financing methods.

PERSONAL SERVICE FEES

Personal service fees and user fees are basically synonymous terms in relation to financing of health services. User fees have become more prominent as a method of mobilising resources from inside the public health sector, and as community-financing of low-level services (McPake 1993; Creese 1991; Griffin 1988; de Ferranti 1984). User fees as a method of public health sector financing in Kenya has been examined also (Ellis 1987; Mwabu and Mwangi 1986).

Within the Maua Programme, personal service fees consisted of the KSh 25 registration fee for the mobile MCH service and, thereafter, a fee of KSh 2 for MCH and family planning services. Except for oral contraceptives, drugs are not provided as part of the service. Mothers attending the mobile clinic were supposed to pay the registration or clinic fee on the day they received the service. The procedure for women who did not have the fee was that they must be identified by their respective CHV who became their referee. They were then expected to repay it no later than at the next monthly clinic visit. For some very poor and destitute cases, CHVs or health committee members provided the KSh 2 fee.

The Maua Programme services were not the type usually recommended for personal service or user fee coverage. One of the eight principles underlying user fees for health services recommended by Ellis (1987, pp. 996-997), based on Kenya was,

> "...No fees should be charged for services with strong `public good' characteristics. For example, most vaccinations and preventive care should be free, along with prenatal care, health education, and health promotion. The benefits of these services extend by reducing disease transmission or preventing diseases that have higher curative treatment costs at later dates."

Nevertheless, because of the necessity to recover costs, even public good health services must be charged for within the Maua Programme. This situation is faced by other church mission, NGO and private health providers. An informed community, however, is in a better position to make choices and to be supportive of the service, particularly if it designed to assist the community. Jancloes et al. (1985, p. 103) stated that local financing directly by the beneficiaries fostered a spirit of self-reliance, with a decentralization of decision-making.

Eighty-eight percent of the household respondents (N=365) were either aware of the KSh 2 monthly fee (64%) or the KSh 25 registration fee (24%) (Table 73).

Table 73: Awareness of Mobile Clinic Fee

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*365*	*64*	*30*	*25*	*65*	*56*
1. KSh 2 (%)	64	59	70	40	68	66
2. KSh 24 (%)	24	30	17	4	17	28
3. More than KSh 24 (%)	8	3	3	40	11	2
4. KSh 5 - 20 (%)	4	8	10	16	4	4
Total (%)	100	100	100	100	100	100

Respondents least aware of the mobile clinic fee were from Kangeta where the service is not provided. Moreover, thirty-six percent of the household respondents (N=324) were aware of the main purpose for the fee, `fuel for the vehicle' (Table 74).

Table 74: Awareness of Reason for Mobile Clinic Fee

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*324*	*59*	*29*	*13*	*58*	*50*
1. Fuel for vehicle (%)	36	41	48	8	39	22
2. No idea (%)	19	17	10	46	21	18
3. Registration card (%)	15	22	10	38	12	20
4. General maintenance (%)	13	3	17	0	9	32
5. Improving other projects (%)	10	14	14	8	19	6
6. Lunch for staff (%)	2	2	0	0	0	0
7. Other (%)	5	1	1	0	0	2
Total (%)	100	100	100	100	100	100

An additional 30% stated one of the other purposes, i.e. registration card (15%), maintenance of clinic facility (13%), lunch for health workers (2%). However, none of the household respondents were aware that the income was used for rewarding CHVs at Christmas time through a gift by the health committee. Awareness of the reasons for the personal service fee and how the proceeds were being used could be one of the reasons for the willingness of people to pay for this type of health service.

Jancloes et al. (1982, p.377) claimed that people would be willing to pay for services which they perceived to be useful and for which a concrete product was provided in return, such as common drugs and vaccines. Ninety percent of household respondents (N=455) in the Maua Programme said that people were willing to pay for health services (Table 75).

Table 75: Willingness to Pay for Health Services

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*455*	*67*	*30*	*95*	*70*	*60*
1. Yes (%)	90	94	90	92	91	90
2. No (%)	10	6	10	8	9	10
Total (%)	100	100	100	100	100	100

When asked what type of health services, 38% of household respondents (N=384) mentioned general health services, which probably referred to curative-oriented services (Table 76).

Table 76: Types of Health Services

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*384*	*57*	*26*	*85*	*60*	*50*
1. General health services (%)	38	26	50	34	40	56
2. Medical check-up/exam (%)	21	26	23	28	23	4
3. Drugs (%)	13	16	11	17	13	10
4. Clean water(%)	8	5	0	5	10	12
5. Mobile clinics (%)	8	11	8	1	5	14
6. Hospital care (%)	4	7	4	2	7	2
7. Health education (%)	4	7	0	7	0	0
8. CHVs home visits (%)	3	2	4	5	2	2
9. Antenatal care (%)	1	0	0	1	0	0
Total (%)	100	100	100	100	100	100

Other respondents were more specific regarding curative services, stating medical examination (21%) and hospital care (4%), while 13 percent said drugs. Responses associated with health promotion were mobile clinics (8%), clean water (8%), CHVs home visits (3%) and health education (4%). Respondents from Kirindine (56%) and Kilili (50%) were especially interested in just receiving general health services from any contributions which they would make. Mobile clinic services were cited most by Kirindine respondents (14%).

The tradition of paying for health services had been twofold in the case study area. The first was for treatment from a traditional healer and the second was for medical services provided by the Maua Methodist Hospital. Regarding the former, it was not an objective of this study to determine the nature and extent of traditional healing practices in the case study area. However, all CHVs, HCMs and local leaders interviewed (N=10) stated that some community members did go to traditional healers for treatment. A CHV from Kiengu said, "Few people attend the services of traditional healers, but the old generation still go." A local leader from Athiru Gaiti estimated that, ..."one out of a hundred pay for traditional healers." Those who go to healers pay heavily, according to a health committee member from Kiengu.

A traditional healing clinic was located in Kiengu. It also offered a mobile traditional healing service which utilised a long-wheel base 10-seat Landrover. It must be one of the few, if only, mobile traditional medical services in the country. The practice was reported

to be thriving, and proven so, by its ability to operate and maintain a Landrover vehicle. The vehicle could be seen operating as far away as Kirindine, a distance of over 18 kilometres from Kiengu. It was not possible to obtain a schedule of fees and charges, but the researcher was informed of a patient in Kirindine who paid KSh 800 for treatment of amoebiasis.

In the Maua Programme case study the willingness of community members to pay for and contribute towards the delivery of a health service, which was basically preventive and promotive in nature, was borne out by the attendance figures for the Maua Programme mobile MCH service (Chapter 8, Tables 25-28).

Besides the demand for these services, the quality of the service no doubt favourably influenced the community's willingness to pay. Perceptions of quality of service vary. A health professional was likely to judge quality of a medical service on the basis of the quality of inputs used to provide that service. A consumer's judgment was likely to be based on perceptions of medical results after using a particular service or on the manner in which the health personnel interacted with patients (Jancloes 1985). Another perception of quality of care can be related to the difficulties in accessing health services. Distance (31%), lack of drugs (24%), lack of transport (18%) and waiting time (16%) were the main difficulties identified in seeking health services by household respondents (N=442) (Table 77).

Table 77: Difficulties in Seeking Health Care

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*442*	*62*	*31*	*93*	*70*	*60*
1. Distance (%)	31	39	53	22	37	20
2. Lack of drugs (%)	24	16	11	37	18	25
3. Lack of transport (%)	18	18	7	10	23	23
4. Waiting time (%)	16	16	7	30	16	7
5. All listed (%)	8	5	18	0	0	25
6. Lack of funds (%)	2	6	4	1	0	0
7. Poor services (%)	1	0	0	0	6	0
Total (%)	100	100	100	100	100	100

Distance was a major difficulty in seeking health care cited by Kilili respondents (53%), reflecting the remoteness of this particular sub-programme. Lack of drugs was mentioned most by Kangeta respondents (37%), probably based on their experience with the government Kangeta sub-health centre. They also cited waiting time (30%) more than other sub-programmes (16%).

COMMUNITY LABOUR

One of the main ways communities participate in community development projects is through voluntary labour. This has been traditional practice in Africa - local citizens coming forward to offer their labour to assist their relatives and neighbours for the betterment of their community and its environment. There was coercion, however, during tribal rule and colonialism for community members to provide labour for community projects and activities which was discussed in Chapter 3. Even currently in Kenya, the local administration, in the form of chiefs and assistant chiefs, can exert pressure on community members to help with road construction, building of schools, clinics. But no punitive action occurs for not participating.

Stinson (1982, pp. 26-28) cited various ways community labour can be applied towards health development, based on his review of primary health care projects. Among these were health facility construction and maintenance, provision of services by volunteers, and exchange of services. This section examines these aspects of community labour in the case study area as well as willingness of community members to participate in health-related communal labour activities.

Health Facility Construction and Maintenance

Examples of community construction efforts for health facilities abound and, often communities are responsible for routine maintenance of facilities they have built (Stinson 1982, p. 27). In the Maua Programme area, community labour was a common way people participated in community projects by helping construct health facilities and being involved in their maintenance. A CHV from Kirindine related that, "Community members helped in carrying stones for cementing in the construction of the health post at

Mukiokiama (the site of the mobile clinic visits)." Another example was provided by a Kiengu health committee member who said, "Some local craftsman assisted in constructing the mobile clinic building in Kiengu free of charge."

This latter comment helps explain why community labour has been included as an important type of community finance. The cost of skilled labour for capital construction projects would be prohibitive to most communities. When it is provided voluntarily, the construction costs are reduced significantly. Community members in the Maua Programme area have demonstrated generally that they did provide community labour for the construction of health posts for the Maua mobile clinic services. Only one percent of household survey respondents (N=434) said that they would be not be willing to help construct a health post or staff house for a health worker.

Nevertheless in the Kangeta area, the experience has been a different one regarding community labour for maintenance of the Kangeta Sub-health Centre. This health facility, although staffed and operated by the government, is technically a Harambee health facility which means that the Kangeta community was responsible for its maintenance. However, the local administration had not been able to organise community labour for construction of three latrines for the three new staff houses which were built through a grant from Plan International. The staff houses had been ready for occupancy for approximately six months. The maternity wing of the sub-health centre was converted into staff quarters awaiting completion of the new staff houses. This meant that maternity services could not be provided, even though the appropriately trained staff were available. The responsibility for this dilemma also rested with the local administration, besides the community, but it does point out that community labour is not necessarily a straightforward matter. Leadership and organisational skills are required to capitalise on people's willingness to contribute their labour for community development projects.

Provision of Services by Volunteers

Most community-based health care programmes like the Maua Programme, rely on unsalaried community volunteers for the provision of some basic health promotive services

and health education (Ofosu-Amaah 1983; de Zoysa and Cole-King 1983). This has been the case for most CBHC programmes in Kenya, where community health volunteers are usually part-time workers.

The Kenya National PHC Guidelines did not specify whether community health workers should be full-time workers or part-time volunteers (Bennett and Maneno 1986, p.64). For the former they recommended various options for generating the necessary remuneration in cash income, i.e., local taxation, cash recovery of drugs, income-generating activities, and county council assistance. Rewards for part-time volunteers, according to the PHC Guidelines, could include gifts in kind, a certificate or a first aid kit.

As stated previously, CHVs in the Maua Programme are rewarded officially by their health committees at Christmas time with a gift such as cooking pots, a jembe or hoe, or a blanket. The decision on what to give was made by the Igembe Health Council. The main source of funds for purchasing the gift was from the KSh 2 fee collected at the monthly mobile MCH clinics. As described above, a KSh 40 dues from the total collected must be remitted monthly to the Igembe Health Council. One of the major difficulties with the Kangeta sub-programme was that they did not have this source of funds since the mobile MCH clinic did not operate there as the area was served by the government sub-health centre.

Awareness of the reward mechanism amongst household survey respondents (N=424) was ascertained (Table 78).

Table 78: Awareness of CHV Reward

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*424*	*62*	*30*	*92*	*68*	*52*
1. Nothing (%)	48	36	57	59	50	54
2. Materials (%)	22	23	23	20	18	2
3. Don't know (%)	18	29	7	9	22	29
4. Salary (%)	7	5	10	5	10	4
5. Food (%)	3	3	3	7	0	8
6. Other (%)	2	4	0	0	0	3
Total (%)	100	100	100	100	100	100

Forty-eight percent of household survey respondents said that CHVs received no reward for their work for communities, and 18 percent admitted they did not know of one. Only 22 percent of respondents cited materials as the type of reward for CHVs.

Ninety-three percent of household respondents (N=416) said that they believed CHVs should be receiving more rewards (Table 79).

Table 79: Household Respondent Attitudes Towards CHV Reward

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*416*	*62*	*27*	*90*	*66*	*53*
1. More needed (%)	93	97	100	94	85	93
2. Fewer needed (%)	5	3	0	4	11	7
3. No idea (%)	2	0	0	1	4	0
Total (%)	100	100	100	100	100	100

Some dissatisfaction with CHV performance in Kiengu could be interpreted by the fact that 11 percent of respondents believed fewer rewards were needed.

The main reason, stated by 57 percent of household respondents (N=296) for more rewards, was because of the good work, services and education on health they were receiving from CHVs (Table 80).

Table 80: Reasons Why Household Respondent Believe CHVs Should Receive More Rewards

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*296*	*48*	*25*	*63*	*33*	*46*
1. Good work (%)	57	63	48	59	61	54
2. Helpful (%)	10	15	0	10	18	4
3. Devotion (%)	13	8	16	10	9	26
4. Sacrifice (%)	12	6	28	13	3	11
5. Serve as an incentive (%)	5	6	8	8	9	4
6. Other (%)	3	2	0	0	0	1
Total (%)	100	100	100	100	100	100

Twenty-five percent said because of the sacrifice (12%), devotion, commitment and hardship (13%) which CHVs faced in their work. The fact that a reward or more rewards would provide an incentive and more work by CHVs was expressed by 5 percent of household respondents.

Ninety-four percent of health committee members, local leaders and Maua programme staff (N=32) agreed that CHVs should be receiving more rewards. Over half (54%) believed so, because they are doing good work (Table 81).

Table 81: HCMs, Local Leader, Programme Staff Attitudes Towards CHV Reward

No of respondents: 32	
1. Doing good work	54 %
2. Form of motivation	23 %
3. Need compensation	23 %
Total	100 %

Two other reasons were stated, one being that increased rewards would further encourage and motivate CHVs to work harder (23%), and the other that they are leaving their own work unattended and need some compensation for this lost of time (23%).

Nevertheless, some respondents (6%), including one of the Maua programme staff, felt that they should not be receiving more rewards. She said, "When they were trained they were told the work they are doing is quite voluntary." That attitude was also shared by 20 percent of CHVs interviewed (N=10) when asked if they felt they should be receiving more rewards. A CHV from Kilili stated, "He is serving his own community to foster health development, God will reward him." A somewhat less religiously-oriented

response from a CHV from Kiengu was, "I volunteered to serve the community and I do not expect any rewards." Nevertheless, the majority (80%) of CHVs interviewed (N=10) felt that they should receive more rewards. The main reason was because of the hard work they are doing. Other reasons were to feel motivated and the need to be compensated for the time they devoted to their duties. Of the five percent (N=22) of household respondents who felt CHVs should not get more rewards, the main reason (92%) was that the CHVs were not working hard and were lazy.

Money was the predominate form of reward recommended (76%) by household survey respondents (N=405) (Table 82).

Table 82: Recommended Form of Reward Payment

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*405*	*62*	*30*	*86*	*62*	*48*
1. Cash (%)	76	71	76	84	77	77
2.Anything (%)	11	10	17	5	10	17
3. Clothes (%)	7	7	0	9	11	0
4. Foodstuffs (%)	3	7	7	2	0	4
5. Materials (%)	2	2	0	0	2	0
6. Other (%)	1	3	0	0	0	2
Total (%)	100	100	100	100	100	100

Eighty-two percent of HCMs and local leaders (N=17), and eighty-three percent of CHVs (N=12) also recommended money as the form of the reward.

Forty-eight percent of household respondents (N=443) stated that the government should provide the reward (Table 83).

Table 83: Who Should Provide CHV Reward

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*443*	*67*	*30*	*89*	*67*	*59*
1. Government (%)	48	45	50	51	52	37
2. Community (%)	28	27	13	30	25	41
3. Maua hospital (%)	14	18	27	11	11	14
4. Health Committee (%)	10	10	10	8	12	8
Total (%)	100	100	100	100	100	100

Only 28 percent said the community. Fourteen percent said the reward should come from the Maua Hospital, and 10 percent said the health committee. There were no major variations within sub-programmes except for Kilili where even fewer community members (13%) felt the community should provide the reward, but more felt that it was the place of Maua Hospital (27%). On the other hand 95 percent of household respondents (N=413) claimed that they would be willing to contribute to the reward.

Eighty-eight percent of CHVs, HCMs, local leaders and Maua programme staff (N=41) felt that it was the community which should be providing the extra rewards to CHVs since it was the community which was being served. "The community should provide the reward since they selected them and they are serving them," said a local leader from Kirindine. Seven percent felt that the Maua programme should provide the reward. One reason was financially-related, "My community is not mature enough to pay us," according to a CHV from Kilili, while the other reason was programmatic. "Maua programme staff are the people knowledgeable about the value of my work," said a CHV from Kiengu.

The main reason why household respondents (N=383) were willing to contribute for rewards for CHVs was for personal benefit and help (47%) (Table 84).

Table 84: Reasons for Willingness to Contribute to CHV Reward

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*383*	*48*	*22*	*88*	*64*	*42*
1. Benefit, help (%)	47	56	50	44	38	62
2. Community welfare (%)	23	19	36	33	22	19
3. Health promotion/dev (%)	12	6	9	15	14	5
4. Satisfaction (%)	6	2	5	2	11	10
5. More services (%)	6	10	0	3	5	2
6. Incentives to CHVs (%)	4	6	0	2	9	0
7. Other (%)	2	1	0	1	1	2
Total (%)	100	100	100	100	100	100

Importantly, 23 percent expressed a willingness to contribute for the welfare of the community while another 12 percent cited a related reason, health promotion and development. This feeling of community spirit was cited most in Kilili (36%) where

hardship can be a bonding factor for community members. Very few responses related to CHV-specific issues, such as to encourage the CHVs (4%) and because of their satisfactory performance (6%).

It is highly unlikely that the Government of Kenya will provide any salary for full-time CHWs or reward to part-time volunteer CHWs as proposed by just under one half (48%) of household survey respondents (Table 85). Walt (1988, p.4) states that in many countries it is the Ministry of Health that pays the CHW salary or honorarium, even if it is through another agency such as a district council. De Zoysa and Cole-King (1983, p.128) add that a CHW paid from a central government payroll becomes, in effect, an auxiliary based in the community as an extension of the formal health services, and the burden on the government's financial resources is great. Based on a review of national experiences in the use of community health workers, Ofosu-Amaah (1983, p.25) claims that the amount of the resources from both the state and the community that would be needed to maintain a fully-fledged national CHW programme is not evident. Nevertheless, the position regarding community-based health care in Kenya is that the responsibility should rest with the community for rewarding its volunteers for the services they are rendering, the position taken by almost one third of the household survey respondents (28%) (Table 83).

AD HOC CONTRIBUTIONS AND FUND-RAISING DONATIONS

Many communities generate primary health care resources through personal donations and special fund-raising events. In Kenya the latter are called Harambee which were discussed in Chapter 4. The donation of materials is usually related to construction and includes timbers, door frames, window frames and iron sheets for schools, churches and clinics. This was the case for the Maua Programme health posts constructed at Kiengu, Kilili, and Mutiokiama (Kirindine) and Athiru Gaiti. The land was donated either by individuals or communal land was allocated by the village elders. Only seven percent of household respondents (N=439) indicated that they would not be willing to donate materials or any land for community health projects.

The nature of the donation which household respondents (N=422) claimed they could contribute was mainly construction-related (41%), e.g., iron sheets, timbers. Twenty-seven percent of respondents said money and 25 percent specified land (Table 85).

Table 85: Form of Contribution to Community Health Projects

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*422*	*67*	*30*	*88*	*65*	*55*
1. Materials (%)	41	76	13	55	47	16
2. Money (%)	27	6	13	32	26	37
3. Land (%)	25	15	64	11	22	38
4. Anything (%)	4	3	0	0	0	7
5. Foodstuff (%)	2	0	10	1	3	2
Total (%)	100	100	100	100	100	100

The sub-programmes varied considerably in their preferences. Only 13 percent and 16 percent of respondents from Kilili and Kirindine respectively indicated materials, whereas 64 percent and 38 percent from these two sub-programmes said land. This would be logical for Kilili where an abundant amount of unproductive land is available, but it was a surprising response for a high potential area like Kirindine. This latter point held true for Kangeta where only 11 percent indicated land. Household respondents from Athiru Gaiti showed a preference for donating materials (76%). This could be because this area is still heavily forested and timber can be donated without any major financial outlay by the household.

PRE-PAYMENT SCHEMES

An alternative community-financing scheme to personal service fees and donations for provision of volunteer labour or ad hoc contributions is pre-payment schemes. The principle is that people pay for health services and activities on a regular basis before they are needed or before they become sick. Costs and risks of sickness are shared among all participating members, regardless of individual use. According to Stinson (APHA 1982, p.24), the most common objective of pre-payment schemes is to cover health worker salaries and drug costs. Most of the thirty-one pre-payment schemes reviewed in the APHA study also charged service fees and sold drugs, usually at reduced rates for subscribers and full rates for non-members.

Pre-payment schemes can be based either on individual or household payments, or they draw on the resources of a marketing or production activity. For personal pre-payment schemes, cash or in-kind resources are collected directly from beneficiaries. Production-based pre-payment relies upon marketing levies, taxes, or other such mechanisms for deriving the surplus accumulated by productive enterprises and may be supplemented by contributions from workers, through payroll taxes, and governments. Production-based pre-payment schemes have not been as popular a form of community-financing for health services as personal pre-payment.

Pre-payment schemes are not always easy to initiate in rural areas where most people are too poor to afford them, and the poor have more pressing difficulties to take care of, such as food, clothing, shelter and income (Abel-Smith and Dua 1988, p.98). Fluctuating income due to agricultural seasonality can also hamper people's ability to participate in pre-payment schemes. This affects both cash and in-kind contributions. Experiences of pre-payment schemes within CBHC programmes in Africa are limited (Mandl et al. 1988, p.19) but, in India, Dave (1991, p.30) claims that pre-payment/insurance schemes were an important source of funding for community-based health care. The Health Card Programme in Thailand constitutes a community-based insurance system supported by the establishment of revolving funds for village development. Korte et al. (1992, p.6) claim that such risk-sharing schemes in low-income communities cannot be isolated from other community development activities. Abel-Smith (1991, pp.196) states that it still has to be shown that voluntary local pre-payment schemes can make a major contribution to health financing. He adds that their main purpose might rather be to develop greater participation in health matters at the local level which is a step towards empowerment.

The potential for the personal pre-payment scheme was explored as part of the Maua Programme household survey and in consultation with CHVs, HCMs and local leaders. The issues examined in the study were willingness to contribute regularly, the amount of that contribution, expectations from participation in the scheme, and its feasibility.

As a stating point, household respondents were asked if they would be willing to pay a monthly fee into a fund operated by the health committee which would support the work of CHVs and health projects. How the fund would operate, in particular, who would collect the funds, and the mechanism of collection was not explained however. Nevertheless, 95 percent of the household respondents (N=453) stated that they would be willing to participate in a personal pre-payment scheme. Eighty-four percent of CHVs, HCMs, and local leaders (N=70) also felt that community members would be willing to participate in a personal pre-payment scheme involving monthly contributions. One reason expressed by one third of CHVs, HCMs and local leader respondents was because community members appreciated the work of CHVs. Personal benefit to the community member was another main reason (28%) why they felt people would be willing to contribute regularly.

CHVs, HCMs, and local leader respondents from Kangeta and Kilili, however, were less certain. Only 50 percent felt that community members would be willing to contribute on a regular monthly basis. The main reasons were lack of cooperation within the community and lack of income. The CHV leader from Kangeta said, "It is not likely that community members would support such a scheme. Many people are not cooperative because community members are influenced by politics regarding donations or contributions." A Kangeta health committee member told the researcher, "So far they can't accept such a scheme, because this programme has entered into a lot of kitchen politics. But if there is proper leadership from the assistant chief they can contribute." Lack of funds was expressed as a reason by a local leader from Kangeta, saying, "This looks hard since most of the members in the community have no sources of income or are not employed." This was a more understandable reason for Kilili which is a low potential area. A CHV from Kilili said that, "Although some would be willing to participate in such a scheme, they would have problems in getting the money to pay on a monthly basis since the food crops are unreliable, for instance, like now when they are worried because crops seem to be wilting due to the failure of rains to come in time."

Nevertheless, twenty-six percent of household respondents (N=432) stated that they could contribute KSh 10 on a monthly basis and 18 percent claimed that they could contribute KSh 5. Fifteen percent of household respondents indicated a more realistic amount of between KSh 1-4 per month (Table 86).

Table 86: Monthly Pre-payment Scheme Contribution

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*432*	*60*	*19*	*91*	*63*	*47*
1. KSh 10 (%)	26	30	11	29	33	28
2. KSh 5 (%)	18	18	26	19	24	21
3. KSh 20 (%)	15	20	11	16	16	24
4. KSh 1 - 4 (%)	15	2	11	20	16	11
5. KSh 50+ (%)	15	20	15	2	1	4
6. KSh 30-50 (%)	10	10	26	12	7	12
7. KSh 15 (%)	1	0	0	2	3	0
Total (%)	100	100	100	100	100	100

Kangeta is a high potential cash crop area yet more respondents from there (20%) than any other sub-programme indicated that they would only be willing to contribute between KShs 1-4 monthly. This is probably because the CHV programme has been the weakest in this sub-programme. Surprisingly, over half (51%) of the respondents from Kilili claimed that they would be willing to contribute KSh 30 or more on a monthly basis. On the one hand, this response could reflect the need for medical services, but the amount represents an unrealistic level in relation to the agricultural ranking of this sub-programme area. Overall, a comparably significant number (15%) of household respondents claimed they could contribute KSh 20 on a monthly basis.

Thirty-four percent of CHVs, HCMs and local leaders (N=47) felt that community members were capable of affording KSh 10 for a monthly pre-payment scheme, while 18 percent said KSh 5 (Table 87). Nearly a quarter of respondents (23%) believed community members could afford between KSh 15-30 per month.

Table 87: Pre-payment Scheme Contribution Estimated by CHVs, HCMs, Local Leaders

No. of respondents: 47	
1. KSh 10	34 (%)
2. KSh 15-30	23 (%)
3. KSh 35 -50	19 (%)
4. KSh 5	18 (%)
5. KSh 55 - 80	6 (%)
Total	100 (%)

Assuming that KSh 10 would be a representative amount based on the findings, this would mean 10 percent of the monthly income for 40 percent of the household respondents who declared that their cash income was KSh 100 per month (Table 38, Chapter 9).

The APHA study (1982, p.24) stated that only a few projects related premiums to average household income and, also remarked that, on the whole, membership premiums for the personal pre-payment plans appear low, for instance, 0.25 to 0.50 percent of monthly income for the Voluntary Health Service project (India). A more realistic amount for the Maua Programme would be closer to the amount charged for the mobile MCH clinic which is KSh 2. This would still represent 2 percent of monthly income for households with a monthly cash income of KSh 100. Which services these amounts would cover would depend of course on enrolment and the nature of the services being provided.

Expectations from the pre-payment scheme contributions were assessed. Thirty-four percent of household survey respondents (N=389) stated that they would expect better health services (Table 88).

Table 88: Expectations from Pre-payment Scheme Contribution

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*389*	*61*	*23*	*85*	*61*	*49*
1. Better health services (%)	34	44	39	21	38	29
2. Govt help (%)	26	10	0	55	25	16
3. Free drugs (%)	15	18	31	2	11	29
4. CHV advice/services (%)	9	2	13	18	14	8
5. Clean water (%)	5	8	13	0	2	6
6. Nothing (%)	4	8	13	0	2	6
7. Health education (%)	3	8	4	0	3	0
8. Anything (%)	4	2	0	0	2	12
Total (%)	100	100	100	100	100	100

Twenty-six percent said would expect some form of government help and assistance in health care. This was mainly felt by Kangeta respondents (55%) which had a government health facility. Fifteen percent of household respondents said they would expect free drugs, while in Kilili (31%) and Kirindine (29%) this was a dominant expectation. Encouragingly, 9 percent claimed that they would expect either CHV advice or health services. This was particularly so for Kangeta (18%), Kiengu (14%) and Kilili (13%) sub-programmes.

In order to determine what household survey respondents meant by better health services, they were asked what type of services they expected and from whom. Sixty-two percent of household respondents (N=215) said medical services which would include treatment and presumably drugs, but 28% of respondents cited health education. (Table 89).

Table 89: Types of Services Expected from Pre-payment Scheme Contribution

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*215*	*21*	*9*	*62*	*45*	*14*
1. Medical services (%)	62	62	89	60	60	79
2. Health education (%)	28	29	11	36	29	7
3. Any service (%)	10	9	0	3	11	14
Total (%)	100	100	100	100	100	100

Kilili respondents (89%), along with those from Kirindine (79%) expressed a need of more medical services than health education. Lack of access to a health facility was a particular difficulty for Kilili households.

In regard to who should be providing the services, CHVs were the main health providers mentioned by 34 percent of household respondents (N=218), while an additional 7 percent said the health committee (Table 90).

Table 90: Providers of Services Expected from Pre-payment Scheme Contribution

	Overall	Athiru Gaiti	Kilili	Kangeta	Kiengu	Kirindine
No. of Respondents	*218*	*22*	*8*	*62*	*47*	*12*
1. CHVs (%)	34	14	13	39	38	25
2. Govt health workers (%)	26	58	75	16	15	42
3. Maua hosp/proj mgt (%)	18	5	12	18	19	17
4. Health educators (%)	14	23	0	18	13	8
5. Health committee(%)	7	0	0	7	15	8
6. Other (%)	1	0	0	2	0	0
Total (%)	100	100	100	100	100	100

Twenty-six percent of household respondents mentioned government or ministry of health workers and 18 percent said Maua Hospital or programme management staff. A further 14 percent said health educators which could have included either of the three options - CHVs/HCMs, government or programme staff - but what was interesting was the implication that the service was for health education. Respondents from Kangeta (39%) and Kiengu (38%) perceived CHVs as the main provider of the health services they would expect from their pre-payment scheme. This means that expectations are still high in Kangeta for a CHV programme, even though the current programme was struggling. Respondents from both Kilili (75%) and Athiru Gaiti (58%) seemed to prefer having

government health workers rather than CHVs as the health service providers for a pre-payment scheme.

Abel-Smith and Dua (1988, p.99) observed that in some places, people were less willing to pay for moderately trained community health workers, for which most community-financing was at present being used, than for health workers with a full professional training. Moreover, there was generally more willingness to support curative than preventive activities. The Maua Programme findings offered an interesting dichotomy. On the one hand they supported Abel-Smith and Dua's point regarding curative services, with 62 percent of respondents expecting medical services from their monthly contributions (Table 91), but on the other hand, community health volunteers, who are just moderately trained, were mentioned as the main type of health worker (34%) to provide these medical services (Table 92). Their role and training, discussed in the previous chapter, did not include provision of medical services.

The majority (86%) of CHVs, HCMs, and local leaders (N=50) felt that a personal pre-payment scheme would be feasible. Eight percent were less certain, while 6 percent did not feel that it would work. The majority of that dissenting group were from Kangeta. For those who did not believe it was feasible their reasons were similar to those given earlier in response to why some people might not be willing to contribute, e.g., lack of cooperation among community members, poor leadership from local administration and lack of income.

The CHVs, HCMs, and local leaders (N=43) who were optimistic that a personal pre-payment scheme would be feasible, stated that it would be dependent on certain conditions. The one most stated was good management and leadership from CHVs and HCMs, the local administration and the programme staff. A health committee member from Athiru Gaiti stated it this way, "If there is good management and leadership for the money not to be misused, it can be successful." A CHV from Athiru Gaiti said, "Such a programme has never been started within the community and if there is good leadership, community members can't fail to donate money." "People lack only organisation, if the

scheme is well organised it can be very possible," according to a local leader from Kilili. The assistant chief from Kiengu said, "This can work if there is proper leadership and a particular person dealing with the matter."

An interesting aspect to a pre-payment scheme according to a CHV from Kirindine is that, "People will help get themselves involved through this contribution. They would then take more interest in the programme because they would expect some benefit in relation to their contributions." This would mean that contributions as part of this community-financing scheme would represent more than a mechanism of participation, but rather a process of getting people involved in health care development. As stated by the WHO Study Group on Financing of Health Services, (1977, p.11) it would give them both the right and incentive to participate in the running of the programme.

CONCLUSION

Contributing money was the main way community members said that they had participated in health projects and it represented a major form of community-financing in the Maua Programme. There was also a willingness on the part of community members to contribute labour and materials as a form of community-financing and hence participation in health activities. However, considerable organisational effort on the part of either the health committee, CHVs and programme staff is required to take advantage of these resources and to mobilise community members in this way. Indeed, an argument against community-financing is the claim that a high degree of external support is needed to mobilise and sustain community efforts.

One of the reasons why volunteering community labour, and donating material such as timber products and land appeared to be popular ways of participating in community projects in the Maua Programme was because they represented few real costs to the community members. There are however opportunity costs in donating these contributions. For example, time spent on community labour could be used for one's own agricultural efforts and timber could be sold or used for constructing or repairing one's own shelter and extra land could be used for production. Therefore, since the

opportunity costs are significant, these donations of time and labour, materials and land should not be discounted just because they represent resources of a non-monetarised nature.

The mobile MCH service, which addressed the issue of access and the difficulty of distance, provided by the Maua Programme, was supported partially by community-finance. In doing so it represented savings in transport and time to the community members for MCH and family planning services. Household survey respondents expressed a willingness to contribute towards provisions of medical services and it is reasonable to think that if other services were offered as part of the mobile service, particularly examination and treatment, including sale of drugs, community members would be willing to pay. However, expanding health services based on perceived willingness to pay must be approached with caution. Another argument against community-financing is that it tends to favour the creation of health services which are in high local demand but might not meet professionally perceived needs. Moerover, willingness to pay is not synonymous with ability to pay for health care, particularly for households which are struggling to satisfy basic needs.

In the case of the Maua Programme, it is unlikely that a sufficient amount of local contributions could be sustained through any community-financing mechanism, such as a prepayment scheme, to provide the quality of medical services community members were envisaging, e.g., treatment and drugs. What could occur is that the gains being made through the current health promotive strategy of CHVs could be undermined if a medical service-oriented community-financed scheme involving CHVs was launched which was not able to fulfill its objectives.

Household respondents were willing to contribute to the reward for CHVs, but the motivation was mainly for personal benefit and help which the CHVs might provide. However, about a quarter of household respondents claimed they would contribute for the welfare of the community. Thus, a basis existed for community-financing of a reward system which would be aimed at helping sustain the voluntary services of CHVs.

Community-financing within the Maua Programme, i.e., personal service fees, community labour, financial and in-kind contributions, did provide community members with a certain amount of control and ownership of the Maua Programme. It represented a form of community participation and, based on the level of community contributions, an important indicator of community approval of the Maua Programme.

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CHAPTER 12

CONCLUSION AND POLICY ISSUES

FACTORS INFLUENCING COMMUNITY PARTICIPATION

According to the research, the factors found to be the most influential in relation to impact on community participation in the Maua Programme were:

1) Education

The influence of formal education on participation was found to be of significant value. Local explanations were that community members with some formal education were quicker in understanding health messages, were more aware of what to do in order to stay healthy, had already received some health education through the formal education process and were more likely to set good examples and to influence others since they had some health knowledge. The number of household respondents who had some primary education (41%) was equal to those who had none (41%). Non-formal education also served as an important factor influencing participation in the Maua Programme. Various opportunities for receiving non-formal education were available in the Maua Programme. These were:

a) Attending community meetings where health was discussed;
b) Being a member of a self-help group;
c) Receiving a monthly home visit from a CHV or HCM.

2) Local group membership

Being a member of a self-help group was a strong factor in influencing participation in a community health project or activity. Local explanations were that self-help groups offered an opportunity for members to come together, to develop themselves and to exchange ideas. They provided a forum for CHVs and HCMs to present health messages and information and were a mechanism to receive information from NGOs and government sources. Moreover, self-help groups provided assistance to each other, which enabled members to practice what was being taught for health improvement, such as construction of latrines, general cleanliness, and to aid members when sick family

members needed to be taken to hospital. Church membership also provided similar opportunities.

Fifty-nine per cent of households had at least one household member who was a member of a self-help group. Reasons given why no household members were members of any self-help group were that there were no groups to join (26%), pressure of domestic duties (26%) and other commitments (23%). Thus, for a quarter of these respondents, the reasons were not related to any lack of willingness to join.

3) Household income

Forty-two per cent of household respondents claimed that they only earned up to KSh 100 per month. Forty-three per cent of respondents said household income was used primarily for food, while others identified clothes (23%) and general domestic use (10%), thus, for meeting basic needs. Twenty-two per cent said it was allocated for paying school and other fees. In many households it would appear that making contributions to development activities would be problematic and a constraint to participation, even though this was the main way respondents (68%) said they had participated in community health projects, and the main way they could best participate in the future. In reality a household's willingness to contribute might was not necessarily matched by their ability to contribute, particularly if the levels of income stated by respondents were accurate.

Local explanations on the impact of household income on participation were that community members with little income were not in a position to contribute to development projects, join self-help groups, make improvements to their households to promote better health or provide themselves with basic needs such as food or clothing.

4) Socio-domestic issues

Three sociological factors associated with household characteristics were found to influence participation. These were family size, women's time and harmony in the household. These were inter-related in that large families demand more time from women to address domestic duties and had higher financial demands for basic needs and fees

which potentially can cause more stress within the household. Excessive alcohol consumption and substance abuse (miraa) in the Igembe Division were behavioural practices which were contributory factors to disharmony in the household. Case study households which were only partly participating or not participating at all in the Maua Programme exhibited at least one or more of these socio-domestic characteristics, particularly those related to causing disharmony in the household.

5) Local institutional support

Health committees and community health workers were categorised as a local organisation. How well they enhance participation is directly related to how effective they are perceived by community members. In the Maua Programme eighty-nine per cent of household respondents believed that health committee members were doing a good job. Their role in promoting health education was the main reason given (30%). Eighty-four per cent of respondents also judged the performance of CHVs similarly. CHV's work in health promotion was cited by 42 per cent of respondents as the reason for their favourable assessment, while 33 per cent said they were pleased because of the health advice they were receiving. Over half (54%) of household respondents claimed that they were visited at least monthly by CHVs. Seventy eight per cent of household respondents claimed that they had followed the advice of CHVs regarding changing health behaviours.

The influence of the number of visits by CHVs on participation in community health projects was analysed and for respondents who were visited monthly, participation was five times greater. This compared to households which had never been visited but still participated (two times greater) and those which were visited only once a year or at long intervals (three times greater). Local explanations for this were that home visiting reminded household members of what they had been told either at clinic sessions or community meetings about health issues and it increased the speed at which they undertook health improvements. Household members appeared to be motivated to effect changes when they were visited. They also feared being questioned by CHVs on why they had not done what was advised and did not like to be found at the same stage they were at the last visit. However, the introduction of CHVs and HCMs to the sub-programme

areas did not appear to have any significant impact on increased mobile clinic attendance, but their impact could be more indirect by making the mobile service more effective by ensuring that households were aware of when the mobile clinic was visiting and by assisting with some of the administrative tasks of the service.

In order to sustain a CBHC programme which is comprised of volunteers, motivation and incentives are crucial. The main motivating factor for health committee members in the Maua Programme to carry out their role was a sense of community service in promoting health. Seeing health improvements stemming from the programme's activities and exposure to outside ideas were other reasons. For CHVs the main motivating factors for continuing to serve were similar to HCMs, those being, a sense of duty to continue to serve the community and satisfaction from seeing people adhere to one's advice, and, thus improving their health status. Knowledge acquired through training was also important. The token annual gift to CHVs at Christmas was probably more significant for its recognition value by the community of the work done by CHVs than its material value.

CBHC workers need technical support in order to increase their effectiveness. For the Maua Programme this pertained most singularly to dealing with households reluctant to participate in any of the programme activities. This was a programme management issue which needed to be addressed during both basic and in-service training and as part of on-going technical support. Many of the factors for this reluctance are related to socio-economic variables which should form part of the training curriculum and be incorporated as part of the technical support role of programme staff.

Some of the influencing factors identified in the case study programme were also identified by WHO, for example education, the relationship between group membership and participation, and the need for clear mechanisms for involving people. The Kenya PHC guidelines also identified socio-economic-cultural factors as ones which could influence community involvement, along with the education status of the community.

Factors identified by WHO and in the Kenya national PHC policy guidelines which did not have much impact in the case study programme were national policies and practices, communication, and inter-sectoral coordination. Although Kenya is a signatory to the Alma Ata Declaration and primary health care remains a health priority, government policy now stresses community self-reliance and the responsibility of the individual for their own health and well-being. Thus, the influence of national policies should be reflected rather in government's ability to meet its partnership role in primary health care development.

The issue of decentralisation of decision-making within the national health system did not effect the case study programme significantly since the main health service provider in Maua Division was the Methodist Hospital in Maua and its CBHC mobile outreach clinic service. Control of resources and specific and regular budgetary support to rural health facilities were also not major issues in the case study programme. The government sub-health centre at Kangeta and the government clinic at Kanuni appeared to be receiving the level of resources common to these facilities in other parts of Meru District. The Maua Hospital was in a position to determine and control its own allocation of resources which came from donor sources, donations and fees-for-service. Having a relatively stable financial support base was a distinct difference from government hospitals or health centres which do not have direct access to independent sources of funding to help them provide community health outreach services or supervisory technical support. This is one reason why the majority of CHBC programmes have been NGO-oriented.

Communication was a factor cited by WHO in relation to its impact on enhancing a community's readiness to accept change. The influence of communication was a relative factor among some Maua sub-programmes, but not a significant factor in influencing participation. Its importance was mainly due to the managerial aspects of enhancing participation, for example, communicating the future dates of mobile clinic visits. In the Maua Programme few household survey respondents (4%) mentioned improved communication systems as a reason for progress, while just six per cent cited population influx as having a bearing on how new ideas were introduced into the community.

There was minimal collaboration between government extension staff operating at community level and Maua Programme staff so it was difficult to assess the potential of inter-sectoral collaboration as an influencing factor in relation to participation. However, one main adverse effect was the delay in establishing and registering self-help groups caused by ineffective community development agents.

Based on the case study research, a revised composite grouping of factors influencing participation in health development programmes, particularly focused at the community level, would be:

1) Education

Educational status and literacy of the community; access to education, both formal and non-formal, facilitating cooperation and understanding.

2) Local organisations

Prevalence of local organisations such as self-help groups, church groups and their potential for an expanded role in development.

3) National policies, decentralisation, and mechanisms to involve community members

Development strategies and resource allocation to provide facilities, services, support and activities in which community members can participate and local administrative practices which provide an enabling environment for participation to occur.

4) Economic potential and household income

Economic realities, household income levels, potential for income generation schemes which all influence the capability of community members to make contributions and to have the resources to undertake promotive health measures.

5) Local institutional support

Effectiveness of health committees, community health volunteers and local leaders and their collaborative relationship with local administration, local health staff and other extension agents.

6) Socio-cultural, community attitudes and infrastructure

Social dynamics at play and influence of factors of cultural setting within communities, role of women and availability of time to participate, tradition of cooperation, readiness of community to accept change, communication network within the community.

POLICY ISSUES

Specific policy actions, related to the primary influencing factors, stand out. They are aimed at enhancing participation at the community and operational level. These policy recommendations are directed at international development agency, government and non-government organisation policy makers, health service managers, development specialists and staff involved with enhancing participation in CBHC programmes and in PHC development generally.

1) Education as a Development Priority

The influence of education on health development and participation was found to be a significant research finding as community members with some formal education participated more in health projects and activities than those with no formal education. For international and national policy-makers primary education must continue to be a major development priority as it does have an impact on the potential for general development and people's participation in development activities.

Participation can be said to be essentially an educational process. It involves information on when and how to participate in development programmes, and an awareness and understanding of how particular actions and behaviours can result in improving health status. Non-formal education is an important way health awareness can be raised. Self-help and church groups and CHVs, through home visiting, can play important roles in

providing information, raising health awareness and understanding of linkages between behaviour and health status. In rural and peri-urban areas, priority should be given to ensuring that girls receive at least some level of primary school education and that women are the main focus of non-formal education programmes.

2) Active Promotion of Strengthening, Developing and Supporting Local Groups

The research findings confirmed the importance of the role of local groups, particularly self-help groups, in promoting and enhancing community participation. The majority of community members who claimed to have participated in the Maua Programme were members of self-help groups. CBHC community representatives, local leaders, local administration authorities, health staff and programme managers should make every effort to strengthen the further development and support to self-help groups as a strategy to enhance community participation and develop their communities. This also involves inter-sectoral collaboration with community development officers responsible for promoting self-help group development.

Non-governmental organisations which have the capability to support local groups, health committees and community health volunteer cadres should assist them to develop the organisational capability to plan and manage activities, such as mobilising physical labour and contributions and operating prepayment community-financing schemes in order to capitalise on the willingness of the community members to participate in this way. The role of local government should be to cooperate with these groups as partners. These efforts require community meetings to be held which need the cooperation and clearance from the local administration. Their cooperation can be a significant contribution to the process.

3) Policy Directives Aimed at Enhancing Partnership Relations at the Community Level

International and national policy makers have called for decentralisation of decision-making as a major requirement for increased community participation. However, one of the main constraints identified in WHO's 1993 global review of PHC was excessive centralisation. It does not appear that decentralisation is occurring in any meaningful way.

Even decentralisation to the district level is still far removed from community levels and the support CBHC programmes need from the formal health service.

An alternative strategy regarding decentralisation would be policy directives from the central, provincial and district levels to local administration and local level technical ministry staff. The policy directives should stress that they must cooperate fully with local organisations and local leaders who are attempting to develop community-based programmes aimed at addressing their development needs. These directives could help enhance the establishment of viable cooperative partnership arrangements at the local levels between community-level government staff and community members.

It is unrealistic to believe that most governments in the developing world have the human or financial resources to initiate, support and supervise community level development activities. Nevertheless, with some political will they should be able to provide selected inputs in training and in facilitating community mobilisation. This in itself could influence whether a community-based programme is successful and sustainable. It will take policy directives to help initiate the establishment of a partnership relationship in the first place, and budgetary allocation of resources to support activities such as training and maintaining community level facilities to at least a minimum standard of efficiency to serve as potential focal points for community involvement.

WHO's 1993 Global Review confirmed that it was essential that a partnership relationship was developed between health services and their professionals and local people. Individual and collective leadership at community level was necessary along with sustainable mechanisms at community level to involve community members in programme activities.

4) Inter-sectoral Collaboration and Income Generation to Enable More Participation to Occur

Income is another major influencing factor in relation to people's ability to participation in health projects and activities and health behaviour change. However, financing primary

health care has been more of a concern of international and national policy makers than the area of community-financing. At Alma Ata minimal reference was made to community-financing as a form of community participation.

A combined community and government effort was recommended by WHO to finance primary health care at the local level. Ways such as social insurance, cooperatives and mobilisation of all available resources at the local level were called for at Alma Ata (WHO 1978). In order to facilitate the latter, WHO (1978) proposed that authority should be delegated to communities to establish and carry out components of PHC, that participatory mechanisms should be created and community members should be members of various health bodies, and that individuals should take responsibility for self-care and family care, mainly hygiene and nutrition. These recommendations had more to do with long-term structural and policy changes within the health system than with more immediate ways in which communities could actually start financing and sustaining community-based health care activities.

A key reason why inter-sectoral collaboration is important is because of its potential influence on enhancing community-financing. Income generation can result from actions initiated by extension officers representing agriculture, animal husbandry, rural development, credit and savings, community development. More collaboration is needed between these sectors, CBHC community representatives, and health staff with communities to focus on health-related rural development activities focused on nutrition, safe drinking water and hygiene and sanitation improvements. However, health sector staff and CBHC workers need at least some orientation training in rural development strategies and income generation in order to help recognise opportuntiies to raise the standard of living of community membes. This would then put them into a much strong position to initiate inter-sectoral collaboration.

The research findings showed that financial contributions were the main way community members participated in the Maua programme and also that there was a strong willingness to contribute physical labour and participate in prepayment schemes. Such programmes

do require organisational capability at community levels for local groups such as health committees, self-help groups, church groups. This capability can be developed through training and on-going support by the relevant government staff and NGOs.

5) Innovative Ways to Technically Support Community Level CBHC Programme Staff

CBHC programmes cannot operate in a vacuum. Technical support is necessary. However, it is unlikely that the formal health staff will be able to supervise CHVs in the field or be able to operate mobile clinics. A major contribution which they can make, therefore, is to cooperate with the local organisations, self-help groups and NGOs who are providing the first line support for CHVs and HCMs. The role of the government technically can be to provide the basic training of community health volunteers and health committee members and then later regular re-training. Health staff should recognise the role being played by CHVs and HCMs in health promotion and this partnership relationship should be apparent to the community. In fact, the community should insist on it if for some reason it is not occurring, or, if the health staff are not fulfilling their partnership role. The technical supervision can come through CHVs and HCMs interacting with health staff at the local health facility as part of training, however, they must be welcomed and accepted there by the health staff.

Kenya national policy guidelines cited various ways in which communities could participate in health development programmes which involved an active partnership relationship between community members and their representatives and health units. This can only occur, however, if community members are encouraged to visit health facilities to assess what assistance they can provide, to cite a specific example.

A major concern is whether the local health facility and its staff can function as a focal point for community involvement. The main problem facing the delivery of rural health services in Kenya during the 1980s was the low standard of services provided at health facilities (Bennett and Maneno 1986). If rural health services are severely under-resourced by government and mismanaged and staffed by a demoralised cadre of health workers then they will not serve that focal point role. Re-orientation training on the

dynamics and process of community participation will have to be done for district and peripheral level health staff. This point has been stressed by the WHO CIH Study Group (1991) which stated that health personnel must have a sound theoretical understanding of CIH and be equipped with a socio-anthropological understanding of communities and how they function, what binds people together, and prevents the kind of collaboration that CIH seeks to promote.

Another important area for re-orientation training is the appreciation of the benefits of a partnership relationship between government health workers and communities which, according to a former Senior Deputy Director of the Kenya Medical Services, is lacking (Willms 1984). Nevertheless, if government is not going to provide the necessary resources in order for peripheral health facilities and staff to serve as focal points for participation, the value of re-orientation training is questionable. Moreover, health workers cannot realistically be expected to promote community participation in a health system which is not oriented towards community activities.

The value of CHVs in encouraging and coaching community members to participate in health care activities and particularly behavioural change was demonstrated in the research findings. Significantly more community members participated in the Maua Programme who had received regular monthly visits from CHVs than those who had not. As stated above, the motivation for HCMs and CHVs in the Maua Programme was a sense of community service and satisfaction of seeing health improvements. This was not related necessarily to any church mission influence nor was it NGO-specific. Therefore, this motivational and sustaining factor for HCMs and CHVs could exist in non-NGO CBHC programmes, if other CBHC components were in place.

6) Appreciation of the Impact of Socio-Economic-Cultural Factors on Participation

From the research findings and, particularly the case study households, a case can be made that socio-economic-cultural factors within a community have a definite influence on levels of participation. A finding by WHO (1981) was that community participation never began effectively prior to communities reaching a certain threshold in economic, social and

educational development. Moreover, the level of development was a determining factor in relation to the capability of communities to shoulder part of the financial burden of health development (WHO 1978). In Latin America (PAHO 1984) it was found that certain community characteristics were essential for the success of community participation. These were a common need for basic services including health as priority need, a history of success in achieving goals through community action, an existence of an organisational structure through which action can occur, a relatively high level of education which facilitated communication and understanding, adequate communication and transportation facilities in place and the presence of dynamic leadership and community consciousness.

An awareness and understanding of the inter-relationships and impact of socio-economic and cultural factors on participation in health development is essential. It re-enforces the need for much more inter-sectoral collaboration. However, the issues are complex and thus require close consultation between CBHC workers, local leaders, those community members who are in vulnerable situations, and programme and health service staff. Health sector staff and CBHC workers will need to take a broader developmental approach to their work if they are to be successful in addressing socio-economic issues. A starting point would be at least having orientation training on how these factors influence people's participation and what are some of the strategies to help overcome those which are negative and to build on those socio-economic and cultural factors which are positive.

The question that remains is whether some minimum standards are necessary for community participation to occur in health development. It is probably correct to assume that there must be at least some minimum level of development in each of the six essential influencing factors identified by this study before a CBHC programme is viable. The overall level of community participation would then be determined by the degree of development within each. As was demonstrated in the case study households the level of individual household participation would be determinant upon how many of the influencing factors are of a positive nature.

Development is a process and it is crucial that CBHC programmes build upon those influencing factors which are positive and prioritise and direct resources to strengthen those which are negative. Enhanced community participation in health development is achievable if policy makers and programme planners and managers target and address the various influencing factors when developing CBHC programmes in full partnership with communities. There is a strong willingness amongst individuals and local groups in most communities to develop and improve their standard of living. What is needed are selected inputs from key partners as part of the development process.

The research undertaken in this study was unique and original in that it focused solely on examining the issue of factors which enhance or impede participation in rural health development. The study combined both secondary research with field research methods, the former being a historical review of factors evolving during the colonial era in Africa and identified by the World Health Organization, along with a case study approach involving a rural community-based health care programme in Kenya. No other known field research study of this nature or size had been carried out in this type of developing country setting prior to this study, nor had any other research study examined participation from a historical perspective during the colonial era in Africa or within the World Health Organization.

The study results have contributed to and enhanced the body of knowledge in the literature on the socio-economic and institutional factors which potentially influence people's participation in rural health care development programmes. The research findings have identified in particular the importance of education, group membership and regular monthly visits by CHVs as key factors which enhance the potential of a community member's participation in rural health development activities. The study has demonstrated the complexity of participation as a development strategy and the importance of understanding the inter-relationship between the various influencing factors. For instance the case study households have shown that a combination of enhancing factors such as institutional support through regular home visits by a CHV and self-help group

membership can help overcome impeding factors such as no formal education and low income.

The issue of participation in health development has been a major concern of international agencies such as the World Health Organization, UNICEF, national ministries of health, and international and national non-governmental organisations over the past twenty years. This research study has added to the understanding of the dynamics of participation at the community operational level. This should enable more effective strategies, aimed at enhancing community participation, to be developed by government ministries and developmental agencies in collaboration with the communities concerned.

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APPENDIX 1

HOUSEHOLD SURVEY QUESTIONNAIRE

A. DEMOGRAPHIC AND GENERAL INTEREST INFORMATION

1. Village

2. Sub Location

3. Location

4. Name of person to be interviewed

5. Sex: 1 Male, 2 Female

6. Age

7. Ethnic group: 1 Meru, 2 Other

8. Marital status: 1 Single, 2 Married, 3 Divorced, 4 Widowed, 5 Separated

9. Are you the head of the household? Yes No
   If person interviewed is not head of household, circle relationship of person interviewed to head of household:

   Wife/husband Mother/father Brother/sister Other

10. Occupation of person interviewed

11. Education: 1 No education, 2 Adult education only, 3 Primary, 4 Secondary, 5 Other

12. Religion: 1 Protestant, 2 Catholic, 3 Muslim, 4 African Traditional Religion, 5 Other

13 a. Were you born in this village? Yes No
   b. If no, how long has the person been living here?

14. Number of people living in this household?

B. COOPERATION AND DEVELOPMENT IN THE COMMUNITY

15. a. Over the years have you seen an improvement in the life of the people? Yes No
   b. If yes, what has brought about this change?

c. In your opinion what have been some of the improvements?
1 In health, 2 In education, 3 In nutrition, 4 In water supply, 5 In agriculture, 6 In transportation, 7 In employment.
d. In which one of the above areas has there been the most improvements?
e. Why and what are the reasons for the improvements?

16. a. Do people help one another in this community? Yes No
b. If yes, give two examples of some of the ways in which people help one another.
c. If no, why not?

17. a. Are there some self-help groups in this area? Yes No
b. If not, why not?
c. What projects are they undertaking?
d. Are you or any member of your family a member of a self-help group? Yes No
e. If yes, why did you join?
f. If no, why haven't you joined?

C. PARTICIPATION IN PLANNING

18. Have you ever participated in the planning of any community projects? Yes No
a. If no, why not?
b. How did you participate in the planning of the projects?

D. PARTICIPATION IN COMMUNITY HEALTH PROJECTS

19. a. Have you or your family ever participated in any community health projects? Yes No
b. If yes, which community health project?
c. If yes, how did you participate?
d. If no, why not?

20. Give two factors which restrict community members from participating in community projects?

21. a. Are community members more interested in participating in some projects more than others? Yes No
b. If yes, which are they interested in? 1 Health projects, 2 Water projects, 3 Schools, 4 Food production, 5 Others (Specify)
c. Why do you think they are interested in these and not others?

22. a. Have you or anyone in your family attended a meeting or baraza about health matters? Yes No
b. If yes, what was discussed?
c. When was the meeting held?
d. How often are such meetings held?
e. Who organises them?

23. a. Is anyone who lives in this household a member of a cooperative, health committee member, community health worker? Yes No
    b. If yes, which one?

24. Is there more or less participation by community members in affairs about health now than in the past? More Less
    Give reasons for the answer.

25. In which ways would you like to see the community members participate more in decisions regarding community health activities?

E. HEALTH SEEKING BEHAVIOUR

26. a. What are some of the health problems in your community?
    b. What are you or your family doing about them?

27. When someone in the family is sick, what do you do?

28. a. Has anyone in the household been sick during the past two weeks? Yes No
    b. Who was sick?
    c. What was wrong?
    d. What did you do?
    e. Which was the health facility visited?
    f. Who attended you?
    g. Why did you attend this facility and not others?
    h. Were you referred by someone?
    i. If yes, who was it?

29. How much did you spend on going to this health facility?
    1 Transport, 2 Food, 3 Treatment, 4 Drugs, 5 Other (Specify)

30. a. Were you satisfied with the treatment that you received? Yes No
    b. If not, why and what was done afterwards?

31. Which of the following do you consider a very bad problem when in need of health services?
    1 Distance, 2 Waiting time, 3 Lack of medicine, 4 Transport, 5 Other (Specify)

32. a. How many children have you given birth to?
    b. How many of these children are alive now?
    c. Where was the last baby born? 1 At home, 2 At a hospital (Specify), 3 Other (Specify)
    d. Who helped at the birth?
    e. Did you see anyone about your pregnancy before the baby was born? Yes No
    f. If yes, who did you see?

E. KNOWLEDGE ABOUT MAUA PROGRAMME

33. Have you ever heard of the Maua Methodist Hospital Community-based Health Care Programme? Yes No

34. a. Are you aware of the ways that the activities of the Programme were decided upon? Yes No
    b. If yes, describe the steps that were taken?
    c. Were the community members involved in deciding upon the activities of the programme? Yes No
    d. If not, do you believe they should have been involved? Yes No
    e. If yes, why?

35. What would you say are the main goals of the programme?

36. a. Are you aware that a health committee exists? Yes No
    b. What do you think their role is?
    c. Are they doing a good job? Yes No
    d. If so, how?
    e. What other things would you like to see them do?
    f. Who is the chairman of the health committee?
    g. How are the health committee members selected?

37. a. Are you aware that there are community health volunteers in your area? Yes No
    b. What is the name of the CHV for your area?
    c. How did your community select it's CHV?
    d. Did you or any member of your family participate in the selection? Yes No
       1 If not, why not?
    e. Do you think this is a good way to select CHVs? Yes No
       1 If yes, why?
       2 If not, what would be a better way?

38. a. What are the CHVs suppose to do?
    b. How often does the CHV visit your home?
    c. When was the last visit?
    d. What did she/he do when they visited you?
    e. Is the CHV doing a good job? Yes No
       1 Explain your answer

39. a. Have you followed any of the advice they gave? Yes No
    b. If not, why not?
    c. Which advice has been most useful?

40. a. Have you changed any of your ways of doing things as a result of visits or meetings with CHVs? Yes No
    b. If not, why not?

c. If yes, what ways or things have you done or changed?

41. a. Would you prefer a male or female CHV?
    b. Why?

42. a. What rewards do the CHVs receive for their work for the community?
    b. Do you believe they should be receiving more or fewer rewards? Explain your answer.
    c. If more, in what form or type?
    d. Who of the following should be providing the rewards?
    1 Government, 2 Maua Methodist Hospital, 3 Community, 4 Health committee, 5 Other (Specify)
    e. Would you be willing to contribute to this reward? Yes No
    f. If yes, why?
    g. Are the CHVs giving enough time for the community health work? Yes No
    h. What would you like to see?

43. a. Do you ever receive any visits from other workers? Yes No
    b. If yes, which ones?
    c. Which other workers should visit you?
    d. For what purpose?

44. a. Do you know of any community health projects started by the health committee or CHVs? Yes No
    b. If yes, which ones?

45. How have these projects helped in the improvement of the health of the community?

F. WILLINGNESS TO CONTRIBUTE

46. a. Are you willing to contribute to health projects and activities? Yes No
    b. If so, why?
    c. If not, why not?

47. Which types of health projects would you be mosting willing to support?
    1 Providing cleaner water, 2 Equipment for mobile clinic, 3 Demonstration gardern, 4 Other (Specify)

48. a. Do you or the community help decide in which ways funds are to be raised for projects? Yes No
    b. If yes, how?
    c. If not, why not?

49. Do you think everyone is able to contribute to health projects? Explain your answer.

50. Should people who are not able to contribute still be able to benefit from the projects? Explain your answer.

51. a. About how much cash income does your household get in a month or a season?

    b. Where do you get cash income from?
    c. What do you spend your cash income on?

52. a. Are there times when it is more difficult than others to have cash income? Yes No
    b. If yes, when are those times?

53. a. Are people willing to pay for health services? Yes No
    b. If no, why not?
    c. If yes, for what services?

54. a. How much do you have to pay for the mobile clinic services?
    b. What is the purpose of the fee?
    c. What is the money used for?

55. a. Where do you have to go to get drugs?
    b. Are they free or do you have to pay for drugs?
    c. Is lack of drugs a problem for you and the community? Yes No
    d. If yes, how can the problem be solved?
    e. Would you be willing to support a community health project which help provide drugs to the community? Yes No
    f. If yes, how?

56. a. Would you be willing to pay a monthly fee into a fund operated by the health committee which would support the work of CHVs and pay for health projects? Yes No
    b. If not, why not?
    c. What could you contribute on a regular basis month by month?

57. a. Do you think self-help groups or cooperatives would be willing to contribute to health projects or support for CHVs? Yes No. Explain your answer.

58. a. Would you be willing to join a self-help group or cooperative whose goal was to raise funds for health projects or support to CHVs? Yes No
    b. If not, why not?
    c. Would you expect the projects and work of the CHVs to only be for the group members? Yes No. Explain your answer.

59. a. Would you be willling to help plant, weed, water or harvest the shamba of a CHV as a way to help or reward them for the work they are doing for the community? Yes No
    b. If not, why not?

c. Would you be willing to the same for a community shamba run by health committee to raise funds for community health projects or rewards for the CHVs? Yes No
d. If not, why not?
e. Would you be willing to help construct a health post or staff house for a health worker? Yes No
f. If not, why not?
g. Have you ever been asked to help in this way? Yes No

60. a. Would you be willling to donate materials or any land for community health projects? Yes No
b. If not, why not?
c. If yes, what could you contribute?
d. Would you be willing to contribute at a Harambee for community health projects? Yes No
e. Which types of community health projects would you be most willing to contribute towards in this way?

61. What would be the best way for you to contribute to or participate in community health programmes for your area?

Note: Questions were translated and administered in the local Kimeru dialect. The form had ample space for documenting responses.