AKHS Kenya

Policy Brief No.4

Best Practices in Community-Based Health Initiatives

Health Facility Committees: The Governance Issue

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This is the fourth of a series of 'policy briefs' produced by the Community Health Department of the Aga Khan Health Service in Kenya. It focuses on a number of issues related to the management of health facilities: the rational for decentralisation of health services, the role of the community in the management of health facilities, the membership of local management committees, selection criteria - and, finally, the involvement of local politicians.

The brief is based on the experience of a pilot project in the Kwale District on the coast of Kenya that had as its key objective the strengthening of the dispensary health committees (DHCs) set up to share in the management of the local dispensaries. This was a project of Aga Khan Health Service in close collaboration with the Kenya Ministry of Health.

These briefs are primarily intended for directors and managers of community-based health care programmes - whether working within ministries of health, international donor agencies or non-government organisations. For these people, at a time when there is an increasing interest in the decentralisation of health services, this fourth brief takes up three main questions:

- What is the rationale for public participation in health facility management?
- What should be the extent of a facility management committee's authority?
- What relationship should the committee have with local government - and should local politicians have membership?

Policy Contexts

Decentralisation

For the last twenty years, many countries - whether rich or poor, authoritarian or democratic - have pursued decentralisation policies. Decentralisation involves a central government transferring to local authorities some of its political authority and also, crucially, some of its responsibility for delivering social services. Decentralisation, then, brings government closer to the people - or, putting it in a stronger way, decentralisation enables local people to actually participate in government.

The case for decentralisation improving governance is made very convincingly in the Human Development Report 2003. It identifies the following achievements in countries where decentralisation policies have been activated:

- Faster responses to local needs;
- More accountability and transparency - and less corruption;
- Improved delivery of local services;
- Better information flows;
- More sustainable projects;
- Stronger means for resolving conflicts;
- Increased energy and motivation among local stakeholders;
- Expanded opportunities for political representation.

Decentralisation of Health Services in Kenya

In the early 1990s, in line with its own decentralisation policies - and in common with public health services in many other developing countries - the Kenya Ministry of Health established District Health Management Boards and Hospital Management Boards, as a consequence of instituting cost-sharing mechanisms. The boards' key roles were:

- To increase the community interest in the health planning process of a district;
- To work with the District Health Management Teams (DHMTs) to coordinate and monitor the implementation of the government and non-government health programmes in the district;
- To identify implementation problems and seek corrective action;
- To act as advocates for cost-sharing and promote health awareness among the general public.

One of the six 'strategic imperatives' of Kenya's Health Policy Framework, published in the mid-1990s, was to 'create an enabling environment for increased private sector and community involvement in health sector provision and finance'. It was to further this purpose that, in 1998, the Ministry of Health issued a circular concerning the establishment of rural health centre and dispensary management committees. The move was intended to enhance community participation in the planning and development of the facilities' health care and health education programmes.

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In accordance with this circular, responsible medical officers at provincial and district levels were directed to initiate the process for communities within the catchment area of each facility to elect ten members to form a facility management committee, who would hold office for a period of three years.

The roles and responsibilities of these committees were given as:

- To oversee the general operations and management of the health facility;
- To advise the community on matters related to the promotion of health services;
- To represent and articulate community interests on matters pertaining to health in local development forums;
- To facilitate a feedback process to the community pertaining to the operations and management of the health facility;
- To implement community decisions pertaining to their own health;
- To mobilise community resources towards the development of health services within the area.

The powers of the committees were defined as:

- The committee shall have the authority to raise funds from within itself, the community or from donors and other well-wishers for the purpose of financing the operations and maintenance of the facility;
- The committee shall have authority to hire and fire subordinate staff employed by itself in the health facility;
- The committee shall oversee the development and expansion and maintenance of the physical facilities within their respective area.

Finally, the circular emphasised that the technical management of the health facility would remain the responsibility of the technical staff of the Ministry of Health.

However, it should be noted that the Ministry of Health circular makes no mention of the management committee's authority in relation to the nurses. Though it has the specific power to 'hire and fire' subordinate staff, it has no clearly defined relationship with the nurse 'in-charge'. It is not clear to what extent the nurse is accountable to the committee.

This is a most significant issue that can seriously affect the performance of the committee. In practice, in the Kwale project dispensaries, when the committee members were concerned about any kind of unprofessional behaviour of the nurse - arriving late for work, for example, or treating patients in an arrogant manner - if they could not solve the problem in a 'talk' with the nurse, then they could only report the matter to the District Health Management Team.

In serious disputes over professional staff performance - and recognising that District Medical Officers might well be inclined to downplay complaints from 'lay' community members - one argument for having local politicians on the committee is that they would add weight to the community side of such arguments.

The Kwale Health Systems Strengthening Project

In 1997, the Kenya Ministry of Health, through its Provincial Office at the Coast and its Kwale District Health Management Team, began a collaboration with the Aga Khan Health Services (AKHS) that focused on the quality of health care at the local level. The Kwale Health Systems Strengthening Project (KHSSP) was a demonstration, a model-building, project that sought to show how the management of six sample dispensaries could be strengthened and their services improved.

The project was both significant and timely in Kenya, in as much as the Ministry of Health was, as indicated above, promoting reforms that involved a decentralisation of decision-making to provincial, district and local levels, an implementation of cost-sharing mechanisms, greater public participation in the management of facilities and services - and a closer co-ordination with private agencies active in health care.

As argued in the training package that was one of the key outputs of the Kwale project, AKHS decided to join forces with the Kenya Ministry of Health in this systems strengthening initiative because of its commitment to the improvement of health care delivery at the local level. AKHS's experience in many community-based health care projects in various countries and continents had shown that, with regard to the educational messages that can be passed, the preventive measure that can be taken, the range of diseases that can be combated, and the large numbers of people that can be treated, the dispensary level of health care is the most critical one. Moreo-

ver, AKHS is convinced that one of the most crucial ways of improving the quality of basic health care is to make the dispensary and outreach staff accountable to the communities they serve - through making the committees more representative and by giving them more management responsibilities. Thus, the committees are empowered - they are enabled to manage their own health care.

KHSSP took on five key tasks:

- Establishing good governance, by encouraging genuine community representation on the dispensary health committees (DHCs), and by clarifying the interacting roles and responsibilities of committee members and nursing staff;
- Building the management and leadership capacities of the DHCs, by developing their needs-assessing and action-planning skills;
- Establishing administrative systems for collecting and managing the revenues and expenditures of the dispensaries;
- Establishing a basic health management information system that could be used by the DHC for identifying problems, deciding on action plans, and raising the awareness of the community about health issues;
- Improving the quality of services offered by the dispensary - including outreach activities health care and health education activities.

Key Features

The 'good governance' aim of KHSSP - an aim that was largely achieved in the six pilot communities - was a dispensary that had the following characteristics and facilities:

- A functioning Dispensary Health Committee (DHC), the members of which are drawn from all villages in the catchment area - and are representative of the whole community rather than only the more powerful or the better-connected groups.
- A constitution for the DHC that was formulated by the committee members themselves, that clarifies the roles and responsibilities of the community representatives and the nursing staff - and that addresses important issues related to fair representation, efficient administration and quality health care.
- A legal standing for the DHC that comes from registration with the relevant authorities. (In the case of Kenya, this authority was the Ministry of Culture and Social Services).
- An operational bank account, the signatories of which are thus in full control of the DHC's finances.
- An efficient system for collecting, recording and monitoring the DHC's finances - a system that ensures accountability and enables transparency.
- A policy and a set of procedures for establishing fee levels - and for allowing exemptions in the case of public health risks and waivers for those patients who cannot afford the fees.
- A basic health management information system for the dispensary that facilitates the identification of community health needs, the planning of health care activities, and the display of key statistics that can help in raising the awareness of the community about health issues.
- Action plans that include outreach health care and health education - and that involve contacts with youth groups, women's groups, schools, and other community-based organisations and institutions.
- A regular and sufficient supply of essential drugs, the procurement and supply of which are monitored by the DHC.
- Protocols, charts and manuals available for the nursing staff on the treatment of common diseases and conditions - and graphic materials on display that inform the public about common health issues.

Achievements

Within only two years of the project's start-up, there were some impressive signs of success in the six participating dispensaries:

- Income of the dispensaries was doubled;
- Utilisation figures for preventive care activities increased by more than 50%;
- Utilisation figures for curative care rose by 15%;
- Immunisation coverage in this remote rural area was maintained at 77% compared to the national average of 65%;
- Proportion of severely underweight children dropped from 17% to 10%;
- Knowledge of family planning increased from 56% of population to 82%.
- All six of the DHCs were meeting regularly, were operating bank accounts, and were using a facility-based management information system to monitor health problems, check on the utilisation of the dispensaries health services - and to make action plans.

All those involved attributed these successes, in large measure, to the commitment and efforts of the DHCs.

The experience of KHSSP bears out the conclusions of the Human Development Report about the benefits of decentralised management structures for the delivery of health care:

- There was an increased utilisation of the health facilities and services; the dispensaries were better stocked with drugs and other supplies - and more women were involved in the management of the service.
- As indicated by the above record of achievements, there was a marked improvement in both preventive and curative services.
- With regard to tackling corruption, there were a number of occasions when those mismanaging the dispensaries' funds were held to account.
- With regard to improvements in information flows, the dispensary management information systems marked a significant improvement in communication with the community and in planning by the staff and committee members.
- And there was certainly an increased energy and motivation among the committee members - and also among the dispensary staff.

The Human Development Report, however, argues that successful decentralisation depends on a sharing of authority between local government and local non-government organisations. In this respect, there was still a question to be asked of the Kwale project - because the DHC linkage with the local councils was quite tenuous and uncertain. The reason can be related to the Kenyan local authorities' lack of resources - and their failure to win public trust. This was an issue explored in a follow-up meeting in Kwale with DHC members, dispensary staff and local councillors.

Health Facility Management Committees and the Politicians

When the KHSSP started, all the dispensaries in the target communities already had management committees. However, in the training programme for the DHC members, there was particular concern to ensure that these committees were fairly representative. To raise awareness about the issue, the following questions were put to the members at the beginning of the capacity-building programme:

- How many members does your committee have?
- Where do the members come from?
- How were you selected?
- Does the committee effectively represent all the villages and main groups in the dispensary's catchment area?
- How important is it that the committee is representative?
- What is the ratio of men to women?
- How important is it that women are well represented on the DHC?

There was no question raised about the involvement of councillors. And there was, also, no mention of links with the local councils in the 1998 Kenya Ministry of Health circular setting up health facility management committees.

In a recent series of consultations councillors from the target locations of Kwale District were quite clear in their claim that they should be represented on the DHCs. They argued that they had been elected by their communities and that they had a responsibility for overseeing the provision of all social services to their constituents.

However, the DHC members and community nurses seemed quite wary about closer contacts with the councils. They talked of the dangers of 'political interference' - a common phrase in Kenya. They also accused councillors of working for their own good rather than for the good of the community. It was another illustration of a paradox in the Kenyan political scenario: on the one hand the people elect the counsellors, but on the other hand they have no trust in the counsellors they elect - and, seemingly, little control over their behaviour once elected.

In the project, two of the six dispensaries suffered quite drastically owing to the negative interference of the counsellors. At one site called Mnyenzeni, which was performing very well and had an efficient fee collection system, a counsellor used his clout to force the Medical Officer of Health to call new elections in order to install his own supporters. The DHC tried to challenge DHMT's decision but in the end they failed. The same counsellor also managed to get the nurse transferred. The result was a serious deterioration of the management and a decline in the services. In only one year, the average monthly utilization of the dispensary went down from 919 to 684.

'The community representatives on the DHCs are there on a voluntary basis,' said one of the DHC members, 'but the councillors would expect to be paid.'

'Politicians will always be looking for things that will benefit themselves,' said another. 'And many of them are too open to bribes.'

'Politicians are too ready to take the credit for any development project,' said a third, 'Because they are always looking for votes.'

'If a councillor from one party takes over from a councillor from another party,' said a fourth, 'then he might well abandon a project just because it wasn't promoted by him or his party.'

'Anyway,' added a fifth, 'councillors know nothing about health services.'

All this is symptomatic of a particular political malaise in Kenya - a recognition of the weakness of local authorities and strong suspicions about the selfish motives of politicians.

In Kenya, local councils are weak because, right from the time of Independence, the central government did not wish them to be strong. Moreover, those who took power at Independence decided to retain the colonial administrative system of commissioners and chiefs. It was a system that they could more easily control. The commissioners and chiefs are appointed by central government rather than elected by the people they are supposed to serve… So there is a parallel system of local government - the councils and the administrations.

But there have been some important changes of late. In keeping with the decentralisation policies discussed at the beginning of this brief - which will be accelerated and strengthened by the constitutional reforms now under review - the Kenyan government has instituted a system whereby local councils receive 5% of national tax revenue - and there are other incentives for initiating development projects that are planned through a process of public consultation.

So in Kenya there are good reasons to take even more seriously the questions as to whether and as to how the local politicians should be included and involved in the management of local health facilities and services. But the answers are likely to be relevant in other countries where there is an interest in enhancing democracy, in facilitating community participation, in strengthening local government - and in improving the management of local health institutions.

Lessons Learnt

Representation

In supporting the establishment of health facility management committees, as wide a representation as possible should be encouraged- and this will mean including representatives of local administrations and local councils. Not to do so runs the risk of isolation from other development initiatives in the catchment area - and of confrontation with those who, rightly, consider that they have a responsibility for overseeing all kinds of social services in their constituencies.

Clarification of powers

Though the conclusions have not always been precise, a lot of attention has been paid to the definition of roles and responsibilities of health facility management committees. Usually, the focus has been on the distinction between the functions and the powers of the professional health service staff - and the lay committee members. Here, unless the committee is to have only a supporting role (rather like a school's parents and teachers association, PTA) then, really for it to manage, it is important to define the 'general' as opposed to 'technical' powers of the committee. However, as long as the professional health staff are not directly accountable to the committees, then there will always be a possibility of confusion and misunderstanding when a committee considers that a staff member is not performing satisfactorily.

Inclusion of politicians

To include local politicians in health facility management should enhance the democratic status of the committees (because politicians are subject to the election process) - but, to maintain independence and ensure appropriate freedom of action, it will become vital to clarify the tripartite relationship between the Ministry of Health, the local authority and the facility management committee.

In this regard, the key lessons are:

- Local politicians should be involved right from the beginning, but with a clear understanding that they are 'patrons' and that their special role is to help resolve conflicts rather than become involved in the day-to-day management of the facility.

- There needs to be a mechanism whereby committee members, including the politicians, can be questioned by the villagers who elect them - in some kind of village-wide forum.

Capacity building

The main business of the KHSSP was building the capacities of the DHCs. The training programme covered seven main themes:

- Governance issues and skills;
- Managing finances;
- Managing information;
- Maintenance;
- Action planning;
- Outreach activities;
- Communication skills.

If there is truth in the statement quoted above - that councillors know nothing about health services - then there is a strong case for involving them in the kind of training programmes that KHSSP provided for the DHCs.

It was an important lesson of KHSSP that, when committee members and professional staff come together in a training programme, then they more quickly and more effectively come to appreciate each others roles and responsibilities. The same strategy should be applied in any orientation for local politicians.

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Some of the material for this policy brief is drawn from the training package, Managing a Dispensary, that has been developed from the experiences of KHSSP. The package is in three parts:

1. A Participatory Model: an introductory pamphlet;
2. A Handbook for Committee Members and Nursing Staff;
3. Guidelines for Facilitators.

The training package is available in printed form and on a CD. It can be obtained from:

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