Critical Analysis of the Kenyan Healthcare System and Models for Improvement

Justin Wellum
Western Kentucky University, justin.wellum460@topper.wku.edu

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CRITICAL ANALYSIS OF THEKENYAN HEALTHCARE SYSTEM AND MODELS FOR IMPROVEMENT

A Capstone Experience/Thesis Project

Presented in Partial Fulfillment of the Requirements for
the Degree Bachelor of Science with
Honors College Graduate Distinction at Western Kentucky University

By
Justin Wellum

*****

Western Kentucky University
2014

CE/T Committee:

Dr. Sam McFarland, Advisor

Dr. Nancy Rice

Allison Smith

Approved by

____________________
Advisor
Department of Psychology
Global epidemics such as malaria, tuberculosis, and HIV/AIDS plague developing countries in Africa. International aid has been given to these countries from public and private organizations in an effort to eradicate these health crises. My research focuses on Kenya as a model for assessing the current state of health care in these developing countries. The effectiveness of Kenya’s health care system was investigated at every level, including central, provincial, district, and rural, by visiting the country and performing specific research. Based on my research, I propose a model that I believe Kenya or any African developing country could adopt to improve their health care. This model suggests the need for equally distributed funds, expansion of non-government organizations, ways to eliminate barriers to health services, and the development of an effective health education curriculum to be taught in the primary schools. This model helps illustrate the need for reform and offers solutions to achieve better health for citizens in developing countries.

Keywords: Kenya, Healthcare, Education, Models, Government, NGO, Empowerment, Barriers, Child-to-Child, Community Development Programs
Dedicated to my Lord, family, friends, and WKU.
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VITA

June 14, 1992 .................................. Born-Chicago, Illinois

2010.............................................. Portland Christian High School,
                                  Louisville, Kentucky

2010.............................................. Began at Western Kentucky University,
                                  Bowling Green, Kentucky

2012.............................................. Harlaxton College, Grantham, England

2012.............................................. Selected as a WKU Spirit Master

2012 .............................................. National Science Foundation Research Experience
                                  National Chung Hsing University,
                                  Taichung, Taiwan

2013.............................................. Internship at Tenwek Missional Hospital,
                                  Bomet, Kenya

2014.............................................. WKU PIC:MIK, Study Abroad Trip, Kenya

2014.............................................. WKU REACH Week Honors Session Winner

2014.............................................. Graduated from WKU

2014.............................................. Teach for America Member, Phoenix, Arizona

PUBLICATIONS

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FIELDS OF STUDY

Major Field: Biochemistry
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CHAPTER 1

INTRODUCTION

“Illness appeared to be part of their everyday life and not an exception from it. Coping with illness is therefore an essential skill” (Geissler, “Children and Medicines” 1778). This mindset and attitude describe many developing countries in Africa. Due to global epidemics such as malaria, tuberculosis, and HIV/AIDS, these countries lack the infrastructure to battle these diseases. The lack of quality health care in Africa is a severe problem, and it does not take very much research to discover that it is a dire issue.

According to a report issued by UNAIDS in 2011, Sub-Saharan Africa has 68% of all cases of HIV/AIDS, even though Africa constitutes only 12% of the world’s population. (UNAIDS 2011). According to another report released by the United Nations, over 50% of people in sub-Saharan Africa are not receiving critical antiretroviral therapy to help combat HIV/AIDS. The report also notes that, without treatment, approximately one-third of children born to women with HIV will become infected (Millennium Development Goals Report 2013).

International aid has been given to these countries from public and private organizations in an effort to eradicate these health crises. The Millenium Development Goals (MDGs) 2013 report shows considerable improvement over the past decade in terms of improving quality of health care due to the result of international aid. There now exists, though, a need for strategic reform. Improvements in developing countries need to
be carefully considered in terms of long-term effectiveness, empowerment of the nationals, and education of the next generation of citizens. As a future physician, I hope to understand the dire health circumstances in developing countries, address some barriers to improving health care, and provide solutions to tackle these global concerns.

I will focus on Kenya as a model for assessing the current state of health care in developing countries. I evaluated the effectiveness of Kenya’s health care system by visiting the country and performing specific research. The first visit took place during the summer of 2013. During that visit, I interned at Tenwek Mission Hospital located in western Kenya. I observed over 200 hours in the hospital, performed patient surveys, and accompanied community health workers to local villages to establish village health programs. I returned to Kenya in January 2014 as a member of Western Kentucky University’s (WKU) Partners in Caring: Medicine in Kenya (PiC:MiK) trip. WKU has been taking pre-professional students, physicians, professors, and volunteers to Kasigau, Kenya for six years with the goal of empowering and establishing a permanent health care presence in the area. Both of these trips provided the insights, data, and experiences to help me evaluate Kenya’s health care needs and to develop possible solutions for improvement.

Based in these experiences, I will propose a model that I believe Kenya or any African developing country could adopt to improve their health care system. This model suggests the need for equally distributed funds, expansion of non-governmental organizations (NGOs), ways to eliminate barriers to health services, and the development of an effective health education curriculum for the primary schools and communities.
It is important to begin with how global organizations such as the United Nations and other countries are tackling these health concerns in the larger context of Africa and in the specific country of Kenya. Kenya’s health care system will then be discussed and how it is meeting the concerns of its citizens. Next, an analysis of the quality of care will be offered from my experiences and research while in the country. Finally, solutions will be proposed to help combat some of the issues in Kenya, with an effort to changing the fatalistic mindset of its citizens and obtaining long-term improvements in health care.
CHAPTER 2

GLOBAL RESPONSE TO AFRICAN HEALTH CRISIS

International Aid to Africa

The African health care crisis is an issue that has been noticed by all of the governments of the world. The U.N. is seen worldwide as the ultimate source and leader in trying to end this crisis. Several U.N. programs have been established, and all of these individual programs fall under the jurisdiction of the U.N. Development Group (UNDG). The programs involved include the U.N. Development Program (UNDP), the U.N. Children’s Fund (UNICEF), U.N. Population Fund (UNFPA), and World Food Program (Miller, 2012, p.5-6). These groups together bring fulfillment the U.N. Charter’s call for “better standards of life in larger freedom” (Charter of the United Nations, preamble). The recent focus of these programs has been to accomplish the MDGs established by the U.N. The U.N. established this bold campaign at the turn of the century to curtail the effects of poverty by 2015. They proposed eight goals and created standards that each country could achieve. The UNDG is one department of the U.N. that is centered on helping to accomplish these goals.

According to the UNDG 2010-2011 biennium budget, the UNDG received $13.6 billion dollars in contributions from U.N. member states and foundations. It is using those funds to accomplish its MDGs, including improving health care in Africa. The total
resource allocation for development projects, according to the 2010-2011 budget, was estimated to be about $11.58 billion. These costs are then subdivided and spread out throughout various regions of the world with 67.1% of expenses budgeted for developing areas such as Africa, Southeast Asia, and Latin America and the Caribbean. The UNDP budget also further states that $900 million was used for management costs.

Benefits of International Aid

Government programs have been able to promote solutions to problems in Africa and are continuing to improve education on current health issues and organizing both international and national campaigns. Globally, the World Health Organization (WHO) has led successful campaigns in eradicating smallpox and polio (Miller, 2012, p.11). The MDGs 2013 report stated that much progress has been made in terms of healthcare. Between 2000 and 2010, mortality rates from malaria fell by more than 25% globally. Additionally, between 1995 and 2011, a cumulative total of 51 million tuberculosis patients were successfully treated, saving 20 million lives. In developing regions, the proportion of people living on less than $1.25 a day fell from 47% in 1990 to 22% in 2010. Many of the MDGs will be met, and some have already been met, before their 2015 target date. The success of the MDGs varies by country and region but one can be very pleased with the current trajectory of accomplishing the MDGs.

Increased Need for International Aid Accountability

Improvements are being made, but concern is now being raised as to whether there is enough aid being given to these developing countries, or whether it is damaging these countries. Some argue that aid is not allowing developing countries to obtain
autonomy. Many governments in Africa, such as Uganda and Ghana, have had more than 50% of their national budgets dependent upon foreign aid (Ayodele et al., 1). Former President Aboulaye Wade of Senegal says, “I’ve never seen a country develop itself through aid or credit. Countries that have developed-in Europe, America, Japan, Asian countries like Taiwan, Korea, and Singapore-have all believed in free markets. There is no mystery there. Africa took the wrong road to independence (Norimitsu, 2002, p.A3).”

However, economist Jeffrey Sachs says that this high level of foreign aid should not raise too much concern, and that they are actually appropriate in order for results to occur. He argues that, even though the MDGs are achieving success, Africa still needs more help. Sachs et al. (2004) performed a study on Uganda, Tanzania, and Ghana (three countries that are behind on achieving the MDGs in their country) and estimated that “…each of these countries will be able to finance between 41 and 48 percent of the total investment needs through domestic sources” (p. 163). This 41-48% is what the countries could contribute to help achieve the MDGs. Help must come from external sources. Currently, it has been estimated that the aid given to developing countries by “rich” countries is about $60 billion dollars or about 0.4% of their own GNP. This falls far below the commitment made in 2000 by countries of the U.N. to help end poverty. Fulfilling this pledge, according to Sachs et al., would require .7% from the wealthy nations. Sachs et al., say that even if aid was increased to 0.5% GNP by “rich” countries that there would be an additional $75 billion dollars of aid produced that would be able to support developing countries (2004). The immediate health concerns require that nations have their own budgets supported by foreign aid. Over time, the hope is that nations will
be able to slowly decrease the amount of their budget allocated from foreign aid and will be able to become completely autonomous countries.

As plans are being developed, there must be a careful accountability instituted about where this aid money is being spent. Many stories have been shared about how much of aid is not directly used to accomplish the MDGs. A number of countries in Africa have been hurt by corrupt governance. In 2005, four of Nigeria’s state governors were accused of money laundering. One was accused of diverting over $90 million into private bank accounts. However, he was not convicted because Section 308 of the Nigerian Constitution protects sitting governors from criminal prosecution (Ayodele et al., 2005, p.2). South Africa’s annual budget of $5.73 billion on military equipment impeded health care (Benatar, 2004). This corruption is also detracting funds away from improving healthcare. The corruption has also affected Kenya where, “ghost-workers” (workers who are no longer alive) in the health ministry were receiving salaries of $6.5 million per year, that other current workers took as their own. In Uganda, has been estimated that over two-thirds of drugs meant for free distribution in the public sector were lost due to theft or could not be accounted for (Ayodele, 2005, p.3).

Changes in International Aid

Many improvements in government aid can be implemented in order to drastically improve the African healthcare system. Different approaches have been suggested over this past decade. Many, like Sachs, have called for the expansion of international organizations such as the U.N. and have urged a call for many other donor countries to help provide financial support (Sachs, 2014). William Easterly and others have
encouraged that focus not be placed on large aid organizations but instead on developing capitalistic structures in these countries (Easterly & Pfutze, 2008). Much debate can continue on these two perspectives but there are many suggestions that should occur in developing countries that all can agree on.

The first thing is that there must be an increase in transparency and streamlining among all aid organizations. The UNDP 2010-2011 budget illustrated this change from the previous budget where they cut $67.1 million in management costs. Secondly, aid should be given to countries that have shown a desire to change. Sachs et al., say that, “In cases [where] the problems of governance run deeper than simple lack of finances…and [where they] do not intend to carry out needed reforms [they] can find too many ways to circumvent the conditions” (2004, 186). Aid should not be denied to these countries, but the reason why they are suffering from poor governance should be identified and those issues need to be addressed first. Finally, there should be a refocusing on discovering the needs of the individuals and improving of coordination of aid agencies. Easterly and Pfutze say that there is a lack of organization and, “Aid agencies split their assistance between too many donors, too many countries, and too many sectors…and forfeits the gains of specialization and leads to higher-than-necessary overhead costs for both donors and recipients” (2008, p. 51). Sachs et al., also say that “Although there is much evidence that aid works, it is true that, even in well-governed developing countries, a lack of coordination and goal orientation leave the current system far from adequate to the task” (Sachs et al., 2004, p.167).

Each individual country will then need to adopt policies for their own country. It will require an emphasis in education, community care, and partnership (Kaseje, 2006,
National budgets should be structured to inform citizens of improving quality health and also to increase the number of medical workers, especially in rural areas. The WHO Report in 2006 estimated that there are approximately 2.3 health care workers for 1000 people in Africa, compared to the 24.8 health care workers to 1000 people in the Americas.
CHAPTER 3

CURRENT REPORT OF THE KENYAN HEALTH CARE SYSTEM

Many of the health problems in Africa are evident in Kenya. According to the WHO Global Health 2012 report, Kenya has a population of about 43 million people, with over 42% of its population being children under fifteen years old. The report also states that the under-five mortality rate still stands at 73 per 1000 live births. Life expectancy for males and females is 58 and 61 years, respectively. Kenya also only spent 4.5% of its GDP in 2011 on health (The WHO Global Health 2012 Report).

The organization of the health care system is divided into central, provincial, district, and rural levels. After the political crisis in 2007, the Ministry of Health was divided into two branches: the Ministry of Medical Services and Ministry of Public Health (Wamai, 2009, p.138). The central level also includes the two national hospitals, Kenyatta National Hospital and Moi Teaching and Referral Hospital, that are used for teaching and dissemination of care. At the provincial level, a Provincial Medical Officer is assigned to each of the eight provincial hospitals that correspond to the number of provinces in the country. The district hospitals then serve as closer referral and medical centers and typically have a District Medical Officer staffed there. The rural division includes health centers, government dispensaries, and clinics (Mburu, Smith, & Sharpe, 1978).
The utilization of health care services is distributed among government, private, NGO, and other facilities. The following figure shows the use of outpatient visits in Kenya:

Figure 3.1: Percent Distribution of Outpatient Visits by Type of Health Provider, 2007

Source: Figure 5.8: Ministry of Health. Kenya Household Health Expenditure and
Ever since Kenya achieved independence in 1963, the Kenyan health care system has been going through constant revisions in an effort to improve the quality of care. A major problem of the health care system has been trying to adequately offer services throughout the urban and rural parts of the country.

One of the issues is the balance between finding the appropriate user fee for revenue without reducing the use of health services. According to the Household Survey of Health Care Utilization and Expenditure 2007 survey, the average “Out-of-Pocket” (OOP) expenditure was KSh 699 ($7.95 USD) in urban areas, and KSh 328 ($2.68 USD) in rural areas for outpatient services. One of the problems that Kenyan citizens stated about the introduction of user fees was that after fees were implemented, there was no rise in quality of care. Drugs were not more available, access did not improve, and wait times were not shortened (Collins, Quick, Musau, Kraushaar & Hussein, 1996). If user fees are to be used, there must be some type of increase in quality of care. Implementing user fees to generate revenue often does not go back to help the poor in developing countries (Peters et al., 2008). Castro-Leal, Dayton, and Mehra state that, “Governments allocate significant shares of their health budgets to hospital-based services, which the poor generally do not use” (1999).

The danger is also that user fees prevent those who really need the medical treatment from going to receive care. Richard Yoder performed a study of utilization services in Swaziland after a user fee was introduced and found that there was a 17% decrease in service. Alarmingly, a large number of these individuals were the ones who badly needed care. According to Yoder, “The hope that the 17% fewer patient visits would consist primarily of minor ailments or self-limiting diseases is not supported by
the data. The decreases in immunizations and treatment for diarrheal and sexually transmitted diseases suggest that the ‘wrong people’ have left the system” (1989, p.41). The study also stated that the user fees only generated about 2.0% of the totally Ministry Of Health budget and made only 0.16% gross contribution to total government revenue. Yoder reported that, “To make a more substantial contribution to government revenue, estimates indicate that fees would have to be increased seven times above their current level” (1989, p.41). Suggestions have been made to grant a fee-waiver system for the “very poor” and protected groups such as children and mothers (Collins, Quick, Musau, Kraushaar & Hussein, 1996, p.54). A very carefully planned system would have to be established at a national level, and one has not been done very efficiently yet.

One solution, throughout the development of the Kenyan health care system, has been a phased implementation of the National Hospital Insurance Fund (NHIF) into the health care system. NHIF was established in 1966 for those who were formally employed (Mwabu, 1995, p.250). Currently though, the Kenyan National Bureau of Statistics 2013 report estimates that about 40% of the population is unemployed and that is projected to rise to as high as 50% in 2014. The Kenyan Ministry of Health, in 2007 about 10% of the entire population in Kenya had some type of insurance. The disparity of coverage, however, ranged from 24% in Nairobi to 2.8% in the North Eastern province. NHIF insurance is expanding and becoming more affordable to all citizens (2007). Current premium rates according to the NHIF site are approximately less than 2% of an individual’s gross monthly income (“Premium Rates,” 2014). The current NHIF policy covers only inpatient services. Expansion of types of coverage and extending use in rural areas needs to be a central piece of expanding NHIF in the future. This would support the
ongoing goal of the Ministry of Health to continue to decentralize health services. This decentralization of health services has been the official focus of health care reform since it was proposed in its 1974-1978 Development Plan (Mwabu, 1995, p.249).

Decentralization would allow for the entire country to have funds used appropriately and strategically to provide health services to all parts of the country. However, achieving this decentralization of care has been a major issue in the last few decades. Finding a way to balance user fees, expand NHIF coverage, and decentralize services is needed for Kenya to be able to improve health coverage for its citizens.
CHAPTER 4

EVALUATING QUALITY OF CARE

To fully investigate and assess the health care in Kenya, I arranged to visit and serve in two different levels of the medical community. I went with the goal of assessing the quality of care through a model developed by David Peters and his colleagues (Peters et al., 2008). Current research has identified two main areas of determining quality of care: access and effectiveness. Campbell, Roland and Buetow (2000) propose this question when approaching a health care system, “Do users get the care they need, and is the care effective when they get it?” (p.1614). Access and effectiveness can also be broken down into more specific health factors.

Peters et al. propose four main dimensions of access: geographic accessibility, availability, financial accessibility, and acceptability. Geographic accessibility is defined as “…the physical distance or travel time from service delivery point to the user.” Availability is “…having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials. Financial accessibility is “…the relationship between the price of services and the willingness and ability of users to pay for those services, as well as be protected from the economic consequences of health costs.” The last dimension, acceptability, is stated as “…the
match between responsive health service providers to the social and cultural expectations of individual users and communities.” (Peters et al., 2008, p.162).

Effectiveness, on a societal level, is assessed based on user evaluation, health status, cost, and equity (Peters et al., 2008, p.162). Two key elements of effectiveness are clinical effectiveness and the effectiveness of inter-personal care (Campbell, Roland, and Buetow, 2000, p. 1612). The goals for effective care are to improve the structure, delivery, and experience of health care facilities.

Peters et al. provide a visual representation of assessing access to health services and it can be seen in the Figure 4.1 (2008, p.162). It highlights the individual decisions and barriers that one must overcome to achieve access and quality care. It also lists some determinants at both the policy and household level to pursuing medical care.
Figure 4.1: Conceptual Framework for Assessing Access to Health Services


Determinants
Each system that I visited was assessed through this framework. I decided to focus on assessing the access of health care through the four dimensions seen in Figure 4.1 and try and identify possible barriers to accessing care and solutions for improvement. I highlighted areas that were successful in the four dimensions of access and identified ways that each system can improve. My conclusions for these four dimensions are based on my personal experiences with the many doctors, medical workers, and citizens of Kenya and are presented in a qualitative and anecdotal analysis in Chapters 5 and 6.

The goal of this analysis of quality of care was to help improve the status of the poor. The definition of poverty that I used comes from Peters et al. and they say that, “Poverty is recognized as extending beyond the concept of deprivation of income or material assets. It also can be understood as the lack of freedom to lead the life people have reason to value, with people and communities empowered to lead healthy lives seen as both a means to overcoming poverty and an end in itself” (2008, p.161). When applying this definition, overcoming poverty involves allowing individuals to have the ability to make their own choices in terms of their own health and empowering other members in their community to have this freedom as well.
CHAPTER 5

ASSESSMENT OF NGO/PRIVATE SECTOR

Figure 5.1: Tenwek Mission Hospital, Bomet, Kenya, 2013

History of Tenwek Hospital

The majority of African countries have a three-tiered system of receiving medical care: public, private, and NGOs. My first trip to Kenya had the purpose of analyzing and examining the effectiveness at a private/NGO health center. I spent four weeks at Tenwek Mission Hospital in Bomet, Kenya. Tenwek has a long-standing history of serving those
in the western part of the country since its inception in 1937 by World Gospel Missionaries (WGM). According to the WGM website, this three-hundred-bed hospital, “…treated more than 140,000 outpatients for dental care, stomach aches, broken bones, HIV follow-up visits, and other health needs and saw more than 14,000 inpatients and performed over 3,000 major surgeries in 2013” (“Tenwek Hospital,” 2014). It serves as a major referral hospital for patients from all over the country and even the continent due to advanced services for a rural area such as a CT scanner, ultrasound machines, and surgical specialists in heart, brain, and laparoscopic procedures. The hospital has about ten full time medical missionary physicians and hosts over 150 visiting physicians each year to provide health care to Kenya.

A major component of the mission at Tenwek is educating and training health care professionals and community members. Tenwek opened a nursing school in 1987, has trained over 300 local nurses, and currently has plans for expanding the school. Also in 1987, Tenwek launched the Tenwek Community Health and Development (TCHD) program that will be extensively discussed later in this paper.

While there, I was also able to observe and participate in the Tenwek Internship Program. The hospital invites between 16-20 Kenyans who have just finished their formal four-year medical school education to complete their one-year mandatory internship at Tenwek. These Kenyan interns rotate among disciplines such as general surgery, endoscopy, urology, orthopedics, family medicine, and obstetrics, and then
choose to specialize in one of these areas after their internship. I accompanied these interns on their rounds at the hospital, daily classes, and into the community.

Tenwek also boasts a five-year surgical residency program. Every year, two new Kenyan physicians are mentored and taught by the full-time surgeons at the hospital. The ultimate goal of the program is to teach the surgeons and provide hands-on experience with the commitment to perform surgeries in other parts of East Africa.

**Assessment of Tenwek Hospital**

The trip to Tenwek was very enlightening and encouraging. I was very impressed with the facilities offered by the hospital. The patients left encouraged and confident that they were receiving the best treatment possible. The impact from Tenwek was so well known that, even while I was there, patients from all over Kenya and from other countries came to receive care. For instance, a family from Ethiopia was flown in to receive specialized heart surgery performed at Tenwek. The quality of the care that was received by Tenwek helped improve the overall health in the entire area.

The quality of care received at Tenwek can be evaluated through the proposed model discussed previously in this paper and seen in Figure 4.1. The access to Tenwek is viewed as very favorable in three of the four dimensions. The first dimension is geographic accessibility. There is an excellent paved road that runs to the hospital aiding the geographic accessibility of the hospital. It is located in the middle of several villages.
and patients frequently walk along the very defined paths. It is a major referral site for several nearby villages and they even have the capability to transport patients in certain circumstances.

The second dimension is availability, and Tenwek is a very well equipped hospital and offers many unique services. There is a functioning 24-hour emergency room, and many specialists are available. Scanning and screening of rare conditions is possible, and medicine is readily available. There were covered waiting areas and, even though wait time for a patient was considered long (1-2 hours) for primary care visits, there were six to eight physicians managing the health clinic and making sure people were seen. There were also beds for people to stay and receive long-term treatment, a cafeteria for people to eat meals, and long-term health counseling available.

The third dimension is financial accessibility. In addition to the up front costs of treatment, there are other costs that must be taken into consideration. Peters et al. says that, “These indirect costs include the opportunity cost of time of both the patient and those accompanying him or her, transportation costs, and expenses on food and lodging” (2008, p.166). This is the one area that Tenwek can and is trying to improve. Almost all of the health services have some type of user fee associated with them. The exceptions are for family planning, vaccinations, and pediatric health services. Many sections of the community, however, felt the costs at Tenwek were too expensive. While I was there, a small girl named Esther came to Tenwek three months after she had fallen into a fire. Her
parents were deterred from visiting the hospital due to the costs. Because of this, she had to undergo an emergency skin graft and ended up barely fighting off severe infections that could have ended her young life. Due to the ongoing donations given to Tenwek, they are able to keep costs low. The full-time physicians also raise their own individual support in their home countries so that they do not have to charge more to the patients for the their own salaries. Financial accessibility will have to be addressed in the future, but the NGOs/private sector facilities are actively working toward making health care affordable for all.

The final dimension, acceptability, is hard to determine in developing countries. Unfortunately, many people do not have the option of visiting several facilities and choosing their preferred avenue of treatment. Many citizens also already have a perceived impression that Western medicine may be better, but that it is also more expensive. In a study done by Yoder (1989), he found that individuals in Swaziland visited the mission facilities over the government facilities, which was “…consistent with the popular perception that mission facilities provide higher quality care than the government facilities” (p. 39). Tenwek is also viewed very highly in the community but has made it a goal to empower the citizens and incorporate them into their plan for the community. Establishing a lasting presence in this community also takes time and effort. Over time though, the community has experienced great improvement. For example, there was an increase in the knowledge of family planning and contraception. According to Mark Jacobson of the Maasai Health Service Project and other colleagues, Tenwek Hospital
saw over a three-year period that there was an increase of women using contraceptives from 4% to 12%, and a 13% increase of women knowing more about family planning (1989, p.1062). Many Kenyans feel very comfortable at Tenwek due to the fact that a Kenyan health care worker typically treats most of their needs. This allows for the missionary and visiting physicians to help with the difficult cases and train new physicians.

Overall, I would say that Tenwek is an example of an NGO/Private sector facility that is delivering quality care. The access to care is carefully delivered and there are many different resources available to the Kenyans. They are incorporating the Kenyans into their plan for better health, and have built long-standing connections with community leaders. Patients leave the hospital very satisfied with their care and often return when they have an issue. The quality of health in the country, however, is still below to where it should be and there are always ways for improvement.
CHAPTER 6

ASSESSMENT OF RURAL CLINICS IN KENYA

Figure 6.1 Rukunga Rural Health Clinic, Kenya, 2014

History and Need for PiC:MiK Trip

According to the Ministry of Health’s survey, government facilities accounted for 57% of all outpatient visits in 2007 (Ministry of Health). They are usually the most readily available to many Kenyan citizens. Therefore, in order to fully understand the Kenyan health care system, it was necessary for me to investigate and spend time at a
public health care facility. I returned to Kenya during the winter of 2014 as a member of the Western Kentucky University (WKU) PiC: MiK 2013-2014 group. We worked for two weeks in the region of Kasigau at three village clinics located in Rukunga, Buguta, and Makwasinyi. WKU has been sending students to this area for six years, and previous connections in the WKU Biology Department with this area go further back in time. The clinics are typically run by a nurse or a physicians assistant and have a few trained health workers to help distribute medicine, run samples and tests, and perform basic health services (vaccinations, immunizations, weighing babies, etc).

This particular WKU group consisted of fifteen pre-professional students, three physicians, a WKU Biology professor, and a public school teacher and her husband. The responsibility of the students was to assist the physicians in patient triage, which included reviewing medical history, recording patient vitals, and presenting the patient to the physician for evaluation. The waiting time provided an opportunity to build relationships with a patient and to also ask them their opinion of the status of their health and the care they receive normally. During our time there, the group provided treatment for approximately 750 Kenyans.

Many of the patients had basic medical needs such as joint pain, cold/flu symptoms, and respiratory infections. However, some patients had medical concerns that needed to be evaluated at a more specialized hospital. For example, a young boy came with a broken femur and needed to have the leg set correctly, which could not be performed at the clinic. Transportation funds were provided for him to go to the nearest referral hospital by WKU. Several patients came with very severe conditions such as
HIV/AIDS. I personally, met a little boy named, Matthew and was devastated to have to deliver the news that he had HIV.

**Analysis of Rural Clinics in Kenya**

The same method was used to evaluate these clinics as was done earlier for quality of care at Tenwek Hospital. The access to these clinics will again first be considered. The geographic accessibility of the clinics is an area that could see improvement. The three clinics were all located in strategic areas to make the most immediate impact to the greatest number of people. However, many of the patients we saw walked great distances to reach the clinics. A small, six-year-old girl walked four miles by herself to reach our clinic in Buguta to receive medicine for flu-like symptoms. The roads also were in poor condition, so if any type of emergency were to occur, it would be very difficult to get immediate treatment.

Next, the availability of the clinics is another issue that can see improvement. With the clinics severely understaffed, wait times for patients can be quite long. Most of the patients we saw arrived early to the clinics and would need to wait most of the day for us to see and treat them. There were also patients who needed to be referred to see more a more specialized medical workers but the availability of these professionals was not accessible to many Kenyans.

The services provided at these clinics are not as extensive as at a large hospital. The role of the clinics is to provide basic medical care and to evaluate whether patients need to seek further treatment. The clinics, however, were not able to adequately meet these goals. The clinics did not have a consistent supply of drugs and medicines available
for their patients. Many of the clinic workers would prescribe smaller dosages than medically recommended to ration their medicine. If the clinic was out of a particular medicine, they recommended to the patients to pick up their medicines on their own and from their own expense from the chemist (or pharmacist). We were told though that many did not pick up the medicine because they viewed it as not a worthy expense. Wamai says that a recent survey showed that 15.5% of patients did not use their nearest health facility due the unavailability of medicine, and that 69.4% of out-of-pocket spending is on drugs (2009). Many new ideas will need to be proposed to advance the availability of services and supplies at some of these rural clinics that provide many Kenyans with the bulk of their care.

Financial accessibility is a dimension that did not hinder most individuals from coming to the clinics. While we were there, the only thing that we required of them was to bring their own medical record book. These were simply composition notebooks that cost about 10 KSh and contained a partial medical history, including what prescriptions they had received in earlier visits. Some of the medical tests required additional charges, but all tests and vaccinations for children are free. The costs for individual patients vary tremendously, but typically they are lower than at a hospital that treats more severe illnesses and ailments. Compared to the private sector, the public run health care facilities have an advantage in terms of financial accessibility, and this is why many patients go to these facilities for their most basic health care needs.

Acceptability is another dimension on which the public sector is performing well, but a few cautionary reasons must be considered. Most often, these facilities are the ones that are closest and available, and private facilities are not as common. Many Kenyans,
like other citizens of developing countries, do not have the opportunity to choose among several medical facilities. That is why a bias toward these clinics could be present when evaluating the acceptability of the clinics. The people, though, felt very comfortable when they came to the clinics. The clinics were typically run and staffed by fellow Kenyans who spoke their language, and many of the medical workers personally knew (or in some cases were related to) many of the patients. This particular area in Kasigau has received support from WKU in ways that will enhance the acceptability of care. WKU has been sponsoring a young man named Brian for three years, and he will be graduating from Physician’s Assistant school in the spring of 2014. The hope is that he will be able to return to Kasigau, which is his home, and provide services to members of his community. Our presence in the area also is encouraging and inspiring some of the children. A little girl named Naomi told me in English that she wanted to be a doctor just like me when she got older. WKU is creating an environment that is empowering the individuals in this community who will hopefully be able to run the clinics and sustain them without our involvement.

The quality of care received at these public rural clinics falls below even the expectations for a developing country. The clinics are difficult to access because of the poor roads, and this puts an increased burden on the patients. The availability of medicine proved very inconsistent, and many did not receive medicine for their conditions. The acceptability and financial accessibility for these clinics were sufficient for the purpose of these clinics, but the patients’ needs were not fully met, as many left with very little help.
CHAPTER 7

OVERCOMING BARRIERS TO ACCESS HEALTH CARE

Demand vs. Supply Barriers

I was only able to witness and assess the health care facilities and speak with the people of the country who actually pursued treatment. Utilization rates in Kenya vary by district and whether one is located in a rural or urban district. There are many barriers that each citizen must overcome to receive care, and it is from addressing these barriers that solutions can be found. Barriers are often categorized into supply and demand barriers.

Many of the tenets of the previously discussed model for quality of care would be described as a supply barrier. According to Tim Ensr and Stephanie Cooper, these supply barriers are, “…determined by factors derived from the health care production function, that interact to produce effective health care services” (2004, p.70). These factors are things such as quality of the staff skills, protocols of treatment, availability of supplies and acceptability of health facilities in the community. Additionally, barriers related to technology, management, and price of treatment create supply barriers that often prevent citizens from using health facilities. Supply barriers are typically seen as infrastructure issues by the individual health facility. Most of health care policy and
reform goes into empowering citizens to overcome these barriers (Ensor & Cooper, 2004 p.70).

Demand side barriers are often based on the Grossman model, which “…analyzes individual investment and consumption decision to improve health and utilize health care” (Grossman, 2000, p.347). Ensor and Cooper say that, “Demand is influenced by factors that determine whether an individual identifies illness and is willing and able to seek appropriate health care” (2004, p.70). These barriers are influenced by individual and community factors as well as the price on households for medical services and goods. Individual factors can be age, sex, income, education, and knowledge and need for medical treatment. For example, those who have received more education are more likely to go to a healthcare facility (see Figure 8.1). Community factors include cultural, religious and social and religious factors (Ensor & Cooper, 2004, p.71). These factors can be seen, for instance, when individuals will not seek contraceptive care due to religious reasons. Price is derived from the direct price of medical services, distance cost, opportunity cost of treatment, and any additional informal fees. Much of the current barriers to health care are identified within this category and it is here that changes must be made (Ensor & Cooper, 2004, p.70-71).

Kenya’s Ministry of Health has been trying to identify the barriers that are present for its citizens. The department issued the Household Survey of Health Care Utilization and Expenditure in 2003 and a follow-up report in 2007. One part of the survey tracked individuals who became ill during the study but did not receive care. The following table (Table 7.1) is based on this study but I have added the type of barrier that this would be classified as based on classifications used by Ensor and Cooper.
Table 7.1: Percentage of Persons Reporting Being Ill in the Four Weeks Prior to the Survey And Not Seeking Care, and Their Reason for Not Doing So, 2003 and 2007

<table>
<thead>
<tr>
<th>Reason</th>
<th>Supply or Demand?</th>
<th>2003</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of money</td>
<td>Demand</td>
<td>39.4</td>
<td>37.7</td>
</tr>
<tr>
<td>Self-Medication</td>
<td>Demand</td>
<td>37.2</td>
<td>34.5</td>
</tr>
<tr>
<td>Poor quality service</td>
<td>Supply</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Religious</td>
<td>Demand</td>
<td>1.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Fear of discovering serious illness</td>
<td>Demand</td>
<td>1.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Long Distance to Provider</td>
<td>Demand/Supply</td>
<td>16.4</td>
<td>11.2</td>
</tr>
<tr>
<td>Other</td>
<td>Supply or Demand</td>
<td>3.0</td>
<td>12.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>


The survey makes it clear that the majority of barriers for individuals to not go to a medical facility are due to demand barriers. This is an encouraging but also troubling trend. In a country that only spent 4.5% of its GDP (WHO 2012 Report) on health, and incorporates donations from other nations and organizations into its national budget,
many of these barriers cannot be addressed financially. It also illustrates that this problem with health care goes beyond maintaining a steady flow of drugs and medicines across the country. It involves developing programs that will empower individuals to make better health care decisions. These choices will enable Kenyans to take charge of their health and will help ensure that they are able to make educated, thoughtful, and insightful decisions about their health.

**Definition of Empowerment**

Long-term solutions must be found in order to enable Kenyans to live a high quality of life. The first essential step toward achieving these goals is by empowering the citizens to take charge of their health decisions. According to Aujoulat, d’Hoore, and Deccache, “Empowerment puts an emphasis on the rights and abilities rather than the deficits and needs of the individuals and communities” (2007, p.2). McGuckin and Govednik define empowerment in a health care setting by saying that, “Empowerment refers to the process that allows an individual or a community to gain the knowledge, skills, and attitudes needed to make choices and participate in their care” (2013, p.192).

Any long-term development program will have to instill in individuals a sense of personal empowerment and meet certain features including “…continuity, patient centeredness, mutual acknowledgement, relatedness, positive atmosphere, interest and non-judgmental responsiveness” (Aujoulate, d’Hoore, & Deccache, 2007, p.4). Empowerment is possible and needed at every age in the community and can be achieved from focused and diverse forms of education.
CHAPTER 8

EMPOWERMENT THROUGH EDUCATION

According to Ensor and Cooper, “Education, which is often measured by level or duration of schooling, has been shown to be the most important correlate of good health” (2004, p.71). The Ministry of Health 2007 survey also concludes “Education can lead to a healthier lifestyle, either directly or through increased earning capacity. It also improves access to care through better information, and again, through higher earnings” (p.46). Figure 8.1 from this survey shows a strong correlation to education level and use of health care services:

![Figure 8.1 Annual admission rate per 1,000 population by Education](image)

*Source: Household Survey of health Care Utilisation and Expenditure, Fig. 6.1 (b), 2007, Kenya*
The survey shows that many individuals do not use health care services if they receive no more than primary school education. Many do not complete primary school education or they enroll late. The reason for this, according to Geissler et al. (2000), is that “…the parents can not afford to pay fees and uniforms, but a number of older boys prefer fishing and a more independent lifestyle to school and some girls become pregnant or get married” (p.1772-1773). They then grow up with limited health education and rely upon tradition and cultural practices for treatment. Because of this, health education reform needs to be addressed at the primary school to educate the needs of the next generation of Kenyans, and at the community level to provide insight to current adults on health care decisions.

Previous health education programs have focused on prevention as the primary way to encourage healthy lifestyles. However, these encourage, a passive attitude toward one’s own health and do not allow individuals to feel like they have an active voice in their health decisions. According to Geissler et al., health education in Kenya, “…focuses on disease prevention – mainly by avoiding doing certain things – rather than on active coping with illness” (2001, p.365). Health education will need to take a more active role and have a goal of creating a basic level of “health literacy.”

Health literacy, according to Nutbeam, “…is a relatively new concept in health promotion. It is used as a composite term to describe a range of outcomes to health education and communication activities” (2000, p.259). Nutbeam adds to this definition of health literacy by saying that, “Health literacy means more than being able to read pamphlets and successfully making appointments. By improving people’s access to
health information and their capacity to use it effectively, health literacy is critical to empowerment” (2000, p.264).

Nutbeam classifies health literacy into three distinct levels based and can be seen in the Table 8.2:

Table 8.2: Levels of Health Literacy

<table>
<thead>
<tr>
<th>Health literacy level and educational goal</th>
<th>Content</th>
<th>Examples of educational activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: Functional health literacy: communication of information</td>
<td>Transmission of factual information on health risks</td>
<td>Transmit information through existing channels opportunistic interpersonal contact.</td>
</tr>
<tr>
<td>Level 2: Interactive health literacy: development of personal skills</td>
<td>Opportunities to develop skills in a supportive environment</td>
<td>Tailor health communication to specific need; facilitation of community self-help and support groups</td>
</tr>
<tr>
<td>Level 3: Critical health literacy: personal and community empowerment</td>
<td>Provision of information on social and economic determinants of health, and achieve policy changes</td>
<td>Provision of advice to support community action, advocacy to community leaders and politicians; facilitate community development</td>
</tr>
</tbody>
</table>

The first level is basic/functional literacy. Nutbeam defines this as having, “…sufficient basic skills in reading and writing to be able to function effectively in everyday situations” (2000, p.263). The second type is communicative/interactive literacy which is described as, “…more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and drive meaning from different forms of communication, and to apply new
information to challenging circumstances” (Nutbeam, 2000, p.264). The final distinction is critical literacy and is seen as having, “…more advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations” (Nutbeam, 2000, p.264).

Health literacy must be a new direction for education programs in Kenya and must have a goal of achieving critical literacy. This can be done through a revised health education curriculum in primary and secondary schools and also through community development programs. These two solutions are not mutually exclusive, but must work together. Both will empower citizens of all ages.

**Children as Advocates of Health Change**

According to the Government of Kenya and the WHO 2012 report, about 42% of the population of Kenya are children under fifteen years old. An estimated 7.2 million children are enrolled in primary school (Republic of Kenya, 2003). Many see these children as the ones to enact public health changes. According to Onyango-Ouma, Aagaard-Hansen, and Jensen, “Children can engage with health knowledge and skills in their own right and are not merely passive recipients of other people’s care and interventions (1712).” Unlike in many Western cultures, the idea of a “childhood” free of responsibility does not apply to East African children. Geissler et al. say that three differences between children and health in Western and East African cultures must be addressed. They say that,
(1) Children here [East Africa] are not passive creatures constantly supervised by adults, but are responsible community members.

(2) Knowledge of medicines is not an expert’s domain, but is common property and everybody participates in healing.

(3) The state does not have the capacity to provide health care or control the trade in medicines (2001, p.364).

Geissler et al. add that when medical knowledge about drugs and medicines is withheld from children, “…this described ideology meant to protect children from harm, endangers their health” (2001, p.364). The disturbing news is that according to Geissler et al., “Children experience almost three quarters of all illness episodes alone, only one quarter of illness episodes is reported to adults” (2000, p.1780). Because of this, Geissler et al. says that, “…the medical practices of children carry a number of dangers, since self-treatment on insufficient knowledge and limited funds can lead to misuse of pharmaceuticals” (2000, p.1782). Chloroquine, a common anti-malarial drug, is a major source of fatal drug poisoning in Kenya, and insufficient dosages and irregular use of other antibiotics have contributed to pathogen resistance (Geissler et al., 2000, p.1782). Clearly, it is an essential that future health education focuses on empowering children to become knowledgeable advocates for better health.

Current health education in Kenya would be placed on Level 1 of Nutbeam’s health literacy scale (Table 8.2). It is focused toward health promotion and disease prevention. It covers basic topics such as hygiene, sanitation, family life, HIV/AIDS and STDs, reproduction, nutrition, immunization, the body, alcohol, smoking, drugs, first aid, caring for sick or disabled people, and the causes and symptoms of various diseases.
Geissler et al. says that the health education is rooted in the British colonial mindset that insinuated that, “…the local people are passive, ignorant recipients of western curative services or disease control” (2001, p.366). Health education in Africa has thus become a list of “dos and don’ts.” It is also seen with low priority since there are no tests or standards that students must obtain before passing this course (Onyango-Ouma, Aagaard-Hansen & Jensen, 2005, p.1713).

Future health education in Kenya must break this passive mindset and provide tangible ways for children and adults to, “…cope with bodily afflictions in their daily lives and to handle the potent medicines that are readily available to them” 2001, p.365). It needs to have a goal of raising health literacy to Level 2 for all students and to Level 3 for some students. Practically, teachers can do this by incorporating metaphors and examples into their lessons in other subjects. A math lesson could have problems about appropriate dosages for body weight, and metaphors about the “stubbornness” of parasites and that they need to be completely “taken care of” in order to feel better. The topic of pharmaceutical abuse can also be used to reflect on national and global politics and ethics. When appropriate integration across multiple subjects is done well, it has proven to be workable and effective (Nichter, 1989). Collaboration between education, health, and community departments need to be established to develop good curricula to create awareness of common current issues in health care in Kenya.

Furthermore, Onyango-Ouma, Aagaard-Hansen, & Jensen say that ‘action’ and ‘participation’ are two concepts that need to define future health education, adding that, “The concept of action has two key characteristics: it is targeted at change and it should be decided upon by those carrying out the action. Participation refers to the active
involvement of students in the learning process and is considered to be the most important pre-condition for developing ownership among students.” It shifts the role of teachers from instructors to facilitators, “…who promote dialogue, suggest action strategies, and put barriers into perspective” (2005, p.1712).

A specific example of this approach has been developed through the child-to-child program (CtC) proposed by Hugh Hawes in 1988. CtC is seen as being action and participatory-oriented and empowering to children and community individuals. Pridmore says that, “The concept of CtC promotes the understanding that children can work together with others in their communities to solve health problems. It is assumed that parents will be willing to learn from children and include them in family decision-making” (2003, p.17). Onyango-Ouma, Aagaard-Hansen, & Jensen conducted a CtC study with 80 schoolchildren from grade/standards three to five and 40 adults in the Bondo district in western Kenya. The grade five students became health communicators (HCs) and each had one child recipient (CR) from grade three and one adult recipient. After a base-line health survey was completed by the HCs, personal instruction and participatory teaching was given to HCs for 2 months regarding to malaria, diarrhea, and hygiene. The HCs then shared the information with the teachers as facilitators and resources if they had questions or needed support. The following chart illustrates the flow of the study and serves as a model for many CtC approaches:
Figure 8.3

SCHOOL

CRs

Rest of School Population

HCs

COMMUNITY

Rest of community members

Families

Teaching Activity (Intervention Phase 1)

KEY:

CRs-Child recipients

Direct influence on HCs

Direct influence of HCs

Indirect influence of HCs or CRs

HCs-Health communicators

The study concluded that, “Significant improvements in knowledge was detected in every single group, but behavioral changes were more evident among the children than among the adults” (2005, p.1711). However, the findings did show also that the HCs were able to communicate to their peers and community members particular health knowledge, but had difficulty in turning the newly acquired health knowledge into lifestyle changes for the majority of adults. This is an area where CtC falls short, but it opens the door for more community involvement and encouragement for the children, and adults, to take this new knowledge and to apply it in their lives and communities.

Changes in the primary health education system can have great impacts on the status of health in the country, and very cost-effectively. Action and participatory education will allow students to progress from Level 1 to Level 2 health literacy and to begin to apply and use their health knowledge in their own lives. Nutbeam says, however, that in order to obtain Level 3 ‘critical health literacy’ and long-term health benefits, one must be able to apply this interactive education to the community and larger population. Nutbeam says this will “…improve capacity for social action which may in turn be directed changing public policy and organizational practices related to health. Examples of this form of action can be found in many community development programs” (2000, 264). The partnership between focused health education and community development programs will help Kenya and other developing countries reach its goal of better long-term health.
CHAPTER 9

COMMUNITY DEVELOPMENT PROGRAMS

Tenwek Community Health and Development Program

According to the Ministry of Health 2007 report, about seventy percent of all outpatient morbidity is due to preventable diseases such as malaria, respiratory diseases, diarrheal diseases, and intestinal worms. Table 9.1 is adapted from the report listing the leading causes for seeking outpatient care:

Table 9.1: Causes For Seeking Outpatient Care, Kenya, 2007

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>30.6</td>
</tr>
<tr>
<td>Respiratory disease including pneumonia</td>
<td>25.0</td>
</tr>
<tr>
<td>Immunizations (prevention)</td>
<td>6.4</td>
</tr>
<tr>
<td>Skin diseases (boils, lesions, etc)</td>
<td>5.5</td>
</tr>
<tr>
<td>Prenatal/antental care</td>
<td>4.6</td>
</tr>
<tr>
<td>Intestinal worms</td>
<td>4.3</td>
</tr>
<tr>
<td>Accidents and injuries</td>
<td>3.7</td>
</tr>
<tr>
<td>Physical check-up (prevention)</td>
<td>3.1</td>
</tr>
<tr>
<td>Eye Infections</td>
<td>2.9</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
</tr>
<tr>
<td>All others</td>
<td>8.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
</tr>
</tbody>
</table>


Due to the high volume of preventable diseases in Kenya, community development programs are necessary to address these health concerns. Community health programs are relatively new to healthcare in Kenya and are established by hospitals, NGOs, or local governments with the goal to promote healthier lifestyles at villages and individual homes. One example of a community health program is the Tenwek Community Health and Development (TCHD) program. I was able to work with members of TCHD while at Tenwek Mission Hospital.

TCHD was established in 1984 with the goal, “…to serve Christ by facilitating change through primary health care and appropriate development with needy communities.” The projects of the program include HIV/AIDS prevention and care, safe and accessible water, food security, hygiene and sanitation, maternal and child health, and gainful employment. (“Tenwek Hospital,” 2014). According to Jacobson et al., “The major emphasis of the program has to establish significant community participation in the program planning and control” (1989, p.1060). This is done by training and mentoring local Kenyans to be the community health leaders.

The TCHD program was developed in the following systematic way. First, contact with church and other community leaders was made to see if there was any
interest in the program. After a few meetings discussing the needs of the community and possible solutions, a village health committee (VHC) was elected by other community members. Each VHC decides on a constitution, meets monthly with project staff, and selects seven community health workers (CHWs). The qualifications for a CHW are determined by each VHC. The CHWs are trained in two two-week sessions at local health care facilities. Each village is responsible to support their CHWs for that time and for their entire service as a CHW. Their training focuses on group discussion and team work in solving, treating, and providing basic preventative health care. Each CHW is given approximately fifty homes and is expected to routinely visit these homes and provide their services. There is also a community health program staff that consists of a registered nurse, three non-medical CHW supervisors, and a medical doctor who oversee the CHWs. They provide guidance, keep the CHWs accountable for their work, and ensure they are performing their duties (Jacobson et al. 1989, 1060-1061).

Currently, this health program staff has to oversee many VHCs and CHWs. I was able to accompany a CHW as he visited some of the homes in his community. We performed demonstrations about the importance for hygiene, asked how their crops were doing, and asked if there was anything that we could do to help. These communities were receiving medical attention and community support from Tenwek Hospital even though it was an hour away from their home.

**Development of Community Health Centers**

The success of TCHD is possible in many other communities in Kenya and offers a model others could follow. I propose that to increase communities to level 3 health
literacies, countries like Kenya need to focus on finding ways to partner with NGOs and local communities to expand community development programs. A practical way to accomplish this goal is to begin restructuring communities around community health centers. The village lifestyle in Kenya can be centered on either the clinic or the local hospital as the source for support, medical information, and treatment. A combination of empowerment and education at both the community and school level will allow for communities to achieve level 3 of health literacy and to begin making lasting changes in the community, larger populations, and public policy. This model follows the idea proposed by Nutbeam when he says,

“Improving health literacy in a population involves more than the transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community-based educational outreach” (2004, p.267).

A proposed way this would look is found in Figure 9.2 below:
Figure 9.2: Community Health Center Model

KEY:
VHC-Village Health Committee
CHWs-Community Health Workers
HCs-Health communicators
Indirect influence
Direct influence
Figure 9.2 begins with the community health centers at the top facilitating and passing information to the communities. These community health centers can be distributed strategically to oversee between three and five rural health clinics. The rural clinics each then help foresee the election of the VHCs previously discussed. The VHCs then train both the new CHWs and the Teachers and HCs needed in the CtC approach. The CHWs then are responsible for going into villages and people’s homes while the Teachers and HCs help instruct the Kenyan students with a focused and applicable health education curriculum. The people the villages and the Kenyan students will then be able to learn from each other and share new pieces of information about health care. This will allow the whole community to be engaged and become active changes in community health. The whole process is also monitored by particular NGOs.

Influence of the NGOs

A crucial part of this model is the direct and indirect influences of NGOs. Both totally private and public services by themselves cannot solve the problems by themselves. There has to be a way to create a partnership between both all of these modes of care. Recent studies have suggested that the mode that the African countries, like Kenya, should embrace is the NGO route (Leonard, 2004, p.50-51).

The NGO system is very effective due to the fact that the facilities are independently run and are responsible for its own independent finances. This provides the facility with a higher motivation to produce quality care in order to cover its expenditures (Leonard, 2004, p.61). These facilities, compared to government run facilities, have the option of hiring, firing, disciplining, and rewarding their employees in order to make sure quality care is produced (Leonard, 2004, p.62). These NGOs should work closely with
the Kenyan government and obtain approval to begin working. In 2005, a Health NGOs Network (HENNET) was established with the objective “to stimulate linkages and strategic partnerships among health NGOs, government, and private sector” (Wamai, 2009, p.138). In the future, NGOs can be licensed through similar networks to ensure that qualified and appropriate NGOs are receiving funds to offer services to those in Kenya.

Government funds should then be distributed at the community and local levels to strengthen these community development programs. NGOs in these areas then can employ and train citizens of the area to help run the community development programs. By having citizens given responsibility and ownership within the NGOs, this will allow for the organizations to know what is needed in the community and then can use government resources to provide quality services. A major critique of purely government organizations, such as the United Nations and other national governments, is the fact that they do not understand what Africa truly needs. David Karanja, a former Kenyan member of parliament said that, “Today, Africa’s development plans are drawn thousands of miles away in the corridors of the IMF and the World Bank. What is sad that the IMF and World Bank experts who draw these development plans are people completely out of touch with the local African reality (Ayodele, 2012, p.3).”

NGOs can also help develop a new health education curriculum to improve the community. The NGOs can help break the passive, fatalistic attitude towards health that plagues so many Africans and Kenyans. Unfortunately, many Africans are trapped in a mechanism that has been termed the “entrapment of households.” This happens where, “Poverty leads to ill health and ill health leads to poverty” (Peters et al., 2008, p. 161). This is why change must occur at the individual and community level. Medical facilities
should be teaching methods for improving health. They need to form relationships with patients and provide opportunities for them to succeed in managing their own health needs by increasing health literacy that will impact all members of the community and the country.
CHAPTER 10

CONCLUSION

It is clear that much work must be done in Kenya to improve the quality of life for its citizens. Globally, organizations like the U.N. and other countries must be careful to offer aid and support in a way that reduces high administrative costs and avoids giving money to corrupt political leaders rather than to the people in need. Nationally, Kenya should decentralize health services and partner with NGOs in a way that streamlines the process of care. Kenya also needs to continually work on expanding insurance plans to more of its citizens and find a balance in user fees so that all have access to health care. Locally, communities should be restructured around health centers that can educate and empower leaders and students to address the health concerns in the area. Community development programs must train CHWs who will go out and expand health knowledge to individual homes and primary schools.

An African proverb suggests that, “Hope is the pillar of the universe.” (Steine, Lewin & Fairall, 2007, p.962). After visiting the country, hope is a word that is central to the Kenyan spirit. They wake up everyday grateful and hoping for a better tomorrow. Careful and strategic reform can help give them this better future. It will allow for kids like Matthew to not be diagnosed with HIV at age 6 but to instead live a healthy and successful life. It will allow for parents of Esther to not be scared to take their little girl to the hospital after falling into a fire three months prior to receiving treatment at Tenwek.
will allow for Naomi who after seeing our service in Rukunga said to me, “I want to be a doctor just like you,” to fulfill her dream and serve the community. There is hope with citizens like Brian who has been supported by WKU to attend PA school and who has a desire to go back and serve in his local community. Even amidst all of the statistics, numbers, and troubling stories, hope exists in Kenya and will continue to grow and seize the country like a lion storming across the plain.
WORK CITED


Charter of the United Nations, preamble.


