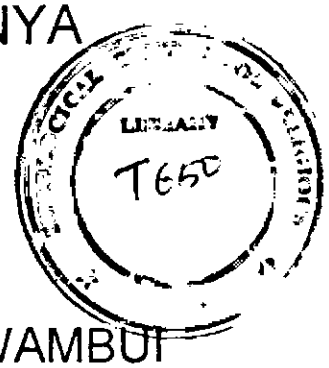
INSTITUTE OF SOCIAL MINISTRY
TANGAZA COLLEGE

CATHOLIC UNIVERSITY OF EASTERN AFRICA

COMMUNITY PARTICIPATION RURAL HEALTH DEVELOPMENT: A CASE STUDY OF NAKURU DISTRICT IN KENYA



BY:
STUDENT: SR. MARY MUNYUA WAMBUI

SUPERVISOR: MR. ZACHARIA WANAKACHA SAMITA

DATE: 31ST MARCH 2001

2001
WAM

PLACE: NAIROBI

INSTITUTE OF SOCIAL MINISTRY
TANGAZA COLLEGE

CATHOLIC UNIVERSITY OF EASTERN AFRICA

COMMUNITY PARTICIPATION RURAL HEALTH DEVELOPMENT: A CASE STUDY OF NAKURU DISTRICT

FULL SCALE PROJECT THESIS, SUBMITTED IN PARTIAL FULFILMENT OF THE AWARD FOR BACHELOR OF ARTS DEGREE (*IN SOCIAL MINISTRY IN SCIENCES AND PRAXIS OF HUMAN DEVELOPMENT*)
(FACULTY OF ARTS AND SOCIAL SCIENCES-CUEA).

SUPERVISOR: MR. ZACHARIA WANAKACHA SAMITA

STUDENT: SR. MARY MUNYUA WAMBUI

DATE: 31ST MARCH 2001

PLACE: NAIROBI

STUDENT'S DECLARATION

I hereby declare that the material herein is my original work. It has not been submitted for academic credit to any other institution. All sources have been cited in full.

STUDENT: SR. MARY MUNYUA WAMBUI

SIGNATURE: .....

DATE: 31st March 2001

SUPERVISOR: ZACHARIA WANAKACHA SAMITA

SIGNATURE: .....

DATE: 31st March 2001

DIRECTOR OF ISM: .....

SIGNATURE: .....

DATE: 31st March 2001

DEDICATION

This work is dedicated to two levels or groups of people. Firstly, to all the communities visited. Secondly, it is also a dedication to all the people in my life through whose relation, be it familial, friendship, or by my faith/religious community, have helped me to be able to show a spark of love in the hearts of these members of the communities whom I have encountered. If you hold me dear, then this work is for you!!!

ACKNOWLEDGMENTS

My profound thanks go to the Almighty Father who has sustained me in good health to the completion of this work. My heartfelt gratitude is due to my mother, as well as my brothers and sisters for their love, prayers and support which have strengthened me all through my life.

In a sincere way I express my deep thanks to Mother Marcellina Akello our former Superior General for she made it possible for me to have a two year course in the Institute of Social Ministry, Tangaza College. I am grateful to Mother Clementina Nasimiyu, our present Superior General for permitting me to complete the third year in the same institute.

Many other people have helped me directly or indirectly in bringing this study to fruition since its inception. It is difficult to specifically recognize each and every one. Nevertheless, I would like to mention a few of them. I thank the supervisor of my study, Mr. Zacharia Wanakacha Samita. He agreed to supervise me, and expended his time and effort to direct me, producing this scholarly and scientific work.

May I acknowledge all facilitators who welcomed me in different communities and centers which I visited, and all who generously, through questionnaires and interviews generated data that has been the foundation of this work.

My appreciations go also to my Evangelizing Sisters for their love and encouragement. Finally, I am indebted to my fellow students of Tangaza College with whom I lovingly journeyed during these three years. I am grateful to all friends from near and far, who offered me advice when I was discouraged. Thank you and God bless you.

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome.
AMREF	Africa Medical Research Foundation.
CBHC	Community Based Health Care.
CBO	Community Based Organisation
CHV	Community Health Volunteer.
CIH	Community Involvement in Health.
CSW	Commercial Sex Workers.
GoK	Government of Kenya.
MCH/FP	Maternal Child Health/ Family Planning.
MoH	Ministry of Health.
NGO	Non Governmental Organisation.
PHC	Primary Health Care.
SIDA	Swedish International Development Agency.
SRDP	Special Rural Development Project.
TB	Tuberclosis
TBA	Traditional Birth Attendant.
TOT	Training of Trainers/ Training of Trainees.
UNICEF	United Nations Children's Fund.
VHC	Village Health Committee.
VHHs	Village Health Helpers.
WHO	World Health Organisation

LIST OF TABLES

TABLE OF CONTENTS

CHAPTER ONE

GENERAL INTRODUCTION

DEFINITION OF COMMUNITY PARTICIPATION

Community constitutes the people living in one locality. In our study context, it refers to rural communities, that is, people living in the rural areas. Participation is taking part, being or becoming actively involved in something or some work. Community participation is, therefore, the active involvement of the whole people in the affairs or realities of concern to their community. Everyone takes part actively in every activity or organisation in that particular community. People become their own agents of development. The community participation for rural transformation is taken as the people's involvement in development projects by contributing human labour and material resources. It also includes the involvement of the same people in identifying their needs for development From there, the planning of a project or programme is undertaken. On this, Francis Wambugu comments, "Common people are seldom consulted in the formulation of the plans and programmes and fixing of priorities". Need arises to acknowledge involving people in development projects that concern them at all crucial levels, namely, designing/planning, implementation and evaluation. In order to be genuine, this community participation should be present. The rural communities should be empowered to solve by themselves, their own problems. If it so, human development becomes totally genuine and embraces the whole person physically, emotionally, psychologically and spiritually. Their daily physical needs especially shelter, food, water, heat and security are addressed. Psychologically and emotionally love, care and company They also have need for personal relationship with the supernatural being. This search for truth about ultimate concerns and the mystery of life, death and God constitute the vital spiritual development

Julius Nyerere emphasised. "Development is for man, by man and of man".[1] It is implicitly true that development is for people, by people and of the people. The work of

[1] Robert. Chambers The Church Contribution in Rural Development; Putting the Last First. Longman. Hong-Kong. 1983 pg 154-160.

development should involve the participation of the broad mass of people and not only a few Julius Nyerere is right in intimating that: "Man can only develop himself, he cannot be developed by another."[2] The goal of developing every person and the whole person can be achieved when the whole people are fully involved in this work for his/her own development. But how can we enable person(s) for this community participation? The next section deals with this question.

COMMUNITY PARTICIPATION AS PRIMARY HEALTH CARE:

In 1976 a cadre of government health workers known as the Family Health Field Educators was started in Kenya. It had similar functions as Community Health Workers (CHWs) However, since they were government employees, they were not community based but community-oriented. Local health committees were formed as early as 1976 and Community Based Health Care (CBHC) programmes were started by NGOs as early as 1977 In East Africa, the development of the philosophy of CBHC first occurred at Nangina Mission Hospital in Kenya in the early 1970s.[3]

In 1977 the Government of Kenya (GoK), with the financial support from United Nations Children's Fund (UNICEF) and WHO launched a pilot project in Kakamega District to assess the potential for community participation in health care delivery. According to Wilms[4], one of the most important issues the Ministry of Health (MoH) hoped to learn from the national pilot project was on how to facilitate the process of community participation, and, in particular how to construct useful links between the government, NGOs and the community in such a way that the relationship between the formal and informal health systems developed in a mutually supportive system.

As a result of the national pilot project, it was concluded that community participation was a feasible approach It took the form of involvement of communities in decision-making and priority-setting, focusing on health promotion and disease prevention. The pilot project demonstrated that community participation could take place

---

[2] Ibid

[3] Roy, Shaffer Beyond the Dispensary, Community Health Worker Support Unit, African Medical and Research Foundations, Nairobi: 1983, pgs. 4.

[4] Williams, Dennis, Epistemological Relevances in CBHC, Programme in the Republic of Kenya. The University of British Columbia, 1984) pg 112.

through an organisation framework and through established community structures. It was possible for a dialogue to be conducted between the community and health workers.

A community mobilisation mechanism used in the national pilot project was local community meetings, *barazas*, to disseminate the concept of CBHC. Community health committees were established. These met regularly and formed a rallying point for action. A community financial account was set up for the pilot project maintained by household levies and a fee for service system for the curative services of CHWs. Leadership training was also undertaken for community leaders and CHWs[5].

Recognising the health staffing constraints that Kenya was facing but building on country's demonstrated spirit of self-help The MoH in the early 1980s developed a policy to foster a system of CBHC, centred around a village volunteer or the community health worker(CHW). This person was expected to be selected and supported by his or her community while the government was responsible for his or her training, technical support and supervision. By the mid 1980s, this model of CBHC was already in existence in over 30 projects throughout Kenya, for instance, Kibwezi, Nangina, Saridida and Maua, operated by local communities with assistance coming from Non-governmental Organisations (NGOs).[6]

According to Shaffer, CBHC is seen as a practicable way to narrow the widening gap between health needs and resources to meet those needs.[7] The key elements are voluntarism, motivation and prevention. The CBHC approach strives for more delegation of responsibility for health promotion, better balance between cure and prevention, more voluntaristic input into the system, increased awareness and sensitization and better cross-disciplinary integration.

In order to evolve a sound policy on Public Health Care (PHC) that was built on practical experiences mainly from NGOs, the MoH with the help of UNICEF, World Health Organisation WHO and Swedish International Development Agency (SIDA) organised a series of workshops in 1983 and 1984. These workshops had a wide spectrum of participants ranging from government, United Nations (UN) and NGOs. The

---

[5] Miriam. K. Were. Organisation and Management CBHC National Pilot Project of Kenya Ministry of Health/UNICEF, Nairobi, 1976) pg 107.

[6] Mburu, F M Whither. Community-Based Health Care Social Science and Medicine 1989.

recommendations which emanated from those consultations provided the basis for developing policy guidelines for implementation of PHC in Kenya. In some international circles, Kenya was considered to be very slow and off the mark in defining PHC policy guidelines. The delay could have been because the MoH wanted to review the operational results of the various NGOs. The CBHC pilot projects included the national pilot project, as part and parcel of the process in developing its national policy guidelines.

Community participation was identified at these PHC workshops as one of the issues that needed special attention to achieve Health for All by the Year 2000. Intensifying community involvement through health awareness and strengthening existing community initiatives for health development care were cited as the rational steps to achieve the PHC goals.

The overall PHC policy of the MoH set out in these guidelines was aimed at increasing the number of communities active in health care, encouraging more community participation, changing the attitudes of health personnel towards PHC and strengthening collaboration and co-operation with the NGOs in the field of PHC.[8] To achieve the aims, the district health management teams in general, and the district medical officers in particular were charged with the responsibility of co-ordinating PHC activities in the district.

The need for re-orientation of CHWs to take more responsibility in promoting community participation was not stressed in the PHC guidelines. This was a major gap in medical services. Hence:

> The role of community participation as a partner in the general effort of improving the health status of families has not been fully appreciated by the majority of our CHWs in our institutions ... a reorientation programme is necessary to inculcate into the minds of our CHWs the need for them to actively seek community participation for their health care.[9]

Shaffer, Roy. Beyond the Dispensary. Community Health Worker Support Unit. African Medical and Research Foundations. Nairobi: 1983.

[8] Bennet, F.J. and Maneno, (eds.). National Guidelines for the Implementation of Primary Health Care in Kenya. Ministry of Health, Nairobi, Kenya (1986) pg. 10.

[9] Williams, Dennis. Programmes in the Republic of Kenya. Unpublished. (1984) pgs. 83-84.

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

The present research examines the determinants of participation of community members in a rural CBHC programme in Nakuru. It draws conclusions on the key factors which can be developed, strengthened and addressed by community leaders, government, NGOs and church health officials to enhance individual and community participation in such programmes in Nakuru, and possibly elsewhere in Kenya.

This study examines the nature and extent of participation of the community in one of the long-standing CBHC programmes in Nakuru, identifying underlying factors The proposition is that community participation can be enhanced and sustained if an integrated approach to development is taken. Such an approach addresses the key factors that influence the participation of community members in health development programmes. Moreover, it is essential that priority is given to addressing those key factors which help to solidly establish the basic levels of participation. These serve as building blocks for involvement in other programme activities such as evaluation, future planning, addressing as well sustainability, among other issues. Mobilising individuals for development activities and services is a vital step in building a base for sustainable participation and establishing a framework for group and community participation. Individual participation in utilizing the services also means a change in health behaviour as a result of community health education, health advice and home visiting services provided by the community representatives of the CBHC programmes.

1.1 DEVELOPMENT OF CBHC IN KENYA

The CBHC approach strives for more delegation of responsibility for health promotion, better balance between preventive health care and curative, more voluntarist input into the system, increased awareness and sensitization in addition to better cross-disciplinary integration.[10]

Many of the CBHC programmes were started between the late 1970s and early 1980s in eastern Africa. They did not initially involve in a significant way communities, be it at the design or planning levels. Programme design was undertaken primarily by planners within NGOs or by church mission health staff. The planners assumed that communities would be readily interested in the said CBHC activities and services are launched Such were mainly mobile maternal and child health/family planning (MCH/FP) clinics being offered and having one of their villagers trained as community health volunteers (CHVs). Many of the programmes were externally funded, hence little need for cost-sharing with the concerned or target communities

The evaluation of many CBHC programmes in Kenya during the late 1970s and early 1980s, can be characterised in three ways First, the CBHC programme idea originated mainly with NGOs or church mission health service staff. This was based on the realisation that hospital-based curative care was having little impact on improving the health status of community members This was a result of the influence of the WHO/UNICEF - sponsored Alma Ata PHC Conference in 1978

Second, communities were selected by the respective programme staff to establish a CBHC programme The idea would be presented to local administration officials and leaders, and then to the communities whose co-operation was sought to participate in the scheme

Third, the participation consisted mainly of selecting community members as CHWs and Village Health Committee Members (VHCs) It also meant utilising the mobile outreach MCH/FP services being provided and selective behavioural change mainly related to hygiene and sanitation This was based on home visits by CHWs, and

---

[10] R Shaffer, Balanced Participation in Development Nairobi African Medical and Research Foundation, 1983) pg 1

making contributions in labour and materials. The programme was mainly for construction of simple health facilities and equipment.

The participation by community members in planning programmes and decisions regarding how the programme activities were to be provided was the exception rather than the rule. This level of participation, however, is the essence of what the WHO described as community involvement in health (CIH). The latter was described as:

> a process by which partnership is established between government and local communities in the planning, implementation and utilisation of health activities in order to increase benefit from self-reliance and social control over the health infrastructure, technology and process.[11]

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

It is important to know whether or not participation is simply a formal action with little meaning or an activity which allows the individual to gain greater control over situations that would alter his/her life.[12] Oakley and Marsden in 1985,[13] intimate that it is the former rather than the latter interpretation which has been predominant. They state that literature on development is overburdened with the documentation of participation

---

[11] World Health Organisation. Community Involvement for the Development. Report Inter-Regional Meeting. Geneva. Unpublished Document. 1985 pg 4.

[12] J.M. Cohen and N.T. Uphoff Participation's Place in Rural Development. Oxford: Oxford University Press. 1980) pg 224-225

strategies which have failed in terms of giving the majority of the rural people any meaningful access to and control over those issues which affect their livelihood. They further contend that the concept of participation as empowering is a radical departure from years of more traditional practice. They admit that this interpretation of participation faces formidable barriers. It is difficult to imagine government and locally established structures offering other than powerful opposition.

An opportunity for broad-based, meaningful participation occurred just after independence in Kenya. For a brief period, community members were able to play a major participatory role in decision-making on development issues. They were empowered through *harambee*[14] movement to plan and undertake community-level development project. This broader participation in Kenya changed the use and allocation of resources in rural societies. However, within a span of a few years, the Government of Kenya reversed this policy and established strict bureaucratic procedures which in effect returned the control of rural development decision-making from the community level to more central levels within the government.

In relation to the health sector, Oakley[15] argues that CIH is a means of extending health services coverage and releasing massive human resources for health development. Such an interpretation of CIH is, however, inadequate. It fails to recognise the legitimate demands for worthwhile participation. The author further contends that CIH cannot be regarded as a mere means of technology transfer. It must imply some notion of the transfer of power and authority to local people to enable them to become effectively involved in health development.

Both the terms "community participation" and "community involvement" can be used interchangeably. The latter term is used by WHO, implying a more active engagement of the community in health issues. In so doing, communities co-operate with health professionals, initiating and taking responsibilities for health action in their own right. However, various forms of participation can also be interpreted likewise. WHO

---

[13] Ibid

[14] Harambee is a concept involving mobilization or pooling of corporate efforts towards a communal effort

[15] P. Oakley, Community Involvement in Health Development, Geneva: WHO, 1989) pg. 72.

officially designated the term as community involvement in health.[16] Both terms are used synonymously in this study.

Some five factors were examined regarding potential influence of communication participation in enhancing or impeding the participation of community members in the Nakuru CBHC programme: education; formal and non-formal; local group membership; household income, socio-domestic issues such as family size, women's time and harmony in the household and local institutional support: Community health volunteers, health committees, health committee members and; local leaders.

These factors were are based on a review of literature, discussions with Nakuru CBHC programme managers, CBHC and PHC development specialists in Kenya, besides the health care development experience of the researcher.

1) The final part of this chapter identifies policy issues particularly those factors which appeared to strongly enhance community participation in the case study of Nakuru CBHC programme. Some policy recommendations to enhance great participation in rural health development, directed at international health agencies, national health policy-makers, international and national NGO health managers, emerged from the research study. In summary they include first, the promotion of primary education and self-help groups as development priorities. Second, is the need to enhance the partnership relations at community level between the formal health service staff and community members. Third there is need to strengthen inter-sectoral collaboration related to income generation. The fourth recommendation is development of innovative ways technically to support community level CBHC programme workers Fifth, is more awareness and appreciation of the impact of socio-economic cultural factors on participation.

1.2 STATEMENT OF THE PROBLEM

The environmental health problems in Nakuru District include cases of diarrhoeal diseases, skin diseases and intestinal worms due to unsafe and inadequate water supply

It is with this respect that the MoH with the assistance of SIDA started CBHC, water and sanitation activities in the district. The broad objective of the programme from

[16] World Health Organisation, Community Involvement for Health Development, Geneva WHO, 1991

the initial stages has been to strengthen and revitalize preventive health care measures aimed at reducing the incidence of preventable diseases particularly those associated with lack of portable and adequate water supply, poor sanitation, poor housing, food hygiene and presence of disease vectors.

The project started in Gilgil Division, Nakuru District in 1996. The division was found to have high incidences of diseases associated with poor sanitation, poor housing, lack of portable and adequate water supply, poor food hygiene and vector-borne diseases. Top on the list of priorities was the CBHC. The strategy of implementation from the beginning has been community sensitization and mobilisation, training CHWs, Traditional Birth Attendants (TBAs), Village Health Committees (VHC) and community members.

The entry point has been organised groups within the community. A lot of health facilities have been installed by the government, NGOs, the churches and the community-based organisations (CBOs) with little success in maintenance. But the factors hindering or promoting maintenance of the same are unknown. The present research study hopes to shed light on this. This research interest sparked a number of research questions.

1.3 RESEARCH QUESTIONNAIRES

What is community participation? What does it practically entail? Do we really need community participation? What problems or challenges does it address? How do these problems manifest themselves and impact society? How is community participation helpful in addressing these problems? What are the challenges community participation confronts in the process of addressing the community issues? What are the achievements of community participation? And how can existing strategies of community participation be improved for more effectiveness?

1.4 GOAL

This study investigates mechanisms through which a partnership could be established between the health system and the communities. This will help to establish an organisational relationship between the health system and the targeted groups. It would

also increase coverage of the population by the health services through increased contact between workers of the health system and targeted communities.

1.5 OBJECTIVES OF THE STUDY

1. To enable communities focus on the need for good sanitation, safe drinking water, proper food handling, nutrition and immunisation.
2. To advocate for appropriate health education programmes aimed at disease prevention.
3. To define community participation.
4. To discuss the importance of community participation.
5. To discuss ways to enhance active community participation in Nakuru District.

1.6 BASIC ASSUMPTIONS OF THE STUDY

That in the context of the harambee spirit in Kenya, the political and government administrative machinery would be supportive of the process of mobilising community potential in identifying and confronting their own health problems.

That the MoH and other government ministries would give the backup and support that would be essential in establishing collaboration between the formal system(s) and the people.

That people are interested in their state of health or that interest can be awakened This interest can be stimulated so that health awareness can be built up toward identifying and working on solutions to their health problems.

That actions taken and services provided through the community-based approach have a greater residual effect in the community This will follow the understanding of the relationship of daily behaviour with health consequences. The recognition of these type of relationships by the communities and the health system should lead to the setting up of appropriate priorities in the organisation of health services.

1.7 JUSTIFICATION OF THE STUDY

The study will enable the implementors to review the strategies of implementation of social work. It will also act as a reference tool for future evaluation of the programme

and a learning experience for the researcher who is also one of the implementors of the said project.

1.8 LIMITATIONS OF THE STUDY

We were confronted with communication constraints in terms of language. Some respondents did not know either English or Kiswahili properly, especially in Mogotio. But a Kalenjin-speaking interpreter we had greatly helped. Due to the limitation of time, the researcher could not organize common groupings as extensively as was intended initially. This was because all the clients were involved in different activities which would not allow them to organize for meetings.

Some questionnaires were not returned due to either illiteracy or lack of time from the respondents. Indeed, the distributed questionnaires were 120, out of which 90 were returned. Nevertheless, this was still a 75% return which is alright. There was a bit of initial mistrust from the respondents. Many were not willing to complete the questionnaire. From experience, they complained that other people have used them in similar manner, promising them that they would assist them to address their plight in vain. After clarifying our intentions, we won their confidence and built good working rapport. Overall, we fulfilled the goal and objectives of our research. Thus, in spite of the problems outlined, the research design and methodology, we followed enabled us to collect data for this study. We will see, in third and fourth chapters, what kind of picture emerge from analyzing the data herein obtained.

ORGANISATION OF THE STUDY

Chapter One discusses the meaning of community participation. It examines features and roles of community participation with particular reference to Nakuru District in Kenya **Chapter Two** discusses community participation with particular reference to the literature review on previous work carried out in this area by others. In the **Third Chapter** is discussion on the design of the present study. It identifies the areas covered in the study, the sampling method, the questionnaire used in the study as well as the data collection and analysis **Chapter Four** presents the results of the study. Various tables are used to present the results under sections of the study, namely, demography, backgrounds, the programme characteristics The chapter also looks particularly at the

change of practice of the community health workers. Our **Fifth Chapter** examines the theological reflections and community health participation. Finally, in **Chapter Six** is the Project Proposal, a practical aspect of this study emnating from the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 PARTICIPATION AS AN INTERNATIONAL HEALTH POLICY

INTRODUCTION

One of the forces underlying the emergence and development of participation as a health policy at international level was the WHO. The other main forces regarding policy development and advocacy of community participation in health development, particularly during the 1970s and early 1980s, were UNICEF and NGOs such as the Christian Medical Commission. In addition to these institutions, individual country experiences were influential in the development of community participation and primary health care (PHC).

The present study focuses on community participation within WHO which was chosen because of its historical leadership role in health policy and its influence on the development of health systems. Moreover, it offered the opportunity for longitudinal study of community participation which involved experiences of WHO member state countries, thus, capturing the individual country study option as well.

The following section reviews the emergence of community participation as policy within WHO prior to the Alma-Ata Conference. In the chapter, we examine as well how community participation was perceived within the context of PHC at the Ama-Ata Conference. This is followed by a section concerned on the strategies WHO proposed for implementation of community participation in health development and how it was to be measured and assessed

2.2 EMERGENCE OF COMMUNITY PARTICIPATION AS A WHO POLICY

PHC as a priority programme initiative, with community participation as one of its key components, first emerged within WHO as a result of debate

> while it is normally necessary for a malaria eradication programme to be implemented by a specialised service, the active participation of the health service assumes considerable importance as the programme progresses towards its goal, becoming fundamental in the maintenance phase when vigilance against the re-establishment of the infection becomes the responsibility of health services.[17]

Participation was mentioned but not in the context of the consumer of the health services or the community. Rather the participatory role in the health service provided was only in relation to the vertically managed malaria eradication programme.

During the 1960s, the issue of consumer involvement or community participation was not yet an issue of concern within WHO health policy. It was becoming clearer that either mass eradication campaigns against diseases or the basic health services strategy were not working satisfactorily. In many countries, less than 15 percent of the rural population had access to health services. In fact, the relative emphasis on programmes to control specific diseases over the 25 year period between the early 1950s and the mid-1970s may have hindered the development of basic health services. The resources needed to expand the basic health services were hardly forthcoming. Newell questioned, "With such a conclusion, who was almost forced to look deeper into distribution, form, and roles of basic health services?".[18]

2.3 COMMUNITY PARTICIPATION IN RELATION TO THE PHC STRATEGY AT THE ALMA-ATA CONFERENCE

Stemming from the results of the various studies undertaken by WHO and UNICEF on promoting health developing, WHO management reckoned that national governments' commitment to PHC was essential to its success. And, a public relations effort on PHC in the form of an international conference was required to help achieve it. Consequently, the international conference on PHC sponsored by WHO and UNICEF was held from 6 to 12 September 1978 in Alma-Ata.

The dedication of Alma-Ata referred directly to community participation, stating that people had the right and duty to participate individually and collectively in the

[17] World Health Organisation, Community Involvement for Health Development. Geneva: WHO, 1991) pg. 5-6

[18] Djukanovic ed. Applications of Behaviour Modification to Health Promotion in the Developing World Social Science and Medicine (March 1987) pg. 108

planning and implementation of their health care. The definition of PHC also embodied the notion of community participation. It stated,

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[19]

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

> PHC requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources, and to this end develops thorough appropriate education the ability of communities to participate.[20]

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

> The conference, considering that national and community self-reliance and social awareness are among the key factors in human development, and acknowledging that people have the right and duty to participate in the process for the improvement and maintenance of the health, recommends that governments encourage and ensure full community participation through the effective propagation or relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and wellbeing.[21]

World Health Organisation, Primary Health Care, Report of International Conference on Primary Health care (Geneva WHO, 1978) pgs. 3-4

Ibid p 4

Ibid. p 23

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

The conference Report set out various ways in which community participation could occur in PHC. These included involvement in assessing the situation, defining the problems and setting priorities, co-operation in utilising the services as a result of responsibility for one's own health care, changing health behaviours and contributing in labour and financially to PHC. Appropriate education enabling communities to deal with their real health problen and the most suitable ways to doing so were also put forward as a mode in which community participation could occur.

There were many perceptions of how community participation could be facilitated mainly through assistance by local and external groups. Such would include government agencies, local leaders, voluntary groups, youth and women's groups, consumers' groups, NGOs as well as by accountability to the people. A main objective of community participation, according to the conference report was to enhance co-ordination of development activities at local level.[22]

> Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community and develop the capacity to contribute to their and the community's development[23].

Accordingly, the process enables individual and families to better know their own situation and to become motivated to solve their common problems. They become agents of their own development instead of being passive beneficiaries of development aid

The conference endorsed empowerment, encouraging communities to challenge the existing health service system. Communities would no longer be obliged to accept conventional solutions that were unsuitable Instead, they needed to improvise and be innovative to find suitable solutions The latter point was equally relevant to government health services

---

[22] Ibid
[23] Ibid

The conference implied that the government health system was not dynamic but static; it still remained where the control, expertise and last word was.

> While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs.[24]

Throughout the report, the need for national policies, including the area of community participation was stressed. Here, policy development was recommended to enhance community cohesion, foster co-ordination at local levels and ensure that the community invests in PHC development. Mutual support between government and the community was called for. But again the responsibility was up to the government to stimulate the community and provide the participation mechanisms. These would include establishing inter-sectoral co-ordinating strategies, passing legislation supportive of PHC and, wherever applicable, providing sufficient human, material, technical and financial resources. Since the responsibility for major actions mainly was with government, the pass of PHC development, including the essential component of community participation, therefore, rested more heavily on the interests, commitment and initiative of a government rather than with community interests and priorities.

The report stated that one of the fundamental principles of PHC was the participation of the community at all stages. The strategy to elicit community participation included communities having easy access to the right kind of information concerning their health situation and how they themselves could help to improve it The source and control of the information was assonated with the government's, the programme managers and the report. It stressed that the information needed to be neither oversophisticated nor condescending. Rather, it was to be in a language people could understand The means of delivering the information stated in the report represented the classic media approach utilised in traditional health education. But this was to be integrated with new media for example, posters, community notice boards among others.

The Alma Ata conference also addressed the issue of financing PHC. [25] A major theme was preferential allocation of resources to PHC, starting from communities and

[24] Ibid
Ibid

progressing through the other levels. It consisted basically of allocating communities and supporting services, financial ceilings which were to be used for the particular purpose defined in PHC programme. The conference, nevertheless, did not recommend re-allocation of resources from the curative level, particularly the tertiary level to PHC.

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

Voluntarism was never a key aspect of the proceedings of the conference. One of the few references to it was in relation to financing where an assumption was made. If people were properly motivated and trained, greater use could be made of voluntary service for various health actions. It includes the development of local water supplies or part-time service in the delivering of health care. The area of financing was an appropriate place to bring in the subject of voluntarism because few governments had the resources to support CHWs hence they needed this type of cost-sharing of personnel with communities.

2.4 ENCOURAGING PARTICIPATION

In health education, participation means that the person, the group, or the community works actively with the CHWs, TBAs and others to addressing their own problems Participation is very necessary at every step, from identifying problems to solving them. Such participation is significant in a number of ways

If people participate, they become more interested in helping themselves. They also become more committed to taking the action necessary to improve their community health, besides being responsible of their own health. The CHWs and TBAs can only guide people in finding solutions to their problems, they are not to take direct responsibility If a mother arrives with a baby having Kwashiorkor, a CHW cannot take the baby and feed it A CHW should not give drugs to people to cure simple sickness, for

instance, headache, stomach ache, fever or cold for this creates a dependence syndrome. S/he would not follow people to their home and ensure that they are strictly adhering to the prescriptions. Should a community complain of lack of good or enough water supply, CHWs ought not to give the money for digging the well. Their help should be restricted to mobilizing people towards self-help. Thus, CHWs have many opportunities in stirring a self-help initiative within families and communities.

2.5 PARTICIPATION AS POLICY IN POST-INDEPENDENCE KENYA

It was a general feeling among Africans that the colonial service was primarily structured to maintain its law-order. The aspirations of the governments of newly independent Africa were qualitatively different. At least in rhetoric, they were more directly committed to the objective of development. The government incorporated the planning for development. It was believed, it would give it a fresh outlook. The civil bureaucracy was no longer primarily a guardian of law and order but the leader in development.[26] Theoretically, the planning process for development should underline community participation.

In Kenya, expectations were high at the time of independence for development initiatives from the new government. Therefore, some development strategies needed to be formulated. This was done in part at a conference on education, employment and rural development held at Kericho in 1966.[27] A series of initiatives stemming from the conference led in 1968 to the survey and selection of fourteen divisions in Kenya. These were considered to be pastoral conditions, for preparation in 1969 and 1970 of multi-sectoral and to some extent experimental development plans for six of them. This project was known as the Special Rural Development Project (SRDP). Experience helps to highlight problems and possibilities of decentralised planning activities involving local-level staff and communities.[28] The most important lesson from the Kenya SRDP is of the

[26] Hyden, G. Reforming the structures in the Public Service. Literature Bureau (Nairobi Kenya, 1982) pgs. 147-148

[27] Heyer, J.D. Ireri and J. Morris, Rural Development East African Publishing House: (Nairobi, 1971) pgs. 1-2

[28] Robert. Chambers. The Church Contribution in Rural Development. Putting the Last First (Longman, Hong-Kong, 1983) pgs 154-160

ability to implement the crux of a good plan. Moreover, effective implementation depends on competent local-level staff.

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

2.6 CO-OPERATION RELATED TO PHYSICAL LABOUR

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

Another important form of co-operation related to contribution of physical labour was to carry a sick person to a hospital, usually to Mogotio Catholic Dispensary. A group of 12-20 men would be mobilised by the concerned family to carry the person, using a locally made stretcher. In many cases, this was a woman with complications during childbirth. Two to three teams of four men would alternate carrying the stretcher, sometimes up to 15-20 kilometres over steep, rocky roads and even at night. It reflects the poor transport and communication system within some parts of Mogotio Division as well as poor access to health care services. Antenatal services were provided as part of the mobile clinics. Training had been given to some TBAs in the sub-programme areas. However, pregnant women who had been advised to travel to Mogotio before delivery were reluctant to do so. This was due to the costs of hospital care, difficulties encountered for the household in their absence, particularly regarding the care of children, and the long journey to Mogotio during this period of terminal pregnancy.

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

2.7 COMMUNITY VOLUNTARY LABOUR

One of the main ways of participating in community development project is through voluntary labour. This has been a traditional practice in Africa. Locals would come forward to offer their labour to assist their relatives and neighbours for the betterment of their community and its environment. There was coercion, however, during tribal rule and colonialism for community members to provide labour for community projects and activities. Even currently in Kenya, the local administration through chiefs and assistant chiefs often still exert pressure on community members in road construction, building of schools and clinics.

There are various ways through which community labour can be applied towards health development, in review of PHC projects.[29] Among these were health facility construction and maintenance, provision of services by volunteers, and exchange of services. This section examines these aspects of community labour in the case study area as well as willingness of community members to participate in health related communal labour activities

2.8 COMMUNITY MOBILISATION

Community sensitisation, motivation and mobilisation are central to effective CBHCs. The target community should be sensitised to the need for CBHC until it becomes the community's felt need. The community has to be motivated towards meeting a felt need, improving health care in their own community and mobilising the required human and material resources to do so.

Community participation is getting people involved and committed to achieving a goal It is a process of assisting people to become more aware of their community felt

[29] Yin Robert K. The Case Study Crises. Adminstrative Science Quarterly 1960. pg. 60

needs, have strong faith that something can be done to relieve these needs and improve their community.

CHWs have a responsibility for community participation. This is where a resident CHW has an advantage over another CHW who lives away from his/her community. For effective community participation, the CHW must therefore possess a thorough knowledge of his/her community. He/she must make himself/herself acceptable to the community and speak the language of the people. This goes beyond talking the same language or having studied together. It means using the same choice of words and symbols to express the same concepts. She/he must be able to identify with the villagers and aspirations for improved health social status. For instance, she/he must acknowledge community needs, respect their customs, beliefs and taboos besides being a good role model. CHWs have to possess a clear understanding of the hierarchical structure of the community and work through such structure in all matters concerning the community. He/she participates fully in the community activities, organises and holds meetings with community groups, making useful and practical suggestions, respecting other people's opinions and willing to learn from others.

Participation and involvement could lead to development of self reliance. They help a communtiy to develop social control over its own infrastructure. The level at which any community participated in its own development process would vary from place to place depending on the level of involvement.

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

The proposed methodology for creating awareness at the divisional level was Training of Trainers (TOTs) by District Health Management teams Briefing divisional development commitees, discusssions in *barazas* or small groups through community elders and TBAs, women, church groups and mobile clinics were also cited The plan was that all community members would be responsible for creating awareness through committees and follow-up by local leaders.

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

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

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

2.9 COMMUNITY HEALTH AND DEVELOPMENT

Generally, poor people suffer more from ill-health and disease than rich people. Besides, the poor use the available health services less often. The more fertile parts of the

country also tend to have healthier people and better medical services. These are two examples which show the inseparability of economic development and good health.

In the 1960s, it was commonly thought that socio-economic progress was not essential for improving the health status of people. But now, health has become essential to socio-economic development.

Economic development alone cannot solve the major problems of poverty, hunger, malnutrition and disease. In its place, non-economic issues like education, productive employment, housing and many others have emerged as major components in development strategies.

Unless national economic development is accompanied by fair distribution of resources and services, a few rich people benefit at the expense of many who stay poor. Villagization and other development policies aim to bring rural people together to participate in their own development. Improved health must be part and parcel of this development.

It is now believed that medical services on their own do little to improve the health of the community. Much more is achieved by everyone having sufficient good food. And simple environmental health are important aspects of village health services.

The development of cash economy, improved agricultural methods, a fair sharing of the land, better educational levels, high adult literacy rates, and improved roads all lead to improved health. Raising living standards through people's participation in development will lead to healthier communities

All CHWs must, therefore, understand that health matters and medical services are only one part, but a very important one of rural development. Development plans and services must be integrated with those from other sectors for instance, agriculture, water and education.

Since health is an integral part of development, all sectors of society have an effect on health. In other words, health services are no longer considered merely in a complex of medical measures but a "sub-system" of an overall socio-economic system. In the final analysis, human health and well-being are the ultimate goal of development.

2.9.1 DISEASES

For generations, the people of Kenya have been known as strong, well built and hard-working I suppose this appellation still applies. But to what extent this label still holds true is the question.

Apparently, people in this country are physically weaker and certainly less hardworking than before. All types of diseases take human lives at an alarming rate. For instance, malaria, fever, TB, and AIDS were little known earlier but are now common diseases. Majority of people feed very poorly. Clean water is rare and medical facilities are far from being available to all. The best one finds is a dispensary in a sub-county. But among other crucial social amenities there are a number of sub-counties without a dispensary. These health units do not always have the necessary drugs at all times. Worse, not all dispensaries have a functional maternity wing attached to them. Therefore, there are no antenatal clinics for expectant mothers. Child births take place at home, very often in unhygienic conditions. Hence maternity risks and deaths are high.

Many homes have no pit latrines Diseases are caused and spread by both the fly and the use of unclean water prevalent under such conditions.

Taking into account the nature of some of the districts and the distance involved before reaching a dispensary due to inaccessibility to transport, it is easy to understand why so many people die due to lack of medical care. The locally-made stretchers for carrying the sick to a dispensary or hospital have their limitations. People are left with no alternative but to resort to local herbs whose dosage is not standardised. They revert to crude primitive methods of treatment by local medicine men/women. Therefore, with such high incidences of diseases and the absence of proper and adequate medical facilities, it is no wonder that people are dying at a high rate Then how do we develop our rural areas with a debilitated population and a community weakened by diseases?

2.10 FACTORS INFLUENCING COMMUNITY PARTICIPATION

From the above discussion, a number of factors can be noted as critically most influential in impacting on community participation in the Nakuru programme Let us proceed to discuss in some detail, these factors.

2.10.1 EDUCATION

The influence of formal education on participation was found to be of significant value. Local explanations were that community members with some formal education were quicker in understanding health messages. Besides, they were more aware of what to do in order to stay healthy. Further, they had already received some basic health education through the formal education process. Since they had some knowledge on health they were more likely to set good examples, hence influence others. The number of household respondents who had some primary education (41%) was equal to those who had none (41%). Non-formal education also served as an important factor influencing participation in the Nakuru programme Various opportunities for receiving non-formal education were available in the Nakuru programme.These were first, attending community meetings where health was discussed. Second, was being a member of self-help group. Third, it called for receiving a monthly home visit from a CHW or TBA.

2.10.2 LOCAL GROUP MEMBERSHIP

Being a member of community health was a strong factor in influencing participation in a community health project or activity. Local explanations were that community health project offered an opportunity for members to come together, to develop themselves and to exchange ideas They provided a forum for CHWs, TBAs and VHCs to present health messages and information. They were also a mechanism to receive information from NGOs and government sources. Moreover, community health projects provided assistance to each other This enabled members to practise what was being taught for health improvement, for instance, construction of latrines, general cleanliness, and assisting members when sick

Thirty three percent of households had at least one household member who belonged to a community health group. Reasons why household members did not participate were that there were no health projects (33 3%), lack of information (22 2%) other personal commitments (16 7%) Thus, for a quarter of these respondents, the reasons were not related to any lack of willingness to join

2.10.3 HOUSEHOLD INCOME

Forty-two percent of household respondents claimed that they only earned up to Kshs. 100 per month. Forty-three percent of respondents indicated that household income was used primarily for food, while others identified clothes (23%) and general domestic use (10%). Thus, for meeting basic needs, 22% was indicated as being allocated for paying the school and other fees. In many households, it would appear that making contributions to development activities would be problematic and a constraint to participation. Yet this was the main way respondents (33.3%) confirmed they had participated in community health projects, and the main way they could best participate in the future. In reality, a household's willingness to contribute might be necessarily matched by its ability to contribute, particularly if the levels of income stated by respondents were accurate.

Local explanations on the impact of household income on participation were that community members with little income were not in a position to contribute to development projects, join self-help groups, make improvements to their households to promote better health or provide themselves with basic needs such as food or clothing.

2.10.4 SOCIO-DOMESTIC ISSUES

Three sociological factors associated with household characteristics were found to influence participation. These were family size, women's time and harmony in the household. These were inter-related in that large families were found to demand more time from women to address domestic duties. Higher financial demands for basic needs and fees were potentially a cause for more stress within the household. Excessive alcohol consumption was a contributory factor to disharmony in the household. Case study households which were only partly participating or not participating at all in the Nakuru programme exhibited at least one or more of these socio-domestic characteristics, particularly those related to causing disharmony in the household.

2.10.5 LOCAL INSTITUTIONAL SUPPORT

CHWs, TBAs and Community Health Committees were categorised as a local organisation. How well they enhance participation is directly related to how effective they are perceived by community members. In the Nakuru programme, eighty-nine

percent of household respondents conceded that health committee members were doing a good job. Their role in promoting health education was the main reason given (30%). Eighty-four percent of respondents also judged positively the performance of CHWs and TBAs. The work of CHWs and TBAs in health promotion was cited by 42% of respondents as the reason for their favourable assessment while 33% recorded satisfaction because of health advice they were receiving. Over half (54%) of household respondents claimed that they were visited at least monthly by CHWs and TBAs. Seventy eight percent of household respondents claimed that they had followed the advice of CHWs and TBAs regarding changing health behaviours.

The influence of the number of visits by CHWs and TBAs on participation in community health projects was analysed. For respondents who were visited monthly, participation was five times greater. This compared lamentably to households which had never been visited but still participated. These were two times greater and those which were visited only once a year or at long intervals three times a greater. Local explanations for this were that home visiting reminded household members of what they had been told either at clinic sessions or community meetings about health issues. This increased the speed at which they undertook health improvements. Household members appeared to be motivated to effect changes when they were visited. They also feared being questioned by CHWs or TBAs on why they had not implemented what was advised and did not like to be found at the same stage they were at the last visit.

In order to sustain a CBHC programme which comprised volunteers, motivation and incentives are crucial. The main motivating factor for health committee members in the Nakuru programme to carry out their role was a sense of community service in promoting health. Seeing health improvements stemming from the programme's activities and exposure to outside ideas were other reasons. For CHWs and TBAs, the main motivating factor for continuing to serve were similar to CHWs, that is, a sense of duty to continue to serve the community and satisfaction from seeing people adhere to one's advice, thus improving their health status. Knowledge acquired through training was also important. The token annual gift to CHWs and TBAs at Christmas was probably more significant in its recognition value by the community of the work done by CHWS and TBAs than its material value.

There was minimal collaboration between government extension staff operating at community level and Nakuru programme staff. Accordingly, it was difficult to assess the potential of inter-sectoral collaboration as an influencing factor in relation to participation. However, one main adverse effect was delay in establishing and registering self-help groups caused by ineffective community development agents.

Based on the case study research, a revised composite grouping of factors influencing participation in health development programmes, particularly focused at the community level, need to be pointed out, albeit in outline form as identified in our research findings.

The issue of participation in health development has been a major concern of international agencies such as the WHO, UNICEF, national ministries of health, international and national NGOs over the past twenty five years. This research study has added to the understanding of the dynamics of participation at the community operational level. This should enable more effective strategies, aimed at enhancing community participation, to be developed by government ministries, churches and development agencies in collaboration with the communities concerned.

2.11 GENERAL OBSERVATIONS ON DISTRICT COMMUNITY PARTICIPATION

The government supported district efforts such as that of Nakuru show the responsiveness of formal health systems towards meeting the needs of the people by decentralisation. The main limitations of these efforts have been because the experience tends to remain in the trial region indefinitely. This keeps it peripheral to central planning and limits the benefits that could accrue from this approach in other districts Thus it was found that even though experiences such as those of Nakuru were initiated in 1990s they were still in the two divisions in 2001

In undertaking the Kenyan National Pilot Project in CBHC, it was thought essential to have a limited geugraphical beginning as a means of obtaining guidelines within a period of 3-5 years This could be used as pointers for CBHC in the context of national health services of the MoH With respect to experiences elsewhere, it has become evident that one of the major bottlenecks in making a localised or regional

experience nation-wide was lack of records of observations on the necessary organisational frame and critically, on the process dynamics of community participation. Record keeping was therefore considered central to undertaking of the pilot project so that what was observed could be available for wider application within a relatively short period of time, three to five years.

Overall, Chapter Two so far has revealed literature on community participation, highlighting what it entails and key participants in it. We now examine, in the next chapter, the research methodology we used in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

The present chapter examines the methodology the researcher used to gather the data from the field. The research was carried out in Gilgil and Mogotio divisions in Nakuru. Both primary and secondary data were collected

3.1 RESEARCH DESIGN

To meet the objectives of this research, questionnaires, interviews and observations focused on the impact of community participation, the role of TOTs,. CHWs and the community itself in the community participation and the response to the programme In this way, we hoped to capture their views and reactions and those of the nearby community members. The reason for carrying out these questionnaires and interviews was mainly to ascertain community participation as a felt need in CBHC.

3.2 QUESTIONNAIRES AND INTERVIEWS

There were three categories of questions (See Appendix 1). The first one was addressed to TOTs on their role in tracing the community CHWs, TBAs and VHCs.

The second category was that of CHWs, aimed at identifying the felt needs of the community Third, was a questionnaire directed to members of the community for instance, the chief, sub-chief and the community elders, trying to establish their understanding and the importance of community health participation Questions designed were both structured and unstructured The total population of the two divisions enrolled in CBHC was about 300 A total of 120 questionnaires were distributed Out of these, 90 were received back The researcher used random sampling in order to represent all categories of people The study interviewed people within Nakuru District Attempt was made to integrate the views of all kinds of people such as CHWs, TOTs, Chief, community elders, women and some of the young people

3.3 OBSERVATION

The researcher tried to observe activities to establish the community's understanding of community participation, involvement and level of motivation. This was done in Gilgil and Mogotio divisions within the community district as well as in church organizations. January to February 2001 was a period dedicated for this work.

3.6 SELECTIVE SAMPLING SURVEY

Selective sampling survey was used in this research to find out possible causes of community participation and how community rural health development can create community involvement. The population sample was drawn from some CBHC members within the two divisions, who cited the need of community participation and the involvement. A group of people who were selected randomly were also interviewed in order to orientate ourselves on the conditions of community participation, involvement in CBHC and problems thereof.

3.7 METHODS OF DATA ANALYSIS

Data collected through questionnaires, interviews and observations was then analysed Distribution tables were used to relate responses to the set questions. The responses were collated thematically and along set objectives and hypotheses. They were then discussed using the methods of grouping in order to draw conclusions. Indeed, the focus of the next chapter is on data presentation and analysis.

CHAPTER FOUR

DATA PRESENTATION AND DISCUSSION

4.1 INTRODUCTION

We have already seen that of the sampled population of 120 to whom questionnaires were posted, 90 responded to various questions in the questionnaire. The present chapter, therefore, presents the data collected, giving us integrated findings from our literature review, questionnaires, interviews and observations in Gilgil and Mogotio divisions, Nakuru District. The data guide us into analysis.

4.2 DEMOGRAPHY AND BACKGROUND TO COMMUNITY PARTICIPATION

Under the sub-heading of personal background the respondents were asked to include the age, sex, marital status. Their responses on these are contained in the following tables.

TABLE 1: AGE IN YEARS AND GENDER

GENDER	MALE	TOTAL	PERCENTAGE	
20	3	0	3	3.3
20-24	10	8	18	20.0
25-29	40	20	60	66.6
30-34	2	2	4	4.4
35	5	0	5	5.7
TOTAL	60	30	90	100%

Table 1 indicates that the majority of respondents were aged between 25-29 years and were male.

TABLE 2: GENDER AND MARITAL STATUS

STATUS	MALE	FEMALE	TOTAL	
Married	40	20	60	66.7%
Single	20	10	30	33.3%
TOTAL	60	30	90%	100%

The data indicate that the majority who were married were married (66.7%) compared to the single (30.3%).

TABLE 3: IMPROVEMENTS IN COMMUNITY HEALTH

Area of Improvement	No. of Respondents	Percentage
Improvements in health	29	32.2
Sanitation facilities	23	25.6
Increased facilities	21	23.3
Mobile clinic/family planning	17	18.9
Total	90	100

Table 3 summarizes responses from a household survey on respondents The survey focused on the main ways that the health sector had improved. These includedimprovement of health 32.2%, sanitation facilities 25.6%, increased health facilities 23.3% and mobile clinics 18.9%. We proceed to establish what led to such improvement Table 4 below provides this information.

TABLE 4: REASONS FOR IMPROVEMENT

Reason	No. of Respondents	Percentage
Education Communication system	30	33.3
New farming methods	20	22.2
Communication system	15	16.7
Harambee/co-operation	15	16.7
Hard work	10	11.1
Total	90	100

According to Table 4 above, the main reason cited for improvement in the lives of the people was education (33.3%). This reason was followed by new farming methods (22.2%). Improved communication system (16.7%) co-operation among community members and contribution through *harambee* fund-raising were cited as influencing factors for improvement evident in the lives of people. Finally, hard work (11.1%) was also identified.

Thus, it seemed that as a result of education, people were more apt to change, were adaptive to new methods of farming and were receptive to outside influence which was represented by NGOs. New ideas were being brought in through population migration and improved communication and probably media. Indeed, this can be confirmed by Table 5 below.

TABLE 5: PARTICIPATION IN COMMUNITY PROJECT

Reason	No. of Respondents	Percentage
Yes	67	74.4
No	23	25.6
Total	90	100

Nearly three quarters of the household respondents conceded that one of their household members had participated in a community health project. Only a quarter had not participated. Table 6 provides reasons for not participating.

TABLE 6: REASONS FOR NOT PARTICIPATING

Response	No. of Respondents	Percentage
No advice	25	27.8
No home visits	20	22.2
Ignorance	20	22.2
No CHVs	15	16.7
No money	10	11.1
Total	90	100

Mogotio sub-programme appeared to have had the least amount of health promotion by the fact it had the highest percentage of respondents claiming lack of advice given (27.8%) and home visits (22.2%). Ignorance of how to put the advice into practice was stated by 22.2% of respondents, mainly from Kamathatha and Kapsala. Lack of money was not a major reason, except for respondents from low potential area of Kitale (16.7%) as well as in the neighboring sub-programme area of Langalanga. Not having CHVs was not a serious problem either (11.1%), except for Kathatha where the CHV component of the programme had collapsed.

TABLE 7: CHWs PERCEPTION OF HEALTH NEEDS IN THE COMMUNITY

Response	No. of Respondents	Percentage
Inadequate facilities	20	22
Communication	15	17
Family planning	15	17
Water	10	11
Sanitation	10	11
Outbreak diseases	10	11
Drugs	10	11
Total	90	100

To ascertain whether participation played a part in meeting perceived community needs, household survey respondents of inadequate facilities 22%, were asked to cite what they were doing to address their own problems communicationn and family planning were 17% each and water, sanitation, outbreak diseases and drugs were 11% each Table 8 below gives us an overview of that.

TABLE 8: THE FAMILY'S ACTION IN ADDRESSING COMMUNITY

Action	No. of Respondents	Percentage
Co-operation	20	22.2
Initiating water project	20	22.2
Contribution	15	16.7
Constructing latrines	15	16.7
Prayers	15	16.7
Nothing	5	5.5
Total	90	100

The main response was (22.2%), comprising co-operation and initiating water project while the other three, namely, contribution, constructing latrines and prayers garnered 16.7% each Lastly, those who were doing nothing recorded 5.5%. The

involvement of the family here is a positive indication towards the success of community participation.

There are other ways through which family members demonstrated their co-operation, namely, contributing cash and materials. Table 9 below gives us the understanding of community participation

TABLE 9: RESPONDENTS' UNDERSTANDING OF COMMUNITY PARTICIPATION

Community Paragraph	No. of Respondents	Percentage
Involvement in health activities	30	33.3
Community action	25	27.8
Doing what told to do	20	22.2
Starting self groups	15	16.7
Total	90	100

The involvement referred to by respondents was mainly in reference to taking part in health-related activities or services (33.3%). As said by one local leader from Gilgil, community participation is the involvement of community members in health activities such as health meetings and contributing towards such efforts. A VHC from Mogotio stated that community action is an involvement in health activities, attending mobile clinics, doing what one is told to do, starting self-help groups, practising family planning and doing whatever is taught related to health.

The community initiative interpretation was also characterized as corporate action. A VHC from Kitale said, "Community participation entails the way members of the community join hands in helping one another as concerns health matters". To a primary school headmaster from Kapsala, "community participation is community members getting together in working towards the welfare of the community at large"

Perceiving community as reacting to authority was described as, obeying health rules, for instance, sinking latrines, maintaining cleanliness and sanitation within their families. It involved attending the clinic facility The interpretation of community

participation as self-help groups was mainly from local leaders who were officers of self-help groups. Table10 specifies projects they would participate in.

TABLE 10: PROJECTS PEOPLE PARTICIPATED IN

Projects	No. of Respondents	Percentage
Health facilities	30	33.3
Self help group	20	22.2
Water	15	16.7
School	15	16.7
Mobile clinic	10	11.1
Total	90	100

Table 10 above suggests projects people involved in. Health facilities got highest rank, followed by self help group and both water and school projects. Mobile clinic got the lowest rating. It is evident that, perhaps due to CHWs and TBAs in their care, they do not a see a need of having mobile clinic at the moment. Yet health is evidently crucial to them.

The understanding of community participation, therefore, appeared to mean community members being involved and co-operating in health activities. But they were involved mainly as recipients of services which already had been planned and were being offered to them This appears to have been a reaction to advice provided by VHCs. Attempt was made in this study to relate education to participation. Table 11 below summarises the responses.

TABLE 11: EDUCATION LEVELS OF HOUSEHOLD SURVEY

Education level	No. of Respondents	Percentage
Primary	37	41
No education	37	41
Adult education	16	18
Secondary	0	-
	90	100

Overall, the proportion of household respondents with some primary school education was similar those claiming to have had no education (41%). Wide variances existed between sub-programmes, particularly in Mogotio among the Kalenjins where 59% of respondents had no education, and Gilgil where 32.5% had adult education and 27% of respondents in Gilgil had no education. Mogotio was the most commercial-oriented sub-programme area. In the Mogotio programme, a major source of income was charcoal. Possibly, therefore, the incentive to attend and to complete some primary school education was less in Mogotio. Children were seen to play an important role in the charcoal trade by helping to cut the firewood into pieces. Local leaders in Mogotio claimed that this was one of the reasons for the high drop out rates in primary school in Mogotio and in some parts of Gilgil.

Gilgil had the highest proportion of community members with adult education. Adult education classes were usually taught by primary school teachers. The relatively high level of adult education beneficiaries in relation to other sub-programme areas was a good reflection of the primary school system in Kamathatha. The encouragement by church leaders for members to attend adult education classes could also have been an explanation for the high proportion of adult education.

TABLE 12: LEVEL OF EDUCATION AND INFLUENCE OF PARTICIPATION IN COMMUNITY HEALTH PROJECT ACTIVITIES

Level of Education	Participation	Percentage
Formal education	50	55.5
No formal education	40	44.5
Total	90	100

The influence of education on participation of respondents in community health projects and activities was analyzed. Two education status were used. One group was for respondents who claimed not to have had formal education and the second group was respondents with some formal education. Overall, 90 responses were analyzed. Respondents were also categorized as either participating or not participating in

community health projects or activities. Among those who participated in community health projects and activities, 55.5% had some formal education as compared to 44.5% who had no formal education. The influence of formal education on participation was found, therefore, to be of significant value as shown in Table 12 above.

Education was considered as an important factor in relation to participation in health development activities. Formal education, for instance, in form of primary, secondary or adult education was examined separately from non-formal education. This later was defined by CHWs, TBAs and local leaders as obtaining knowledge and information from others. Need arose to establish the ways people participated in a health project. Table 13 below is specific on such ways in which of community involvement in health-related projects.

TABLE 13: WAYS PEOPLE PARTICIPATE IN HEALTH PROJECT

Ways	No. of Respondents	Percentage
Manual labour	35	38.9
Contributing material	25	27.8
Planning	20	22.2
Contributing money	10	11.1
Total	90	100

The responses on how people participated in health projects reflected in part, the economic potential of their sub-programme areas. Manual labour was mentioned by more people in the two divisions (38.9%) This was followed by contributing materials (27.8%) such as food during the working hours, firewood, making bricks and thatching roofs with grass. Planning for the welfare of the project (22.2%) and contributing money (11.1%) scored the lowest. This was probably because the aim of this programme is to help each and every individual person in his/her family or household

TABLE 14: COURSES AND THEIR RELEVANCE TO THE COMMUNITY WORK

Courses	Yes	No	Total No. of Respondents	Percentage
Communicable diseases	29	11	30	33.3
Community diseases	20	21	21	23.3
Child health	11	0	11	12.2
Environment	10	1	11	12.2
Family planning	10	2	12	13.3
Nutrition	5	0	5	5.7
Total	85	5	90	100

From Table 14, it is apparent that the most popular courses were communicable diseases (33.3%) and community health (23.3%), followed by family planning (13.3%). Environment and child health got the same (12.2%) and nutrition (5.7%). The table suggests individual involvement in CBHC training courses. Such courses, therefore, enhance the concept of community participation which can only be realistic if individuals are thus empowered.

TABLE 15: PROJECTS PEOPLE WERE MOST INTERESTED IN

Project	No. of Respondents	Percentage
Health	30	33.3
Education	20	22.2
Agriculture	15	16.7
Church related projects	15	16.7
Water	10	11.1
Total	90	100

Table 15 indicates that prioritised projects in the interests of the people are health (33.3%) and education (22.2%). Agriculture and church-related projects are both with the

same percentage (16.7%). Last but not least was water (11.15). All these were the most preferred by the community members. Lack of access to health facilitities, drugs and the above projects were a major concern for CHWs, TBAs, VHCs and localers, for instance, chiefs, sub-chiefs and village elders. The majority viewed health as top-most in their list of priorities. This was a preferred project area. The rest would then follow.

CONCLUSION

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

As in the organisation study, the alternative approaches study stressed the importance of utilising untapped resources within the communities themselves. All the approaches from the case studies employed one or more methods of gaining the understanding, co-operation and support of the population as a prerequisite for their participation in the programme. These methods were mainly political, relying on party organisations and on mass mobilisation of the people Some of the ways were community participation in the decision-making process on how resources would be raised Locally recruited primary health workers supported by their communities forming the front line of the health system and the entry point into it for the population. Receiving health, nutrition and hygiene educational messages from primary health workers who belonged

to the community, hence, enjoyed its confidence and shared the same views, aspirations and language were among other ways community participation was taking place.

The alternative approaches study recommended the need for far-reaching changes in the organisational structure. Management practices of the health services is to include a new brand of health professionals with a wider social outlook. The trained personnel should respond to the actual requirements of the population. The basis and the strength of such services was to lie in a cadre of suitably trained CHWs chosen by the people from among themselves and controlled by them, rather than in a reluctant, alienated, frustrated group of bureaucrats "parachuted" into the community. The primary health care workers then became the saviours who would overcome the failings of the basic health services.

CHAPTER FIVE

5.0 THEOLOGICAL REFLECTION ON COMMUNITY HEALTH PARTICIPATION

5.1 INTRODUCTION

From biblical perspective, sickness can be categorized in various terms. Both spiritual and physical sickness are always referred to in the bible. In relation to my study, a brief overview of theological understanding and reflection on what the historical episode can reveal to us today. The aspect of community health participation in alleviating the community disorders are included.

5.1.1 COMMUNITY CONCERN

One of the biggest sicknesses dealt with in the Old Testament (OT) is the spiritual sickness. There was always a concern of the people's moral outstanding Their failure in observing the moral uprightness, reflect their unwakefulness. Such instance called for intervention. Somebody had always to come in between the people and God for their healing.

Reciprocal of this in our present community, other human race is facing with many problems. The mystery concerning human suffering. To alleviate these suffering, there is an urge to solicit available resources to combat them. Those who are able are a gift to members of the community and should not sit down and see the human race being wiped away from the earth face. In Genesis 18: 27-32. Abraham is caught in perplexity of interceding to God for Sodom and Gomorrah Abraham is so concerned that he mentions the least number possible. God does not tire because of Abraham pleading The concern of Abraham is genuine and proper However, today God through this creative work has revealed to human beings how to tackle inflicting problems Sickness goes against God's intention for his people He intends His people to be free and happy Therefore, let those who are endowed with knowledge intervene to sacrilege the human suffering through sickness.

During the period of 40 years in the desert the Israelites encountered many difficulties. Many died and at one point, they were so concerned over their continuing decimating people. The people rose against Moses to intervene to God to provide them with what they lacked. This is a call for any community member to participate in any way possible. In identifying and contributing towards a healthy and prosperous society.

5.1.2 THE PREFIGURATION OF THE EUCHARIST IN THE OLD TESTAMENT

The church is a mystery, in that, God had in mind since the beginning of the world. The Eucharist as we know it today did not exist in the OT but like any other realities in the New Testament (NT), it has deep roots in the OT.

Abraham welcomed strangers Genesis 18: 6-8. Accordingly, in Jesus' time, He proclaimed the kingdom of God by sharing meals with outcasts, tax collectors and the like. The event of Abel's offering which was pleasing to God Genesis 4: 4 is seen in Jesus' self offering on the cross which was acceptable to God.

The simple beginnings of the liturgy of the Eucharist began by Jesus' last supper with His disciples, whereby, He shared his best fellowship meal. Unlike the Passover, Jesus started with community participation by washing his disciples' feet, broke bread, gave it to his friends indicating his body, said the blessing over the cup of wine and said it was the cup of the new covenant that they were sharing.

5.1.3 THE EARLY CHURCH

After Jesus' death and resurrection, his first followers continued sensing his presence whenever they met together for their weekly meal of fellowship, "the breaking of bread" (Acts 2: 4-6). They participated by sharing the bread and wine in memory of Christ and continued attending the temple and synagogue services

Around 57 AD Christians began to take liberties at the weekly meal of fellowship, 1 Corinthians 11: 17-34, they are reported to having been drunk. They could not even share the food they had brought from their homes. Hence, Paul corrected them by reminding them of the original purpose of their getting together. The cup they shared was a communion with the body of Christ

The number of Christians increased tremendously, hence the Eucharistic celebration began to be held in basilicas. But the adopted signs and symbols from the

imperial court to help the assembled community to participate in the sacred actions. Consequently, they employed processions, litanies, lights, incense, responsorial chant as the "imperial" culture.

Towards the end of the 4th century it became customary to recite the Lord's prayer before the distribution of the communion. Together with this, the Christians came to identify the bread and wine with Christ. Hence, the Eucharistic elements themselves became an object of reflection. despite this familiarity; the Christians felt unworthy to risk direct contact with the creator and judge of the universe. As a result, there was a decline in the reception of the Eucharist and the liturgy became predominantly a clerical affair. The Eucharistic prayer was only muttered and the people just attended it to watch rather than participate fully.

Community participation is a model given in the Acts of the Apostles where believers remained faithful to the brotherhood, the breaking of the bread, and to communal prayer (Acts 2: 42). Thus, a Christian community demonstrates some communitarian features. It is a community of faith. Believers strengthen one another's faith, making it relevant to daily life, and giving witness to their faith It is a community of worship around the word of God and the Eucharist. Even if the Eucharist is not celebrated regularly, it is always of central significance for the group. It is a community of service and solidarity: they help one another and those who do not belong to their fold through works of mercy, social activity, political activity and involvement.

5.1.4 THE CHURCH FOR THE COMMUNITY

The Church is the community of Jesus Christ's world in view of the promised kingdom of God. The church's role is to prepare and transform the world in view of this hoped-for kingdom of peace, justice and love, that will be at the same time the ultimate future of each individual, family, community and of the entire world-history.

This transforming service to the world in view of the kingdom operates on the individual as well as on the social level It aims at the creation of a new person with a new heart, and the creation of a new society with new structures. The power behind this transforming service is the hope that frees people from the past and the present and offers new possibilities of true humanization A liberation that gives people hope has meaning

in life because it restores harmony with God and with people. In this sense, the Church is a community and institution of effective hope and liberation at the service of each person, and all people.

The transforming power becomes operative in the building up of communities where people gather in the name of Jesus Christ to give a foretaste, in life and action, for the promised kingdom. It is operative in the proclamation of the Good News that infects people with hope and invites them to be freed. It is operative in the effective service This means that with hands and feet, it gives witness of the resurrection when it destroys the signs of sin and death at work in CBHC. It confronts and challenges injustice, oppression, violence, and all other forms of human afflictions.

5.1.5 A SERVANT CHURCH

The Church must be a servant community: a servant of God for the sake of his kingdom. *Diakonia* in the NT does not only mean "to wait at table" (Luke 17: 18) but denotes many different activities siuch as giving doof and drink. extending shelter, providing clothes and visiting the sick and prisoners (Matthew 25: 42-44). *Diakonia* means active Christian love for the neighbour and as such it is a mark of true discipleship of Jesus and genuine conccern for God's kingdom.

Service to people and the world today in Jesus' name requires first of all that the Christian community recognizes in the concrete situations of life what the gospel demands of them. God's kingdom as the final revelation of his loving care for people and the world is already at work in the world. The point is to recognize its signs to participate and promote them. These signs of the coming kingdom can be found inside and outside the Church Wherever they are found, the Christian is called to cooperate with them.

5.1.6 VATICAN II

Before Vatican II, the development of the ecumenical movement and observation of the world wide meetings of the world councils of churches had broken down much of reserve.

One of the goal on the liturgical reform was to recover the rich Eucharistic tradition of the first Christian centuries and to balance these with the Bible. It affirmed

that the celebration of the Eucharist is an action of the whole church and that the baptized assembly ought to participate in this action in fully active and consciously.

We can see community participation is very essential in God's plan. Community needs growth, development, care, love and affection. Jesus himself recognized the people's centrality in God's kingdom and emphasized that they should not, therefore, be exposed to situations that are dangerous to them (Matthew. 10: 13-15). Jesus became human in humble circumstances to make himself accessible to everybody especially for the lowest and the poorest in the community. Therefore the church should continue performing the mission of Christ.

Some concluding remarks can be made here regarding the theological reflection on community participation. In participation, there is awareness raising and community sensitization which leads to empowerment of people enabling them to make their own decisions. It is important to each one of us to facilitate this process effectively.

It is important to re-awaken the community to be able to recognize and appreciate their strength and potential for change. Awareness raising and sensitization is a step towards serving the seeds of empowerment.

The term empowerment implies a process of moving from personal understanding to group action. People are powerless because they lack self-confidence, awareness and sometimes competence to take action for change. The goal empowerment, therefore, is to enable individual families and community at large to read their reality and transform it to conquer dependence on outside resources, services, participation and organization that enables communities to control their own destiny.

5. 2 STRATEGIES ENABLING COMMUNITY PARTICIPATION

A story is given of a community development worker who went to a remote village in Kenya:

> He was highly motivated and fully prepared to solve all the villagers problems and transform the primitive community. Soon he realized the people live under fear and apathy. They were not even prepared to do anything to change their situation. He came to learn that this fear emanated from a strange phenomenon in that village. The villagers reported that they had of late noticed a monster across the valley which they believed was sent by evil spirits to cut them

> They went to show the development worker where the monster was, at one stage the villagers were so scared that they left him to face the beast alone. After crossing the valley he discovered that it was nothing else but an overgrown water melon. To satisfy the villagers, he acted brave by drawing out his sword and dramatically cutting it into pieces. The villagers did not welcome him back in spite of what he had done for them. Instead they requested him to leave their village in peace for fear that he was another monster. They could not understand how he could overcome the monster all by himself if he was not also another monster[30].

This is a way of looking down upon people as too incapable and inefficient in any way to be involved in a development project. Many experts in development projects discouraged such outlook. A development worker should not pretend to have everything or every solution to any or all problems. Instead, he/she considers people's participation. The above illustration underlines how good intentions of a social worker can regrettably be counter productve if he/she does not involve the targetted people through out. Rather than have the known it all attitude, the development worker should journey with the communityn in seeking for solutions.

5.2.1 HUMILITY OF THE COMMUNITY DEVELOPMENT WORKER

It is very important for the development worker to identify himself/herself with the rural people, not going there as a giant or a superman, having every answer to their problem. He or she needs to sit with them, speak their language, put himself/herself in their shoes. From there he/she can use his/her ability for the promotion of the rural communities This humility gives the people courage to co-operate with him/her in order to solve their problems and develop their community. This attitude empowers the people In fact to have faith in people is a fundamental characteristic of authentic participatory approach to development. Every individual has the capacity to develop himself/herself.

---

[30] Francis Wambua M Enabling the Rural Poor Through Participation AMECEA Gaba Publication. Eldoret, Kenya 1987, pgs 16-17

5.2.2 EMPOWERING THE PEOPLE

To be with the people and becoming like them is not enough. The CHW also needs skills for empowering people. To enable them takes active responsibility over their own decision and any consequences thereof. Francis Wambua comments, "Authentic participation is the model which empowers the powerless towards assuming full responsibility over their own destiny within the framework of their cultural and social economic realities".[31] Everybody has potentialities and talents to be developed for the sake of the community. What is needed is someone who can awake in them these potentialities and talents. And when people form a group they become stronger, "Association is strength". When people feel able to overcome their problems with their own strength and ability, they are happy to participate actively. genuine activity participation follows some crucial stages.

5.2.3 DECISION-MAKING

This consists of identifying the real problems and making collective decision-making or planning by the people themselves This involves activities such as holding meetings and initiating discussions in those meetings, voting and stating grievances. In this process, trust and dialogue in groups is needed. Here communication is mutual, not just in one direction (sender-receiver). The dialogue is based on people sharing their own experiences and perceptions. For instance, in Madagascar, it is said that the *dinidinika ambany toyatrano*, meaning that everyone has the right to express his/her own ideas, opinions, feelings, and are listened to. There is a Malagasian saying, "*My hevitry ny maro mahataka-davitra, ny hevitry ny vitsy manodidina ny fatana*", which means the ideas of many people reach further; ideas of the few only reach those around the fire place. If the ideas of development and promotion of whatever project come from themselves, they will participate actively

5.2.4 IMPLEMENTATION

Implementation is an important phase which is action-oriented, after identifying the problems and making decisions about it. The whole community should implement the

[31] Ibid

programmes planned by themselves. The effectiveness of implementation depends on careful organisation. This regards source contribution. who contributes what, how much, when and project work activities. Division of the roles has to be decided upon: who does what, for how long and when. Francis Wambua remarked that "monitoring aspects will also be discussed in order to ensure a regular flow of information to facilitate implementation with specific management and co-ordination roles".

5.2.5 SHARING OF BENEFITS AND LOSSES

the sharing of benefits stimulates community participation. People receive the fruits of their work. They do not only share the benefits but the deficits as well. Francis Wambua classified these benefits or loss into three categories. material: (in cash and kind), social (not easily quantifiable: health, education. welfare, services, etc.) and personal (psychological benefits such as self-esteem, political power, ability to control one's destiny etc.)[32]. Sometimes we learn from mistakes. If there is loss, it is important for the group to establish the casual variables of the harmful results in order to take plans for appropriate counteraction. There is need for evaluation.

5.2..6 EVALUATION OF STRATEGIES

Decision-making and evaluation should take place at all stages or phases of the development cycle as an intrinsic component of the process. People should be able to see success and failure and how they participated in community health, ready to share benefits and losses. Every member should come together at the end of implementing the project, sit together and evaluate. Focus is on what has been done, where strengths and weaknesses have been; whether or not goals have been attained and; if the project is going well, is viable and worth continuing

5.2.7 ASKING THE CHWs TO BE THE STARTERS

CHWS are related to their respective families in which they can get all their basic human needs, for instance food. clothing. shelter and medicine Educating a CHW is, therefore. also beneficial to families and communities. We also need to ask them to implement in their daily life what they have learnt in seminars and workshops For

example, they may use their knowledge to critically assess the situation and problems of the rural communities and health education. They need to practise balanced diet, caring for the environment, cleanliness, primary PHC, caring for the trees and plants around the village of the house, and agricultural education. However, they ought to practise new ways of growing crops, introducing new technology and intensifying agriculture. All of this is for the benefit of the rural communities. If the community will see CHWs carrying work of development, they will follow their example. In this way, they will participate for their own development.

5.2.8 DEVELOPMENT WORKER GIVING EXAMPLE

In implementing new ideas of development, the CHW has to know the people. There are different groups of people in the community who should not be easily discouraged if his/her message is not taken up immediately. The speed of doing things will depend on three factors. First, some people have more sources from where to get information. Second, some are better financially positioned. Finally, others may be more receptive and eager to try new things.

The CHW should himself/herself be exemplary, then the community would follow suit

5.3 THE CHURCH'S PROMOTION OF JUSTICE AND PEACE

The church's work of justice and peace is to help the voiceless have a voice. The poor, the oppressed, those imprisoned and tortured without trial, insult of women, corruption, street people, victims of land clashes and refugees, among many others could be categorized under those who do not have voices today. The church is concerned when people are denied their rights, dignity and freedom. She has been trying to uplift the dignity and freedom of these people by defending the poor, the marginalised and those who are unable to defend themselves. Church lawyers often defend in court those imprisoned and tortured without trial. The Church also promotes health care. This includes education on prevailing health problems, methods of preventing and controlling them. She gives appropriate treatment for common diseases and injuries. Looking at these

---

Ibid

few examples, we can see that the Church's call is to promote justice through the option for the people which is the heart of the gospel (Luke 4: 18-19). Those involved in promoting justice work with the people in their everyday life situations. This process of being present to others is important for people who are broken, where speech or consolation is not enough. The aim of promoting justice and peace in the Church is to set up a guarantee for transformation inspired by the concrete involvement of Jesus Christ in the social issues. Jesus himself talked about redistribution of wealth, cancellation of debts, the liberty of the oppressed and compassion for the suffering. He called people to share and serve. He challenged the authorities and oppressive structures.

The role of the church is to take an active part and to promote Christian values as the basis of social structures so as to transform and to restore people's dignity in socio-economic, political and technological strategies. This is best done through self-help projects for self-reliance, which are aimed at bringing socio-economic transformation, growth and positive change. In self-help projects, all members must participate and work together as a whole or as a unity As the project sets off, the process of reflection on evaluation also starts and continues Whether the project is based on health care, education, arts, crafts or technical knowledge, the objective is for human development to foster change

In the process, people learn to be responsible, accountable and transparent. The aim of this process is to help people see whether there is development or regression and act upon it

The church continues to emphasize that each person is created by God in His own image and likeness, redeemed by Christ, and called to eternal union with God. This is the source of human dignity and the foundation of human rights.

Pope John Paul II continues to emphasize that human life is precious. He says the following:

Every human life, even the most disregarded, marginalised and rejected, has infinite values because it is the expression of God's immense love Therefore, the life of the unborn children, the sick, suffering and the elderly, is equally sacred and absolutely

inviolable The person is the measure and criterion of goodness or fault in very human manifestation[33].

There are special challenges and opportunities for the church in its mission of continuing the healing of Jesus in the world today. The church has tried to advance in medical technology, improving health care starting from bottom to top. This is done through curative and where possible preventive. In its care for the ill, the Christian community, CHWs, TBAs and local leaders must also continue to minister to the whole person and to advocate for medical and pastoral methods which respect the dignity of the infirm.

The social dimension of healing or caring for the sick represents another significant challenge in church's effort to mediate the healing of Christ in the contemporary world Persistent illness and low life expectancy among the poor of the world is often due to malnutrition, inadequate sanitation, and the scarcity of ordinary medicines, a situation that calls out to believers, for involvement and action To be faithful to the task of proclaiming God's reign, Christians must be concerned about socio-political reform that will increase the availability of health care to all. Jesus' compassionate response to the pleading of the man with leprosy in the gospel, of one left impoverished and ostracised because of his illness, must also be the response of Christians in their efforts today (Mark 1 40-45). As Christians and people of good will, we are called to embrace both the physical organ and emotional, intellectual and moral powers attributed to it.

For the same reason,, it is another way we can meet God, and in which God works to cause change, enlightenment and new life.

5.3.1 THE WORK OF THE CHURCH

The church is the community called together by Jesus to continue the liberating work of the kingdom It is a sign of the kingdom by announcing it publicly and by the concrete example of its own So the work of the church is to build up the kingdom. It should never focus on its own strength as an institution rather the church's only aim is to promote kingdom values in society The church has a special relationship to the kingdom

[33] Ibid

because of its unique awareness of Jesus Christ and his Spirit in the world. As church, we must continue with our rich tradition of education preparing people to work with dignity. The person becomes conscious of the love of God through education, especially Christian education. He/she is freed by bidding himself/herself of slavery to the passions and presses forward towards his/her goal by freely choosing what is good. By her/his diligence and skill, he/she effectively secures for himself/herself the means suited to this end. Through religious education, a person becomes aware of his/her dignity and is assured of God's help in his/her struggle. Likewise, the church needs to support and promote family life and participate in programs through which people learn their basic human skill. For instance, a sign of God's Spirit can be seen where the work place has been organised so that each person has a real opportunity to participate in the decision that affects his/her work. Through corporate decision-making, the profound dignity of each human individual will be uplifted. The church focuses on the fact that the centre of social life is the human person. Therefore, the preaching of the kingdom aims at transforming human relationships. The kingdom grows gradually as people slowly learn to love, forgive and serve one another.

Indeed, you bear witness to the fact that the church in the extremely difficult circumstances of our time, is aware that she must with renewed vigour dedicate herself to social action. In order that justice may reign more completely among men and women, the church must gain further knowledge of this world's present needs. She should develop people's consciences towards work for social justice. Finally, she should undertake and encourage every kind of initiative for the relief of the deprived.

The church vocation is to be present in the heart of the world by proclaiming the Good News to the poor, freedom to the oppressed and joy to the afflicted (Matthew 25: 31-46). Her mission since the very beginning was not only to proclaim the word of God, but also to promote human development. The African Synod sees it as "the development of every person, especially of the poorest and the most neglected in the community"[34]. All this is possible where there is good collaboration between the church, the government and the community

[34] Cf Paul VI, Evangelii Nuntiandi, Rome, 8th December, 1975.

5.4 INTEGRATED RURAL HEALTH DEVELOPMENT

Integral means to bring all parts of something together to make something complete. Integrated rural health development is bringing several disciplines together to make a harmonic development of the rural communities. Here, it is a matter of bringing together health education, agricultural and academic education for the benefit of the rural communities Integral rural health development, to be authentic, must promote the good of every person and of the whole person. Pope Paul VI remarked "... the development is primarily about people and the quality of life, not just about the quantity of goods people seek; to do more, know more and have more in order to be more ..."[35]. The reason is that people would like everybody in the community to participate or be involved in all types of development they are doing. This improvement helps the poor people be identified and assisted and the ignorant removed from their ignorancy.

5.5 INTEGRAL DEVELOPMENT AND SOCIAL MINISTRY

The work of a social minister should be to promote integral development. An integral development consists not only in assuring the necessities of life but also in acquiring knowledge and culture, in the realization of human dignity, friendship and other spiritual values such as prayers and contemplation. The work of the social minister is the liberation of all people from all kinds of alienation, for instance, poverty and slavery. But for this, use of violence should be shunned. Rather faith, love, participation and commitment of each and all individuals are used. The African Synod observed that "... the church has to bear witness to the gospel in words and deeds". The formation in social ministry prepares us to respond faithfully to the modern demands or the felt needs of the people of this new millennium, especially the needy. This will lead us to answer on how participation can be integrated with social ministry to benefit rural communities.

5.5.1 EVANGELIZATION AND THE SOCIAL MINISTER

Evangelisation means "to proclaim Christ to those who do not know him" Social ministry is a partnership with Christ It cannot exist without close union with him. When Jesus the Nazarene came, he not only preached the kingdom of God to his people but also

[35] Popoe Paul VI, Populorum Progressio, Rome, 1975, pg. 21.

fed the hungry and cured the sick (Matthew 15: 30-39). Furthermore, evangelization as well as social ministry is bringing the Good News to all humanity, through its influence of transforming humanity from within and without, as Jesus did. So as an evangelizing sister as well as social minister, I am called to do what the master did, to follow his foot steps. Before entering into His kingdom, Jesus sent the Church for a mission: to feed the hungry, clothe the naked, to show love and compassion to prisoners, the sick and the aged (Matthew 25: 31-46). We see now that social ministry involves works of development, James underlines this clearly in his letter when he refers to faith without action as dead (James 1).

5.6 CONCEPT OF COMMUNITY PARTICIPATION

The concept of community participation is not a new one in Nakuru or Kenya at large. The *harambee* (self-help, pooling and pulling together) concept which gained momentum at independence has significantly contributed to development efforts. However, in the health sector, most *harambee* efforts have been directed towards the putting up of buildings which the people hoped would be developed by the government or religious health systems into functional units. Many such potential human health centers remain incomplete or unoccupied The preoccupation with putting of buildings by the people is a reflection of preoccupation that puts disease rather than health as the focal point. It seems reasonable to expect that this existing interest in health, expressed in the rather dead-end preoccupation with putting up buildings, could also be channeled into health promotion and disease-preventive activities that could be undertaken by the people in the context of community participation

The community-based approach envisages a situation in which the health system and community are partners collaborating in the business of establishing services. It implies active participation by communities in decision making regarding the organisation and types of services at the community level A major obstacle to putting the community participation approach into operation is the lack of experience in how this could proceed in the context of established health services

The present study was motivated by the idea that the community-based approach would help to establish dialogue between the formal system represented by health

workers as the facilitators and the people in the communities or the target group It was to investigate how this dialogue could be established and maintained in an atmosphere that would facilitate people's involvement in improving their health environment and habits. It was envisaged as a partnership at the interface of communities and health systems that could be developed by the people These would help in deciding on the nature of the organizational set-up through which community participation could take place.

5.7 TRAINING

The main ways CHC in the Nakuru programme are trying to bring about participation are utilization of mobile clinic service and promotion of health-related behavioural changes at household level. The CHC must present a convincing case to community members before they are willing to change their traditional ways or participate in the programme activities. This requires both good communication skills and solid practical knowledge. The latter enables them to back up their advice with how-to-do-it instructional skills Increased co-operation with government technical staff in the fields of agriculture, water and sanitation would also strengthen their technical capability

Community health volunteers in the Gilgil and Mogotio programmes are trained in groups of about twenty men and women by two to three enrolled community nurses. The training curriculum covered an initial two-week period. A variety of teaching methods was used, including visits to Mathare Hospital, working in the mobile clinic, handouts, home visits and traditional forms of communication- role plays. stories, songs. Training sessions were carried out at community level and at the Community Health Department at Mathare Hospital. After initial training, volunteers had a one day's training each month from the Gilgil programme community nurse who was assigned responsibility for the area. A relationship was thus built up between volunteers, and the community nurse The initial and in-service training period was between three to four weeks over a one-year period.

RECOMMENDATIONS

When identifying areas of expansion of activities, priority should be given to the areas which are not readily well served by government health services.

Every VHC should be encouraged to be more independent in policy development while keeping financial sustainability considerations in mind.

For successful education approach to commercial sex workers (CSWs) in particular, need arises to involve or select peers to be trained as educators. This would enhance the acceptability by other CSWs, give equal representation of different groups and have CSWs committed to educating others selected.

5.8 CONCLUSION

Finding ways to sustain the CBHC programmes financially, other than through external resources is problematic for NGOs and CBHC programmes in Nakuru. Overall, they demonstrated some success in increasing health awareness, getting people to undertake better health practices and utilize health services. The programmes were sustained programatically through strong support by women and church groups. In some cases, this was more significant than in the VHCs.

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

An essential input from the government and the church is promoting community participation in rural areas for communities to utilise and support. An important element is a health facility team which is properly trained and motivated to elicit participation in the health service programme from the particular communities. Due to various reasons including, financial constraints and low morale amongst health staff, this input appeared not to have been attained within the formal health system in Kenya. The government health service did not seem to be in a position to be actively eliciting community participation. Funds were not forthcoming to provide the minimum level of resources, namely, essential drugs and medical supplies and mobility for technical support and

supervision to operate a reliable services in the rural areas. This resulted in general under-utilization of the formal health services. On the other hand, some rural health services operated by the churches and NGOs were managing their services more effectively. Through seminars and workshops, the community will be broaden its outlook and sharpen the people's intellect about the world, including an awareness of all social, cultural, economic and political forces of one's existence. It is encouraging to note that community participation is improving in some places within the district and there is great hope of going up higher.

At the same time, community participation must exist without an individual taking advantage of the other in order to bring about fair and sustainable development in Nakuru and in the country. Many times, in the community there is an outbreak of sickness/disease and death while the people of God and government look on silently. The time to act is now. God still calls, "Whom shall I send, and who will go for us?" (Isaiah 6:8) Affirmatively to this question, social ministers, churches, NGOs and all individuals should join together in encouraging community participation. The vision of the research is to see a new community in which everybody is participating in building God's kingdom. In this way God is glorified unanimously.

CHAPTER SIX

PROJECT NAME

Gilgil Community Based Health Care (CBHC)

PROJECT OVERVIEW

Gilgil CBHC is situated in Gilgil Division in the eastern part of Nakuru District. It has an area 1,039 sq. Km. The township is on the southern part of Nakuru District along Nakuru-Nairobi highway which is the Trans-highway connecting the eastern part of Africa to the central region countries. The division comprises four locations, namely, Gilgil, Karuga, Miti Mingi and Kiambogo. These in turn are subdivided into eight sub-locations. The division head offices are at Gilgil.

According to the District Development Plan 1994-1996, Gilgil community has a population of about 80,943. It comprises largely people of different ethnic groups such as the Agikuyu, Maasai, Turkana, Kalenjin and Luo.

Gilgil is a semi-arid area with bimodal rains spread from March to June (long rains) and October to December (short rains) and with the average rainfall ranging from 500 mm to 1100 mm[36]. The community largely depends on these short rains of October to December to grow vegetables and other short-season crops for sale. Others are pastoralists. Due to low agricultural output, people have migrated from their farms to the township and markets in search of job opportunities which are hardly available. Some of these people are there as "refugees", fleeing from land clashes which took place in other parts of the Rift Valley in 1992-1993. The place itself is very dry and dusty. Gilgil people suffer from various problems. In 1998, there was an acute diarrhoea outbreak followed by measles. Many people lost their lives. The people are very poor due to lack of rain hence depend mostly on micro businesses. Major problems in Gilgil were ignorance, poverty, lack of schools and health services. They have only one health centre. It is a long distance to walk when going to the hospital, given the hustles in transport. Accordingly, need arises to educate the people and create awareness on hygiene. These people themselves

[36] Cf. District Health Officer, interviewed by Mary Munyua on 15th of July 2000.

could assist in, for example, training their community members right from the grassroot level. Eventully, the people will be able to address some of the major diseases at their homes as well as at the community level.

GOALS

1. To uplift the socio-economic of the local community from the grassroots level in order to alleviate the misery and poverty by the years 2002-2004.
2. To establish an organisation relationship between health system and study communities.

OBJECTIVES

1. To educate the community on the importance of using clean latrines, clean water and general by improved sanitation.
2. To advise the community on the importance of balanced diet.
3. To educate the community on the importance of immunisation and family planning in the community.
4. To educate the community on the antenatal and postnatal clinic.

PRELIMINARY RESOURCES

1 At present, I have a group of people ready to work hand in hand with me. These are the Public Health Officer, nurses, midwives, CHWs and TBAs.

2 We have five acres of land and a small building.

3 The church has promised to offer us an old car.

ASSUMPTIONS

1 If we could manage to train more CHWs, the diseases would decrease and the environment will change

2 It is assumed that from this study, a general understanding of how people could participate in their own health care in partnership with formal systems could be obtained The generalisation arising from this understanding would help to speed up the planning of a community- based approach as an integral part of delivery of health services by the MoH in Kenya

3 It was an assumption of the study that people are interested in their state of health. This interest can be stimulated so that health awareness can be built up towards identifying and working on solutions to their health problems.

SWOT ANALYSIS

STRENGTHS

1. There is already an existing history of networking amongst local authorities, NGOs and the church.
2. Having land for building a centre promises success.
3. There will be financial support from the local community and donors.

WEAKNESSES

1. Lack of collaboration between the community itself, the public health co-ordinator, the CHWs, TBAs and VHCs.
2. Opposition from government officials especially social services.

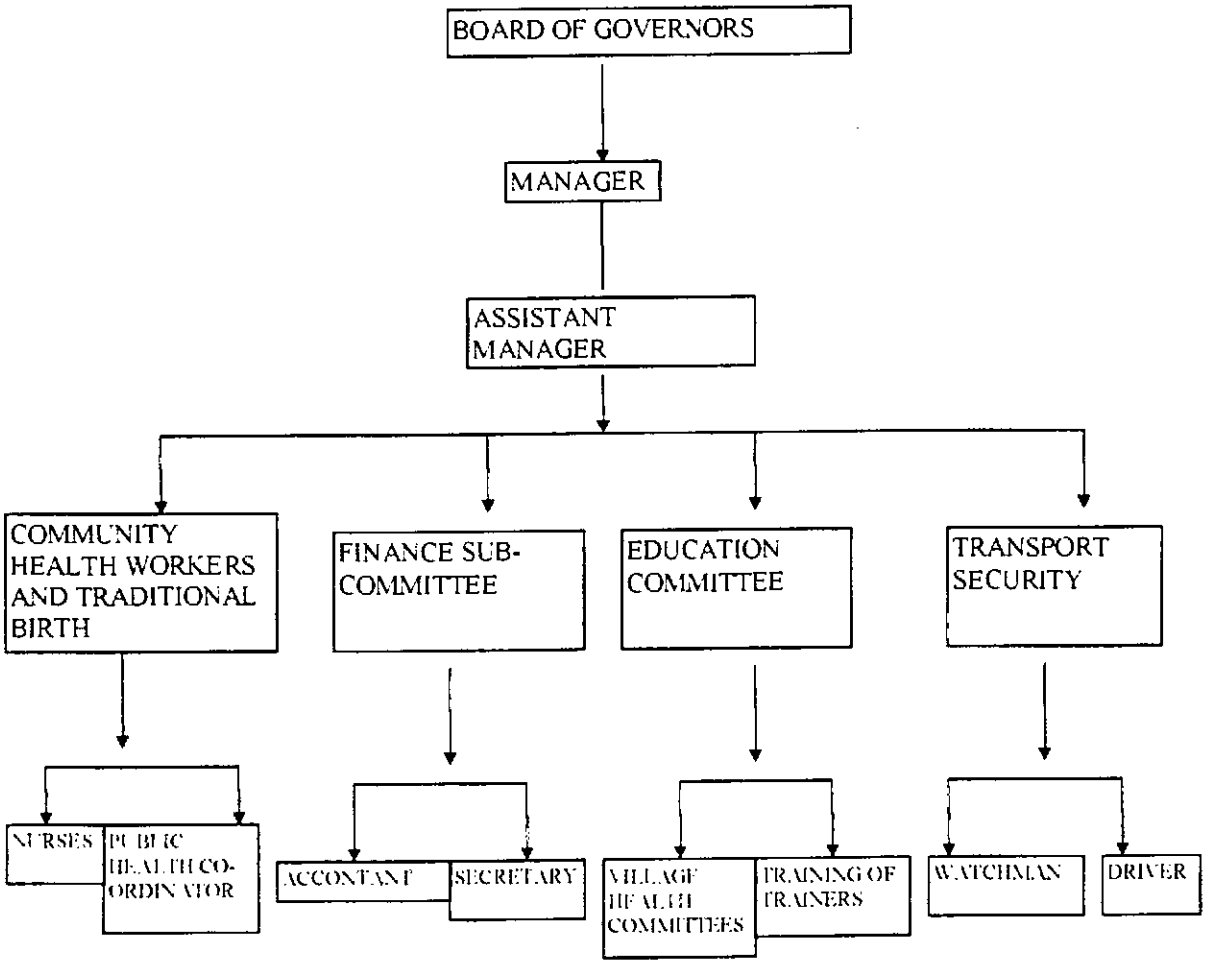
THREATS

1 The project will be a threat to private health centres especially those who work on commercial basis because 80% of the sicknesses will be treated at home and so they will not have the market
2. Financial constraints might hinder the development of the project.

OPPORTUNITIES

1. After having trained enough CHWs, the project will manage to support itself and the members of the community will gain knowledge from it which of course at the end every body will be happy.
2. There is a possibility of networking with other organisations, for instance, churches and government.

PROJECT MANAGEMENT STRUCTURE



DESCRIPTION OF FUNCTIONS

Board of Governors (BOG)

The BOG is made up of individuals who are specialized in issues relating to PHC/CBHC Networking is very important so as to assist those who are really needy. They meet quarterly in a year to discuss the project's matters arising and also to evaluate the project objectives, management and activities.

Project Manager

Will be in charge of establishing the integrated community participation in order to develop it by involving the community, public health officer, nurses, TOTs, and local

leaders, for example, the Chief and Assistant Chief. The social minister will see into how each department is co-ordinating.

Public Health Co-ordinator and Nurses

Will organize and give training to the CHWs, TBAs, and VHCs, supervising them in the field.

Accountant

Will deal with income, expenditure and book keeping of the project.

Secretary

Will deal with keeping the records of the members, ordering the drugs and maintaining the minutes of the meetings.

Village Health Committee

Will liaise between the project and the community especially by advising them, monitoring and supervising the CHWs. They can also appoint TOTs to carry out this work

Training of Trainers

Will be the educators of CHWs, TBAs and VHCs.

Watchman

Will be responsible taking care of the office and the environment.

Driver

Will be responsible for the car and taking the facilitates around the communities for the seminar and home visitations.

WORK BREAK DOWN STRUCTURE FOR GILGIL COMMUNITY BASED HEALTH CARE IN KENYA FOR 2001-2003

OBJECTIVES	ACTIVITIES	WORK PACKAGES	ESTIMATED TIME (MONTHS)	ESTIMATED COSTS
1) To create awareness	- Meeting with the members of the small Christian communities	• Meeting the leaders of small Christian communities	2	50,000
		• Identify community health workers, traditional birth attendants- training.	3	120,000
		• Home visitations	8	200,000
	- Public campaign	• Meeting the chief	1	1,000
		• Open forum	2	24,000
		• Seminar on the actual health day.	2	60,000
2)Pprovide health facilities	- Construction of the health Centre	• Fencing	1	200,000
		• Building the clinic	4	300,000
		• Purchases materials	2	400,000
		• Toilet Block	3	200,000
	- To start operating the clinic	• Staffing	2	5,000
		• Salaries	-	500,000
3) Education	- Networking - Collaboration	• Recruit. CHWs. TBAs and VHCs	3	20,000
		• Collaboration with government sectors and NGOs.	3	10,000
4) Employment (self-reliance)			Continuos	209,000

IMPLEMENTATION OF SCHEDULE (PHASE ONE) YEAR ONE JANUARY 2002-2004

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	WHO IS RESPONSIBLE
OBJECTIVE 1 - CREATING AWARENESS	C	C	C	C	C	C							Evangelising Sisters
- PROVIDING HEALTH FACILITIES	#	#	#	#	#	#	#	#					
OBJECTIVE 2 - EDUCATION/WORKSHOP AND SEMINARS FOR CHWs. TABs AND VHCs	*	*	*	*	*	*	*	*	*	*	*	*	Evangelising Sisters

KEY

C- Creating Awareness

#- Education through seminars and workshops for CHWs. TBAs and VHCs

*- Providing health facilities

IMPLEMENTATION OF SCHEDULE (PHASE TWO) YEAR TWO JAN. 2001-2004

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D
OBJECTIVE 1 Continuous seminars workshops even to the community itself	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health food and nutrition and child immunisation programme	-	-	-	-	-	-	-	-	-	-	-	-

KEY:

✓ = Continuous training

- = Health food nutritional immunisation programme

All these activities will be going on by being integrated into lives of community and also considering their participation

PROJECT BUDGETING OF GILGIL COMMUNITY BASED HEALTH CARE IN KENYA BY THE YEAR 2002-2004 KSH. 3,000,000

ITEMS/PARTICULARS	YEAR PHASE I	YEAR PHASE II	YEAR PHASE III	TOTAL
1. Training				
* Create awareness through seminars and workshops	50,000	30,000	20,000	100,000
* Accommodation	161,000	100,000	41,000	302,000
* Stationery and workshops materials	120,000	40,000		160,000
2. Transport				
* Car maintenance		100,000	150,000	250,000
* Motor bike maintenance	40,000			40,000
* Bicycle	30,000			30,000
* Bus fare	20,000			20,000
3. Administration and staffing				
* Facilitators	60,000			60,000
* Salaries	200,000	300,000	400,000	900,000
4. Local contribution				
* Land and building	880,000			880,000
* Cash	38,000			38,000
* Labour	30,000			30,000
5. Contingency				
* Taxes	40,000	20,000	20,000	80,000
* Overhead	20,000			20,000
* Bills	20,000	30,000	40,000	90,000
6. Grand total	1,709,000	620,000	671,000	3,000,000
Less local contribution money requested from the donor		2,046,000		

Grand Total= 3,000,000

Money Requested= 2,052,000

Local Cotribution= 948,000

1$=Kshs. 78

The money requested is Kshs. 2,052,000= $US 26,307.7

CONCLUSION

The above project proposal is going to help or support community participation. This will meet the felt needs of the members of the community who need to be encouraged, and get adequate support from the local community to the funding donors.

Therefore, according to the present situation, the community around this area needs to educate or train CHWs, TBAs and VHCs among themselves in order this group to educate the community as a whole

These people hope to request other people of goodwill to come to their aid even financially, in order to meet their felt need of the community One main way of supporting them is by uplifting their life standard through educating them or giving them formal education Following my research during my long holiday experience exposure, I really feel with these people It is their most felt need to train CHWs, TBAs and VHCs in order to educate community participation in rural health development. Therefore in order to provide TOTs, we need to educate the community on the importance of CBHC. This requires the above proposal to be met within three years.

The community is ready to contribute money, the land, building social hall for meetings and seminars.

I am hoping you will be generous in supporting this project Feel free to seek clarification on anything that you could be unclear about. As a matter of fact, we are in the very initial stages, optimistic of great improvement soon

Prepared by: Sr. Mary Munyua

Signature .. ..

Date ....

Proposed by ... .

Signature ....

Date .....

BIBLIOGRAPHY

1. DICTIONARIES/ENCYCLOPEDIA

Dyers, J., The New Dictionary of the Catholic Social Thought, Collegeville Minnesota: Liturgical Press Publications, 1994.

The Holy Bible, The New Jerusalem Bible, London: Darton, Longman and Todd, 1990.

2. DOCUMENTS

Flannery, A. Ed., Vatican Council II: The Conciliar and Post-Conciliar Documents Vol. 1, New York. Castello Publishing Company, 1998

John Paul II, The Mission of the Church, Nairobi: St. Paul Publications, 1990.

John Paul II, The Church in Africa, Post Synodal Apostolic Exhortation, Nairobi Paulines Publications.

Vatican Council II, Gaudium et Spes.

3. BOOKS

Agabasiere J. J and B Zabajungu (eds) Church Contribution to Integral Development, Eldoret. AMECEA Gaba Publication, 1989

Alan C H. Health Education in Developing Countries. London, Thomas and Sons Ltd, 1964.

A World Bank Publication Poverty and Human Development, London. Oxford University Press, 1980

Batchelor, Peter, People in Rural Development London The Paternoster Press, 1993

Chambers, Robert Rural Development, Putting the Last First Hong Kong. Longman, 1983

Cohen J M. and N. T. Uphoff. Participation's Place in Rural Development. Oxford: Oxford University Press, 1980

Dakley, P. Community Involvement in Health Development. Geneva WHO, 1989

Dennis, Williams, Epistemological Relevances in CBHC, Programme in the Republic of Kenya The University of British Columbia, 1984

Dennis, Williams Programmes in the republic of Kenya, Unpublished, 1984.

Djukanovic ad. Applications of Behaviour Modification to Health Promotion in the Developing World. Social Science and Medicine, 1987.

Freire, Paulo, Education. A Provocative Empowerment. New York: Winn Publication, 1972.

Hyden, G. Reforming the Structure in the Public Service. Literature Bureau. Nairobi: UNICEF, 1982.

Getrude, Bedrichs (Sr.) Base Christian Community and Health, Nangina CBHC Project May, 1988.

Hope, Ann and Sally Timel, Training for Transformation: A Hand book for Community Workers (Books I, 2, 3). Gweru: Mambo Press, 1995.

Kaseje, D. C. and E K N. Sempebwa. An Integrated Rural Project, Saradidi: Kenya, 1989.

Kerr, C. Community Health and Sanitation, Nairobi: UNICEF, 1990.

Madan, J N. Community Involvement in Health Policy. Nairobi: AMREF 1987.

Maneno, Bennet, F J., eds. National Guidelines for the Implementation of Primary Health Care in Kenya Ministry of Health Nairobi, Kenya, 1986.

Ministry of Health, National Guideline for Implemetation of Primary Health Care, Kenya, 1986

Ministry of Planning and National Development, Nakuru District Development Plan, Nairobi: Government Printers, 1997-2001.

Morris, J. and Heyer, J D. Ireri, Rural development. Nairobi: East African Publishing House, 1971

Ochola, Mismor and Kisubi, Primary Health Care: Experience in Eastern and Southern Africa, Nairobi. AMREF, 1992.

Roy, Shaffer. Beyond the Dispensary, Community Health Workers Support Unity, Africa Medical and Research Foundations, Nairobi: 1983.

Shaffer, R , Balanced Participation in Development Nairobi AMREF, 1983

Uphoff and J. M Cohen Participation's Place in Rural Development. Oxford Oxford University Press, 1980

Vin, Robert K. The Case Study Crises. Administrative Science Quarterly, Unpublished, 966.

Wambua, Francis M , Enabling the Rural Poor through Participation, Eldoret. Gaba Publication, 1987.

Were M K Ministry of Health, Organisation and Management of Community Based Health Care, Nairobi: 1981.

Whiter, F. M. Mburu. Community-Based Health Care. Social Science and Medicine, 1989

WHO, Alma-Ata. International Conference on Primary Health Care, Alma-Ata, 1982.

WHO, Community Involvement for the Development. Report, Inter-Regional Meeting, Geneva: Unpublished Document, 1985.

Young, Frank W. Participation and Project Success: Rural Development Participation Review, Nairobi: AMREF, 1980.

ARTICLE

Barington, Simon. "Health and Development", In Roy Billington, Health: A Surprising Joy. London. Church Missionary Society, 1976, pp. 15

APPENDIX I

RESEARCH QUESTIONNAIRE 1:

QUESTIONNAIRES FOR TRAINING OF TRAINERS

1. Name.....

2 Occupation.....

3. For how long have you been with VHCs, CHWs and TBAs?

.....

.....

.....

4. What are your main objectives with VHCs, CHWs and TBAs?

.....

.....

.....

5 What are your criteria for choosing VHCs, CHWs and TBAs?

.....

.....

.....

6 a. Cite the objectives you have attained

.....

.....

b. For those not achieved, what are the main obstacles?

.....

.....

7 a) After training the VHCs, TBAs and CHWs, do they carry on the work on voluntary basis or they are paid?

.....

.....

.....

b) If they are paid, who pays them?

.....

.....

8. If it is on voluntary basis, for how long do they work as such?

.....

.....

9. Before starting the training, do you first give, for example, awareness seminars?

.....

.....

.....

b) If yes, how do you go about it?

.....

.....

.....

10. If after training for three months, one feels that she/he does not want to continue, what do you do?

.....

.....

.....

11. So far, what are some of the reactions/views of the people to this training in the district?

.....

.....

.....

12 According to your own opinion what would be the most effective way to go about this programme?

.....

.....

.....

RESEARCH QUESTIONNAIRE II: QUESTIONNAIRE FOR COMMUNITY HEALTH WORKERS

1. Name

2. Age

3. Marital status
   a) Single
   b) Married

4. Why did you join the CBHC?

.....

.....

5 Do you expect some payments? Yes or No.

6 For how long have you been with CBHC?

7. Is CBHC important for your community or not?
   b) If yes how?

8. Mention some of the specific activities your work involves.

9 Which are the difficulties that you face in the field?

10. What are some of the possible solutions to these difficulties?

11 Are you motivated in your work or do you feel that something else should be done to boost your morale?

.....

.....

12. Do the people understand the importance of community participation?

.....

.....

13 What are the projects people are most interested in participating in?

.....

.....

14. Which are the specific ways in which people participated in health project?

.....

.....

15. What areas do you think have improved in the community health as a result of your work?

.....

.....

RESEARCH QUESTIONNAIRE III: FOR COMMUNITY MEMBERS AROUND III

1. Name .....

2. Your age in years.....

3. Sex- male ( ) Female ( )

4 Are you married? Yes ( ) No ( )

5 Name some of the activities of CBHC in this area

.....

.....

6. How did you become aware of CBHC programme?

Through a friend/colleague ( )

" " Seminar ( )

" " Newsletter ( )

" " Newspaper ( )

" " Radio ( )

7. When did you enrol in the CBHC programme?

1996 ( ) 1997 ( ) 1998 ( ) 1999 ( )

8. Give the name of course (s) you have enrolled in:

Communicable diseases ( )

Family Planning ( )

Community health ( )

Child health ( )

Environmental health ( )

Medicine ( )

AIDS ( )

Mental health ( )

Helping mothers to breastfeed ( )

Traditional birth attendants ( )

9. Is/Are the course (s) related to your work?

Yes ( ) No ( )

10 What is your level of basic education?

Primary education ( )

Secondary education ( )

Adult education ( )

No education ( )

11 Have you been trained as a community health work?

Yes ( ) No ( )

12. As a community, what do you contribute to facilitate the work of CBHC?

.....

.....

.....

13. Name the role, if any of CBHC in uplifting the living conditions of the people?

.....

.....

.....

14. What are the families doing in addressing community problems?

.....

.....

.....

APPENDIX II: A LETTER SENT TO THE PUBLIC HEALTH OFFICER

Dear Colleague,

May I take this opportunity to wish you a happy and prosperous millennium.

I am pleased to inform you that you have been identified as a respondent to the enclosed questionnaire. The questionnaire is being used to collect information on the community participation, community health workers-CBHC programme as provided by the Ministry of Health and churches.

Your information will help in improving this programme. The questionnaire is divided into three parts, the first part will be answered by training of trainers (TOTs), the second will be answered by community health workers (CHWs) and the third by the community around.

Nearly all the questions have a choice of the responses or answers. Kindly complete the questionnaire

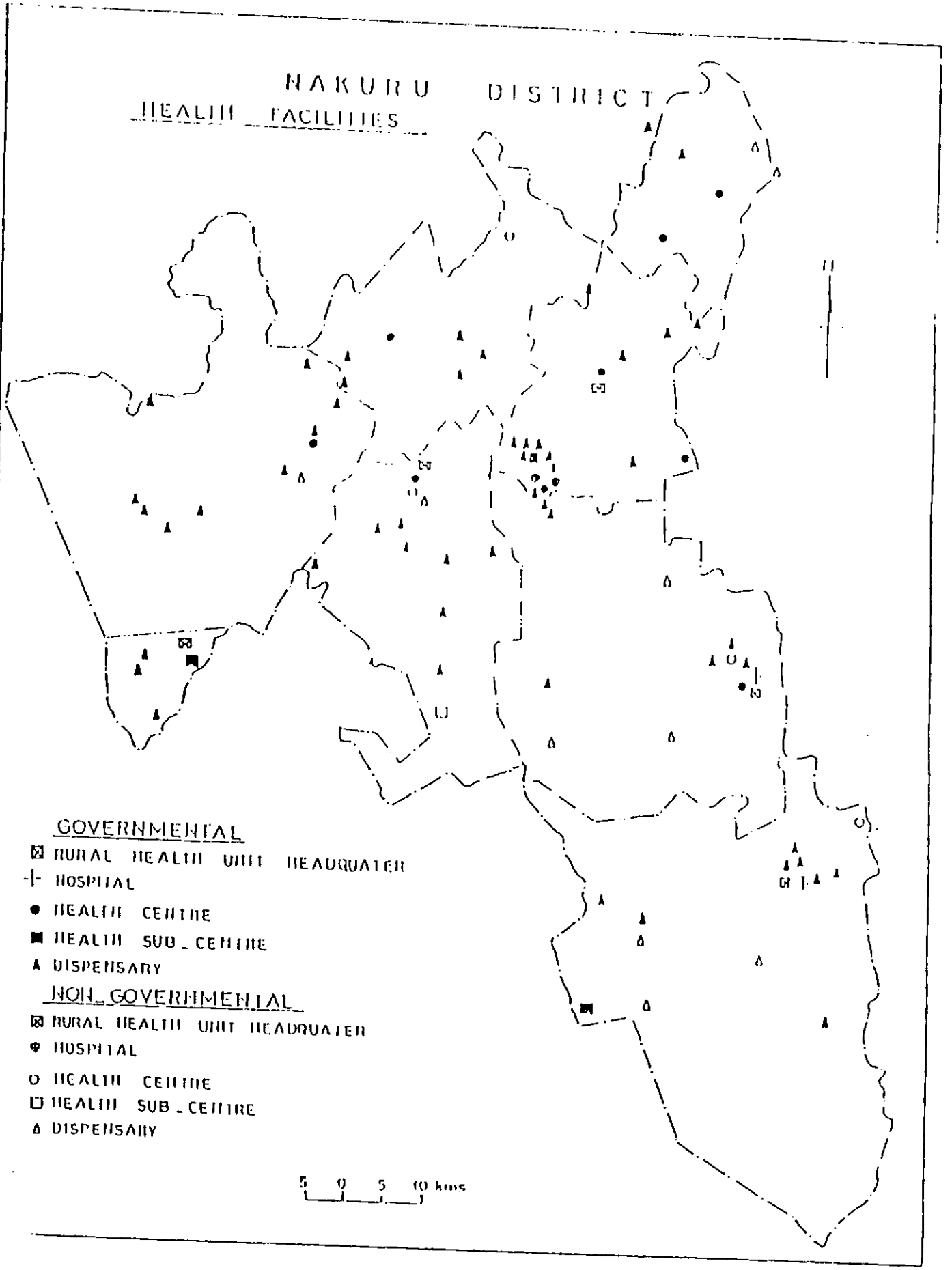
You indicate your choice or opinion by entering the figures or scales, given before the question (s). Enter the figure corresponding to your opinion in the box provided by the response or choice.

Thank you very much for your co-operation in this important exercise.

Yours faithfully,

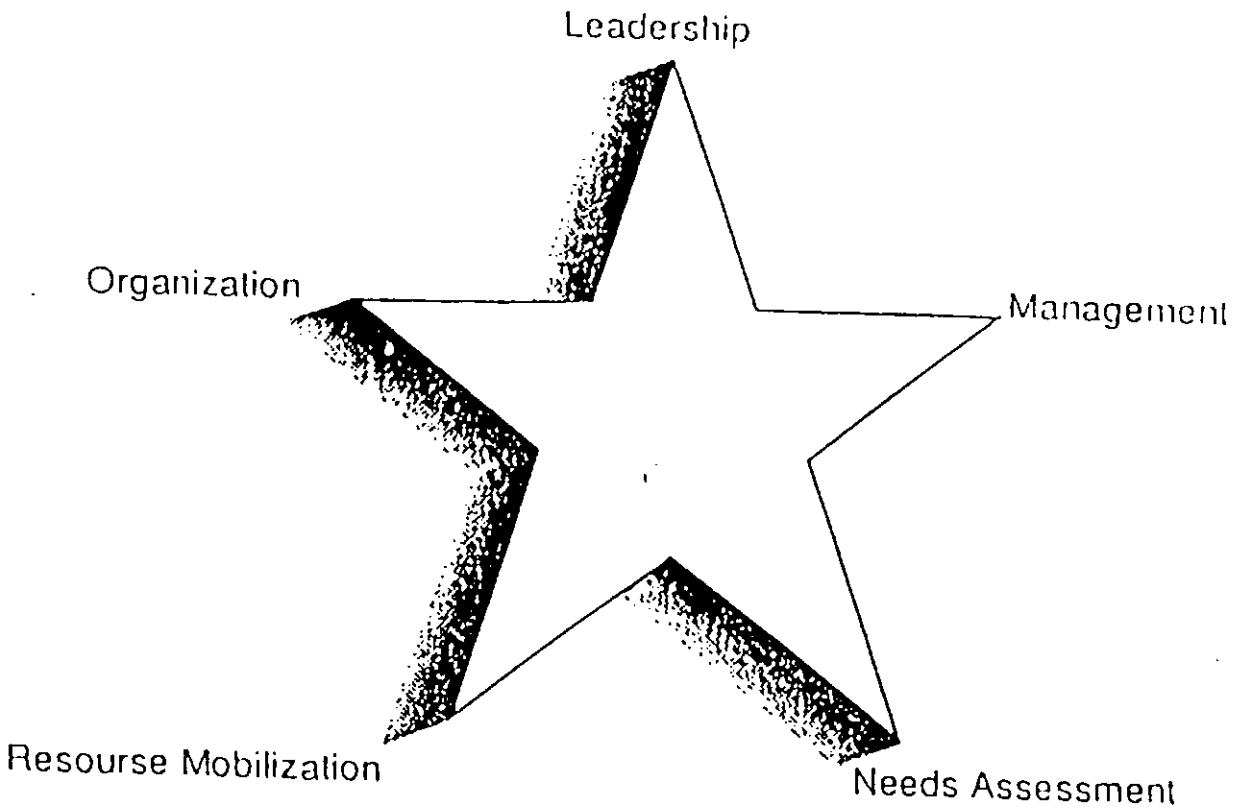
Sr. Mary Munyua.

APPENDIX III: MAP OF NAKURU DISTRICT



APPENDIX IV: MAP OF KENYA

APPENDIX V: STAR OF COMMUNITY PARTICIPATION



Star of Community Participation

Community participation is the star of PHC/CBHC because:

It is the cutting edge of sustainability of PHC/CBHC.

It makes a departure from the conventional view and practice of medicine and the provision of health services

It creates a sense of pride, ownership and confidence in the community.