

MAKING COMMUNITY DISTRIBUTION WORK



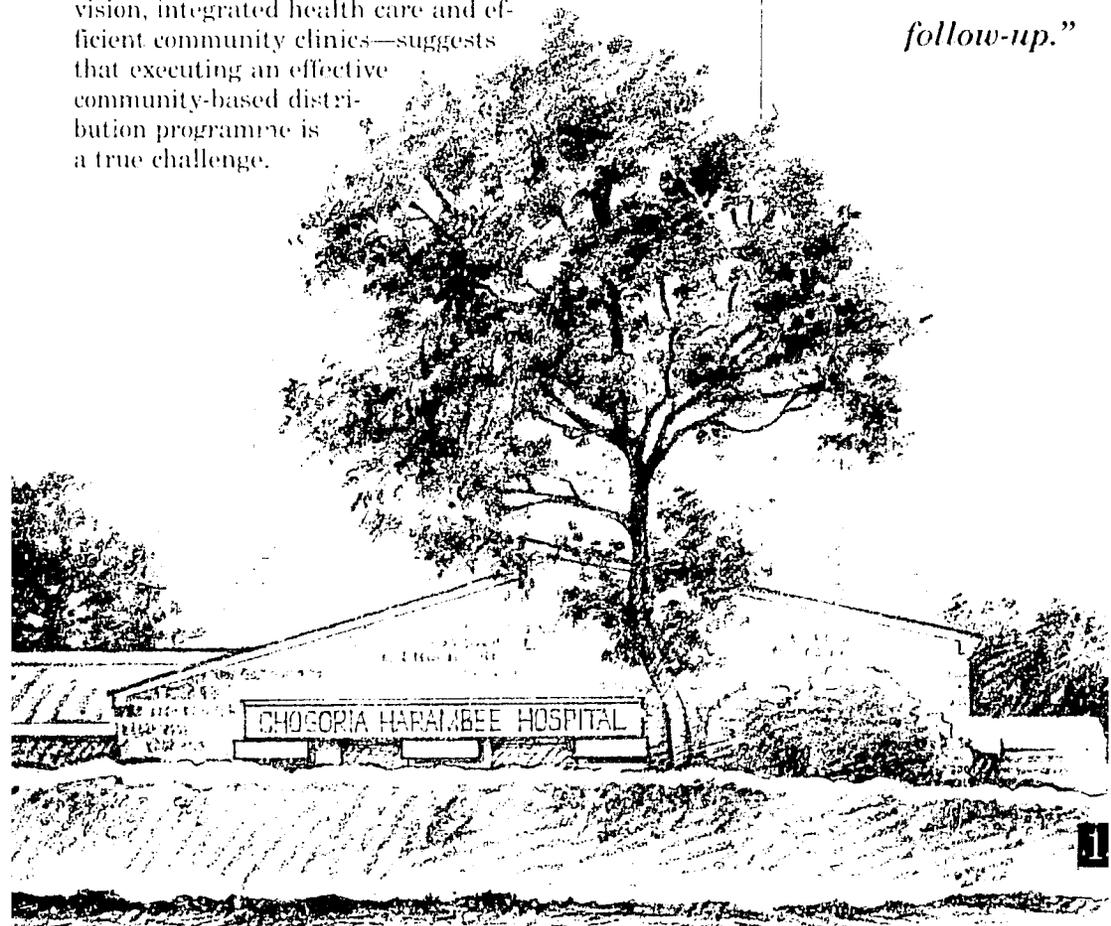
Can family planning work in Kenya, the world's fastest growing country? Chogoria Hospital, situated in the eastern foothills of Mt. Kenya, has demonstrated that indeed it can.

Served by a system of community-based distribution of contraceptives, the 350,000 people of Chogoria's service area have dramatically reduced the regional fertility rate. A survey of the region conducted by the U.S. Centers for Disease Control in 1985 showed that 43 percent of its married women use some form of contraception, compared to 16 percent for the Kenyan nation as a whole. And even more significant, women in the Chogoria area can expect to have 5.2 children on the average, compared to an expected 7.7 children for Kenya as a whole.

The formula for success seems simple enough: the hospital taps the energies of the people of the area. But the long and complex evolution of the programme—popular participation, careful supervision, integrated health care and efficient community clinics—suggests that executing an effective community-based distribution programme is a true challenge.

A CHOGORIA
OFFICIAL:
THE HOSPITAL'S
ROLE

*“Given a chance
people will help
themselves. But a
programme can-
not run itself.
Community parti-
cipation must be
supported by
supervision and
follow-up.”*



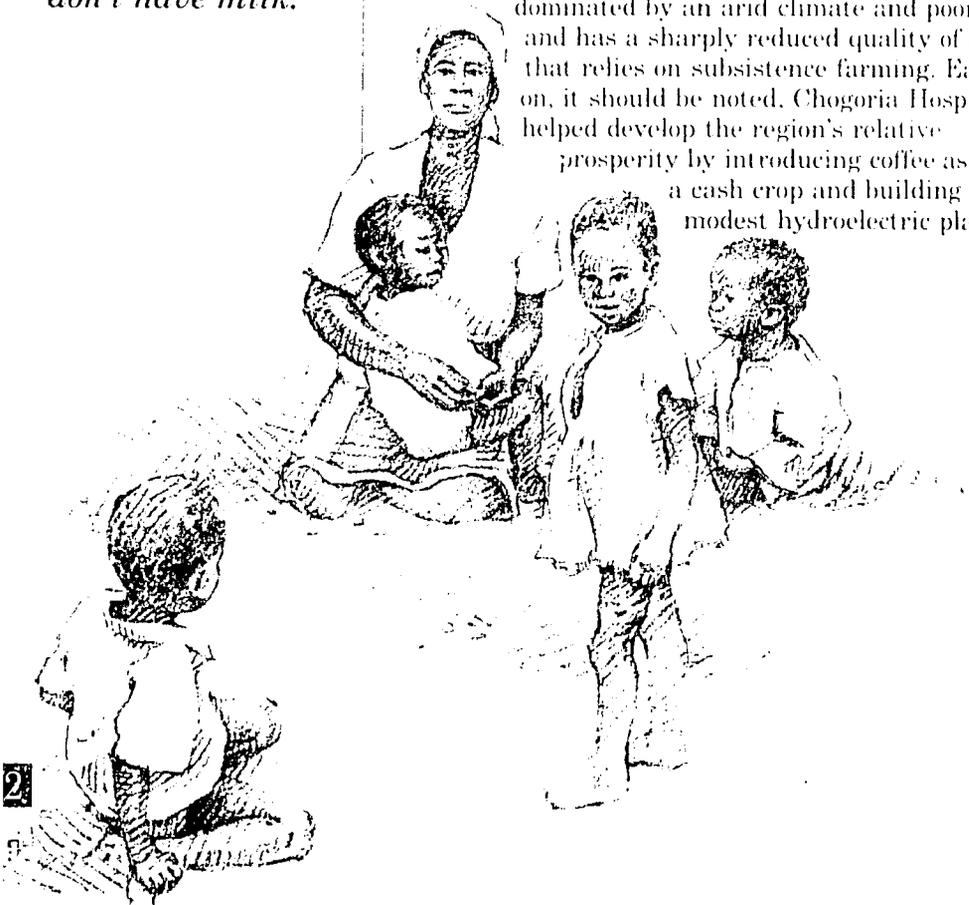


A HOSPITAL
STAFFER:
PEOPLE NOW
SEE ECONOMIC
CONSTRAINTS

“The people have learned about the problems of a large family: schools are costly; there isn’t enough good land to go around; and if there is a drought, children don’t have milk.”

Chogoria, founded in 1922 as a Church of Scotland mission hospital, has deep roots in its service area, roughly 70km long and 50km wide, in Meru District. The people of the area have long counted on its quality health services. Over the years, Chogoria Hospital became an eminently Kenyan institution, staffed 98 percent by Kenyans and presided over by the national board of the Presbyterian Church of East Africa (P.C.E.A.). Further, the service area, in line with the rest of the nation, is largely Christian, with the P.C.E.A. and Catholic church being the largest denominations. A tie to the past is represented by a small group of Scottish volunteers.

The Chogoria region, though small, is topographically varied. Traditionally altitude dictates land values. With 400 people per square kilometer, the densely populated, productive upper reaches of the district are dedicated to cash crops—tea and coffee—and to maize fields interspersed with bananas. The lower zone, sparsely settled with fewer than 20 persons per square kilometer, is dominated by an arid climate and poor soils and has a sharply reduced quality of life that relies on subsistence farming. Early on, it should be noted, Chogoria Hospital helped develop the region’s relative prosperity by introducing coffee as a cash crop and building a modest hydroelectric plant.





Recognizing the need to expand existing health care beyond the hospital walls, Chogoria opened its Community Health Department (CHD) in 1970, an outreach programme—maternal and child health services, sanitation and nutrition information, and curative medicine—that included family planning. Starting in the early 1980s and with the help of funds from the Swedish International Development Agency and USAID through Family Planning International Assistance (FPIA), community-based activities were greatly expanded. The CHD now consists of 28 village health clinics, 6 mobile units and a community network capable of providing contraceptives and health education to villagers in their homes.

The key to Chogoria's successful family planning programme, however, has been the harnessing of the people's tradition of *harambee*, or self-help. With the exception of the lower zone, the catchment area is blanketed by a grassroots cadre, composed of 42 village health committees, 30 enrolled nurses, 42 full-time field health educators, 500 volunteer family health workers, and 250 specially trained traditional birth attendants (TBAs).

A VOLUNTEER:
USING THE WHOLE
COMMUNITY

"I try to visit families three times a week. But some families are ignorant and will not change their ways. Then I get the community involved; my friends contact those families."

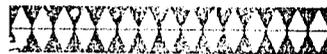
A VOLUNTEER:
HOW I LIKE TO
WORK

"Sometimes I take a whole day—I want to teach people slowly and carefully. I work side-by-side with women picking coffee or working in the fields. We discuss everything."

The system calls for constant dialogue, supervision and education. The village committees, selected by their communities, represent their constituents' interests and oversee the construction and maintenance of the local clinics and staff houses. The hospital then pays for a nurse at each clinic to provide daily curative and preventive medical care and to serve as a link between the community and the hospital. The nurses also supervise the field educators, who are community residents chosen by the village committees, trained by the hospital and paid a minimal salary to travel out from the clinics to the villages. Each field educator, in turn, supervises 10 to 15 volunteers and traditional birth attendants.

"Harambee energizes everyone along the line," explains the director of the Community Health Department. "The committees press their people for support of the clinics; the people demand specific clinic services from the hospital through the committees; and we ask for support and self-help from





A VILLAGE
HEALTH
COMMITTEE
VICE CHAIRMAN:
ON HARAMBEE

“The committee suggests assessments according to means and needs—cash, bananas, labour, or whatever you can give to the community.”

the committees and people. At times the discussions become very direct.”

The volunteers, some of whom trudge long distances, are particularly dedicated. They not only distribute contraceptives but also teach preventive medicine and good nutrition as well as promote oral rehydration and immunization. Why do they give their time? Most answer quite simply, “To help my community develop.” The volunteers, most of whom are women, manifestly enjoy an enhanced role in a rural society that often limits their options for personal development. But increasingly these grass-roots activists demand greater compensation—free health care at the clinics, a food allowance when traveling, or even a bar of soap to wash the travel dust from their clothes. Sometimes their families do not understand. For example, one volunteer explained, “I have trouble when I want to leave home to do my health work. My husband will refuse to let me go, saying, ‘Why should you go away to work for nothing?’” And there are times, during planting and harvest, when farm communities cannot be expected to donate their services.





A TBA: HER NEEDS

“You always wish you had more training and things to give—a small blanket for a new baby.”

The decision to incorporate the TBAs into the process was a bold move. These women, many of whom are illiterate, were considered “wary of authority.” If the training proved inadequate or a clash of culture occurred, hospital officials feared, “news can travel very fast from one area to another.” However, most of the women, invaluable as established confidantes of the village women, proved open to the programme and to training.

The final link in the chain was forged by training courses run in the field by hospital-based nursing facilitators and a subsequent system of supervision of the volunteers and TBAs by the field educators. The training sessions were conducted in the spirit of “sharing ideas” and “not talking down” to the TBAs.

The programme encourages villagers to rely on the health educators, volunteers and TBAs by implementing a dual-fee system. Family planning services provided by the volunteers are free. If a client comes to the clinic, the fee is 2 shillings (US\$ 0.12).

The hospital also charges fees. In fact, 75 percent of the hospital’s operating costs are covered by patients’ fees. Ten percent of the remainder



A CHOGORIA
OFFICIAL:
WORKING ON
THE INCOME
GENERATING
PROJECT

*“Even if I know
that a community
could go into
welding, I don’t
suggest it: if some-
thing went wrong,
Chogoria would be
blamed. We let the
committees suggest
an enterprise,
then we do a
feasibility study
together. We keep
going until we
find a project
that is their
own and
works.”*

comes from the Kenyan government and other funds come from grants by international donors and gifts from individuals. Self-help campaigns also tap the financial resources of the communities.

In seeking ways to ensure future financial security, Chogoria is exploring income-generating projects. The Community Health Department has just received a grant from the USAID-funded Kenyan Rural Enterprise Project to make small-business loans to the community health committees. The committees will use the funds to open a tailoring shop, a maize mill, or a carpentry service. Profits from these enterprises will be used to cover the health educators’ salaries (about \$80 per month on average) when donor funding ends in a couple of years. Described as “an innovative and challenging experiment” by the hospital administrators, income-generating projects could expand each community’s capacity for funding its own health care.

The outreach programme is bound together by a careful monitoring system based on routinely collected service statistics. At all levels, the workers’ effectiveness at attracting new family planning clients and maintaining old ones is traced and remedial action taken in case of a breakdown. This process is aided by recently installed micro-computers. Although enhanced by the computers, monitoring really hinges on open communications up and down the personnel ladder.





A HEALTH
EDUCATOR: MY
MOTIVATION FOR
DOING THE JOB

“I enjoy sharing with the community, laughing and talking, being part of the group. I teach, but I also learn a lot from the people. We work well in the community because we are chosen by the health committees. Everyone knows that we are not making a hidden profit.”

Chogoria, in sum, has capitalized on its advantages: a high degree of popular acceptance, a local tradition of self-help and grassroots democracy, and integrated health services. The field educators, for instance, have the training to handle most routine local health needs, a fact that makes them valued counselors in the community. The community-based distribution of contraceptives and information, then, takes place in an atmosphere of grassroots participation and trust.

Because of its closely woven network, Chogoria is not an easy “recipe” to duplicate. However, nearly 40 percent of health care in Kenya is delivered by church-run hospitals, most of which share a close relationship with their clients. They can learn from the basic point of Chogoria’s system: family planning programmes can be effective in Kenya, if the yeast of popular participation is added.





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