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Original Research Article

Influence of community dialogues on social accountability in the health system in Nairobi County, Kenya

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ABSTRACT

Background: Social accountability encompasses a variety of strategies that enable citizens to express their concerns about the performance of health-care services. Community dialogues provide a forum for community engagement and participation in the health care system. However, there is little documentation on how it is used to improve social accountability within government community health structures. The purpose of this study was to determine the influence of community dialogues on social accountability in Nairobi County, Kenya.
Methods: A qualitative study was conducted that included in-depth interviews with key stakeholders purposively selected. A total of three focus group discussions with 23 participants, eight key informant interviews and document review of minutes were conducted. Data analysis was done using thematic analysis.
Results: Findings showed that community dialogues were held quarterly. The forums were mostly used for education purposes with little evidence on community engagement. Minutes showed what the community health assistant and community health volunteer said to the community with minimal input from the community members. Feedback was a challenge because the health management team hardly attended community dialogues due to logistic and workload issues.
Conclusions: There is need of practical strengthening community dialogues through use of tools like chalk board and community scorecard as advocated in the community health policy. However, in practice, these tools were hardly used resulting to missed opportunity for the community to voice their opinions on health services.

Keywords: Community dialogue, Social accountability, Community participation, Health systems

INTRODUCTION

Community participation has been a central theme of health programming since the Alma Ata Declaration in 1978, which aimed to achieve 'people-centeredness'.[1-3] Participation is defined as the active inclusion of affected populations in policy formulation, implementation, management and evaluation.[4]

The community health approach in Kenya is founded on the concept of primary health care, with community participation serving as one of the guiding principle.[14] In this context, community participation within health facility catchment areas and localities should be maximized through a variety of activities.[14]

One of these activities is community dialogue. Community dialogue is a forum that brings participants from across the community, including health providers, to exchange ideas in face-to-face moderated sessions, share personal stories and experiences, express perspectives, clarify viewpoints and develop solutions to health problems, and is thus used as a participatory tool.[14,20,22] Social accountability refers to approaches in which citizens can express their opinions

about the quality of services, the performance of service providers, or policymakers, who are then required to respond to citizens and account for their actions and decisions.[7] Power dynamics, social economic status and illiteracy level prevent health clients from speaking up, even when there is evidence that they are mistreated or are not receiving expected health services.[1,2,11,12,15,18,23] In this regard, community dialogues can be important forums for health clients to air their concerns, particularly those related to health; however, the extent to which community dialogues achieve this is not well documented.

Most of community dialogue research has concentrated on participation in health promotion and service utilization, rather than community involvement and empowerment in health service governance.[17,20,24] For example, a research conducted in Kenya, South Africa and Zambia used community dialogues to engage community members and health providers in discussions about family planning.[26] Similarly, a study in Zambia used the approach to facilitate discussions on how to achieve quality care in family planning and contraception provision, guided by ground rules agreed upon by the various stakeholders.[20] However, there is little documented literature on how community dialogue has been used to raise awareness, enforce and provide feedback on health issues. Successful social accountability intervention ensures the achievement of voice, enforceability and accountability on health issues.[9]

This study examined how community dialogues were used to express community concerns and provide feedback within government community health structures. Even with the increased emphasis on the importance of community dialogues as a key deliverable in community health, many questions remain unanswered. Questions about how health concerns raised in these forums are handled, as well as their articulation and feedback, are rarely documented, particularly as a routine activity in the community health systems. Understanding how community dialogues achieve social accountability is critical in achieving quality services and health outcomes, particularly when client feedback is used to shape the health care system. As a result, the goal of this research was to complement primary evidence on the effectiveness of community dialogues in promoting social accountability.

METHODS

Study design and setting

A cross-sectional qualitative survey was conducted between July 2021 and August 2021 among community health volunteers (CHVs) and their supervisors attached in health facilities in Nairobi. The study was carried out at community health units attached to Kayole 1 health center, Kayole 11 sub-district hospital and Dandora 1 health center in Embakasi Central and Embakasi North sub-counties.

Study population

The study population included CHVs, CHCs, community health assistants and officers (CHA/O) and health facility in-charges. Participants were chosen purposively based on their work experiences in community health field.

Inclusion criteria

Participants (CHVs) were included if they had 80% performance score in the previous reporting months and attended at least one community dialogue meeting in the past three months. Key informants included Community Health Assistants/Officers, CHC and Health Facility incharges. Community dialogue minutes from January 2019 to August 2021 were included for review for data triangulation purposes.

Exclusion criteria

The study excluded participants (CHVs) that were from community health units not attached to a health facility providing maternal health services.

Sampling of study participants

This was a qualitative study; therefore, the participants sampled were those with experience working with communities and could share their perspective on community dialogues. Respondents included CHVs, CHA/O, community health committee and those involved in health facility management. Participants for the study were purposively selected. The CHVs involved in the focus group discussion were selected in consultation with the CHA/O. This was done to ensure that participants in the study had extensive experience working with the community and could freely share their experiences. The KIs were purposively chosen to be the CHA/O supervising the selected CHVs and the health facility in charge responsible for managing health services in the selected facilities.

Data collection

The focus group discussion guide (FGD), key informant interview (KII) guide, and document review checklist were used to collect data. The data collection tools were used to evaluate the influence of community dialogues on social accountability.

Three FGDs were held in the three selected health facilities. Participants in each FGD were invited to discuss the extent to which community dialogues were an important tool in social accountability. KIs were chosen to represent the key players in community health in the selected sub-counties and were interviewed. A total of eight key informants were interviewed with the help of a guide. With the permission from the participants, FGDs and KI were audio-recorded and transcribed verbatim.

Access to previous community dialogue minutes was requested. Previous minutes from January 2019 to August 2021 were reviewed to aid in data triangulation. A total of 11 community dialogue reports were provided, and it was noted that there was less reports available in the year 2020. This was as a result to COVID-19 restriction guidelines of limiting social gatherings.

Data analysis

The data was read and re-read for familiarity. FGD and KII data were audio recorded and transcribed in Microsoft word. Two coders coded the data separately, but they were routinely discussed to address any coding biases and improve inter-coder reliability. The researcher created a coding guide, which was followed during the coding process. Coding was done in Microsoft word. Thematic analysis was used and themes were created based on the research objectives and questions of the study.

Ethical approval and consent to participate

Written and verbal informed consent was obtained from all participants. Prior to the commencement of the study, approval was obtained from the Kenya Methodist University's scientific ethics and research committee (KeMU/SERC/HSM/36/2021), National commission for science, technology and innovation (NACOSTI/P/21/12157) and Nairobi metropolitan health department. This enabled permissible access to all information that was necessary for the research. The participants who voluntarily consented were involved.

RESULTS

Demographic characteristics of participants

The demographic characteristics of participants in the study are presented in Table 1. Most participants were female 74.2% compared to male 25.8%. Most of the participants were aged between 40-49 years (51.6%). Those with primary education were 38.7%, 35.5% had secondary education and 25.8% had tertiary. Most of them had worked between 5 to 10 years (64.5%).

Perception of community dialogue

Participants interpreted community dialogues as meetings that engage the community and health system stakeholders. Community dialogues were used to educate the community on health issues as quoted as: *"Community dialogue is a meeting where we educate the community members on health matters"* (KI, female).

Community dialogues were also used to inform citizens on various health interventions. Participants' responses gave the impression that community dialogues were a one-sided (health system) activity rather than a collaborative effort as envisioned by the Ministry of Health, as illustrated by the following quote: *"When we want to educate the community on good health practices, we invite them to dialogues"* (FGD, female CHV).

Table 1: Demographic characteristics of the respondents.

Characteristics	Frequency	Percentage
Gender		
Male	8	25.8
Female	23	74.2
Total	31	100
Age		
20-29	3	9.7
30-39	9	29.0
40-49	16	51.6
50-59	3	9.7
Total	31	100
Level of education		
Primary level	12	38.7
Secondary level	11	35.5
Tertiary level	8	25.8
Total	31	100
Work experience (years)		
Less than 5	3	9.7
Between 5-10	20	64.5
More than 10	8	25.8
Total	31	100

The KII findings collaborated with those of document review, where most information captured in the minutes were of educating the community on hand washing, breastfeeding among other practices as illustrated by the following excerpt:

'The CHA sensitized them on the importance of breastfeeding…' (minute 8).

Minutes were taken in a way that showed what the CHV or CHA did or said during the dialogue, with little information on what the community thought or said. This made capturing community voice or participation in community dialogues difficult. This was attributed to either a lack of skills in writing the minutes or a lack of opportunity for the community to express their opinions.

Results showed that community dialogues were held quarterly. This was in line with community health policy. However, they could hold more dialogue days in a quarter, but on demand, as illustrated by the quote: "*We hold community dialogues on quarterly basis according to the guidelines"* (KI, male). *"Sometimes we hold more than one dialogue in a quarter, upon request from the CHA"* (FGD, female CHV).

Participants in the community dialogues

According to the findings, the Chief, CHV/CHC and CHA were the most active participants in community dialogues.

There was limited evidence of other health facility staff and sub-county health management team (SCHMT) participating in community dialogues. The study findings showed that, health facility staff and SCHMT hardly attended these dialogues because of 'high workload' and 'insufficient logistic' support as shown by the following quotes.

"We are unable to attend community dialogues due to our heavy workload, but we are usually willing" (KI, female).

"We do not attend community dialogues because of a lack of logistical support, especially if they are held far away from the facility" (KI, male).

Despite the fact that there was limited participation by diverse stakeholders in community dialogues, it was noted that comprehensive inclusion of stakeholders is important. This was due to the community's emerging complex issues, which necessitate joint brainstorming of solutions, as stated below.

"Today we are having so many issues in the communities so we need to think outside the box and involve opinion leaders like pastors, the nyumba kumi initiative because there are things, we cannot do without them so we need to work together" (FGD, male CHV).

Due to the non-attendance of health management team responsible for service delivery, the findings revealed that community dialogues lacked adequate feedback on concerns raised. As illustrated below, it was difficult for the CHA or CHVs to respond to concerns that were beyond their scope:

"The CHA is in charge of community health, but a doctor or health facility representative should be present to answer questions about the health facility, such as drug shortages" (FGD, female CHV).

The participants agreed that, over time, community dialogues had been left to only CHVs and, on occasion, the CHA:

"Most times it is only the CHA who attends our community dialogues" (FGD, male CHV).

Findings showed that the lack of feedback caused community members to be disinterested in attending dialogues because they did not achieve the goal of sharing experiences, clarity and joint solutions. As a result, CHVs sometimes held dialogues with no or very few community members who were not a representative of the community.

"*Sometimes you call on members of the community to come, and they ask you... What new information will you be telling us?*" (FGD, female CHV).

Participants brainstormed ideas for making dialogues more inclusive and serving the purpose of participation. The proposed solutions included prior planning, sending invitations to all stakeholders on time and holding community dialogues on the time and day that is suitable for community members. They also suggested integrating health outreach services into community dialogues so that it attracts community members to attend.

Future research should look into how all of these suggestions can be combined to improve the performance of community dialogues.

Agenda in community dialogue

Participants shared the concerns and issues that were addressed during the community dialogue. Dialogues were used to empower the community by clarifying myths and misinformation and health promotion activities. For example, they are used to educate the community on proper hand-washing techniques, as well as to promote family planning and immunization services, as highlighted below.

"If it's about family planning for example so many mothers will come even fathers will come to know more about family planning and they will have so many questions so at the end of the day that dialogue will be so active" (FGD, male CHV).

These findings revealed little evidence of a community dialogue agenda focusing on health rights, complaints, and compliments. This could be attributed to the approach of using dialogues as primarily educational forums rather than also being used to discuss community concerns about health service delivery issues.

Documentation of community dialogue

The review of minutes revealed that capturing key issues discussed in dialogues was difficult. In most cases, evidence of minutes documenting the dialogues held was lacking, despite the CHVs verbally acknowledging holding community dialogues as shown in the quote below.

"We record community issues in our minute book" (FGD, female CHV).

"When you look at our minutes you will find what the issues the community raised" (KI, female).

Except for two documented minutes out of nine, issues raised from the community could not be established by review of minutes.

Instead of sharing the minutes in the event of a complaint directed at the health facility, the CHA would only report verbally to the health facility in charge.

"I hardly look at the dialogue minutes but the CHA tells me the issue that the community raised during dialogue" (KI, female).

DISCUSSION

These study findings showed that community dialogues were mostly used to educate the community and health promotion activities. The findings also showed the dialogues were mostly one sided (health system) and not collaborative. The purpose of community dialogues is to bring community members together; including health providers so that they can share ideas in face-to-face moderated sessions, experiences, clarify viewpoints, and propose health-related solutions.[14,22] Previous research has shown that community dialogues are more successful when everyone participates.[17,21] A study in Uganda used community scorecards and dialogues to enable community leaders and communities to collaborate and identify innovative solutions to health care delivery and utilization challenges. Local leaders in their study created safe spaces for dialogues where performance and utilization issues could be identified and collaborative solutions implemented.[17] In Mozambique, use of participatory communication techniques allowed for the correction of misinformation through consensus building in their study.[21] These findings showed that community dialogues are more effective when all stakeholders participate in identifying issues and jointly proposing solutions. In this regard, adaptation of tools such as chalkboards and community scorecards among others can be explored so as to strengthen these forums.

The finding on holding community dialogues quarterly were in line with Kenya community health strategy policy 2020-2025. In Malawi, similar findings were reported on the successful implementation of community bwalos (forums), which were held either monthly or quarterly, allowing citizens to voice concerns and receive information from duty bearers.[27] A feature of community dialogue was collaborative problem identification and analysis that led to a preferred future. Each community dialogue was participatory and empowering because it allowed members of the community to analyze, share and utilize information. Unlike debates, community dialogues emphasized listening to deepen understanding, the development of common goals, and the expression of participants' opinions on courses of action.[19] The frequency of holding community dialogue is important however, the quality of these forums need to be emphasised.

This study findings showed that most agenda discussed on dialogues were to educate community member on health interventions like hand washing and use of safe water. However there have been studies that have established that community dialogues can be used as a tool for the community to be empowered on health rights and also demand for their rights. For instance, a study conducted in Uganda revealed that community members demanded for responses from the district leaders on emerging health issues after sensitization on health rights during community dialogue.[22] Participants proposed and implemented actions during their dialogues, which disproved the belief that community dialogue is "a lot of talk" that never achieves significant action.[22] Similarly, a study in India found that through the process of information and dialogues, women were empowered to make collective demands on the health system.[18] Ultimately, joint meetings improved trust and collaboration between women and the health system, as well as elicited appropriate responses from the health system. A study in Uganda reported 20% increase in utilization of public health services and 30% reduction of child mortality after conducting community dialogues.[10]

The findings showed that health management teams hardly attended community dialogues which affected feedback significantly. In sufficient feedback contributed to low participation of community members. Feedback is an essential component of effective social accountability activities.[7] Success of social accountability is dependent on collective action of different players in the community. For instance, a study in Sierra Leone documented the presence of district health management team (DHMT) staff at dialogue meetings backed village health committees and created stronger feedback links between them, significantly improving health worker behaviour. However, when no DHMT member attended the dialogues sessions, there was little change. Therefore, the intervention ensured the DHMT received clear feedback on shortcomings of primary health care delivery in their area. For three years of implementation, the average scores and quality of care at the winning clinics improved year on year and the health providers improved their responsiveness.[25] To achieve a successful community dialogue, studies have recommended a more balanced representation of stakeholders in this forums, including adolescents and consideration of issues of power differentials related to age, profession, and gender.[19,20,26] In addition, meaningful community dialogue forums require use of powerful tools such as community scorecards, citizen report cards, and chalkboards.[14,19,20] However, this study lacked evidence on the use of such tools in the study sites.

Incomprehensive documentation of community dialogue meetings resulted community issues not being captured. Documentation is a process in complaint handling mechanism as it helps in following the process of how issues are handled and can serve as future reference.[14] These findings are consistent with previous research where they have documented preference of verbal reporting of complaints to formal writing.[2,16]

Limitations

The focus group discussion approach was used as a data collection method with potential limitation of knowledge and power asymmetry with a likelihood of one group being dominated by another. To ensure equal power dynamics and prevent asymmetries between participants during focus group discussions, the researcher was attentive to create fair and meaningful participation. In the first round of focus group discussions, the researcher took measures such as dividing stakeholder groups, ensuring equal

numbers of participants for each of the groups, selecting open-minded participants, selecting a range of representatives, and ensuring that the selection process was purposeful to tap their common experiences.

CONCLUSION

Community dialogues provide platforms for the community and the health providers as duty bears to interact and address health concerns. However, these findings reveal that this might not be the case. This study established that most community empowerment sessions targeted disease prevention messages with minimal evidence on information about health rights, service charters and health system responsiveness. Document review findings revealed that most information captured on the minutes was what the facilitator told the community and not what the community raised or said. This made it difficult to get the voice of the community from the minutes. This could be associated with skills of writing minutes as FGD findings reported that communities were given an opportunity to speak up.

The findings revealed that the majority of dialogues were not attended by health providers, resulting in missed opportunities for duty bearers to respond to community concerns. The CHA was the only one who was frequently mentioned as participating in and facilitating the dialogue. The CHVs, on the other hand, felt that more health providers from various departments should be present because the CHAs would be unable to articulate all issues. However, given the high workload of public health facilities and the low provider-to-population ratio, the feasibility of this request needs to be investigated further.

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REFERENCES

1. Sudhinaraset M, Treleaven E, Melo J, Singh K, Diamond-Smith N. Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: a mixed methods study using cultural health capital theory. BMC Pregnancy and Childbirth. 2016;16(1):332.
2. Gurung G, Derrett S, Gauld R, Hill PC. Why service users do not complain or have 'voice': a mixed-methods study from Nepal's rural primary health care system. BMC Health Services Res. 2017;17(1):81.
3. World Health Organization. Towards people-centred health systems - an innovative approach for better health outcomes. 2008. Available at: https://www.euro.who.int/__data/assets/pdf_file/0006/186756/Towards-people-centred-health-systems-an-innovative-approach-for-better-health-outcomes.pdf. Accessed on 24 February 2022.
4. Sachs J. The End of Poverty: Economic Possibilities for Our Time. Eur J Dent Educ. 2008;12:17-21.
5. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, et al. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy and Childbirth. 2015;15(1):224.
6. State of the World's Cities 2010/2011- Cities for All: Bridging the Urban Divide | UN-Habitat. Available at: https://unhabitat.org/state-of-the-worlds-cities-20102011-cities-for-all-bridging-the-urban-divide. Accessed on 03 June 2022.
7. Lodenstein E, Mafuta E, Kpatchavi AC. Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees. BMC Health Serv Res. 2017;17(1):403.
8. Hamal M, Heiter K, Schoenmakers L, Servais J, Dieleman M, Broerse JEW, et al. Social Accountability in Maternal Health Services in the Far-Western Development Region in Nepal: An Exploratory Study. Int J Health Policy Manag. 2019;8(5):280-91.
9. Camargo CB, Jacobs E. Social Accountability and its Conceptual Challenges: An analytical framework. Conference: Accountable Governance for Development - Setting an Agenda Beyond 2015. 2013.
10. Svensson J, Bjorkman M. Power To The People: Evidence From A Randomized Field Experiment Of A Community-Based Monitoring Project In Uganda. The World Bank. 2007.
11. Afulani PA, Phillips B, Aborigo RA, Moyer CA. Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. The Lancet Global Health. 2019;7(1):96-109.
12. Panday S, Bissell P, van Teijlingen E, Simkhada P. Perceived barriers to accessing Female Community Health Volunteers' (FCHV) services among ethnic minority women in Nepal: A qualitative study. PLoS One. 2019;14(6).
13. George M, Pant S, Devasenapathy N, Ghosh-Jerath S, Zodpey S. Motivating and demotivating factors for community health workers: A qualitative study in urban slums of Delhi, India. WHO South-East Asia J Public Health. 2017;6(1):82.
14. Kenya Community Health Policy 2020-2030 - Nurturing Care Framework for Early Childhood Development. 2020. Available at: https://nurturing-care.org/kenya-community-health-policy-2020-2030/. Accessed on 03 June 2022.
15. Wangũi Machira Y. Integrating Social Accountability in Healthcare Delivery: Lessons Drawn from Kenya. World Bank. 2015. Available at:

https://openknowledge.worldbank.org/handle/10986/21666. Accessed on 03 June 2022.
16. Gal I, Doron I. Informal complaints on health services: hidden patterns, hidden potentials. Int J Qual Health Care. 2007;19(3):158-63.
17. Kiracho EE, Namuhani N, Apolot RR. Influence of community scorecards on maternal and newborn health service delivery and utilization. Int J Equity Health. 2020;19(1):145.
18. Hamal M, de Cock Buning T, De Brouwere V, Bardají A, Dieleman M. How does social accountability contribute to better maternal health outcomes? A qualitative study on perceived changes with government and civil society actors in Gujarat, India. BMC Health Serv Res. 2018;18(1):653.
19. Mahmood SS, Rasheed S, Chowdhury AH, Hossain A, Selim MA, Hoque S, et al. Feasibility, acceptability and initial outcome of implementing community scorecard to monitor community level public health facilities: experience from rural Bangladesh. Int J Equity Health. 2020;19:155.
20. Munakampe MN, Nkole T, Silumbwe A, Zulu JM, Cordero JP, Steyn PS. Feasibility testing of a community dialogue approach for promoting the uptake of family planning and contraceptive services in Zambia. BMC Health Serv Res. 2020;20:728.
21. Martin S, Rassi C, Antonio V, Graham K, Leitão J, King R, et al. Evaluating the feasibility and acceptability of a community dialogue intervention in the prevention and control of schistosomiasis in Nampula province, Mozambique. PLoS One. 2021;16(8):e0255647.
22. Muhwezi WW, Palchik EA, Kiwanuka DH, Mpanga F, Mukundane M, Nanungi A, et al. Community participation to improve health services for children: a methodology for a community dialogue intervention in Uganda. Afr Health Sci. 2019;19(1):1574-81.
23. Oluoch-Aridi J, Smith-Oka V, Milan E, Dowd R. Exploring mistreatment of women during childbirth in a peri-urban setting in Kenya: experiences and perceptions of women and healthcare providers. Reprod Health. 2018;15(1):209.
24. Wegs C, Creanga AA, Galavotti C, Wamalwa E. Community Dialogue to Shift Social Norms and Enable Family Planning: An Evaluation of the Family Planning Results Initiative in Kenya. PLoS One. 2016;11(4):e0153907.
25. Pieterse P. Citizen feedback in a fragile setting: social accountability interventions in the primary healthcare sector in Sierra Leone. Disasters. 2019;43.
26. Crankshaw TL, Kriel Y, Milford C, Cordero JP, Mosery N, Steyn PS, Smit J. "As we have gathered with a common problem, so we seek a solution": exploring the dynamics of a community dialogue process to encourage community participation in family planning/contraceptive programmes. BMC Health Services Res. 2019;19(1):710.
27. Butler N, Johnson G, Chiweza A, Aung KM, Quinley J, Rogers K, et al. A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi. BMC Health Serv Res. 2020;20:568.
28. Altheide D. Qualitative Media Analysis. SAGE Publications, Inc. 1996;2:24-44.

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