

Factors Influencing Roles Played by Church Leaders in Community Health Programmes' Sustainability in Homa Bay District-Kenya

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Abstract

Introduction: Sustainability of community health programs in resource limited countries within sub Saharan Africa like Kenya, pose major challenges to most of the governments and the perceived benefiting communities. Churches around the world are involved in one way or another in various types of community development programs. Their involvement promotes sustainability of these programs. Key health indicators in Kenya have been worsening day by day for over decades. Though there is a reverse in most of the indicators, they still remain poor in regards to World Health Organization's standards. Worse, sustainability of the on going programs remains one key observable challenge that seeks for synergistic partnership.

Direct roles played by Church leaders in community Health programs in Homa-Bay District were not clearly understood. What influenced them to or not to play a role in these programs were also not known, yet there were adequate evidences which showed that sustainability of community health programs remained a challenge for decades. This caused a concern for investigation.

The aim of the study was therefore to assess factors influencing the roles church leaders' play in community health programs sustainability in Homa Bay District. It specifically looked at the roles played by church leaders in the design, implementation, monitoring and evaluation of the on going programs together with other partners, their unilateral roles in churches that promote sustainability of ongoing programs and also to determine institutional factors that influence the roles they play in Community Health Programs at the District.

Methodology: The study was a cross-sectional exploratory study that employed qualitative approach of data collection. The study population were ordained church ministers, who were either priests or pastors together with their local lay leaders from Catholic, Seventh Day Adventist, Anglican Church of Kenya, Baptist and Full Gospel Churches in Homa Bay District.

The **findings** of the study revealed that, Church leaders play very minimal roles in the programs and they vary from one church to another. What influences their roles were:

- The degree of support from overall church leaders to respective internal committees.
- Adapted policies by partners / church.
- The functionality level of relevant government coordinating structures in the District.

In conclusion, church leaders are established to have minimal support to ongoing health programs due to inadequate sensitization and involvement by the government coordinating structures. So there is a need for government to strengthen its commitment towards sensitising church leadership to be involved actively and consistently among other partners

1: Introduction

Community Health programs are both direct and indirect health related activities which are geared towards promotion of good health, prevention of ill health, rehabilitation and to a lesser extent curative services within a community. Sustainability of these programs in resource limited countries within sub Saharan Africa like Kenya, pose major challenges to most of the governments and the perceived benefiting communities. (MOH 2005).

A comparison of health indicators of Millennium Development Goals' baseline survey of 1990, with

National Health Sector Strategic Plan one's baseline survey of 1999/2000 together with Kenya Demographic and Health Survey (2003), key health indicators in Kenya showed an upward trend, they remained poor while most worsened between those years. An analysis of HIV prevalence in Kenya AIDS Indicator Survey also showed an increase in HIV prevalence from 6.4% in 2003 to 7.4% in 2007 among adults aged 15 -49 years. (KDHS. 2007).

Though the Kenya Demographic Health Survey (2008/9) reported a reverse in most of these indicators, they were still not encouraging and sustainability of the on-going health programs such as Home Based Care and Community Strategies among others is an observable challenge.

Ministry of Health (2005) provides adequate evidence that sustainability of Community Health Programs in the whole country particularly Nyanza Province remained a challenge for years. Partners collaborate and net work with one another to ensure that health needs in the society are effectively addressed and sustained; however, the direct role played Church leaders is not understood. What influence their roles was also not known.

Analysis of District's Medical annual reports between the year 1992 and 2006, provided information on a number of health programs which had been undertaken in the district along side their sponsoring partners and collaborators. Roles played by church or their leaders in these programs were missing. Therefore the purpose of this study was to investigate factors that influence roles played by church leaders in community health programs sustainability in Homa Bay District.

2:Methodology:

This was a cross-sectional exploratory study that employed qualitative approach of data collection. It was conducted in Homa Bay District, which was purposively selected as a result of being the District where most well established churches expected to demonstrate some roles in these programs were situated, the District had also benefited from initiatives of Primary Health Care Programs.

The study population were both ordained church ministers, who were either priests or pastors and local lay leaders from Catholic, Seventh Day Adventist, Anglican Church of Kenya, Baptist and Full Gospel Churches. Well established churches were purposively sampled so were their ordained leaders as key informant interviewees. A stratified random sampling was also adapted in each selected church to help form focus groups for discussions, taking into consideration age and sex as variables among the lay leaders; this was done through application of dichotomous questions of 'YES' or 'NO'. There was a sample size of one hundred and forty four, of which there were ten Focussed group discussions of twelve people each and twenty four Key informants. Two semi structured interview schedules were used for both Key Informant Interviewees and the Focussed groups.

The data were categorised and grouped into themes and sub-themes. The categorised data were then classified into thematic coding and put into tables for analysis and interpretation through verbatim and narrative approaches.

3: Result

3:1:1Roles of church leaders in programs planning:

The roles played by church leaders in the design/ planning of community health programs were looked at. The study established that among the churches involved in the study, all had plans for spiritual support to needy members of the society both in church and community level and another cross cutting finding was that all do mobilize for resources both internally and externally to support their various development projects/programs. Catholic and ACK churches conduct needs assessment as their initial step in planning and also develop proposals for funding by other development partners. SDA Catholic and ACK churches sometimes plan with development partners aligned to them.

Findings in Focused group discussion were similar to those given by the Key Informants Interviewed at the churches, these were: Focussed Group Discussions from Catholic Church and ACK reported that in their churches, assessment of members social and spiritual health needs were done then they plan and draft proposals. This was confirmed by key informants from both churches, while Focussed Group discussions from SDA, Baptist and Full gospel churches reported that, planning of community health programs were done by the church boards/council or assembly, however, they did not know the processes they take. A key informants from SDA church however reported that their church had a health department which was charged with the responsibility of planning for all health issues on behalf of the church, so depending on the ability of that department to assess and plan on health needs of members/ community, it would take long for health activities to be undertaken in the church unless a partner initiate and involve the church. He had this to say:

"In this church there is a health department which is charged with the responsibility of planning for all health issues on behalf of the church, so depending on the ability of that department to plan, it would take long for health activities to be undertaken in the church unless a partner initiate and involve us. However, a church board has a final say in such plans".

In the Full gospel church, a F.G.D reported that, their pastor do all planning and development of

proposal specifically for Orphans and vulnerable children (O.V.Cs) then seek for funding from foreign countries. They did not know much detail on how. One had this to say:

“In our church, pastor always writes proposals and lobby for support from foreign countries but we do not know the process he undertakes to do that”.

The key informant from the same church confirmed that he plans as per guidelines from sponsors, and that in most cases church members were hardly involved in that process but technocrats. Meanwhile, a Focussed group discussion from Baptist and their key informants reported that for health activities they do not have tangible plans but work with Ministry of health in relevant areas like advocacy when invited.

When key informants from government were asked similar question it was confirmed that Catholic, ACK and Full Gospel churches do Plan and write proposal for funding. It was also established that Ministry of health always involve Catholic Church and ACK in Annual Operation Plans regularly because they had functional health facilities in the district. However, key informants from development organizations were not aware of what churches do in planning for community health apart from CRS and IDCCS respondents who reported that Catholic leaders and ACK representatives attend their planning forums respectively.

3:1:2 Roles of church leaders in implementation

While responding to a question that asked the roles that church leaders play in the implementation of community health programs within that district, five cross cutting responses were given among all respondents in F.G.Ds and key informants, these were that; leaders provide social support to needy members either materially or financially, they spearhead health advocacy to members and public, either in partnership or unilaterally. Offer spiritual support to spiritually burdened individuals regardless of their religious affiliations; they partner with other development organizations mostly ministry of health in health related activities and also lobby for construction of health facilities or social amenities by their headquarters. The construction of health facilities or social amenities was realized not to be within their mandate to decide, a key informant from SDA had this to say:

“Construction of health facilities or any other social institutions like schools by church is a decision to be made at church headquarters, what local church leaders do is to lobby or propose the need and follow up with them”.

Key informants from the five churches had similar views to those of F.G.Ds in regards to their roles in the implementation of C.H.P; however they added that their level of participation mostly depended on availability of funds, time and partners’ policies consistency.

The study established that Catholic and Full Gospel Churches initiate I.G.As to support their Development initiatives. SDA actively participate in community sanitation particularly within the municipality. ACK leaders reported to be holding training workshops on health issues once in a while. The study also found out that, both Catholic Church and ACK had programs for supporting needy children in education while in SDA, Baptist and Full Gospel Churches it was reported to be an inconsistent project which was occasionally done in crisis.

3:1:3: Roles of church leaders in Monitoring and evaluation

The role of church leaders in monitoring and evaluation of community health programs in the district was also looked at. When this was asked, all F.G.Ds did not know, however one lay leader from catholic had this to say:

“We don’t know but in our church, development committee meets regularly, so I do think that one of the things they discuss is to review the progress of those programs among other things”.

A key informant from Catholic reported that they appraise partners; this was actually verified by A District Medical officer who further reported that, churches with functional health facilities were always invited in Annual Operation Plan review meetings like any other partner

Cross cutting responses from key informants in all churches were that, they follow up progress of any funded health programs and other planned activities. Catholic SDA and ACK churches participate in review meetings held by partners aligned to them. ACK reported that their Bishop was a member of district health management board.

3:2: Direct Unilateral roles played by church leaders in their respective churches that promote sustainability of Community Health Programs

In Catholic and A.C.K church leaders build capacity of the community on health and involve government and community in their programs, they encourage community to take over programs however the community were over expectant of hand outs as they ask for *“Kitu kidogo”* (tokens) whenever called for trainings. Contributions from K.I.Is did not only confirm the F.G.Ds’ findings but also had the following additions, they reported that they were actually not adequately committed to sustainability of initiated community health programs, nonetheless, occasionally they lobby for construction of health facilities and resources to support needy members of the society. Baptist church sensitize community to work hand in hand with Ministry of health, A.C.K and Catholic churches participate in partners review meetings and also that, they help people realize their potentials through building their capacity / training.

A.C.K and Catholic reported appraisal of partners work in the District. However other churches reported not to be having any direct action on that line. Government and development partners who said that

apart from appraisal, church leadership was actually not making any effort to ensure that funding period is lengthened to any partner.

Regarding direct action that church leaders were undertaking to ensure that there was high level of partners' collaboration and net working in the program's implementations in the district, it was reported that, church leaders net work with other partners and participate in related health programs when invited.

3:3: Institutional Factors that influence the roles church leaders play in community health programs.

3:3:1: Policies/ Doctrines

Policies and doctrines in churches that influence the roles church leaders play in community health Programs were investigated; only Catholic Church was established to have a doctrine that was not consistent with government policies on contraceptive use and termination of pregnancy. However, other four churches were reported to be liberal. A respondent from A.C.K reported that in their church they do always recommend use of condom by couples who were HIV positive. A youth respondent from S.D.A church also reported that their church was liberal on health issues and clarified that, they do not have any policy talking against contraceptive use, however, they don't promote condom use, and he had this to say:

"In this church there is no policy or doctrine which is against use of contraceptives however it does not mean we promote condom use among us".

The study also looked at the policies from development partners and government side that influence roles played by church leaders in Community Health Programs. The National Government Policies were found to be pro church leaders' active roles in the programs, in a case where a government policy was not consistent with international policy, partners go for an international policy.

3:3:2: Leadership

The study investigated the leadership structures / systems in churches and government sectors that would influence the sustainability of church leaders in community health programs.

All focussed group discussions were aware that in their churches, there existed either, council, assembly or church board which was comprised of priest or pastor and lay leaders. They reported that, those bodies were the decision making structures in their churches. The council / assembly and church boards were reported to be actively functional. Nonetheless when asked the same question, the key informants from A.C.K, S.D.A and Catholic churches did not only agree with the focused groups' findings but also added that in their respective churches there are committees or departments which deal with health issues and also consult the councils / assemblies or boards on challenging issues. However, when asked about those committees or department functionality, the key informants reported that the committees and departments functionality rate was dependent on four factors, which were:

The availability of time for its leaders to undertake the expected tasks, they sighted that sometimes a leader may get an opportunity to attend a workshop in health programs but hardly get chance to give feedback to members. Another factor was availability of other needed resources like funds, the capacity of the committee/ department to assess and plan for health needs together with degree of support from church pastor/priest or Bishop. One pastor had this to say:

"With adequate resources, including time to undertake intended activity, the committee becomes active, while with limited resources their functionality rates slow down".

Leadership structures in government side were verified, a number of structures were mentioned which were, District Health stakeholders' forum, District health Management boards, District AIDS coordinating committee, divisional health stakeholders' forums, Divisional AIDS coordinating committees and Community Health Committees. When asked their functionality, the Medical Officer of Health reported that, District Health Stakeholders' Forum was most active due to adequate support from partners. He went further and clarified that in the District Health Stakeholders' Forums, they had committees for each program, and these were TB /AIDS committee, malaria, water and sanitation, child health, reproductive health among others. The Medical Officer of Health stated that other committees especially at divisional level were non functional due to funding system/ financial constraints. He said most sponsors only support District coordinating structures by that time of the study.

4:DISCUSSION

The study established that church leaders play insignificant roles in community health programs in the district, most of their plans were done in crisis. It was only in ACK and Catholic Church where there was occasional systemic planning. The other three churches could only plan when there was an external sensitizations by a partner. The findings revealed that both Baptist and Full gospel Churches dependent mostly on foreign support for community health programs, This approach is discouraged by MOH (2005) citing dependency syndrome which is poisonous to sustainability.

Actions that church leaders undertake to ensure that government or community takes over initiated

community health programs after active funding period was not well known by lay leaders, majority reported that they were not doing anything tangible, leading to most programs collapsing immediately after active funding. The findings supports Danladi (2008) observed that, the local church leaders in most cases have not been involved in the development process in most African countries, and that, the lack of involvement has made church not to be truly the light and salt of the community in which it is situated hence not having a positive influence on communities leading to its evangelistic efforts less effective.

One of the main factors that were found to influence the roles church leaders play in community health programs was inconsistency in policies. Catholic Church has a doctrine that was not consistent with government policies on family planning practice. This gives an explanation on what might have contributed to the collapse of a GTZ/MOH reproductive health program on Community Based Distribution of contraceptives in the year 2004 when funding ended.

Skills, awareness or knowledge level of church leaders in the sustainability of community health was interpreted to be adequate, as all leaders interviewed had accessed relevant training in community development and leadership. This finding agrees with what Danladi (2008) observed in his study, he stated that even though many pastors receive training on the role of the church in community development, most of them are yet to translate that into involving the local church in the development process. He goes further and says that most local church leaders see their ministry as limited to evangelism, teaching and discipleship, that Social work is often limited to financial and material assistance to the needy, he stresses that little or no efforts are made to mobilize communities to take action to solve common problems that affect the community.

Among several views raised, participants stressed on the need of leaders to show effective leadership skills in all sectors. This finding is in conformity with what Kodja (2005) observed that, Church leadership can make an immense contribution to overcoming development challenges like sustainability. However, he lamented that the local churches are not committed in that direction. He explicitly states that, it is not due to lack of knowledge but attitude and assumption.

5: Conclusion and Recommendation

In regards to the findings of this study, the following conclusions were arrived at: Roles played by church leaders in community health and development programs were established to be very minimal and vary from one church to another. In consideration of their consistency, they are described as insignificance. Their roles in monitoring and evaluation together with other stakeholders were described as extremely inadequate and worse, than planning and implementation. Uniquely, the erratic conducted activities were coordinated unilaterally as an institution.

The main factors determined to be influencing roles played by church leaders in community health programs were: the degree of support from overall church leaders to their development/ health committees, the adapted policies or doctrines by a partner and the functionality of government coordinating structures in the district,

In regards to the findings in this study there is need for the following interventions to be undertaken so as to strengthen Church leaders' roles in sustaining Community Health Programs in Homa Bay and beyond

Ministry of Health needs to strengthen synergistic partnership among all stakeholders to facilitate functionality of all health coordinating structures. They also need to strengthen commitment towards sensitising church leadership to be involved actively and inconsistently among other partners

The government needs to take the initiative of harmonizing inconsistent policies so as to promote church leaders' roles in sustaining community development programs.

There is need for a concept paper to be developed on the rationale for the local church leaders as key agents in community development.

Reference

1. Anthony D'SOUS (2007) "Leadership". *Trilogy on Leadership and Effective management*: Pauline Publications Africa.
2. David H. Kodja (2005) *poverty in Grace*: - Social responsibility of the church and society in war against poverty.
3. Dekoning, K and Martin, M (1996) *participatory research in health*. Macmillan London
4. Gosling, L. and Edward, M. (1995) "tool kits" *A practical guide to assessment, Monitoring, Review and evaluation*. Save the children London.
5. Green, A. (1992) *an introduction to health planning in developing countries*: oup. Oxford.
6. Huddart, J. (1993) *HIV/AIDS project planning manual for NGOs*. UNDP. New Delhi.
7. *Kenya Demographic and Health Survey (2003, 2008/9) Routine Statistical Reports*. Kenya national Bureau of Statistics.

8. Kenya National AIDS STI Control Program NASCOP (1999) *policy paper 1* Nairobi.
9. King James Version, 11th Edition (1996)
10. Marum E. Epino H. Chimwasa M. Kachiza C. (2000) *Assessment of Home Based Care services in Malawi*. Unpublished
11. Ministry of planning and national development: (2002) *Homa-bay district development plan* Government Printers.
12. Ministry of Health (2005) *the second Kenya National Health Sector strategic plan*. Government Printers.
13. Moser C. (1993) *Gender planning and development*: routledge and Kegan, London.
14. Olive M. Mugenda and Abel G. Mugenda(1999) *Research Methods*. Quantitative and qualitative approaches. Kenya act press.
15. Paul Smith (1994) *health financing and sustainability*, a review and analysis case studies. Working paper NO.10.
16. Rifkin. (2000) *A joint WHO/UNICEF Conference at Alma Ata accepted Primary Health Care*.
17. TICH (2007), *Community Health and Development Lecture notes*. "Development of National Policies". Prof. Muga
18. Una Mac Askill and Dan Kasege (1998) *Community Based Health Care programme in Southern Sudan*. An evaluation report. Nairobi.
19. Wermer D. and Bower B. (1998) *helping Health workers learn*: Hesperian Foundation London.
20. World Health organization (1978) *policy paper*: Geneva
21. World health organization (2005) *knowledge management strategy* Geneva.

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