

Abstract

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Year: 2014

Thesis title: Improving access to quality health care for the poor: An analysis of different targeting mechanisms in Kenya's health sector.

Key words: Community based targeting, proxy means test, Kenya, access to health care, social health protection, qualitative research

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Abstract:

To achieve universal health coverage, the Government of Kenya (GoK) intends to implement social health protection schemes, which will include the subsidy of the poorest of society. Within this framework, the identification of the poor, so called targeting, is a crucial element.

This study analysed and compared a Community Based Targeting (CBT) mechanism and a Proxy Means Test (PMT) mechanism currently used in the context of two health programs supported by German Development Cooperation (GDC) in Kenya. The mechanisms were assessed in regard to their effectiveness of implementation, perceived accuracy, costs and acceptance. The study thereby aimed at providing evidence on the applicability of those mechanisms for the Kenyan context and more generally at contributing to the discussion about targeting effectiveness in low-income settings.

This research was carried out in Matuga and Kilifi district in Kenya's Coast province and the informal settlement Korogocho in Nairobi. Secondary data from both programs as well as qualitative methods such as Focus Group Discussions (FGD) and Key Informant Interviews (KII) were used to answer the research

questions. Interview partners were local health staff, Chiefs and other stakeholders involved in the projects as well as beneficiaries of the two programs. The data was analyzed using a context analysis approach.

The results of the study show that the two mechanisms differ in terms of the variables under analysis. The CBT showed substantial flaws in implementation and was not monitored properly, leading to the capture of the process by local elites. Consequently, the perceived inclusion error was higher for the CBT than for the PMT and acceptance of the process and the results lower, especially amongst facility staff. The CBT also showed more potential for social conflict than the PMT. The PMT seemed less complex to implement and the process was realized in a timely and efficient manner. Employing external agents was perceived more objective and unbiased than using community agents and the PMT was generally regarded as more neutral than the CBT mechanism. At the same time the PMT was more costly to implement and induced higher private costs on beneficiaries such as waiting time and transport costs than the CBT. Lastly, the target group of the OBA program, using a demographic component, was easier to communicate than the more vaguely defined group of "hardcore poor households" of the WM program.

Although both mechanisms had advantages in some and disadvantages in other areas, this research concluded that the PMT is the preferable option as a mechanism to identify the poor in the context of a national health protection scheme in Kenya: PMT seems less complex to implement than a CBT and less prone to elite capture and fraud. It is verifiable and thereby includes a possibility for sanctions, which is lacking for the CBT. External agents seem less associated with corruption than internal agents and the PMT guarantees horizontal equity. Lastly, CBT would not be applicable in many areas of Kenya, where social cohesion is low and it is difficult to define a homogenous "community".