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Performance and Sustainability of Community Health centres in Kenya's Rural Areas: Case study of centres in Kathonzweni Division of Makueni District

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Abstract
Communities in rural areas often face the challenge of limited access to healthcare services. The barriers that exist in accessibility of healthcare in rural areas are vast geographical distances, shortage of medical personnel and medications or essential services required by communities. Medical personnel are an important resource in the rural health facilities but many communities continue to experience shortages of qualified medical personnel. Therefore enabling rural populations to access and improve their health is a major challenge worldwide. Kenya, like several low-income countries, has a large proportion of poor people with limited access to health and social services. Lack of adequate access to primary healthcare is a major challenge this is because health care services are wanting and in many rural areas communities have to walk for over 6 kilometers or more to access health care. The quality of health care in rural areas in Kenya is unsatisfactory and its quantity is inadequate to meet the ever-increasing demand for health care. In response to the challenges faced rural areas communities are mobilizing human and financial resources to build community health centers that will address the gaps. However the problems in health service provision have proved difficult to overcome and many community health institutions remain heavily dependent on donors for their ongoing operations.
Keywords: health centres, community health centres in Kenya, performance, sustainability

1. Introduction

Health is a basic need for all people. The well-being of a people determines a country's development in all aspects. This may include the levels of socio-economic statuses in terms of per capita income, literacy levels, good housing, communication and infrastructure, education and a country's demographic behaviors among other things. Health can be defined in terms of the general well-being of persons both physically and psychologically. Health also encompasses a stable state of the mind, good nutrition and above all the mere absence of a disease.
Improving the health of the general population is now a priority in developing countries. According to Oyugi (1192:222)[28]poor quality services provided by most rural public health facilities still persists and are widespread. Many are regarded as unreliable, inaccessible, and inefficient in providing health care, lack modern facilities, essential drugs and are disadvantaged in recruiting medical personnel

Kenya's health reform policies have consistently called for the private sector to play a greater role in meeting the health needs of her people to complement government efforts in providing health services (Oyaya and Rifkin, 2003:115)[29].However there is there is a narrow focus on measurement of cost effectiveness, the role of external support and whether services provided are sustainable and the gap that needs to be addressed is that of factors that influence sustainability.(Shediac-Rizkallah 1998:87-88)[30]

A study was conducted in Gambia that analyzed the influence of village level primary health care on mortality rates on children During the 15 years studied, funding and support for primary support grew, was maintained then dropped. The authors found out that while the program was well funded and supported, the mortality rates of 1-4 year olds were significantly lower in the villages. After support for the health care staff weakened, mortality rates in those villages actually rose. (Hill, 2000:110)[31] This suggests that when the continuation of programs is far beyond the means of the community, the end of external financing does not represent the beginning of the sustainability phase but leads to the end of the sustainability process.

While many of the concerns related to community- based health development have been described in detail, one of the major themes that has been paid inadequate attention to has been the sustainability of community-based health projects. This is so despite the growing recognition of the importance of

[28] Oyugi, Walter O. (1992) "Bureaucracy and management of health services in Kenya." In H.K Asmerom, R.Hoppe and R.B Jain, Bureaucracy and development policies in the Third World. Amsterdam : Vu University Press.

[29] Oyaya, Charles and Samuel Rifkin (2003). Health sector reforms in Kenya: An examination of district level planning. Health Policy 64: 113-127.
[30]Shediac- Rizkallah, Mona and Lee Bone (1998) Planning for the sustainability of community-based health programs. Conceptual frameworks and future directions for research, practice and policy. Baltimore: Oxford University Press.
[31] Hill, Anne and William Macleod (2000) "Decline of mortality in children in Rural Gambia: The influence of village level primary health care." Tropical medicine and International health, 5:107-118

sustainability issues in projects funded by the international community (Bossert, 1990;Hill, 2000;Lafond, 1995). The focus on sustainability should also underscore the fact that several community- based health projects have had to be discontinued soon after donor funding has been terminated (Bossert, 1990; Sarriot, 2004; Goodman and Steckler, 1987/88).

According to Lysack and Zakus (1998:3)[32] the organization and delivery of health services is reported to benefit from community participation. The authors continue to argue, that health services are provided at a lower cost and added resources can be brought into the system, partly due to greater access to fundraising opportunities but more specifically to availability of volunteers.

The problem of achieving equity in the spatial distribution of health services still persists. As a result, there are more health facilities and doctors in the urban areas than in rural areas and yet only about 20% of Kenya's population resides in the urban areas. In Kenya, for example, there is one doctor on average per 500 people in Nairobi, compared with one per 160,000 people in rural Turkana (Shaw and Elmendorf, 1994:46).[33] It is as a result of this and other challenges that have led to the emergence of community based health facilities managed and sustained by the community.

2.0 The research objectives and methodology

Makueni District has 60 established health facilities, yet most of the facilities lack adequate medical personnel, supply of drugs is irregular, some facilities have no electricity and many are inaccessible to the communities (GOK, 1997/2001:92-93)[34]. The district has 5 doctors against a population of 810,000 people (GOK, 1997/2001:92). This means the population is underserved in terms of health facilities.

Kathonzweni division in Makueni district is classified as a low potential zone, it has 8 health institutions serving a total population of 86,452 people (GOK, 1997/2001:92).[35]These institutions lack adequate facilities, personnel and medical supplies are inaccessible. Approximately 50% of the communities in this division live below the poverty line and therefore most of the people cannot afford the services provided by the government and private health institutions. (GOK,1997/2001:41-43).

The study was conducted to understand the contribution of community health centres that are initiated by the community to address the gap of lack of adequate facilities in rural areas and the challenge that rural communities cannot afford health services provided by government institutions and private health facilities. This study sought to highlight the challenges and success in community based health centres (CBHC) in Kanzokea, Yinthungu and Mbuvo sub-locations of Kathonzweni division.

The study was inspired by La Vonne's (1992:70)[36] argument that the future viability of rural health facilities will be determined to a large extent by performance along three interrelated dimensions: scope of services offered; relative quality of those services and overall financial viability of the institution.

2.1. Broad objective

To assess the performance and sustainability of Community Health Centres in Kathonzweni division.

2.1.1 Specific Objectives

The specific objectives were to:

1 To determine the extent to which communities participate in healthcare service delivery in Kathonzweni division of Makueni district.
2 To establish the major strengths and weaknesses of community-based health care centres in terms of performance and sustainability in Kathonzweni division.
3 To examine the role of development partners (GOK, NGOs, CBOs, Donors) in supporting community-based health care centres in Kathonzweni division.

2.1.2 Site description and sampling

The study was confined to Kathonzweni division, a rural area in Makueni District, which lacks adequate essential health care services. The main district hospital is almost 40 kilometers from Kathonzweni location and the doctor patient ratio stands at 1:162,000 in the district (GOK, 1997/2001).[37]

The study focused on selected community- initiated health centres within 3 sub-locations, namely Kanzokea, Mbuvo and Yinthungu in Kathonzweni Division of Makueni District. These were health facilities that are initiated and managed by the community through committees of management.

The health centres were purposively selected because they fall within Kathonzweni division and have

[32] Lysack, Catherine and David Zakus (1998) Revisiting community participation. Toronto: Oxford University Press
[33] Shaw, Paul and Edward Elmendorf(1994) Better Health in Africa. Washington: The International bank for reconstruction and Development/the World Bank .
[34] GOK, (1997-2001) Makueni District Development Plan. Nairobi: Government Printer.
[35] *Ibid*
[36] LaVonne, Straub and Norman Walzer (1992) Rural health care. Westport: Connecticut Preager Publishers.GOK, (1997-2001) Makueni District Development Plan. Nairobi: Government Printer
[37] GOK, (1997-2001) Makueni District Development Plan. Nairobi: Government Printer

community health centres that provide services to the community and are managed by committees. Cluster sampling technique was used to select the households. The respondents comprised of residents of Kanzokea, Yinthungu and Mbuvo sub-locations, health service providers, development partners and health centre management committees.

The researcher listed all the villages in the 3 sub-locations and randomly selected 12 villages, from which 105 households' heads were selected. The researcher purposively selected 6 key informants from each of the sub locations and these were persons who had a direct or indirect contact with and knowledge of the activities being undertaken by the health centres. They were representatives from the Ministry of health (MOH), local administration, NGO representatives, nurse in charge and committee members.

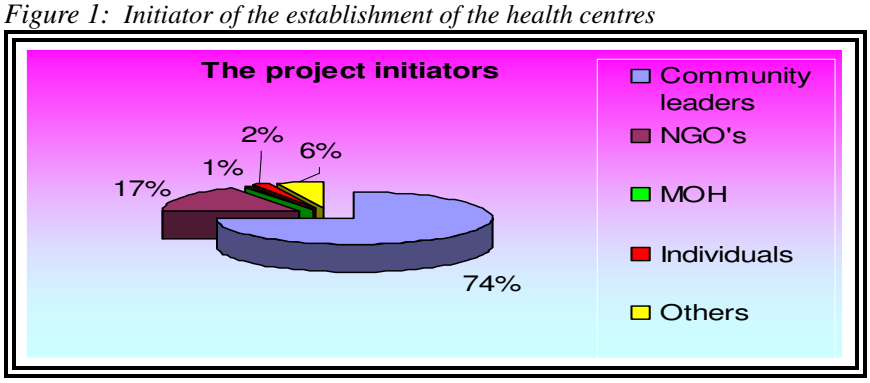
The proposed study used both qualitative and quantitative research methods. Primary data was obtained from the beneficiaries of the health services in their respective villages using face-to-face structured interviews with the aid of a standardized interview schedule, which had open and close -ended questions.

An interview guide was constructed and used to conduct in depth interviews with key informants. Checklists of questions were used to guide personal interviews with key informants, who included the health service staff, collaborators and management committees.

3.0 Presentation of selected data

This section presents the selected findings from data collected through the use of household questionnaires, key informant interviews and personal observations of the health facilities that were sampled during this study.

Figure 1: Initiator of the establishment of the health centres



Source: field data

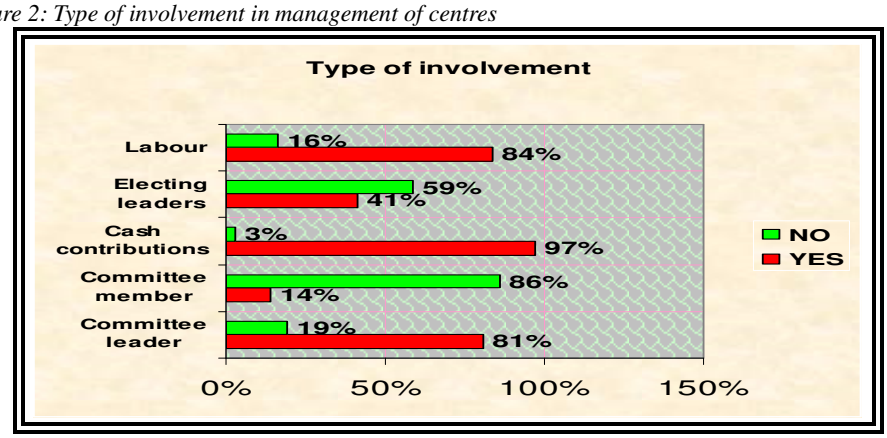
Most of the respondents (74.0%) indicated that community leaders initiated the idea of establishing all the 3 health centres. Seventeen percent (17.0%) indicated the centres were initiated by NGO's, 1.0% by MOH, 2.0% indicated by individuals while 6% indicated other institutions namely Kijabe hospital, churches and World Vision.

3.1 Community participation in health care service development

The study found strong levels of community ownership however it became evident during the study that needs assessments were not conducted prior to the initiation and establishment of the health centres.

Strong community mobilization skills of community leaders encouraged community's contributions of local resources that supported the centers' operations. The presence of a management committee enabled the health centres mobilize resources from the community and external donors. This helped the centres employ staff, purchase equipments, construct additional buildings and undertake other development activities such as assisting orphans within the community.

Figure 2: Type of involvement in management of centres



Source: field data

The above findings of the study show that the community members were involved in the following; contribution of cash (97%), participation as committee members (86%), in leadership (81%), labour (84%).The respondents indicated that community members participated in the establishment of health centres by providing labour; working tools such as 'jembes', spades, 'pangas', money; as well as local materials such as sand, stones, and water

Seventy two point two (72.2%) percent of respondents acknowledged that planning meetings were held while 17.8% respondents indicated otherwise. When asked whether they did attend the meetings, 55.7% respondents indicated that they did, while 44.3% did not. When respondents were asked why they did not attend planning meetings, 34.4% of the respondents indicated they were not informed of such meetings, 46.9% were too busy, in the farm or other business, 18. 8% had attended another meeting.

The research wanted to establish the extent of community participation during project implementation. Fifty eight point nine percent (58.9%) respondents indicated that those involved in the health projects were local artisan, 3.3% indicated health personnel and 34.4% indicated community leaders.

3.2 Performance and sustainability of health centres

The centre that were most visited was African Inland Church (AIC). Mumo community health center was visited by (36.48%) of the sampled respondents. This was followed by Kanzokea dispensary with (34.58%), Yinthungu dispensary was third with (23.36%), Kianguni dispensary had (2.86%) and lastly, Kithuki dispensary as was indicated by 1.86% respondents. It was interesting to note that the top three health facilities visited were the community health centres.

3.2.1 Community perceptions on quality of services provided in the health centres

Thirty eight point nine percent (38.9 %) of the respondents indicated that services were good while (25.8%) indicated the services were average and finally (35.3%) ranked the services as poor.

3.2.1.1 Adequacy of services offered by the sampled health facilities

The findings of this study show that some of the sampled health centres services were not adequately meeting the needs of the family as was indicated by (55.2%) of the respondents while (44.8%) indicated that they did. Those that indicated that requirements of their families were not adequately met listed the following services that they would like to be introduced: Laboratory services, maternity services, theatre services (surgery), ambulance services, VCT centre, ward services, X-rays services, dental services, home-based care, open hospital services, orthopedic, counseling and morgue services.

3.2.1.2 Adequacy and Qualifications of the Staff

3.2.1.2.1 Number of staff operating the sampled CHC-Centre

The nurses in charge approximated the number of patients treated per year as being between 6,000 -

8,000 per year. The busiest months were between January to April and the lowest from May to October but this will vary from area to area.

The respondents indicated that the number of employees working in the sampled health facilities Kanzokea had employed between 7 staff, Mumo health centre had 5 while Yinthungu when operational had 3 staff. This shows that the sampled health centres were very small in nature but have the capacity to grow.

3.2.1.2.2 Perceptions of the respondents about qualification of health centre staff

Ninety point nine percent (90.9%) of the respondents perceived the staff were qualified while (9.1%) indicated they were not qualified. The high score was because the communities felt the staff were able to attend to patients and most of them were government employees.

3.2.1.3 Time taken to get medical attention

The findings of this study show that 2 of the sampled health facilities were efficient in delivering services to patients. This was indicated by sixty four point one (64.1%) percent of respondents who reported that queues were normally short. It also came up during this study that there were some specific days that the queues were very long. These were mainly during heavy rains, during outbreaks of diseases such as malaria and cholera, and during market days in some area, Monday, Wednesday and Friday. During these days, a patient took more time before they were served.

3.2.1.4 Availability of drugs in the sampled health centres

Eighty three (83%) percent of the sampled respondents indicated that drugs were often available, 14.0% indicated that they were sometimes available, while 2.2% indicated that they were not available. Where the communities were not able to get drugs from the centres they bought them from chemists. Since most people in the sampled community are very poor, most end up not purchasing the drugs and resorting to taking herbal medication.

3.2.1.6 Community perceptions on factors affecting performance of the centres

Eighty two point seven (82.7%) percent respondents gave reasons why some of the health centres were unable to provide quality services as follows inadequate/unqualified staffing, competition from other health providers, financial capacity of the centres, inadequate drugs, many referrals to other health facilities or medical staff, lack of infrastructure/facilities and poor management by the committee of the centres.

For example by the time of conducting the study, Yinthungu health centre was not operational. The respondents attributed this to external interference and lack of funds to support the services required. However there was a mobile clinic that operated once a week on Wednesdays in Yinthungu health centre yet the structures built for the health centre were in existence.

3.3 The role played by development partners

The findings of the study, noted that support from other development partners was seen to be crucial for the general performance and sustainability of the community based health centres (CBHC).

Table 1:The contributions of development partners.

INSTITUTION/PARTNER	CONTRIBUTION
MOH	▪ Provision of drugs(vaccines) ▪ Education and supervision ▪ Giving machines ▪ Management ▪ Supervise and inspection of the health centres
World Vision Makueni	▪ Committee capacity building trainings ▪ Drugs and equipment donations ▪ Funding the dispensary/projects ▪ Helping to build incomplete building
Church/Church agencies(MEDs)	▪ Form part of committee ▪ Drugs ▪ Staff and management team trainings in medical fields and leadership
CBOs/self help groups	▪ Community mobilization ▪ Management of the project ▪ Monitoring progress

Source: field data

The health centres received support from the MOH, Non -governmental organizations (NGOs) and the community through the CBOs. The government was also able to provide support in terms of health personnel however possible although the number was not sufficient.

Most respondents indicated that too much external support would not affect the health facilities but strengthen them. They believed that only through external support would they be able to construct facilities and purchase equipment which were required for the sustainability of the health centers.

3.4 Sustainability measures employed by the health centres

The health centres had activities that provided additional revenue to support services as indicated by (39.5%) of the respondents and this would enhance sustainability and reduce dependency on external donors. For example, Kanzokea health centre had a guest house, telephone bureau, paraffin pump as income generating activities that support health centre services

The findings of this study show that (99.0%) of the sampled health centres were charging a minimal payment fee for services provided. The payment was dependent on type of sickness, the ability of the patient to pay, drugs and other factors. This helped the facilities collect some funds to support purchase of additional drugs and payment of local workers.

A strategy that was also seen to strengthen the sustainability of the health centers was that the centres were managed by organized CBOs that were registered and had members who contributed resources to support the centre activities. This meant that the centres continued receiving support from the community through contribution in some cases annually. This is a good strategy that can provide centres with revenue if members were to contribute frequently

The research findings established that the centres received a lot of support from the Ministry of health (MOH) in terms of posting a government nurse to the establishment, registration of the facilities and monitoring of progress of the centres. This ensured the health centres' performance was aligned with the government standards.

3.4.1 Factors affecting sustainability of the health centres

Despite the health centres being able to support themselves (84.3%) of the respondents highlighted the following factors that are likely to affect progress towards sustainability of the centres

- The heath facilities generate very little income (cost sharing) thus resulting in lack of funds to facilitate

its growth or to sustain them.

- The health facilities lack some essential equipment which were expensive to install.
- The poverty level among the communities was high.
- The health facilities were located in ASAL areas where there is frequent drought that kill animals and destroy food crops. This made the communities to depend heavily on assistance from development agencies.
- Some of the health centres cannot be sustained in the absence of support from the Government and NGOs which have provided drugs, capacity building trainings, personnel and funding .They were identified as significant partners in the health centres.
- Competition from herbal practitioners at community level.

4.0 Summary discussion of results

This section highlights the extent to which the research questions were captured based on the findings of the research. Sohani (2005:10)[38] highlights two concerns in health care, one is on how to deliver the basic package of quality services to a population that is increasingly comprised of the poor and secondly how to finance and manage services in a way that guarantees their availability, accessibility and affordability to those most in need.

4.1 Community participation in health care service development

The first research objective was to determine the extent to which communities participate in health care service delivery in Kathonzweni division. According to Lysack and Zakus (1998:2)[39], participation is a strategy that provides people with a sense that they can solve their problems through careful reflection and collective action. Participation in health can range from relatively passive involvement in predetermined activities, to full control of the health organization and health related affairs

The findings of this study show that 80.2% of the respondents fully participated in the health centre activities while 19.8% did not participate. The findings show that lack of commitment, lack of information/knowledge, engaging in other economic activities and lack of funds had contributed to non participation but cultural beliefs had not.

The findings of this study also showed that (52.8%) respondents did not participate in assessing progress of the health centres. Only a small fraction of (47.2%) indicated they did. This shows there was minimal involvement of communities in assessing the progress of the health centres when the services in the centres begun and minimal individual involvement in planning.

One of the key achievements of the community health centres was the ability to motivate the communities to take responsibility for paying and establishing health services. The communities were seen to make contributions towards the establishment through provision of cash, labour and building materials. However decision making was left for the leaders chosen and health management committees.

The responsibility of management of the sampled three health centers was found to be dominated by the community members who have formed committees, indicated by (62.7%) of the respondents. Some (33.3%) of the respondents indicated that NGOs such as World Vision were involved in the management while the government contribution in the management of the health facilities was said to be least by (3.9%) of the respondents.

All the three health centres were managed by Community Based Organizations (CBOs) that were registered, had a functional account and a committee that oversaw the activities of the health centres. The CBOs had a membership of between 150 to 400 members.

The findings further showed that 53.2% of committee members were female, while 46.8% were male. This is a good indication to that shows there is almost an equal balance of participation in the committee from both the genders. However the researcher found out that although the number of women in the committee was high, most leadership positions were being held by men.

The communities' capacity to consistently contribute resources to support the health centres was low. The contribution from the community was not enough to assist construction, equip the health centres and handle complex activities of management of the health facilities without external donor support.

4.2 Performance and sustainability of health centres.

The second research objective was to establish the major strengths and weaknesses of community- based health care centres in terms of performance and sustainability.

[38]Sohani, Salim (2005) Health care Access of the very poor in Kenya .Nairobi: Agakhan Health Services.

[39] Lysack, Catherine and David Zakus, (1998) Revisiting community participation. Toronto: Oxford University Press

The research noted that the health centres provided essential services to the community and they were accessible to the communities and queues were normally short as indicated by (64.1%) of the respondents. This means the community health centres have improved access to health services among rural communities in the selected area.

The research suggests that the communities were getting their health care services from the two functional centres that is Kanzokea and Mumo health centres. The findings of this study showed that Kanzokea and Mumo health centres were efficient in delivering services to patients because they offered services that the communities needed and they were also closest to the community. During the time of the study, Yinthungu community health facility was not completely operational due to lack of some health facilities structures, equipment and inadequate number of staff.

The research findings established that the centres received a lot of support from the MOH in terms of posting government medical personnel to the establishment, registration of the facilities and monitoring of progress of the centres. This ensured the health centers' performance were aligned with government standards.

Inadequate funds and poor management was identified as affecting the operations in the health centres. For example, services in Mumo health centre and Yinthungu health centre had to be discontinued at a certain point during the centres operations due to inadequate funds to support services. Although majority of the respondents indicated they paid for the services they received from the health centres the funds collected were not sufficient to adequately support services over time. The centres were found to be lacking in many important infrastructures which if not supported, would cause services in the centres to be discontinued in the future.

The findings of this study show that the staff employed by the sampled health centres were perceived to be inadequate (as was indicated by 65.7% of the respondents) to meet the growing population in the study region. Only one health centre had employed more than four medical personnel spread in different cadres.

The community health centres are generally providing services to the communities and are to some extent self sustaining .The health centres had activities that provided revenue to support services and this would keep them going even after support from development partners stopped for example Kanzokea health centre had a guest house, telephone bureau, paraffin pump as income generating activities that support health centre services. Sources of funds available that enabled the facilities run its services in health care were listed as follows; community contribution, laboratory fee, medicine/ drugs selling, consultation fees and income from guesthouses.

4.1.3 The role of development partners

The third research objective was to examine the role of development partners in supporting community-based health centres.

Three primary partners identified were the government through the MOH structures, NGOs and communities (through CBOs) but their main supporters of the health facilities were dominated by NGOs as was indicated by 59.8% of the respondents. The findings of the study show that development partners' support had a very significant impact on the management and operations of services within the centres through their support in financial and technical resources. The contribution of the partners was in terms of training of medical staff, drugs, training of management committees, funds, construction and expansion health centre buildings, employment of qualified staff provision of equipments. This enhanced the performance of the centres.

Routine monitoring and support (including deployment of medical staff, drugs) received from Ministry of Health (MOH) has also ensured that the centres continue providing quality services to the community. In summary, external support has enabled the centres mobilize resources both internally and externally to respond to community health needs.

5.0 Conclusion and Recommendations

The research noted that the health centres provided essential services to the community. Yet they faced numerous challenges like inadequate staffing capacity, poor physical conditions of the centres, inadequate essential services and drugs lack of consistent funding and external factors like high degree of poverty of the population, prices charged and services offered by competitors, political interference from community leaders.

The study was able to identify four key areas that the centres need to address to ensure improved performance and the sustainability of the health centers.

5.1.1 Membership renewal and participation

The study revealed that there were moderately high levels of community engagement in the health centres. The management committee needs to identify ways in which the community members can be fully involved in the various steps in the project implementation.

The centres need to explore ways of engaging the community more and one way would be the development of a community fund through registration of members and involvement of the members in the health committee.

Introduction of incentives and benefits for participation will enhance members' commitment and

satisfaction. For example, the CBOs managing the centres can think of waiving off a certain percentage of fees especially for those who are members of the CBO and members recruitment drives.

5.1.2 Diversification of financial and non financial resources

The degree to which, community are involved in planning and decision making is often determined by available resources. Performance of the health centres will be supported by how much resources are available to consistently address communities' health needs.

The health centres need to explore other avenues to enable them get funds. This could be in terms of initiating IGAs as seen in some health centres, having fundraising events, using the Bamako approach in the pharmacy area.

However the leadership needs to ensure proper management of the business set up if they are to yield good returns. The health centre leadership and other staff needs to be given sufficient training in financial and enterprise management. This will ensure that the current income generating activities are managed well and bookkeeping is done well.

Low staffing and the unavailability of drugs and essential services affect communities' utilization of CBHC and hence the committees managing the health centres should identify strategic development partners who can support them with adequate funding for infrastructure development and provision of essential services.

It would be crucial for the health centres to develop strategic plans for the health centres as this will guide them in their resource mobilization efforts and will ensure the development of the health centres is systematic and sustainable.

5.1.3 Need for strong leadership and management structures and systems

Good leadership and management are key to community organizing. Leadership identification and development are critical to future mobilization of communities and growth of the centres.

The respondents cited poor management as one of the factors that affected the performance of the health centres. Leadership and management of the centres was seen to be affected by interference from local leaders, low involvement of the members and over dependence on external donors to support the services being undertaken in the centres.

Improved quality care and management can be ensured by enhancing the capabilities of management committees and the clinical team through mentorship and onsite trainings to equip them with skills on fund raising and resource mobilization, health institution management, dealing with stakeholder interference, analyzing consumer demands/needs, financial management and project planning.

The health centres also need to lobby the government to support in the recruitment of medical personnel and other personnel to improve the quality of services provided and improve overall health centre management.

5.1.4 Develop effective partnering and networks

The respondents noted that development partners were important for enhancing the performance and sustainability of the centres. The partners provided support in terms of supervision, training of staff and management committee, provision of drugs and staff and contribution of resources. Yet the study findings noted that the centres did not have strong linkages with the other development partners.

World Vision and the Government were the only consistent collaborators deeply involved in the operations and management of the sampled health centers. Seventy eight percent (78 %) of the respondents highlighted factors that were faced during collaboration as follows; the capacity of the committee to engage with other development partners was minimal, inadequate skills in proposal writing and project formulation, development partners were out of reach and few, lack of continuous forums to engage other development partners, communication and information exchange is inadequate and lack of adequate records.

This means the CBHCs to develop strategies to ensure constant resources are available without necessarily over depending on external support. This can be done through diversification of funding bases through engaging in income generating activities that will provide extra funds to support and sustain the centres.

Donor agencies and government (MOH) need to provide capacity development initiatives that are systematic and consistent so that the institutions supported can build their internal capacity and rely less on donor support.

Finally, the development partners and the health centre management committee leadership need to develop indicators for that will guide in terms of planning what is to be sustained, how, by who, cost and timeframe can serve as objectives to be monitored throughout the project lifecycle.

Community ownership is important to effectiveness and long-term sustainability of the health centres. The results suggest that functional community leadership and management structures, increased members' participation, improved service delivery, shared decision making, strengthened linkages with other organizations,

external strategic donor and goverment support and a stable resource base are key determinants of the performance and sustainability of the health centres.

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