

## **Equity, Empowerment and Choice : From Theory to Practice in Public Health**

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# Equity, Empowerment and Choice

## From Theory to Practice in Public Health

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### Abstract

The purpose of this article is to illustrate how a framework that links equity and empowerment to improved health outcomes for those who live in poverty can be a useful tool for planning and managing health programmes. Using the work of Amartya Sen, Susan Rifkin has developed a framework described in the acronym CHOICE. The article applies the framework to two case studies from Kenya seeking to reduce the disease burdens of malaria and HIV/AIDS. The article examines how the process of pursuing equity and empowerment either supports the positive health outcomes identified as objectives and/or strengthens these outcomes.

### Keywords

- *community participation*
- *empowerment*
- *health equity*
- *Kenya*

## Background

THE STATE OF economic inequity in the world is growing, not only between countries but also within countries. This trend in the disparities of income is mirrored in people's health status and their ability to access health care. The link between poverty and ill-health has long been a recurrent theme throughout the history of public health discourse. In the late 19th century Friedrich Engels looked at the social origin of illness and analysed the link between the spread of infectious diseases and poor housing conditions, bad sanitation and overcrowding. In the same period, Rudolf Virchow expanded upon Engels' work in his study on the spread of a typhus and cholera epidemic in Europe concluding that bad living conditions and poverty were fundamentally linked to the emergence of epidemics (Gautam, 2001).

In recent years growing interest has again emerged in the inequalities of health. Wilkinson (1997) in his study of the industrial countries highlights the relationship between income differences as a determinant of health standards. In the developing world the World Bank study 'Voices of the poor' found the most common trigger for the poverty spiral was ill-health that not only led to impoverishment but also acted as an obstacle to breaking out of the poverty-cycle (Narayan & Walton, 2000). Such evidence shows that people's health and access to adequate health care reflect social inequalities and demands attention be paid to the underlying structural issues. Poverty leads to the social marginalization of poorer or minority groups and impacts on health and subsequently people's quality of life. It emphasizes the importance of putting health and social objectives at the centre of the policy-making agenda as a means to development.

Equity concerns, which also include empowerment, have again been placed on the public health agenda acknowledging the importance of examining social and structural causes of poor health. However, the impact of health programmes in practice still uses epidemiological or economic tools (Farmer, 2001). Only using these tools presents a real danger that the assessment of structural barriers to health will be bypassed or sidelined in favour of other programme objectives that are easy to quantify. It is just recently that tools and models that tackle how social inequalities can be addressed are emerging (Braveman, 2003; Dahlgren & Whitehead, 1991; Diderichsen & Hallqvist, 1998).

The purpose of this article is to present and examine the value of a tool to help planners and managers

assess the influence of equity and empowerment on health outcomes. Using the work of the Nobel Prize laureate, Amartya Sen (1999), Susan Rifkin (2003) has developed a framework described in the acronym CHOICE. We will use this framework to examine two cases studies from Kenya. The first case study is an employer-based insecticide treated bed net project. The second case study is an economic evaluation of a health centre-based Voluntary Counselling and Testing (VCT). In the next section of this article we describe concepts and methods used in this study. We then present a brief description of the case studies in the context of the CHOICE framework. In the discussion we draw some wider conclusions of the value of the CHOICE framework to planners and managers by reviewing our findings. The conclusion uses the evidence to present the value of the framework and suggest a way forward.

To be clear this article seeks to examine the value of the CHOICE framework. It does not propose to use the framework to evaluate the two case studies.

## Concepts and methods

### *The conceptual basis*

This study is an exercise in translating theory into practice. This section on methods starts by describing the concept on which the assessment tool is based. It then discusses how the concepts can be developed into an assessment tool by using the CHOICE framework. We begin by briefly reviewing views about the importance of equity and empowerment to health outcomes.

The WHO definition of health is, 'a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity' (WHO, 1946, p. 2). To date, the bio-medical approach, efficiency-driven perspectives and quantitative tools to measure cost-effectiveness have dominated recent literature on assessing health outcomes. They have failed to examine health as comprehensively as defined by WHO, focusing instead on physical health status (Wolffers, 2000). It can be argued that these approaches have been narrowly focused, ignoring the root causes and structural determinants of ill-health.

Recent analyses have suggested it is necessary to look at other factors that influence health. For reasons stated above, equity is a main area of concern. Equity means that everyone should have fair opportunities to gain their full potential in health and that no persons

should not have the advantage of obtaining this potential if it possible to avoid (Whitehead, 1992).

Paul Farmer (2003), in his most recent book *Pathologies of power* examines the human rights dimension of equity in terms of data and personal experience. He chronicles how the poor are those most vulnerable to human rights abuses that result in deteriorating health and ultimately unnecessary death.

Research and practice on gender equity also provide important insights for equity and health. Much work on gender equity and health has already been done and guidelines have been established (see WHO's (2002) guidelines on gender mainstreaming). Gender and equity will be further explored in the case studies.

Community participation and its evolution into empowerment has also been seen as a key component to improve health especially of the poor and disadvantaged (Sen, 1997). Recent literature, however, argues that participation is limited in its contribution to health improvements. Because participation is usually translated as mobilization, it does not address concerns about more long-term and sustainable change. To address issues concerning deep-rooted, inequitable and structural obstacles, it is necessary to pursue empowerment (Laverack, 2004).

Empowerment can be defined as creating opportunities and inspiration to enable those without power and/or influence to gain skills, knowledge and confidence to direct their own lives (Rifkin & Pridmore, 2001). It can be examined at the individual (psychological), organizational (group) and community (political action) levels (Laverack, 2004). These levels are seen in the descriptions of the case studies in this article. Examining empowerment is critical to assessment of health outcomes in part because it focuses on the process not only the product of change.

### *The contribution of Amartya Sen*

In his book *Development as freedom* (Sen, 1999), Sen examines the importance of equity and empowerment in the context of human and economic development. He highlights how deprivation and oppression constrain people from contributing to growth of the economy and to the realization of their own potential. He notes that poor health is both a cause and effect of inequities of resources, access and opportunities.

Sen argues that people will pursue their own best interests when they have knowledge, skills and resources to pursue these interests. Empowerment and participation enables these interests to be realized. Further Sen argues that people identify and seek

what they value when their rights and freedoms are insured. Any discussion of inequalities therefore must take into account people's ability to influence the context of their individual, social, economic and environmental situation.

Sen's central theme is freedom, and how the processes of development must expand the freedoms people can enjoy. He defines substantive freedom as enhancing people's capacity for deliberate choice and positive freedom as developing capability and empowerment of people. Five freedoms expounded by Sen are seen as a means to development, these include: political freedoms, economic facilities, social opportunities, transparency guarantees and protective security. Political and civil participation are highlighted as key freedoms to achieve full potential of human development. Human rights play a central role in the protection of freedoms. Overall Sen's theories have provided a new way of looking at equity and empowerment and the basis for developing a tool for programme development planning and assessment.

### *The CHOICE framework*

Moving from theory towards practice, Susan Rifkin has developed the CHOICE framework (see Fig. 1) in order to explore the relationship between health equity and community empowerment based on Amartya Sen's (1999) concept of development as freedom.

Rifkin uses Aday's (2000) idea of deliberative justice that argues that health programmes need community participation and empowerment in order to be effective. She sets out the CHOICE framework by asking a critical question to assess each domain in any specific programme. These questions are:

- Capacity-building—Can local people obtain and act upon new skills and /or knowledge to improve their health?
- Human rights—By exercising their rights, can the poor influence the circumstances that produced poverty?
- Organizational sustainability—Can organizations be developed and maintained to ensure sustainability of health gains for the poor?
- Institutional accountability—Can mechanisms be developed to ensure resource allocation and decisions benefit those most in need?
- Contribution—How does the contribution of a programme's intended beneficiaries influence its development?
- Enabling environment—What is the contribution of the existing environment to pursuing equity and empowerment for health improvements?

- C** *Capacity building*—defined as a process by which people gain skills, knowledge, and the improved lives of beneficiaries by beneficiaries applying new skills to the political, social and economic environment. Capacity building stresses the importance of local knowledge and is an important step for empowerment.
- H** *Human rights*—is a moral and ethical concept that allows people to better sustain their well-being when they can participate in decisions about their own lives. It allows people to take action.
- O** *Organizational sustainability*—sustainable health gains depend on long-term organizational structures. Key factors are financial resources to maintain structures. Sustainability therefore is key to equity. Empowerment is a key concept to ensure sustainability because it contributes to beneficiary ownership of the programme.
- I** *Institutional accountability*—developing accountable relationships with health service providers in order to receive adequate care, the community can build capacity and address equity issues. Accountable and transparent mechanisms that respond to communities are essential.
- C** *Contribution*—contributions can provide resource contributions, though stakeholders are often given little choice about that to which they contribute. Second, contributions can be time and support in initiation, implementation and monitoring, which can improve the responsiveness of health care providers.
- E** *Enabling environment*—is created through changes in perceptions, attitudes and behaviours of those in power. Information availability and ownership of information are key, as they help lay people to partner with professionals.

Susan Rifkin (2003)

Figure 1. CHOICE framework.

### Applying the CHOICE framework: case studies from Kenya

The Kenya case studies are desk studies. They seek to address two diseases (malaria and HIV/AIDS) that have the largest impact on the population of Kenya. They were chosen because although not explicit, equity and empowerment are key to the

objectives of the programmes. As these studies are not studies that used the CHOICE framework to set the programme objectives and they are based on written materials not field work, they must be seen in the following context. First, programme objectives did not explicitly establish those for which the CHOICE framework was developed. Second, they provide unequal and incomplete information about the six domains. Third, it is not possible to detail the process of change. However, they do provide information that enables us to examine whether the framework might be of value planning, implementing and evaluating programmes' objectives.

## Case studies findings

### The Kenya context

Kenya is a low-income country with a severely limited health budget (World Bank, 2006). Access to good health services is poor especially in rural areas. In the late 1970s Kenya expanded its rural health facilities to meet the needs of its predominantly rural poor population adopting the 1978 Alma Ata Declaration on Primary health care (WHO, 1978). In the 1990s Kenya followed the shift in health policy towards institutional and structural reform and market orientation of health services based on the 1993 World Development Report (World Bank, 1993). In 1994 the Kenyan government established a health policy framework stating a commitment to equity and health care for all, reaching vulnerable groups and underserved areas (Kenya Ministry of Health, 1994). Despite this goal care for most of the population remains severely limited. Implementation failures have been documented by Oyaya and Rifkin highlighting the problem of poor policies, ignorance of policy processes and gaps between policy makers and implementers. Oyaya and Rifkin (2003) emphasize the Government's need to continue to play a part in protecting citizens' health rights and establishing good governance and management structures for the health sector.

Within this political and economic climate, diseases such as malaria and AIDS have a large impact in Kenya and place a heavy disease burden on the State, the economy, on families and on social networks. Malaria accounts for more than a million deaths per year, 90 per cent occurring in sub-Saharan Africa and affecting children under five years of age (WHO, 2004).

It is estimated that over 2.2 million people are living with HIV/AIDS in Kenya while about 500

people per day die from the epidemic (UNAIDS, *Kenya Country Profile*). HIV prevalence is about 7 per cent among adults but higher in the urban areas where it is estimated to be between 12 and 13 per cent. Life expectancy has gone down from 60 years in 1993 to 47 years in 1999 (NASCO, 1999). This situation where there is a lack of financial resources, and a weak economy with weak health infrastructures challenges the Government to respond adequately to these disease problems. Prevention and treatment programmes for malaria and HIV/AIDS must work within this environment in order to make sustainable and viable interventions for the control of disease and equitable distribution and access of preventive care and treatment.

### *Insecticide treated bednet programmes: background*

The case study of the Employer-based Malaria Control Project represents an initiative for the prevention of malaria. One of the key interventions for malaria prevention has been insecticide treated nets (ITNs) which are a well-established method of reducing morbidity and mortality associated with malaria. Randomized controlled trials in African settings of different transmission intensities have shown that ITNs can reduce the number of under-five deaths by around one-fifth (Lengeler, 2001). In Kenya the public sector lacks the financial or logistic capacity to extend net use to the scale required and therefore needs both public and private sector involvement (UNICEF/WHO, 2003). Equity and empowerment issues are important because poor households are less likely to be able to afford ITNs but usually have a higher burden of malaria.

The Employer-based Malaria Control Project (EBMCP) was a Department for International Development (UK) (DFID) funded project implemented by the African Medical and Research Foundation (AMREF) over five years (1998–2003). The goal was to improve the 'health and socio-economic status of workers, farmers and members of women's groups and their families in large industries located in malaria endemic areas of coastal and lake regions of Kenya' (Edmondson & Webster, 2000).

AMREF's role was to create a sustainable delivery system of ITNs with the additional aim of providing income-generation activities in the local community. The project covered 14 employers' sites in the Lake Victoria and coastal region in the agricultural and tourism sector, with a baseline population of 82,330.

AMREF provided ITN supplies on credit to Organized Community Groups (OCGs) in the employers' neighbourhoods (women's groups) who were willing to undertake the bednet promotion and selling. OCGs sold nets to employees who were reimbursed by their employers, who in turn deducted instalments from salaries that allowed for a credit system that made nets affordable. The OCGs also sold nets and retreatment of the nets with insecticide to the wider community in order to increase coverage.

At the end of the project 45,600 insecticide-treated nets were sold, 80 OCGs were functioning, 483 community health motivators were trained. AMREF reported a 50 per cent reduction in reported malaria episodes and hospital admissions and a 36 per cent increase in the regular impregnation of nets (AMREF, undated).

A review of the EBMCP was carried out mid-term of the project in November 2000 by consultants from Malaria Consortium, AMREF and DFID. The review concluded that farmers were not being reached because of the bad economic climate but that progress had been made in ITN promotion, and in selling nets and insecticides to the majority target population. However in phase two of the project, important questions of equity, sustainability and cost-effectiveness needed to be addressed (Edmondson & Webster, 2000).

A cost-analysis of the project was published in 2004, 'A cost analysis of the employer-based bednet programme in Coastal and Western Kenya', by Ngugi, Chiquzo and Guyatt (2004) where the supplier's cost for an ITN was estimated at US\$15.80. The article concluded that the project was profitable for OCGs giving them enough funds to continue buying and selling bednets without donor support.

*Capacity building: can local people obtain and act upon new skills and /or knowledge to improve their health?* Capacity building has been defined as a process by which people gain knowledge, skills and confidence to improve their own lives. In terms of empowerment capacity building relates to the bigger picture of social function and the capacity of communities to solve their own problems by also taking into consideration equity issues within their community (Rifkin, 2003).

The EBMCP has so far been successful in training the OCGs in promotion of bednets as well as sustaining ongoing distribution networks. The level of knowledge among household heads and mothers of children under five was already high in terms of

knowledge about malaria transmission, treatment and prevention (Edmondson & Webster, 2000). This was due to the high number of NGOs (non-governmental organizations) working in the area and so the OCGs managed to sustain awareness and knowledge regarding malaria.

The EBMCP has shown overall that local people can act upon new skills, especially when it helps sustain local livelihoods and that this does have a positive impact upon the wider community. It also highlights the fact that in order for the system to be set up a great deal of time and expenditure is needed in the initial start-up process to sustain and fine-tune the distribution systems. Initial investment in capacity building therefore is paramount.

A critique of the training received by OCGs has been that OCG members have themselves not always been convinced about retreatment of bednets and this affected knowledge transfer. Specialized training including symptom recognition was recommended for a small number of OCG members who could then go ahead and train trainers.

The problem of equity was raised by the fact that the project did not manage to reach the farmers it had intended to reach. Farmers made up the poorer target group of the project. Due to worsening economic conditions and deteriorating relations with the Companies, they could not access credit in order to buy bednets. These low-income groups had competing priorities like food, education and shelter.

A useful evaluation of capacity building would have been to use local knowledge and experience to strengthen the OCGs and employers to set up a distribution system to include poor and marginalized groups. This action could sustain community networks that were more equitable. A constructive approach has been used in Benin focusing on women and ITNs. A study in Benin has shown that it is the women in a household who take on health care and who are the ones who buy bednets from their own income, despite earning a lower income than male counterparts (Rashed et al., 1999). Women are also at high risk of malaria (during pregnancy). This study suggests further investigation needs to be done regarding the impact of cost on women, as well as increasing the perceptions of men about malaria transmission and prevention. It reflects on Sen's work on women's agency and well-being: 'Understanding the agency role is thus central to recognising people as responsible persons: not only are we well or ill, but also we act or refuse to act, can choose to act one way rather than the other' (Sen, 1999, p. 190).

In the EBMCP the OCG women's groups were from better-off communities. A distribution system to impact wider into the community and giving both responsibility and choice to women could have involved poorer women in community networks.

*Human rights: by exercising their rights, can the poor influence the circumstances that produced poverty?*

The project did not directly focus on the human rights aspect, however a major component of Sen's *Development as freedom* is based on the language of human rights. Sen (1999) sees human rights as a set of ethical claims and emphasizes the freedoms that are associated with particular rights.

Sen's theory on human rights is linked to positive and negative freedoms and the idea of capabilities (i.e. the opportunities and choice of taking action). In these terms the EBMCP went a step towards this approach. It established the OCGs where local communities and individuals were able to participate in decisions about their own lives. In terms of choice employees were able to make decisions about health by accessing credit from employers and improving their family health.

Commitment to equity and justice is part of rights-based thinking and engages a larger debate about the status of women, children and marginalized groups. Perspectives on workers' rights would have been useful in this case study in terms of their access to financial resources as well as health services. Some employers provided health care for their employees and their families while others did not. Employers did not extend health care provision to farmers, so when employers failed to pay for farmers' crops the group was further impoverished and unable to afford bednets.

Further awareness in the OCGs of people's fundamental right to health and life may have had the possibility of leading to further action at the community level as well as expanding membership of the OCGs to represent a broader cross-section of the community. Rights expand people's freedom to act and marginalized groups are often aware of violations of their rights. In this case a more active inclusion of farmers into the project may have been an avenue to explore how the poor can influence their circumstances.

*Organizational sustainability—can organizations be developed and maintained to ensure sustainability of health gains for the poor?* Sustainability can be looked at first, by quantifiable measurements in terms of programme

continuation and/or a sustainable distribution network of ITNs and second, sustainability can be seen as a process (which is harder to measure).

In terms of structures, the EBMCP has done well in establishing sustainable structures of the distribution and promotion of ITNs. It is uncertain how long the OCGs will be able to continue their distribution networks due to high prices of their bednets compared to the local market. The OCG bednets remain more expensive than those on the market at Kshs 664 in the coastal region and Ksh 705 in the western region. However employees perceive the OCG bednets to be of better quality, especially those with the AMREF logos and have a choice of sizes, colours, hand-made or ready-made nets as well as choice in terms of insecticide treatment Peripel (permethrin)-treated nets versus K-O Tabs as people have different preferences of insecticides (Edmondson & Webster, 2000; Ngugi et al., 2004). It is also well supported by employers as it reduces absenteeism (due to malaria illness<sup>1</sup> and mortality). The provision of credit and payment schemes by employers for purchasing bednets bodes well for the sustainability of the project.

In terms of process, the set-up of the project and relationships with key stakeholders is important. Initial ideas of creating a Project Steering Committee and creating Workers' Health Committees did not work. However due to local interest in creating income generation by OCGs, employers' interests in malaria prevention and employees' awareness of malaria transmission provided both the enthusiasm, support and funding for the ITN distribution to continue.

If the project were to be measured in terms of ITN distribution and health impacts in the wider community (especially the poorest)—much more work would have to be done in order to reach this target. Ministry of Health (MOH) involvement would also be crucial for project development, sustainability and scaling up (Sarriot et al., 2004).

*Institutional accountability—can mechanisms be developed to ensure resource allocation and decisions benefit those most in need?* Neither of the two project evaluations examined institutional accountability. This is important if systems are to be set up for the sustainable equitable distribution of resources.

Accountability works from the global to local level. Donor funding and resource allocation need to be transparent and accountable; the reasons for funding

specific interventions over others; the targeting of certain countries and groups are all fundamental issues when talking about equity from the global perspective. Further down the line the same can be said for government policy as well as implementing NGOs. The institutional and social problem of accountability and transparency in Kenya impacts on equitable access and the issue of sustaining equitable distribution networks. This line of enquiry gives a fundamental picture of the structural reasons of inequality and access and can provide avenues for intervention.

Accountability mechanisms can also open up pathways for community involvement in health service delivery. The ITN employer-based project has the potential to open dialogue with employers about health care as well as set up institutions in the company and the wider community to co-ordinate the further provision of services. The legitimacy, accountability and transparency of community representatives are also key in creating equitable systems.

*Contribution—how does the contribution of a programme's intended beneficiaries reflect its development?* Contribution by stakeholders to a project can be in terms of resources (money, materials, human resources, labour). This enables people to contribute to a project and be able to define a sense of 'ownership' of the project and an interest to see it continue. It is important when discussing contribution to protect the poor from the burden of payment that the decision-making structures need to represent intended beneficiaries (Rifkin, 2003).

Another form of contribution that is part and parcel of participatory literature is contributions towards the start-up, plus the implementation, monitoring and evaluation of the project (Rifkin & Pridmore, 2001). This enables beneficiaries to learn new skills, contribute to institutions as well as making services more responsive. Professionals act as facilitators in this scenario.

In the EBMCP some industry health staff contributed considerably. The Bamburi Cement Company produced ITN T-shirts for employees. OCGs in Mombassa Old Town Women's Group included poems about ITNs in their recitals and some groups had gone to various institutions and communities to talk about the project, including 1500 school children (Edmondson & Webster, 2000). In general the contribution of key stakeholders—employers, employees and OCGs—has ensured the continuation



of the project once donor funds have been removed.

*Enabling environment—what is the contribution of the existing environment to pursuing equity and empowerment for health improvements?* It is important to look at the enabling environment including Sen's (1999) five freedoms: political freedoms, economic facilities, social opportunities, transparency guarantees and protective security.

Political and civil participation are important but limited in Kenya however progress has been made towards an ITN strategy. The aim is to reach 60 per cent net coverage in the population at risk of malaria with 25 per cent being regularly treated with insecticides by 2005. The Government of Kenya cannot afford to provide everyone with nets so aims to create an enabling environment through the public, private and NGO sectors to co-ordinate and maximize long-term private sector delivery of ITNs. Equity of access is attempted through targeted subsidies. The existing environment has therefore been advantageous for the EBMCP.

In terms of economic facilities, the signing of the Abuja Declaration by the Government will also help the OCGs by the waiving of taxes and tariffs associated with bednets and thus make the nets cheaper to buy and sell (*News and Views on Africa from Africa*, 2003). The Abuja Declaration is a political commitment by the governments of 55 malaria-affected African countries—backed by WHO, the World Bank, UNDP and UNESCO—to 'roll back malaria'. It includes a pledge to reduce or waive taxes and tariffs on mosquito nets and other materials including drugs related to malaria control.

Political support for the ITN strategy exists. However the MOH structure remains weak. In addition, corruption remains rife and donors have differing priorities and aims, which sometimes conflict with government strategy (World Bank, 2004). For example, foreign donors suspended aid in 1997 fed up with the perceived corruption within government. The 1997 suspension impacted negatively on health outcomes and had an immediate negative impact on the economy. Additionally IMF Structural Adjustment Programmes (SAPs) further impacted severely on the economic climate in Kenya at the beginning of the project. Relationships between farmers and sugar factories in the West broke down. Farmers who were owed money by the sugar factories turned to other crops and were unable to take

advantage of the project—thus leaving the poorest from the original target group out of the project. An enabling environment therefore is key in contributing to the success of such projects.

### ***Voluntary Counselling and Testing: background***

The case study of Voluntary Counselling and Testing (VCT) interventions through health centres is the second case study. The Kenyan government is committed to the large-scale introduction of voluntary counselling and testing for HIV in its primary health care centres. Donor funding has been made available to support start-up of VCT services in NGOs, community-based organizations and 'stand-alone' sites as studies have shown VCT sites to be cost-effective (Sweat et al., 2000). VCT is an important tool for the fight against AIDS acting as an entry-point for comprehensive HIV/AIDS care, bridging the gap between care and prevention and also preventing new HIV infections (Baggaley, 2002). The availability of anti-retroviral (ARV) therapy also means that more people will want to access VCT. Traditionally VCT costs have been high but innovative interventions are being explored in order to integrate affordable VCT into existing health service provision while maintaining quality and providing equitable access.

Economic evaluations on VCT services have been carried out in order to assess the cost-effectiveness of VCT as a viable option in Kenya. These economic evaluations have determined affordable interventions for low-income countries but provide limited information regarding access and equity of services or strategies for intervention. The Kenya programme uses two models of service provision: stand-alone sites and those integrated into public health facilities such as large hospitals, smaller health centres and rural dispensaries; both delivery systems raise their own issues. VCT services integrated into health centres will be discussed below.

*Assessing the cost and willingness to pay for HIV counseling and testing in Kenya*, by Forsythe and colleagues (2002) looks at VCT as an integrated service in existing health centres. It looks at health centres where VCT had been introduced in two rural settings and one urban setting. An economic evaluation was performed with client participation that dealt with willingness to pay, sexual behaviour and socio-economic status. The article concludes that integrated services can reduce the cost of VCT compared to vertical VCT sites, and that cost reductions can be amplified through the use of health centre staff

as counsellors. The VCT evaluation determined costs for labour, materials equipment, furniture, property, utilities and operating costs. Cost-recovery mechanisms and clients' ability to pay was also established by interviewing clients. Principal costs were salaries for counsellors (59%), then materials (38%) and equipment (3% annualized cost of equipment). Integrated VCT programmes increased the total cost of providing health centres by about 9 per cent

*Capacity building: can local people obtain and act upon new skills and/or knowledge to improve their health?* The evaluation does not address capacity building directly, but indicates that costs could be reduced by training government health workers instead of using private counsellors. This assumes that quality can be maintained while bringing costs down and allowing more people access to the service. In order for this to happen health systems need to be able to provide counsellors who are well trained and have structures in place that make VCT accessible. Capacity building of staff and the investment of initial set-up costs are key for the success of VCT.

Community mobilization is mentioned in the evaluation to promote VCT services. Partnerships between the community, government, health workers, researchers and NGO are very important for early case detection, and has been shown to enhance compliance at a later stage with treatment and PLWA (People Living with AIDS) programmes. For example, the Family Planning Association of Kenya (FPAK) built capacity of existing VCT services for youth by including linkages to community leaders and volunteers (PACT, 2002).

The evaluation of VCT in Kenya needs to include evaluating capacity building (as defined within the CHOICE framework discussed earlier) in order to establish fully economic costs of training and community mobilization. It also needs to look at opportunity costs, including working with communities, in order to determine the viability of access for the general population as well as vulnerable and marginalized groups. By empowering communities with knowledge on HIV/AIDS, issues of stigma can be addressed and help can be given to rebuild and support social networks that have been put under strain due to the heavy burden of the disease.

*Human rights: by exercising their rights, can the poor influence the circumstances that produced poverty?* Much has been written about the human rights response to HIV/AIDS. The review

of this literature is beyond the scope of this article (for useful reviews see, for example, Deacon, Stepney, & Prosalendis, 2005; Farmer, 2003; Kalipeni, Craddock, Oppong, & Ghosh, 2004; Parker & Aggleton, 2003). The evaluation does not directly deal with human rights, however rights are fundamental to VCT operations and the protection of rights often determines the success of VCT operations. Ethical codes of conduct, confidentiality and informed consent and a respect for people's rights are the mainframe for VCT services (Kenya Ministry of Health Republic 2001).

In Kenya where infection rates for women are five times higher than that of men (NASCO, 1999), women's access to services becomes important as does the underlying socio-economic and cultural factors that effect high transmission rates for women. A more extensive rights-based approach to HIV/AIDS, linked to Sen's theory on freedoms, incorporates a broader approach to interventions. In Tanzania for example, a community-led rights-based approach involved the community from local services through to national-level policies. This increased the participation of marginalized people in decision making, allowing for choice and feedback to health care providers encouraging partnerships and networks to emerge (HASAP, 2000).

A rights-based approach to VCT services and other HIV/AIDS interventions in Kenya, can create environments that can challenge structural blocks like racism, gender discrimination, stigma and lack of resources. Assessing cost and willingness to pay are narrowly focused evaluations that do not include larger social costs or inputs of this broad framework. Nor do they pinpoint responsibility for action. A rights-based approach makes governments responsible for prevention, treatment and control of diseases and the building of sustainable conditions to ensure access to health services and goods, but also emphasizes community involvement and participation in the process (Braveman & Gruskin, 2003).

*Organizational sustainability—can organizations be developed and maintained to ensure sustainability of health gains for the poor?* The evaluation supports the potential sustainability of VCT services within existing health structures depending on operational research and outcomes (including costs) of training health workers and community mobilization. Other considerations would include their willingness to pay. The evaluation concluded that 80 per cent of VCT clients were willing to pay between US\$2 and \$6

for the services they received. Operational research may show a different figure in future; additionally systems to include poor and marginalized groups would have to be incorporated into VCT services in order for VCT services to have the intended impact.

Organizational sustainability of health facility-based VCT sites is also very dependent on the wider health system, which is currently weak and under funded. However a pilot study run by the Liverpool School of Tropical Medicine in three government primary health care centres between 1998 and 2000 showed that integration of quality VCT is feasible and services are accepted well by the community (Taegtmeier, 2002). The study concluded that government health staff could provide professional full-time services without further financial incentives and those sustainable services can be established within a year.

However in order for VCT services to be sustainable financial resources need to be committed in order to maintain policy. A better inclusion of community members and PLWAs can support the maintenance and quality of services provided. However this needs to be explored further in terms of how it can be used to ensure sustainability and the promotion of equity of access.

*Institutional accountability—can mechanisms be developed to ensure resource allocation and decisions benefit those most in need?* Institutional accountability is not directly dealt with in the evaluation but is an important aspect for good service provision as well as a means to provide more equitable services. Cost recovery for services demands transparent financial mechanisms in place, as well as systems where those who cannot afford services can access VCT.

Community involvement can promote accountability and transparency if real partnerships between health service providers and community are formed. To do this health workers have to view clients as partners who can monitor, evaluate and provide feedback into programmes and services. It would have been useful if the evaluation could have taken this into account to determine how formal and informal institutional financing mechanisms work and how money can be, or is diverted as this would impact on cost and consequently on access.

*Contribution—how does the contribution of a programme's intended beneficiaries reflect its development?* Contribution by stakeholders to VCT can be in the form of cost

recovery, or community participation in start-up, implementation, monitoring and evaluation of the project. This enables beneficiaries to learn new skills, gain knowledge about HIV/AIDS and VCT and make services more responsive and sustainable.

Sen's focus on human capability links to more structural and environmental issues that impede or allow people to make choices. An interesting line of enquiry is to attempt to look at people's access to VCT and factors that affect their choice.

*Enabling environment—what is the contribution of the existing environment to pursuing equity and empowerment for health improvements?* Kenya has expanded its VCT services and aims to increase coverage of VCT in primary health care centres. Political support therefore is present, as is donor funding with funds coming in from the Gates Foundation and other main donors. The main constraint to increasing external funds is the pervasive corruption in the country (World Bank, 2004). Corruption also means that limited resources are diverted from intended beneficiaries.

Resource constraints mean that difficult decisions need to be made on spending and further research on VCT needs to be carried out to establish the best method of providing VCT services to as many people as possible. Ethical considerations that look at prevention strategies also have to take on board issues of equity of access to prevention and care services.

The enabling environment is, therefore, critical when looking at VCT effectiveness as a service provision at the primary health care level. International, national, local and community factors affect service provision. VCT services, depending on how they have been set up and how processes that involve the community evolve, have the potential to address issues such as the stigma to people infected with HIV/AIDS, as well as the impact on women, the poor and other marginal social groups carrying the biggest burden of disease.

## Discussion

In the earlier descriptions, we related the value of the CHOICE framework to analysis of its contribution to equity and empowerment to health outcomes. In this section we highlight broader contributions using the lessons from the case studies.

The case studies highlight that this broader approach to project development and evaluation can

not only put marginalized groups at the forefront of project development but also provide a framework for lines of enquiry that take into consideration structural, cultural and environmental factors. In this, the framework demonstrates its adaptability to analyse the very different case studies, in terms of disease, and project intervention, thus adding critical information to the evaluations. The framework also points to lines of action and to complementary programmes and initiatives that can support project aims. By posing critical questions, the framework focuses on the poor and vulnerable demanding attention be given to their plight.

In terms of capacity building the EBMCP highlighted the need for OCGs and community networks to be strengthened in order to broaden distribution networks so that vulnerable community members could participate in the project. The VCT evaluation highlights the view that if knowledge and skills with increased participation of stakeholders and community members were enhanced, general HIV/AIDS awareness in the community could tackle issues of stigma and also provide a means to support already frayed family and social networks to tackle the disease.

The human rights framework in the broader sense, of commitment to equity and justice highlighted by Sen, identifies the practical need to recognize and overcome obstacles such as race, gender, beliefs and language that keep those in disadvantaged groups from accessing full benefits of health provision (Braveman & Gruskin, 2003).

The EBMCP looked at the importance of workers' rights in general and their rights to access health care and credit facilities in particular, which expanded the choices they could make for themselves and their families. In this case study, farmers who could not exercise their rights not only lost their income but were also unable to participate in the ITN project. The VCT evaluation highlights a rights-based approach to HIV/AIDS programming that identifies an acceptance of responsibility for prevention and treatment as well as community involvement in the process.

Organizational sustainability in both case studies is an important aspect of being able to achieve equitable access to services. The EBMCP has sustainable mechanisms in place largely because interested parties have found the project beneficial to their needs: (1) the employers invest time into the project because it reduces absenteeism from work; (2) OCGs make profits from the selling of bednets; and

(3) employees can access credit for the buying of bednets to protect their families from malaria. The EBMCP however still needs to set up distribution networks to reach more vulnerable groups. Sustainability of VCT services are dependent on the larger health system environment and need funding as well as community involvement in order to ensure they will have the required impact.

Institutional accountability is a major factor in Kenya for both the EBMCP and VCT projects. Lack of transparency and accountability in systems can jeopardize equitable distribution of resources and mechanisms to reach marginalized groups. Community involvement in both projects, in terms of monitoring and evaluation, could be a way of creating partnerships between stakeholders and the community in question.

In terms of contribution, the case studies highlight the need to incorporate Sen and colleagues' theory of capabilities in order to assess people's ability to take action given their current environments. This can lead to actions and programmes to enable people's environments so that choices for better health can be more readily made. The EBMCP in this sense could have expanded networks to farmers allowing their contributions to be made in kind, but also expanding their capability to make health choices regarding malaria prevention. In terms of the VCT evaluation people's access to services and their reasons for engaging services, or not, needs to be explored further in order to set up cost-recovery schemes, or in order to establish viability of the project and its access to poorer groups (see Fig. 2).

Sen's five freedoms are useful definitions for exploring an enabling environment: political, economic and social freedoms, transparency and protective security. Political support for malaria and HIV/AIDS exists as does global commitments for funding. However international policies are often value laden, sometimes inappropriate, contradictory or insufficient (Kalipeni et al., 2004). The SAP's impact on the farmers in the EBMCP is one such example. National and local economic, social and

National level	Economic facilities
Country level	Social opportunities
International/regional	Transparency guarantees
	Protective security

Figure 2. Enabling Environment.

cultural conditions and the lack of accountability and transparency hamper interventions highlighting the importance of targeting interventions and supporting enabling environments.

Going beyond Rifkin's definition of contribution, Amartya Sen, Martha Nussbaum (2000) and others have focused on human capability as an intrinsic value for the well-being of people. Given social inequities and asymmetrical relations of power people can exercise only a certain amount of choice and take limited action towards their well-being. Capabilities are therefore expansions of freedom and having the resources and the space to choose (Nussbaum, 2000). In this sense contribution is intrinsically linked to people's capabilities and functioning, which is linked to more structural and environmental issues.

## Conclusion

This article aimed to review in the light of practice Amartya Sen's 'development as freedom' theory and Susan Rifkin's CHOICE framework by applying the framework to practical case studies.

The summary above illustrates that specific elements of the framework taken individually may not address equity and empowerment issues in themselves. However the principles of CHOICE taken as a whole highlight the need for addressing each issue in order to be able to tackle root causes of ill-health. The CHOICE framework can therefore help to engage planners to recognize the value of engaging communities to work towards sustainable solutions, and empower individuals and their environments so that they have the freedom to make choices.

The recent concern from major donors regarding equity issues and their link to ill-health means that models, conceptual frameworks and practice mechanisms are being sought. Equity and empowerment frameworks however need to go beyond the ability of technocrats to use the right rhetoric.

Amartya Sen's approach to development and Rifkin's CHOICE framework provide a broad base of development from which to start. It engages in political, economic and social freedom, and rights. This base provides a practical foundation with which to tackle structural obstacles for equity of access to treatment and care. The case studies described earlier illustrate the applied use of the framework and its main function of addressing equity through

empowerment, asking the critical questions and following lines of enquiry that can lead to positive action and initiatives.

In conclusion the case studies have demonstrated the importance of incorporating equity into public health discourse and have shown that the CHOICE framework is a useful tool for assessing health interventions in terms of equity and empowerment. The next step is to field test the CHOICE framework to investigate whether planners and managers find this approach useful and how it can be incorporated into the planning cycle.

## Note

1. WHO (1999) notes for instance that on average four days of work are lost due to one episode of malaria (in Burkina Faso), three (Kenya), 2.7 (Malawi), two (Nigeria), three (Rwanda) and 6.2 (Sudan).

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