HEALTH THROUGH DISTRICT FOCUS

Phase III Mid-term Review, Kenya-Finland Primary Health Care Programme

Review Mission:

Malcolm Segall, Bryan Haddon, Tuuliki Hassinen-Ali Azzani, Lasse Topo

Volume I: Main Report

Written by Bryan Haddon and Malcolm Segall

October 1990

Western Province, Kenya

Prepared for the Finnish International Development Authority and the Ministry of Health, Government of Kenya

Jake M.
Lindholm KIO-
Kauhainen "
P. Virinen "

Annex 3: Mission Preparatory Documents

PROPOSALS FOR THE

1990 K-F PHC PROGRAMME SUPPORT MISSION

From Bryan Haddon and Malcolm Segall, IDS Health Unit, September 1990

Mission Objectives

Suggestions for the main objectives of the Support Mission are as follows:

-- To review the current activities and progress of the KFPHCP

-- To make recommendations for the remainder of Phase III and put forward some perspectives for the next phase

-- To hold consultations with the Director of Medical Services, Finnida officials, the Programme staff and the Provincial and District Health Management Teams of Western Province, including holding a joint workshop with all these parties.

In the course of its review, the Support Mission will concentrate on examining the Programme's components; training and research activities; and progress in strengthening district health planning and organisation. It will cover the following issues, but not be restricted to them:

1. Rural Health Services:
   -- Programme health centres
   -- target areas
   -- community involvement and CBHC
   -- links with DHMTs.
2. Sanitation:
   -- progress with V.I.P. latrines
   -- affordability
   -- community involvement
   -- cooperation with Water Project
   -- joint health education.
3. Construction:
   -- present strategy and progress
   -- survey results
   -- utilisation studies.
4. Training of personnel:
   -- present strategy and approaches.
5. Research:
   -- plans and priorities
   -- links to programme activities
   -- current progress.
6. Strengthening district health planning and organisation:
   -- implementation of 1989 survey and provincial seminar
   -- functioning of district and provincial teams and committees
   -- support and supervisory activities
7. The planning process of the K-F PHC Programme
   -- 1991 Operational Plan: proposals, structures and procedures.

Mode of operation of the Mission

It is proposed that the Support Mission aim for an active involvement of Programme staff plus the Provincial and District Health Management Teams (HMTs) in reviewing progress and developing proppsals and strategies.

The first stage of the Mission would be to assist Programme staff and HMTs to prepare reports on each of the above topics. These reports would analyse objectives, achievements

HEALTH THROUGH DISTRICT FOCUS

Phase III Mid-term Review, Kenya-Finland Primary Health Care Programme

Review Mission:

Malcolm Segall, Bryan Haddon, Tuuliki Hassinen-Ali Azzani, Lasse Topo

Volume I: Main Report

Written by Bryan Haddon and Malcolm Segall

October 1990

Western Province, Kenya

Prepared for the Finnish International Development Authority and the Ministry of Health, Government of Kenya

9 Some Key Issues and Future Perspectives

There has been a fundamental change in the strategy of the K-F Programme since the time of its inception. The process began in Phase II and is being consolidated in Phase III. It is the shift from seeking to deliver some PHC services directly to trying to strengthen the organisation and capacity of the district health systems, so they can deliver their PHC services more effectively and efficiently. In other words, the K-F Programme has been changing from a parallel health service to a developmental project which, given its major donor support, it should be.

It has taken some time for this change to be fully understood and methods are still being developed for completing the transition. However, during this Review, and particularly at the Review Workshop, there was evidence of a clear grasp of the new strategy. Each of the components has been seeking ways to work more closely with the DHMTs and reduce their direct involvement in service delivery; activities are underway to develop many aspects of the DHMTs' working methods and practices; and the reports prepared for the Review by and large differentiate between the complementary roles of the K-F Programme and the DHMTs.

Four issues have emerged in the course of this Review that will be vital in consolidating this change of direction and the new role of the K-F Programme. Each of these issues will be summarised here. To some extent this chapter repeats points dealt with already in this report, but we want to draw the key issues together and restate them where necessary.

1. Increasing Integration

The K-F Programme was launched initially as a distinct and self-standing organisation, that operated effectively in parallel to the existing health services in the Province. Since the start of Phase II there has been a series of qualitative shifts. First, the management of the Programme was Kenyanised and the executing agency became the Ministry of Health. Next a process was started of integrating it with the existing health services and the principle of support to the DHMTs was adopted, but there was still no clear idea of how to go about it. Now in Phase III, since the 1989 Planning Seminar, a clear strategy has emerged for

Table of Contents

Acronyms

CHW----------Community Health Worker

DHMT ----------District Health Management Team

(D)MOH ----------(District) Medical Officer of Health

DPHN----------District Public Health Nurse

EHS----------Environmental Health and Sanitation

FIM----------Finnish Marks

HMT----------Health Management Team

IDS----------Institute of Development Studies (UK)

K-F Programme ----------Kenya-Finland Primary Health Care Programme

KSh.----------Kenya Shillings

MCH ----------Maternal and Child Health

PHC ----------Primary Health Care

RHS----------Rural Health Services

TBA ----------Traditional Birth Attendant

VIP----------Ventilated Improved Pit (latrine)

List of Recommendations

Chapter 3: Construction and Maintenance

Recommendation 3.1.

Given the present level of access to health services in Western Province and the lack of operating resources of the health units that exist, the Programme should not embark on the construction of new health facilities until more precise data on population access and facility utilisation have been assembled, analysed and presented to the competent authorities. The alternative use of the available funds to renovate, re-equip and maintain existing health facilities should be considered. In the meantime, the present plans for the rehabilitation of facilities should be implemented.

Chapter 4: Environmental Health and Sanitation

Recommendation 4.1.

In the light of the serious problems being encountered in promoting VIP construction by individual households, a thorough review of objectives and strategies of the EHS component is needed and should be the first and most important task in the component's operational plan for 1991. A position paper on the subject should be produced by June 1991 .

Recommendation 4.2.

The Programme should continue its assistance for VIP latrines in public places.

Recommendation 4.3.

In future sanitation activities, the focus should be on practical methods of assisting the 40 per cent of households without latrines to build standard pit latrines.

Recommendation 4.4.

The Programme should not enter seriously into the difficult area of malaria control until it has first developed a clear strategy for its intervention, preferably after seeking advice from a malariologist.

Chapter 5: Rural Health Services

Recommendation 5.1

The RHS Component should reduce its reliance on seminar-type teaching and evaluate the impact of this training. Greater emphasis is needed on in-service and practical training, follow-up of trainees and other component priorities. The component should aim to spend not more than a third of its staff time on seminars.

Recommendation 5.2

The Programme should maintain the idea of reference health centres and areas for the development of pilot PHC experiences, but only in the context of strict collaboration with DHMTs and working towards the establishment of a single district health plan. The RHS component should support the DHMTs in developing a system of regular and comprehensive supervision of health centres on the basis of checklists. The system should include the centres' curative care (which will require the attention of the Programme's medical officer and the district MoH) and their outreach activities with dependent dispensaries and in communities. Selection of PHC programme priorities should be made with effective community involvement.

Recommendation 5.3.

TBA training should continue to be a priority activity for K-F Programme support, but it needs to be evaluated, paying particular attention to: impact, coverage, training methods, and follow-up and support.

Recommendation 5.4.

The K-F Programme should ensure urgently that:

-- every health facility in the province that undertakes blood transfusion has the equipment, supplies and trained staff to screen for HIV

-- every health facility in the province is adequately supplied with sterilisation equipment and the staff are trained to use it
-- in co-operation with the DHMTs establish a system of support and supervision of staff at all health facilities to ensure the continuing practice of proper sterilisation and sterile techniques.

Chapter 6: Health Service Organisation at District Level

Recommendation 6.1.

The K-F Programme should shift its focus increasingly to promoting the capacity for district health organisation, with particular emphasis on establishing:

-- appropriate and effective structures
-- an effective system of support and supervisory visits
-- a simple system for operational planning
-- provincial support and supervision of the district health structures and processes.

Recommendation 6.2.

A priority task in strengthening the organisation of district health services in Western Province should be the creation as functioning units of the structures that were agreed upon at the 1989 Provincial Health Planning Seminar, particularly the committees for regular province-wide and district-wide coordination.

Recommendation 6.3.

The Programme Manager and the Provincial Medical Officer should investigate funding possibilities to provide legitimate incentives, such as day and over-night allowances, to encourage more frequent support and supervisory visits by provincial and district health staff.

Recommendation 6.4.

The existing understanding that Medical Superintendents would be posted to district hospitals in the K-F Programme area, to allow the Medical Officers of Health time to undertake Programme-related activities, should be implemented for Busia, as it has been for Bungoma. The additional understanding that DHMT membership should be reasonably stable should also be implemented.

Recommendation 6.5.

In order to improve support and supervision of health services in the province, the K-F Programme should work closely with the PHMT and DHMTs to achieve the following:

1. Each member of the PHMT should make a comprehensive support and supervisory visit to each district at least once every three or four months. Some of these visits should be made jointly with other PHMT members.

2. All health centres and hospitals in a district should receive a comprehensive support and supervisory visit at least four times a year. Two or more of these should be joint visits by two to four DHMT members and all members of the Team should take on a fair share of visits. DHMTs should make a timetable of support and supervisory visits to cover three-month periods.

3. A "comprehensive" support and supervisory visit should be one that is planned in advance; uses checklists; takes at least one full day; allows staff time to discuss problems and successes; gives encouragement to the local health workers; and includes some on-the-job training.

4. The province and district HMTs should modify the 1989 draft checklist as necessary to suit their own purposes. It should be used for all visits to improve the impact of the visits and monitor progress.

5. The K-F Programme's Medical Officer should work with the district Medical Officers to organise regular visits to supervise curative care and improve the quality of diagnosis and treatment. at all rural health facilities.

6. It should be policy that when individual HMT members make visits they represent the full team and should make sure that problems outside their immediate areas of responsibility are followed up by colleagues.

7. Health centre staff should carry out regular support and supervisory visits of their own to dispensaries and communities in their catchment areas.

Recommendation 6.6.

The proposal from the Review Workshop to begin district operational health planning in 1992 should be implemented, based on the six-step process described in the 1989 Planning Survey Report. This will allow districts to develop a single yearly plan for

their activities, based on national and provincial policies and their own priorities.

Recommendation 6.7.

The introduction of annual district health planning with community involvement will be an important step towards achieving the main objectives of the K-F Programme. Support for this planning process should be the priority activity for the Programme for the rest of **Phase III.**

Recommendation 6.8.

The following three organisational tasks should be high priorities for the PHMT in 1991:

-- to hold regular PHMT meetings (preferably every two weeks)

-- to make frequent and comprehensive visits to the districts for support and supervision

-- to launch the Provincial Co-ordinating Committee for Health, to bring together the DHMTs, the PHMT and the K-F Programme for two-day meetings every three months, so they can discuss together programmes, priorities, coordination and the joint resolution of problems.

The K-F Programme should assist in implementing these tasks.

Recommendation 6.9.

The K-F Programme should work closely with the PHMT in assisting the district health structure and should help to build up the capacity of the PHMT to play this role. For long-term sustainability, many of the Programme's present functions will have to be assumed in due course by the PHMT.

Recommendation 6.10

A detailed review should be performed of the needs of the District and Provincial HMTs for operating expenditures, in preparation for the planning of a future phase of the Programme.

Chapter 7: Research and Community Involvement

Recommendation 7.1.

The K-F Programme and the four Health Management Teams in the province should give full support to implementing in 1991 the

proposed study on Strengthening Community Involvement in Health Planning: the Case of Western Province in Kenya.

Recommendation 7.2.

When the investigation of community participation in planning is completed, the provincial health system led by the PHMT and the K-F Programme should use the findings to develop policies, strategies and written guidelines for community participation in health, proceed to implementation and monitor progress.

Some Key Issues and Future Prespectives

Recommendation 9.1.

The 1991 Operational Plan should provide for the selection and introduction of a limited number of measurable indicators to monitor impact of the Programme's work.

Recommendation 9.2.

The Programme should introduce a budgeting system broken down according to the component structure, so it will be possible to compare inputs against outputs/impact for each component.

Recommendation 9.3.

FINNIDA should continue to support the project in at least the medium term provided its character becomes truly developmental along the lines of a R&D and Training Centre for health systems management and research.

1 Introduction

1. The Review Mission and its work

The Mission took place in Kenya from 16 October to 2 November 1990 and spent most of its time in Western Province. Three of the Mission members carried out initial investigations and preparatory work before being joined by Dr. Malcolm Segall (the Team Leader) on 26 October.

The participation of Malcolm Segall and Bryan Haddon was part of a long-term contract between FINNIDA and the Health Unit of the Institute of Development Studies (IDS), UK, for support and consultation to the K-F Programme. While the primary purpose of the Mission was to review the Programme, a subsidiary objective was to pursue this supportive role.

The Review Mission thanks the District and Provincial HMTs and the Kenyan and Finnish staff of the K-F Programme for their warm hospitality and enthusiastic cooperation.

The purpose of the mission was to assess the progress and success of the K-F Programme at the mid-term of Phase III, which commenced in January 1989, looking particularly at:

-- long-term sustainability (both institutional and financial)
-- prospects for its integration into the provincial health system
-- progress in community involvement in planning and decision-making
-- any adjustment needed to the objectives and activities and their implementation
-- perspectives after Phase III.

Full terms of reference and the itinerary of the mission may be found in Annexes 1 and 2.

An important element in the Mission's work was a Review Workshop in the final week, with the members of the Provincial and District Health Management Teams (HMTs), the officers of the Kenya-Finland Primary Health Care Programme (K-F Programme), representatives of FINNIDA and the Embassy of Finland in Kenya. Professor J. Oliech, Kenya's Director of Medical Services, participated in the workshop on the second day. The purpose of the workshop was both to gather information and for the mission to provide an opportunity for district, provincial and K-F Programme staff to:

-- review their own activities and progress

-- consider options for the future
-- discuss their analyses and proposals directly with the mission and representatives of FINNIDA and the Ministry of Health.

Nevertheless the views and opinions in this report are solely those of the mission. The programme of the workshop is given in Annex 4.

The mission members from IDS were given responsibility for the overall implementation of the review. Lasse Topo, Project Economist, was asked by FINNIDA to consider the internal management, planning and administration of the K-F Programme, specifically:
-- financing and accounting procedures and activities
-- procurement and tendering procedures and activities
-- personnel management and staff training
-- financial and economic planning of the project
-- financial and economic sustainability of project activities [within the limits of available time].

Mrs. Tuuliki Hassinen-Ali Azzani, Training Specialist, was asked to assess:
-- present strategy and approaches in training in the different components, including selection of target groups and training of trainers and community involvement
-- coordination with existing training organizations
-- community participation [within the limits of time available].

Unfortunately the Government of Kenya was not in a position to nominate representatives to the mission, but detailed discussions were held with Professor Oliech and the Provincial Medical Officer, Dr. M. Kayo.

2. Structure of the Report

As a mid-term review, this report concentrates on identifying and analysing strategic issues for the current work of the K-F Programme, to support its continuing development in Phase III and give some perspectives for the period afterwards. In an attempt to be concise, the report assumes a working knowledge of the K-F Programme in general and the Phase III Project Document in particular.

Chapter two describes the process of preparation for the Review and of the workshop that was part of it. The three subsequent chapters examine the work of the three main Components of the K-F Programme: Construction, Environmental Health and Sanitation, and Rural Health Services.

One of the main objectives of the K-F Programme, namely, strengthening the organisation of the district health services, is considered in Chapter 6. This is followed by an analysis of research activities and of community involvement, both covered in Chapter 7. Chapter 8, by Tuuliki Hassinen-Ali Azzani, examines training and continues the discussion of community development. The final chapter summarises four key issues and presents some future perspectives for the K-F Programme.

The report of Lasse Topo on the K-F Programme's internal managment, planning and administration is presented separately and forms an important complement to this document.

Volume II of this report comprises the 10 reports prepared for the review workshop by the HMTs and the components. The persons directly involved with the K-F Programme's activities present their often insightful analysis of accomplishments, constraints, the impact of their work and issues for the future.

2 The Review Process

This Review has differed from others carried out for the K-F Programme, with respect to both the process it employed and the "*aim for an active involvement of Programme staff plus the Provincial and District Health Management Teams in reviewing progress and developing proposals and strategies*" (Mission Preparatory Documents, Annex 3, p.1.) Here we give only a brief outline of the review process.

In the preparation for the Review, the Mission members from the IDS Health Unit were asked to propose objectives and a methodology. They drew up preparatory documents and proposed a workshop format as the centrepiece of the review process. In summary, the methodology finally employed was as follows:

1. The Programme components and management, and the HMTs, drafted reports of their activities over the review period based on guidelines prepared by the Mission.

2. On arrival, Mission members helped in the finalisation of these reports and carried out their own interviews and investigations.

3. A three-day workshop was held to focus on strategic issues of the Programme. The workshop was managed by the Review Mission itself, to ensure it could extract the minimum information it required to perform its function. The workshop was attended by members of the Programme, the HMTs, the Ministry of Health, FINNIDA and the Finnish Embassy in Nairobi.

4. The Mission prepared its review of the Programme, based on the reports, the workshop proceedings and its own investigations.

The preparatory documents and details about the workshop are given in Annex 3.

The process had a dual function. The primary one was to serve the Review itself, since it provided the Mission with rapid access to detailed, pertinent and analysed data. In addition, the 'cut and thrust' of the workshop discussions allowed the Mission members to deepen their understanding of some of the issues and contradictions involved in the Programme's work.

The secondary - but very important - purpose of the process was promotive, i.e. to use the review as another element of support to the

Programme's work. By requiring the Programme and HMT members to make critical analyses of their work (which was ensured by the guidelines for their reports and the participation of Mission members in the final drafting), the process of report preparation and writing, and the workshop presentations and discussions, advanced the thinking of the main health service actors in Western Province. Indeed, as we will describe, it resulted in the identification of the next steps to be taken on a number of key problems that had been in existence unresolved for some time. The workshop was also an opportunity for Programme and HMT personnel to present their views directly to senior officials from the Ministry of Health and FINNIDA. In summary, this support element of the review process was to contribute to strengthening the analytical and planning capabilities of the Programme and HMT staff. The outcomes should assist them in the preparation of the 1991 Operational Plan and in developing a longer-term view about the future of the Programme.

③ Construction and Maintenance

Situation Analysis

In Phase III the Construction and Maintenance Component is estimated to be consuming 50 - 60 per cent of the Finnish resources allocated to the Programme (1989 Annual Progress Report ; Jan.-Sept. 1990 Financial Statement in Volume II, p. 59.)

At the end of Phase II a number of construction projects were unfinished, but were estimated at the time to be virtually complete (Final Report, Phase II, 1986-1988). It has now become clear that this estimate was overly optimistic. The strategy in Phase II of using labour-only contracts caused long delays in completing construction and also resulted in serious cost control problems. More than a third of the time and budget for construction in Phase III has now been used to complete Phase II projects and some are still not finished. This has meant that the costs of building Phase II facilities have been much higher than originally estimated and there is correspondingly less money available for Phase III building projects.

The K-F Programme has therefore decided to use "full" building contracts for major new works and to limit the scope of Phase III projects. The report of the Construction and Maintenance Component gives further details (see Volume II, p.13-15).

In addition to developing the maintenance capacity of the K-F Programme, a good start has been made in strengthening the Ministry of Health maintenance teams (see Construction Component Report, Volume 13, Page 17). A major drawback however - with implications for long-term sustainability - is the inadequate level of recurrent ministry funding for maintenance, so that the K-F Programme is currently underwriting the cost of this work.

The main issue now for this component is how best to spend the limited amount of money available for building works. A number of new facilities were planned for Phase III. These included four health centres, which are expensive to build, maintain and run. However, at the same time, a large number of rural health facilities in Western Province are in urgent need of renovation, new equipment and maintenance. The question is: is it better to concentrate the available resources on building a relatively small number of new health facilities or to spread the benefit more widely by upgrading the quality of a larger number of existing units?

It was to answer this question that the Programme undertook a survey in 1989 of health facilites in Western Province. The objectives of the survey were to:

"- identify and locate health facilities both Government and NGO
- evaluate and analyse the technical conditions of the same facilities
- analyse accessibility and collect data on the health services given by each health facility
- review and determine criteria used for district selections by visiting the sites and where possible recommend alternatives
- examine and scrutinise the targets and timing of other donor agencies in Western Province in improving health facilities."

The reports of this survey describe the objectives and methods of the exercise, and come to detailed conclusions about the needs for construction works. However, they give scant information about the actual findings of the survey. In particular, the spatial relationship of health facilities to communities is not presented and nor are data given on the utilisation of the facilities. Without such basic information, it is impossible to come to any rational conclusion about the relative priority of new facility construction as opposed to the rehabilitation of the existing health infrastructure.

In the survey reports, the district medical officers refer to the fact that population access to health care in Western Province is relatively good (perhaps more so in Kakamega and Busia Districts than in Bungoma). The biggest problems they see are the lack of operating resources - staff, equipment, drugs and other supplies - as well as the lack of routine maintenance. The result is a health service lacking quality and efficiency. Adding new health facilities to this system might entail spreading recurrent resources even more thinly.

With these opinions of the leaders of the DHMTs and lacking the hard data necessary for the proper spatial planning of health facilities, we conclude that the Programme should exercise caution at this point and not proceed with the construction of new health facilities until the necessary planning data have been assembled, analysed and presented.

Recommendation 3.1.

Given the present level of access to health services in Western Province and the lack of operating resources of the health units that exist, the Programme should not embark on the construction of new health facilities until more precise data on population access and facility utilisation have been assembled, analysed and presented to the competent authorities. The alternative use of the available funds to renovate, re-equip and maintain existing health facilities should be considered. In the meantime, the present plans for the rehabilitation of facilities should be implemented.

4 Environmental Health and Sanitation

Sanitation has been a priority for the K-F Programme since its inception, because of its complementarity with the Kenya-Finland Western Water Supply Programme Project. The main emphasis of the component has been the Ventilated Improved Pit (VIP) latrine.

According to the Phase III Project Document, the component's main objective is to reduce disease transmission by promoting the VIP latrine through:

- building 3,000 demonstration VIPs in public places
- supporting 32,000 households in reference areas to construct VIPs
- assisting districts with VIP promotion.

The Project Document also sets out some general objectives for mosquito control, occupational health, food and drinking water control, spring protection, co-operation with the Water Programme and so on, but these have been seen as secondary to VIP promotion and have received comparatively little attention.

Promoting VIP latrines

The report of the Environmental Health and Sanitation (EHS) Component made for the Mid-Term Review (Volume II, p. 5-7) indicates that in the first 20 months of Phase III 4,429 slabs were cast and 3,759 distributed for household VIPs in the reference areas, while 1,156 demonstration VIPs were built. If activities continued at these rates, the Programme would achieve 92% of its Phase III target for demonstration VIPs, but only 28% of its target for household VIPs (9,000 instead of the projected 32,000). The EHS report states that insufficient funding has been the main cause of this shortfall; the Programme now has the capacity to cast 20,000 slabs per year (Volume II p. 6).

A total of some 11,000 VIP latrines has now been built during the seven years of the K-F Programme. This is equivalent to less than 2.5% of households in the province. If these rates were continued into the future a maximum 5.2% of households would get VIPs (without allowing for the rise in population), because VIPs need replacing about every 15 years. To reach the whole population in the province a minimum of 30,000 VIPs

by who?

how many are used.

would need to be built in 1991 and the number increased by 4% each year.

Aside from the question of the large number of latrines required, the VIP programme has been encountering problems of affordability. Even subsidised VIPs cost a household KSh1,000-2,000, which is in the region of the per capita income in the rural areas of the province (approximately KSh1,500 per year). It is proving very difficult to involve the large number of less-affluent households in building VIPs. In fact, since the beginning of the Programme, only a handful of households have put up VIPs entirely at their own expense.

A significant increase in the number of subsidised VIPs would also raise financial problems for the K-F Programme. Supporting 30,000 new VIPs in 1991 would cost over KSh50 mn, which would be about half the total budget for the Programme in that year. In addition, the policy of direct subsidies to households raises the problem of its doubtrul replicability on a national scale.

Another major concern is that most of the VIP latrines have been built by households which already had a traditional pit latrine (EHS Report, Volume II p. 6). From this it can be concluded that the main impact of promoting VIPs has been to help a small percentage of more affluent households to upgrade their traditional pit latrine to a VIP latrine. The VIP strategy is therefore unlikely to be having a significant effect on the estimated 40% of households in the province with no latrine at all. Moreover the health benefits of upgrading from pit to VIP latrine are not well documented and may not be very substantial.

The current strategy of promoting VIP construction by individual households is thus exhibiting a number of serious drawbacks:

-- only a small percentage of households in the province are being assisted
-- to boost this percentage significantly would be difficult and require a massive budget increase for sanitation activities
-- the cost of a VIP latrine is onerous for most households, even with a subsidy from the K-F Programme
-- the policy of subsidising households for latrine construction is of doubtful replicability on a national scale
-- very few families have built VIPs on their own
-- most Programme support is probably going to more affluent households who are upgrading from a standard pit latrine to a VIP, with possible limited overall improvement to health
-- the current approach appears to have had little effect on the 40% of households in the province with no latrine at all.

A review of the VIP latrine strategy was recommended in the report of the support mission to the Programme in March 1987 (recommendation 8).

Recommendation 4.1.

In the light of the serious problems being encountered in promoting VIP construction by individual households, a thorough review of objectives and strategies of the EHS component is needed and should be the first and most important task in the component's operational plan for 1991. A position paper on the subject should be produced by June 1991 .

This review should be carried out by the staff of the EHS Component, making use of short-term advisers where required. Other responsibilities must not be allowed to interfere with this task.

Despite these difficulties with support to household VIPs, 'demonstration' VIP latrines appear to be serving a useful purpose. They are built at public places such as schools, coffee factories, churches and health facilities, where they improve hygiene and where their technology is also demonstrated to other institutions and to those households who may be able to build them.

Recommendation 4.2.

The Programme should continue its assistance for VIP latrines in public places.

Standard Pit Latrines

There is no mention of standard pit latrines in the Phase III objectives. The EHS Component report to the Mission indicates that families which cannot afford a VIP latrine are encouraged to build an ordinary pit latrine, but without any material assistance (Volume II p. 2). According to the report the proportion of households in the province with pit latrines was 44% in 1984 and is now 60%, with the proportion being 69% in the Programme's reference areas.

While the K-F Programme has doubtless helped to increase the number of pit latrines in the reference areas, environmental staff at the Review Workshop felt that the province-wide increase was largely the result of growing population density (making privacy more difficult) and public health legislation requiring all households to have a latrine.

It was generally agreed at the Review Workshop that sanitation activities need to focus on the 40% of households which do not have any latrine facilities at all. However, effective strategies to reach some of these households will not be easy to find. A substantial proportion will be relatively poor, aged, disabled or living in remoter parts of the province. The Component will need to avoid setting up a diffuse health education campaign that is unlikely to produce tangible results. It should instead

concentrate on researching and developing a well-focused approach to promoting the construction of standard pit latrines by the target groups of households.

Recommendation 4.3.

> **In future sanitation activities, the focus should be on practical methods of assisting the 40 per cent of households without latrines to build standard pit latrines.**

Malaria

In Phase III some plans have been made to buy and distribute mosquito spraying equipment and carry out a survey, but these have not yet been implemented.

Malaria remains one of the most serious health conditions in Western Province, but its control is extremely problematic. The cornerstone in much of Africa is now seen to be early and effective treatment.

The Programme seems to have moved towards involvement in malaria control because of its importance in the area, but without having a clear strategy of what particular role it should play as a developmental programme in this difficult problem. If the Programme wishes to become involved it should first get advice from a national or international malariologist and then propose a clear strategy for action. Given that curative care is likely to be an important part of any such strategy, it may be appropriate to move any responsibility for malaria control to the Rural Health Services Component.

Recommendation 4.4.

> **The Programme should not enter seriously into the difficult area of malaria control until it has first developed a clear strategy for its intervention, preferably after seeking advice from a malariologist.**

Cooperation with the K-F Water Supply Programme

It is reported that the Technical Committe established to link the work of both programmes has been meeting every two months as planned and coordinating a number of specific activities. These include a limited amount of joint community-level education on water and sanitation; production of a joint newsletter and other health education materials; vehicle maintenance; and sharing of resources. This represents an important advance during the last few years.

It had been hoped originally that an extensive initiative in joint community mobilisation would take place on water and health at villiage level. The biggest problem with this (as will be further discussed in Chapter 7 under community involvement) has been the capacity at present of the health services in general and the K-F Programme in particular to support long-term and widespread activities at villiage and sub-villiage level, where the Well Committees are functioning. A related difficulty is that the Water Supply Programme is covering a much greater geographical spread in its direct involvement than the Health Programme. We think, therefore, that the present level of cooperation between the two programmes is more or less appropriate to their current capacities.

5 Rural Health Services

Introduction

According to the objectives for this component, it has responsibility for a wide range of activities, including:

-- improving use of PHC services in the reference areas
-- training health staff
-- community involvement and health education
-- strengthening mother and child care (MCH), including training of Traditional Birth Attendants (TBAs) and Community Health Workers (CHWs)
-- AIDS prevention
-- improving nutrition activities, dental care, school health care and mental health care in the province.

These objectives are ambitious and the component has been able to address only a few of them. The wide range of objectives may also have encouraged staff to focus on training, as this is a relatively easy activity to implement. We will concentrate here on some aspects of training of the RHS component, reference health centres and areas, TBAs and AIDS prevention, because most of the work of the component has focussed on these areas. Chapter 8 looks in greater detail at the training activities of the K-F Programme, including CHW training.

Component training activities

According to the component report to the workshop(Volume II, pp 19-37), some 60 per cent of component staff time during the review period has been spent on seminars/ courses, excluding preparatory and organising time. Over the 20-month period the component held 41 seminars/courses and assisted the districts to hold another 101. That makes an average of seven seminars/courses per month.

In these seminars/courses 12.5% of participants were health workers and the remainder came from the community or other sectors. Traditional Birth Attendants made up the largest group of participants.

The component has been using classroom-style teaching as its main pedagogic strategy. There has been only limited follow-up of training and no assessment of its impact. Chapter 8 examines such activities more fully. However, the point we are making here is that the focus on

seminars has left the component with little time for other activities. Although staff are busy and hard-working, the emphasis on training has diverted them from other important tasks (see below).

Recommendation 5.1

The RHS Component should reduce its reliance on seminar-type teaching and evaluate the impact of this training. Greater emphasis is needed on in-service and practical training, follow-up of trainees and other component priorities. The component should aim to spend not more than a third of its staff time on seminars.

Reference health centres and areas

An important objective of the RHS component is to support the functioning of the five reference health centres and strengthen their capacity to develop PHC activities in their catchment areas with community involvement. So far the main activities in this respect appear to have been the training of CHWs and TBAs. This training will be discussed later, but here we consider this objective of the component more generally.

The original idea behind the reference health centres was that they would be able to develop in their catchment areas innovative PHC strategies, which could subsequently be replicated more widely by the DHMTs. While the Programme was supposed to pay special attention to these centres and areas, it was always to do so in close consultation with - and whenever possible jointly with - DHMT personnel. The reference health centres were to remain an integral part of the district health services under the authority of the DHMTs.

Has this objective been achieved? The Programme has developed PHC activites in the reference areas, but DHMT involvement (at least until recently) appears to have been quite small. It is not surprising, therefore, that there is little evidence as yet of wider demonstration effects. In the workshop DHMT members said that they had often felt by-passed by Programme personnel, who would go to work directly with health centre staff in the reference areas. Programme members admitted that this had occurred, but it was clear that this was a response, at least in part, to a lack of action on the part of the DHMTs. It appears that there has been right on both sides. What is important, however, is that the problem has now been identified clearly and that the situation is improving, with better coordination all round. There was a consensus that the Programme should maintain the idea of reference health centres and areas for pilot developments, provided proper DHMT involvement is achieved and it does not detract from the Programme's ability to support the DHMT's themselves.

The support of the RHS component to the reference health centres appears so far to have been limited in amount and scope. (The activities of

the EHS component have been discussed already.) As mentioned, it has concentrated very much on CHW and TBA selection and basic training, and follow-up visits appear to have been brief and irregular. Little attention seems to have been paid to the overall functioning of the health centres themselves - including the very important function of primary curative care - on which the reputation of the local health service in the community largely depends. We will note in the next chapter that support and supervision of health centres by DHMTs leaves much to be desired. The RHS component should be developing with the DHMTs a system of regular and comprehensive supervision of health centres, based on checklists of activities. In addition to supervising preventive and promotive activities, the system should address health centre diagnostic and therapeutic practices (notably the use of drugs), and this will require the specific attention of the medical officers of both the Programme and the districts. The system should also concentrate on the health centres' outreach activities, both in supervising their dependent dispensaries and in acting directly with communities.

The workshop debated the question of health programme priorities, since it was felt that not all PHC programmes could be given equal weight at the same time. The importance of community involvement in the selection of priority programmes was emphasised, in order that the local population should identify with chosen promotive and preventive activities. Health staff should adopt a consultative style of work and be expected to sound opinions in at least a sample of communities before deciding on PHC priorities.

Recommendation 5.2

The Programme should maintain the idea of reference health centres and areas for the development of pilot PHC experiences, but only in the context of strict collaboration with DHMTs and working towards the establishment of a single district health plan. The RHS component should support the DHMTs in developing a system of regular and comprehensive supervision of health centres on the basis of checklists. The system should include the centres' curative care (which will require the attention of the Programme's medical officer and the district MoH) and their outreach activities with dependent dispensaries and in communities. Selection of PHC programme priorities should be made with effective community involvement.

Traditional Birth Attendants

Pregnancy-related deaths remain one of the major causes of mortality in Kenya, including in Western Province. Although reliable data are not available, it is believed that around 3 to 5 of every 1 000 deliveries ends in the mother's death. As an estimated 80 per cent of deliveries in the province take place at home, the role of the TBAs is clearly crucial.

Training of TBAs has been a major activity of the RHS component for a number of years. The aim of the training has been to raise the hygienic standards of TBAs, improve their ability to recognise risk factors, and increase their referrals of at-risk cases to health facilities.

In Phase II, from 1986 - 1988, 1,134 TBAs were trained in 32 courses. In 1989, 520 were trained in 13 courses carried out in cooperation with the district public health nurses and TBA trainers at the reference health centres. Sixteen courses have been planned for 1990 with an expected output of 535 trained TBAs.

The TBA training course consists of an intensive five-day seminar, held at a training centre or hotel, and is supposed to be followed by a six-month period of supervision by the nearest health facility. The participants are selected with the involvement of the community and come from all around the province, not just from the reference areas. The K-F Programme has also trained a substantial number of health workers as TBA trainers and the courses are well integrated with DHMT efforts in this field.

Assessing the impact of TBA training is not easy. District and K-F Programme staff believe it has contributed significantly to:

- a major reported drop in cases of neonatal tetanus since 1986 in the province (see for example Busia District Report Vol II page 63); while the decrease in neonatal tetanus incidence could have resulted from the immunisation of women with tetanus toxoid, the immunisation coverage rate has seemingly not been high enough to explain it and at least part of the explanation probably lies with the TBA training; this is a very significant impact of the Programme
- increased attendance at ante-natal clinics
- early referral of at-risk pregnant women to health facilities
- a reported reduction in cases of ruptured uteri seen in hospitals
- an increase in the registration of births.

It has also been suggested that TBA training has led to a fall in the number of deliveries at rural health centres, although not at hospitals.

While these reports are encouraging, a major issue which still needs to be addressed is the systematic assessment of the effectiveness of TBA training. The Final Report for Phase II stated that evaluation of TBA training would be carried out in Phase III, but this has not yet been planned or implemented. Four important areas for an evaluation to examine are:

1. **Impact**. It is necessary to assess the effect of TBA training on: their identification and referral of at-risk pregnant women, their delivery practices, maternal and perinatal mortality, and so on.

2. **Coverage**, i.e. What percentage of TBAs have been trained and which ones are not being reached. It seems that no estimates are available of the total number of practising TBAs in the province, so the Programme does not know what proportion has been trained and

how many remain to be reached. this quantification should form the basis for the component's TBA training programme.

3. **Suitability of the training methods**. The current intensive classroom teaching may be difficult for older women with little or no formal education to follow. It is also an expensive training method (participants have to be fed and accommodated), which limits the numbers of TBAs that can be trained and implies problems of long-term sustainability. There are other teaching options and these should be examined e.g. a once a week class for some months held close to where TBAs live.

4. **Follow-up and support**. The development of close links between TBAs and the maternity staff at their nearest health facility should be one of the most important aspects of a TBA training programme. This can only be achieved if there is continued follow-up and support of the TBAs by the nearby staff. It is essential to assess how follow-up activities are working, and to evaluate the effectiveness of the training and written materials for health facility maternity staff who are to support and work with the TBAs.

Recommendation 5.3.

TBA training should continue to be a priority activity for K-F Programme support, but it needs to be evaluated, paying particular attention to: impact, coverage, training methods, and follow-up and support.

AIDS prevention

Wide-ranging objectives were set in Phase III for assisting the districts with AIDS control. These include staff training, preventive education, counselling and provision of equipment. The main activity that has been undertaken so far is the delivery of laboratory equipment and supplies for HIV screening of blood and the training of laboratory staff in diagnostic testing. As a result all three government hospitals in the province can now perform ELISA tests and Kakamega recently became the first Provincial Hospital able to perform Western Blot confirmatory tests.

In the past year a Provincial AIDS Monitoring and Control Committee has been set up with assistance from, and linked to, the National AIDS Control Programme. It will undertake staff training, public education and other activities. The most useful role for the KK-F Programme appears, therefore, to be to supply equipment and train staff in its use.

At present it is of great concern that there are still non-government health facilities in the province which are transfusing unscreened blood. Also sterilisation equipment and practices are inadequate in many health facilities.

Recommendation 5.4.

The K-F Programme should ensure urgently that:

-- **every health facility in the province that undertakes blood transfusion has the equipment, supplies and trained staff to screen for HIV**
-- **every health facility in the province is adequately supplied with sterilisation equipment and the staff are trained to use it**
-- **in co-operation with the DHMTs a system of support and supervision is established of staff at all health facilities to ensure the continuing practice of proper sterilisation and sterile techniques.**

⑥ Health Service Organisation at District Level

The introduction of the PHC strategy in Kenya has led to a substantial increase in district responsibilities over the past 12 years. New initiatives (such as growth monitoring, development of CHWs, TBA training, control of diarrhoeal diseases and acute respiratory infections, and AIDS control) plus long-standing responsibilities (curative services, maternity care, communicable disease control, dental and psychiatric services, and so on) add up to a total of 40 or more different health programmes and services that districts are expected to implement.

By any standards this places highly complex management responsibilities on the districts. It is not surprising they have many problems in shouldering these responsibilities and organising health services effectively. Nor is it surprising that the three DHMTs in Western Province often feel overwhelmed by their tasks -- particularly given the difficult conditions (especially the lack of resources) under which they work.

Nevertheless, as Programme Project Documents and previous reports have pointed out, long-term sustainable development of health care in Western Province depends on effective district-level organisation, above all else. For the first time in the Phase III Project Document, the goal of strengthening the organisational capacity of DHMTs and thereby improving the operation of district health services, was put as a priority objective for the K-F Programme. In our view this was an important and strategic shift of focus.

The first major activity in this direction was the organisation of the 1989 Survey of District Health Planning. This survey investigated the planning work of district health services[1]. The Survey Report (which was revised and adopted by a working group of district and provincial health managers):

-- identified the need for annual operational (as distinct from development) planning in each district; this planning should provide for community participation

Who was invited??

[1]Provincial Health Management Team, District Health Planning in Western Province: 1989 Survey Report, September 1989, Kakamega.

-- proposed a six-step process for achieving this planning capacity
-- identified a number of basic organisational weaknesses that would have to be overcome.

In December 1989 a Provincial Health Planning Seminar[2] was held by the K-F Programme and the PHMT to discuss and follow up the results of the District Health Planning Survey. It was decided that before district annual planning could start, it would be necessary to strengthen the organisational structures themselves: the DHMTs, PHMT, hospital executive committees, district-wide co-ordinating committees, health centre committees, and so on. The second step would be to improve support and supervisory activity. Each district and the province worked out how its own health management team and committees should function, including detailed terms of reference, lists of members and schedules of meetings. They also drew up a plan for support and supervisory visits to all health facilities.

As the respective reports show, the planning survey and seminar started a process by the health management teams of analysing organisational difficulties and identifying measures (with targets) for resolving them. If implemented these initiatives should provide a good framework for running the province's health services more effectively and efficiently.

The Review Workshop was another step in the process of organisational analysis for the HMTs. It looked again at the decisions made and the targets set in the previous year; critically examined what had been achieved in 1990; re-affirmed the importance of having effective district/provincial health structures, and of making effective and regular supervisory visits; and identified certain areas that would require particular attention in 1991.

There are six basic requirements for good district health organisation:

1. **Appropriate and effective structures** (teams/committees etc)

2 **Support and supervisory visits to all health facilities; the visits should be frequent and comprehensive**

3. **A simple system of operational planning** to set work priorities and monitor progress

4. Sufficient **provincial support and supervision of the district structures and processes**

5. **Adequate funding of basic operating inputs**, such as transport, maintenance, supplies, allowances, etc.

6. A measure of **decentralised authority**, sufficient for fulfilling district responsibilities.

---

[2]Ministry of Health (Kenya), Western Province and K-FPHCP, Summary of Seminar Proceedings on Planning district Health Services. December 1989, Kakamega

The first four requirements can be addressed directly by the province and the districts, while the last two call for national-level action.

Recommendation 6.1.

The K-F Programme should shift its focus increasingly to promoting the capacity for district health organisation, with particular emphasis on establishing:

- **appropriate and effective structures**
- **an effective system of support and supervisory visits**
- **a simple system for operational planning**
- **provincial support and supervision of the district health structures and processes.**

We will make more specific recommendations as we review Programme-related activities under each of the above six headings.

Appropriate and effective structures

Significant progress appears to have been made in this area by the Programme over the past few years, but particularly during 1990. DHMTs now apparently exist as real and functioning structures, playing an increasing role in organising and setting directions for the district health services. Three years ago they existed mostly on paper.

At the Health Planning Seminar in 1989, the district and provincial representatives set themselves specific targets to improve the way their teams and committees worked. If achieved, these targets would provide a solid organisational framework for running the health services.

The reports to the Review Workshop indicate that both the districts and the province have fallen short in meeting their targets. None of the health management teams has met as frequently as planned and some committees have not been established. In particular, none of the DHMTs has held co-ordinating meetings to bring together representatives of the various health services in their districts. The continuing lack of DHMT co-ordination with mission hospitals and outlying health facilities is clearly apparent in all districts.

Nevertheless it is important to note that significantly more district meetings were held in 1990 than the year before. In addition the Review Workshop reports and discussions show increasing attention to basic organisational tasks, which should show results in the future. We also observed that the K-F Programme has been strengthening its own organisation in the past year by holding regular Co-ordinating Committee and staff meetings, as well as getting together more with the PHMT. Lasse Topo's report discusses these internal meetings in more detail and makes specific recommendations to improve them (p. 5).

Recommendation 6.2.

A priority task in strengthening the organisation of district health services in Western Province should be the creation as functioning units of the structures that were agreed upon at the 1989 Provincial Health Planning Seminar, particularly the committees for regular province-wide and district-wide coordination.

There are many difficulties that continue to constrain the work of the DHMTs, especially with regard to their district-wide responsibilities. An important constraint is probably low staff morale, related to the erosion of the real salaries of health workers in recent years. A system of incentives in the form of legitimate allowances for supervisory visits should be considered.

Recommendation 6.3.

The Programme Manager and the Provincial Medical Officer should investigate funding possibilities to provide legitimate incentives, such as day and over-night allowances, to encourage more frequent support and supervisory visits by provincial and district health staff.

After the Phase II Mid-Term Review there was an understanding with the Ministry of Health that Medical Superintendents would be posted to Bungoma and Busia District Hospitals, to allow the Medical Officers of Health to concentrate on district-wide work (Kakamega already had a Medical Superintendent by virtue of having a Provincial General Hospital.) These postings were considered to be part of the Kenya Government's contribution to the work of the K-F Programme. A Medical Superintendent has been posted to Bungoma Hospital, but one has not yet been appointed to Busia. Another understanding with the Ministry was the composition of the DHMTs would remain reasonably stable, whereas in fact the turnover of district managers is still quite high.

Recommendation 6.4.

The existing understanding that Medical Superintendents would be posted to district hospitals in the K-F Programme area, to allow the Medical Officers of Health time to undertake Programme-related activities, should be implemented for Busia, as it has been for Bungoma. The additional understanding that DHMT membership should be reasonably stable should also be implemented.

Support and supervisory visits

The 1989 Planning Survey Report and the subsequent Provincial Seminar emphasised the importance of regular support and supervisory visits for all levels: province to districts; districts to health centres; and health centres to dispensaries and the community. At the seminar the DHMTs,

the PHMT and the K-F Programme set themselves clear targets for support and supervisory activities in 1990.

The provincial and district reports at the Review Workshop admitted frankly that both these levels had achieved few of their targets. From what we can understand it appears that in 1990:

- the PMO and his team went out to the districts twice; they did not spend much time in the hospitals and health centres
- few rural hospitals, health centres or dispensaries had more than two or three visits from district-level staff lasting longer than 30 minutes; these visits did not cover PHC activities comprehensively and it does not appear that the district or K-P Programme medical officers are supervising curative care; the DHMTs carried out joint visits to only some health facilities
- there is no evidence of any major change from the 1989 situation when health centres were undertaking little outreach work with dispensaries or in communities
- the draft checklist for support and supervisory visits that was distributed at the Planning Seminar was tried out only briefly in Kakamega District
- the K-F Programme had not yet supplied vehicles to the DHMTs. [It was understood these were to be distributed in December.] All districts reported that transport continues to be a major problem in outreach work.

Recommendation 6.5.

In order to improve support and supervision of health services in the province, the K-F Programme should work closely with the PHMT and DHMTs to achieve the following:

1. **Each member of the PHMT should make a comprehensive support and supervisory visit to each district at least once every three or four months. Some of these visits should be made jointly with other PHMT members.**
2. **All health centres and hospitals in a district should receive a comprehensive support and supervisory visit at least four times a year. Two or more of these should be joint visits by two to four DHMT members and all members of the Team should take on a fair share of visits. DHMTs should make a timetable of support and supervisory visits to cover three-month periods.**
3. **A "comprehensive" support and supervisory visit should be one that is planned in advance; uses checklists; takes at least one full day; allows staff time to discuss problems and successes; gives encouragement to the local health workers; and includes some on-the-job training.**

4. **The province and district HMTs should modify the 1989 draft checklist as necessary to suit their own purposes. It should be used for all visits to improve the impact of the visits and monitor progress.**

5. **The K-F Programme's Medical Officer should work with the district Medical Officers to organise regular visits to supervise curative care and improve the quality of diagnosis and treatment at all rural health facilities.**

6. **It should be policy that when individual HMT members make visits they represent the full team and should make sure that problems outside their immediate areas of responsibility are followed up by colleagues.**

7. **Health centre staff should carry out regular support and supervisory visits of their own to dispensaries and communities in their catchment areas.**

Simple system for operational planning

The capacity of DHMTs to analyse and plan appears to have made considerable progress over the past two years. The teams are now playing a substantial part in preparing the K-F Programme's Annual Operational Plans and the quality of their input has clearly improved. The district reports for the Review Workshop, as well as the Workshop discussions themselves, also reflected the increased ability of DHMT members to analyse constraints and impact, select indicators, and identify important issues and priorities for the future. These abilities are the heart of effective planning.

A major difficulty under which the DHMTs operate is the multiplicity of external demands made on them by various actors, including the different departments of the Ministry of Health, the Provincial Health Department, donors and other agencies. These bodies seldom take account of other agencies' demands on the districts' time. With these pressures it is very hard for the DHMTs to decide and act on **their own** priorities.

One reason why these problems arise is that the DHMTs are not yet producing annual operational plans of their own. If they were doing so, the annual planning process would provide an opportunity to incorporate the programme priorities of other bodies into the districts' activities in a rational and orderly manner.

The demands of the annual planning process of the K-F Programme have also been somewhat disruptive for the districts for the same reasons. However, the Programme planning process has now been adapted to involve districts substantially in selecting their own priority activities each year and we see this Programme involvement as neccessary to bring district operational health planning into existence.

Recommendation 6.6.

The proposal from the Review Workshop to begin district operational health planning in 1992 should be implemented, based on the six-step process described in the 1989 Planning Survey Report. This will allow districts to develop a single yearly plan for their activities, based on national and provincial policies and their own priorities.

The planning process as outlined in the Planning Survey Report provides an opportunity for community involvement in identifying priority health problems and needs. An applied research project of the K-F Programme will investigate in detail how to operationalise this community participation. (It is discussed in more detail in Chapter 7).

Recommendation 6.7.

The introduction of annual district health planning with community involvement will be an important step towards achieving the main objectives of the K-F Programme. Support for this planning process should be the priority activity for the Programme for the rest of Phase III.

Provincial Support and Supervision

The introduction of the District Focus Policy led many Ministries, including Health, to downgrade somewhat the importance of the provincial level. Many of the Head Office departments and health programmes started working directly with the districts and by-passed the province. Funds went directly from national level to the districts.

Over the years, however, the Ministry of Health has begun to reconsider certain aspects of this process. The underlying question is how best to provide adequate support and supervision for the districts. Most national departments do not have the capacity to serve every district in the country satisfactorily -- they are fortunate if they can visit each district once a year.

For the districts there have also been difficulties with this direct link to the centre. In particular they find it hard to deal with the numerous different Ministry departments and sections, who are usually aware only of their own programmes or services. Nairobi often appears remote, communications are difficult, and national staff cannot provide much help with the hundreds of small problems that constantly arise at district level.

The Ministry of Health is therefore becoming increasingly aware of the crucial role that provinces can play in implementing the District Focus Policy. National departments can cope with eight provinces and the provinces in turn are in a position to provide direct support and supervision to their districts. As the provinces are not much involved in

service delivery, they are are in a better position than districts to liaise with the numerous national departments and sections. Provinces can in fact be the major interface between the 'vertical' elements of specific health programmes that start from the national level and the 'horizontal' (integrated) delivery systems located in the districts.

At the moment the PHMT for Western Province is not fulfilling this liaising role effectively. Partly this is because of organisational difficulties similar to those in the districts; partly it is because the province continues to be by-passed by some national offices and its authority is limited; and partly it is because there is a serious lack of funds for provincial recurrent expenses.

To deal with its organisational difficulties, the PHMT set itself a number of targets at the 1989 Planning Seminar and again at the Review Workshop. The reports presented at the workshop indicate that so far the Province has had less success than the districts in reaching its targets. It has not done well in establishing its committees, holding meetings, arranging supervisory visits, appointing a transport or health information officer, and so on. Three tasks are particularly important for organisational effectiveness at both provincial and district levels and need urgent attention. We recommend accordingly.

Recommendation 6.8.

The following three organisational tasks should be high priorities for the PHMT in 1991:

- **to hold regular PHMT meetings (preferably every two weeks)**
- **to make frequent and comprehensive visits to the districts for support and supervision**
- **to launch the Provincial Co-ordinating Committee for Health, to bring together the DHMTs, the PHMT and the K-F Programme for two-day meetings every three months, so they can discuss together programmes, priorities, coordination and the joint resolution of problems.**

The K-F Programme should assist in implementing these tasks.

The 1989 Planning Seminar and 1990 Review Workshop can be considered as examples of how the Co-ordinating Committee might function and how its meetings might help to plan and organise health activities in the province.

When the organisation of the PHMT is stronger, it will be in a good position to take on more responsibilities as the interface between national programmes and the DHMTs. We suggest that the Ministry of Health should then arrange for its national departments and offices, as well as donor agencies, to deal with the Provincial Health Department rather than going directly to the districts.

Recommendation 6.9.

The K-F Programme should work closely with the PHMT in assisting the district health structure and should help to build up the capacity of the PHMT to play this role. For long-term sustainability, many of the Programme's present functions will have to be assumed in due course by the PHMT.

Adequate funding of basic operating inputs

It is not possible for the DHMTs and PHMT to function effectively without adequate funding for transport, vehicle upkeep, supplies, allowances, facility maintenance and other operating items. (The question of health worker salaries is outside the remit of this review.) This funding is of crucial importance for the quality of health care and the operational efficiency of the service. If lack of supervision means that preventive, and curative work at health facilities is done badly, then much of the money spent on salaries, drugs, buildings and so on will be wasted.

The recurrent budgets of the DHMTs and PHMT are presently quite inadequate for them to fulfil their responsibilities. In the short term, the K-F Programme will strengthen district and provincial health organisation by assisting with transport, some supplies, maintenance of facilities and other such inputs. This support is necessary under present circumstances if significant improvements in the health system is to be achieved. Nevertheless it must be recognised for what it is: support to the recurrent health budget of the province.

The character of this assistance will need to be taken into account when the medium- and long-term sustainability of the Programme's activities is considered during the planning for the next Phase. This is **not** to imply that all such support should be ended after the present Phase, but rather that FINNIDA and the Ministry of Health will need to plan a transition to self-sufficiency over a defined period of time.

Recommendation 6.10

> **A detailed review should be performed of the needs of the District and Provincial HMTs for operating expenditures, in preparation for the planning of a future phase of the Programme.**

Some decentralised authority

The question of decentralised authority is a national issue and Western Province cannot be dealt with in isolation. Nevertheless, it needs to be recognised that at present the DHMTs and PHMT are not delegated sufficient management authority for them to fulfil their responsibilities adequately. In practice there are few decisions that they can take on their own, particularly regarding staffing or financial matters, which are central

to the management process. At an appropriate time it will be necessary to consider the responsibilities carried by the different levels of the health service in relation to the decision-making authority they hold for performing their tasks.

7 Research and Community Involvement

Research

Research has always been an objective for the K-F Programme, with a view to studying priority health needs and issues of service delivery in the province. While no major investigations have been undertaken, there has been some success with smaller-scale surveys and other studies. Those that have taken place already in Phase III are listed in the Research Report prepared for the the Mid-Term Review (Volume II, p.46). Among the studies that have been of direct use in the Programme's work have been the EHS Component survey of latrine coverage, the Construction Survey and the 1989 Planning Survey.

A research strategy document was prepared by Plancenter Ltd. in 1989. It left open, however, the question of which options and directions the Programme should take in research. An overall research plan has not yet been developed, although a number of areas have been identified which Programme staff consider important to investigate.

Perhaps the most important of these is a detailed proposal to investigate how community involvement in health planning can be strengthened.[3] The Phase III Project Document recognises that community involvement in "*identifying their own health needs and developing solutions for them*" is a cornerstone of PHC and of government health policy. This proposal puts forward "*a process for examining carefully the practical aspects of how to develop community involvement in health planning. It seeks to build and test an organisational framework for local people to influence the opinions and decisions in district health plans.*" Despite the widespread advocacy of PHC, very few health systems in the world have achieved significant community participation in planning. The study thus aims to address an area of considerable general significance, as well as one of great pertinence to the work of the K-F Programme.

[3]G. Miriti, D.Ogutu, S.Makama, Strengthening Community Involvement in Health Planning: the case of Western Province in Kenya, April 1990 (29 pp.)

Recommendation 7.1.

The K-F Programme and the four Health Management Teams in the province should give full support to implementing in 1991 the proposed study on Strengthening Community Involvement in Health Planning: the Case of Western Province in Kenya.

Other study proposals supported at the Review Workshop were on the subjects of:

-- latrine strategies for the EHS Component(see Chapt.4)

-- the use and accessibility of health facilities in Western Province (see Chapt 3)

-- TBA training strategy for the RHS Component (see Chapt 5, and Volume II p. 97).

While there is widespread enthusiasm for the idea of doing research, staff in the Programme and HMTs find themselves with little time to design or set up studies. Indeed, they are often daunted by the prospect of doing so, especially as they feel themselves untrained for the task. They have tried to obtain outside help, including from research institutions in Nairobi, but so far without much success. The process of initiating and organising research seems to be a difficult task for the Programme in its present form.

The K-F Programme has a full agenda of work for the next two years and it is probably not feasible to do much research beyond what is already planned. If, however, the Programme reduces its direct operational involvement, it may in the future be able to serve more as a centre for research on health and health services in Western Province, and indeed more widely (see Chapter 9).

Community Involvement

The Western Province health system has been facing similar difficulties with community involvement to those encountered elsewhere: it has proved difficult to move from theory to practice, except in a few small areas. Hence the significance of researching into how communities can be involved in health planning, as just described. However, there are other aspects of community participation in which the Programme is engaged, that are also important.

In the Programme the EHS Component has had the most success in setting up community committees. These select the households to receive assistance for a VIP latrine and they then oversee the construction. People can thus see the benefits of community organisation. It is not clear, however, if these committees will continue

once the latrine construction is complete and if they will become involved in other health activities.

It appears that few other health committees are active in the province. Under the District Focus Policy there are meant to be five strata of Development Committees at district, division, location, sub-location and village levels. The 1989 Planning Survey found that "committees below divisional level meet irregularly or not at all." It was originally intended that there should also be a health committee or sub-committee at each of these levels attached to the development committees, but this has been recognised as being unrealistic.

In recent years the main policy in the province's health services has been to encourage health centre committees. These committees are intended to represent the community, but how their membership should be determined has not been defined. Their responsibilities are also not spelled out. Most staff at health centres have seen the purpose of the committees as helping to implement different programmes, such as immunisation and sanitation -- the concept of community involvement in identifying priority problems and determining solutions is not widespread. All of these factors are likely to have contributed to another finding of the Planning Survey that "there are few health committees in existence at present and some of these are not functioning effectively."

It has been suggested that the K-F Programme work with the Water Project to expand the scope of well committees to include health activities. The Water Project has established a large number of these committees around the province. When they investigated this option, K-F Programme staff came to the conclusion that it would not be feasible, because the well committees cover a very small population at village level (usually less than a hundred households) and had been set up for a single, very particular task. Staff felt that there was not currently the capacity in the health services to support or work with committees at such a level, as even dispensaries usually cover dozens of villages.

At present there seem to be few tangible benefits that the people will gain from cooperating with health committees. There is no clear strategy for mobilising community participation in health in the province. Many different types of committees are being tried or have been tried for a variety of different purposes, but with no overall co-ordination and no promising prospects so far of long-term sustainability. This should not be regarded with surprise because, as mentioned, the same situation pertains in most countries.

Community participation is a basic and important principle of PHC which, for successful implementation, usually requires careful investigation, analysis and planning. The research project on community participation in planning may be a useful start in this area. However, the K-F Programme and the provincial health system will need to follow up its conclusions.

Recommendation 7.2.

When the investigation of community participation in planning is completed, the provincial health system led by the PHMT and the K-F Programme should use the findings to develop policies, strategies and written guidelines for community participation in health, proceed to implementation and monitor progress.

The work of the Programme in training CHWs is discussed in the next chapter on Training and Community Development. Here we will limit ourselves to saying that many of the problems that have arisen in connection with the CHW training are because it has been treated as a discrete, almost 'vertical' activity, abstracted from the more general considerations of community participation referred to above. CHWs should arise as a natural consequence of community mobilisation, rather than being grafted on to communities from 'outside' in the absence of a broader community involvement. The current problems of sustainability and remuneration will be approached best in this broader context. They should be re-addressed when study of community involvement has been completed and the provincial health structures are formulating their policies on popular participation. Problems with CHW programmes are widespread[4] and in Western Province have to be resolved in consultation with the Ministry of Health.

[4]Gilson, L., 1990, "National Community Health Worker Programmes" in World Health Forum Vol 11 No. 1 p.85-86.

8 Training and Community Development

Written by Tuuliki Hassinen-Ali Azzani

1. Training Planned

According to Project Document, the following objectives can be identified in relation to training:

Human Resource Development
- to improve the professional qualifications of the health staff and other health workers and to promote their ability to participate in planning and providing Primary Health Care services.

District Focus Policy
- the programme will support districts to implement their Primary Health activities in an endeavour to respond to the needs for training from provincial level downward.

Community Involvement and Health Education
- to create awareness and activities in health and primary health care in communities in order to increase their participation and self-reliance in all the fields of action of the programme.

Construction and Maintenance
- strategies for maintenance of the units upgraded or renovated will be developed by assigning and training specific personnel to each centre.

Management Planning, Administration
- to provide staff training services and prepare a staff training strategy in collaboration with the programme team.

Additional sections of the Project Document give further details regarding training, i.e. 3.3, 3.5, 4.2.3, 4.2.6, 4.2.8, 4.3.2, 4.3.5, 4.3.8, 6.3.2 and the job descriptions of the Project staff.

2. Target Groups

The main groups to be trained, according to the Project Document, are:

Rural Health Services:
- District Health Management Teams, Trainers of Community Health Workers and Traditional Birth Attendants, Health Unit Teams, Community Health Workers, Women groups, Local Health Committees, Teachers, Traditional Healers, Intersectoral groups.

Environmental Health and Sanitation
- Except Public Health Technicians, other groups are not clearly identified. Reference to the training of artisans is done while describing the activities of first phase and in the job description of the Public Health Officer.
  Progress Report identifies the following groups: opinion leaders like party officials, church leaders, village elders, committee members, local artisans (masons, carpenters) women group leaders, Public Health Officers, Social workers, laboratory technicians.

Construction and Maintenance
- technical staff

Management, Planning and Administration
- Programme staff

The above analysis of the objectives and target groups shows that the definition of the objectives and the target groups are in very broad terms.

3. Training Resources

In the programme organisation, there is no training coordinator or officer in charge of the training activities as a whole, but each component is in charge of arranging its own training programmes related to specific component activities. As an example, under Rural Health Services, Community Based Health Care Trainer (CBHCT) coordinates the training of CHWs. Public Health Nurse co-ordinates the training of TBAs with the respective officers in districts and health centres. Since the programme components are to a considerable extent addressing the same target groups, such as committee members, women groups, etc., there is a need to strengthen the coordination between the components to avoid overlaps or gaps and to ensure similar approach in the training. Furthermore, in the present organisational structure, it is difficult to implement systematic monitoring and evaluation of the training activities.

Regarding the cooperation and utilisation of common resources with the water project, the Project Document states that the training centre will be established and equipped with health education material for the joint use of both programmes. Initial steps had been taken to establish the resource centre but the realisation of this goal has not reached its full potential. The development of health education material has lagged

behind due to the time constraints. However, the programme has a well equipped Health Education van which use should be maximised in collaboration with districts and health centres in carrying out other activities such as immunisation campaigns etc.

A new seminar centre has been functioning since October at Sirisia in connection with the Sirisia Health Centre. This seminar centre provides residential accommodation for 30 trainees. The centre will serve the training needs of Moi University Medical Students as well as for community training.

In the past, most of the training programmes had used the private venues such as hotels. Since the venue for the training programmes was transferred to the seminar centre, programme costs have been reduced. Furthermore, the training environment is more appropriate in the seminar centre, since it is located near the model health centre, which can be used for demonstration purposes during the training programmes.

4. Cooperation with other training Institutions

There is a Medical Training Centre in Kakamega which undertakes the training of Nurses, Public Health Technicians and Clinical Officers. The cooperation and the linkage between the programme and the Medical Training Centre has been rather limited so far. Under the Environmental Health and Sanitation component Public Health students have been involved in carrying out surveys related to the sanitation component of the Project.

Visit to the Medical Training Centre and discussions with the programme staff indicated that in the field of nursing there is no well established linkage and cooperation. This is an area which needs to be seriously considered for the future, particularly for the long-term sustainability of the programme benefits. The utilisation of the model health centres as a practical training field for nursing and medical students needs to be further investigated. As accommodation for the students is a key issue, it should be considered whether it would be worth while to renovate some of the old facilities (like Mathayos) to serve as a students' hostel. This would facilitate the use of the health centre for practical training and would transfer the programme benefits on a long-term basis to the health staff.

Cooperation with local universities like Moi University and Nairobi University has also been rather limited. Collaboration with those institutions would be useful in improving the quality and effectiveness of the training, but especially in the area of research. Various research needs related to the programme components were pointed out by the programme staff and the district staff as well. University graduates could be involved in carrying out studies (for their theses) on subjects related to the programme needs.

5. Present situation - Training

There has been a long-standing need for an overall training plan and strategy, which has been pointed out during previous Missions, e.g. Appraisal of Phase III, 1988. The Annual Operational Plan for 1990 states that the training strategy preparation will be started once Finnida issues guidelines for the Project-related training.

At the time of the Review Mission there was no progress in the preparation of training strategy, since the above guidelines had not been received yet. The guidelines would certainly be useful in developing the training plan and strategy, but in the meantime more could be achieved at the programme level in cooperation with the district level organisations. An appraisal of the present situation regarding training and in particular an assessment of the actual training needs, to prioritise the target groups and to establish priority areas is urgently needed.

Regarding the form of training activities seminars and workshops have become by the most dominat form of activity. Most of the training programmes had been implemented in the form of seminars, the duration varying from 1 to 10 days, most being 5 days. The training of CHWs is longest being 10 weeks and training of trainers lasts 3 weeks.

Two of the most essential training programmes for community involvement are the training of TBAs and CHWs. TBA training has already been covered in Chapter 5, and CHW training will be analysed in more detail later in this report.

According to the progress report prepared for the Review Mission, a wide range of seminars have been organised during the past 20 months. As an example, under the Rural Health Services component, 142 seminars have been held with a total number of 4262 participants, from both programme/Provincial level and District levels. This is an average of seven seminars per month. Rural Health Services Component staff have spent about 60 per cent of working time on seminars of which 80 per cent have been for intersectoral and community groups.

Under the sanitation component, 61 seminars have been held during the past nine months for 2777 participants, an average of seven seminars per month. Furthermore, there have been joint seminars with the Rural Health Services, Sanitation component and Water Project as well.

The content of the training programmes covers a wide range of subjects from Primary Health Care orientation to more specific subjects of various components to communication skills.

According to the Budget Control Report, September 1990, the Rural Health Services Component has spent 81 per cent of its total expenses during the period January-September 1990 for training. This is a relatively high figure, but since the breakdown of these expenses is not available, a detailed analysis of the training expenses is not possible. The

respective figure for Environmental Health and Sanitation is 36 per cent. According to the same report the Management, Rural Health Services and Environmental Health and Sanitation Components have spent about 42 per cent of their total expenditure for training out of their total expenses used during the past nine month period.

It was pointed out that the existing allowance policy for training staff has distorted the training priorities and favoured the seminar type of training. The allowance policy appears to be to an issue which needs to be clarified in cooperation with the Ministry of Health and in such a way that both the Health and the Water Project should adopt similar practices concerning the allowances.

Excessive training activities with lack of follow-up on impact is not a new issue, but it has been identified earlier both by the province/district staff and programme staff e.g. Provincial Health Management Team, Survey Report 1989.

6. Training of Community Health Workers

Objectives and Strategy

Based on the PHC philosophy specifying self-reliance of resources and responsibility, the programme has assisted in the training of Community Health Workers (CHW) to strengthen the Primary Health Care services at the village level. A Community Health Worker is a respected community member, a man or a woman, and selected by the community itself for training.

She/He is committed and willing to work as a volunteer and is a key link between the health workers and the community. The role expected to be played by the Community Health Worker in improving the health of the community is quite large, varying from health needs assessment to educator, facilitator, supervisor and change agent in the community. The coverage by one CHW at present is between 50-100 households.

Regarding community mobilisation and participation, CHWs are encouraged to belong to women's groups in their respective villages to maintain effective community involvement and participation.

According to the national guidelines for implementation of Primary Health Care Programme in Kenya, CHWs will be responsible to community leaders or Health Committee and through them to the community. Technical supervision will be carried out by the nearest Health Unit personnel or by the trainers.

Implementation

The training of CHWs takes 10 weeks spread over a period of one year. The methods used in the implementation of the programmes vary from specific courses/workshops to practical work and projects which should

take place in their own village. At the end of the programme simple tests are carried out to measure the impact of the training.

The training curriculum has recently been revised, in cooperation with the District Officers and CBHC trainers. The revised curriculum covers all the major elements of Primary Health Care as agreed in the National Guidelines. Furthermore, there is an effort underway to strengthen the role of CHWs and TBAs in family planning activities and CBD workshops have been organised to prepare CHWs and TBAs to distribute contraceptives in their communities.

During the third phase of the programme, the training of the CHWs has expanded significantly. For example during 1990, 144 CHWs have been trained, compared to 42 CHW s trained during the period 1986-1988.

The selection of CHWs is carried out at public meetings. A large number of CHWs are males. In performing health education and disseminating health information at the village level, the performance of male CHWs has been shown not to be as effective as female CHWs.

It was found that the role and job description of the CHWs is somewhat unrealistic and ill-defined. He/She is expected to work on a completely voluntary basis. On the other hand, the community is expected to provide material support for their work, but that support has been limited. Furthermore, there seems to be high expectation for paid employment among the CHWs after their training.

For the above reasons, the drop-out rate is estimated to be around 20 per cent. Recent studies in Kenya have observed that effective supervision is the most important determinant of whether CHWs continue to work or drop out. Feed-back on performance can be a major motivation for CHWs. Furthermore, since supervision by professional staff is the most expensive component of Primary Health Care, group supervision can be as effective as individual supervision, but more cost effective.

Impact and Usefulness

It was found that there are no follow-up surveys by the programme to assess the post-training performance of CHWs. However, observations by the programme staff indicate that CHWs have contributed positively in raising community awareness of Primary Health Care.

Due to the limited number trained, and smaller number still working (34), the areawise coverage by the CHWs is very limited compared with the whole programme area, and their impact in improving the health of the community remains marginal.

Major Issues

The training curriculum package appears to be too extensive. The selection of a few (3-4) priority areas would be more appropriate with more specific job description and systematic follow-up and supervision by the district/health centre professionals.

Selection process - whether right persons are selected if the community support to them is limited. Should the selection focus more on women? In the selection process, the community should be well informed about the criteria and the job description of CHWs.

The appropriateness and effectiveness of the training might need rethinking. Shorter training cycle would enable closer supervision of the progress. The practical field work period needs even closer supervision by the trainers than the classroom training.

The programme should assess carefully the expansion of CHWs' role in supplying drug and distributing contraceptives at the village level.

7. Staff training

Regarding programme staff training, it is one of the tasks of the personnel administration to be responsible for preparing a staff training strategy. The annual plans for staff training are included in the operational plans. The Annual Operational Plan for 1990 consists of various training courses for staff groups in the country and overseas. However, not all of the overseas training planned for 1990 was undertaken for various reasons.

The programme administration has developed more efficient procedures, computerised the operations, accounting, budgeting, monitoring and stores control, and training was given to staff members in computer programming. Favourable changes were observed in the skills and motivation on the trained staff.

Some of the programme officers have studied at IDS, England, and as a part of this training, officers prepared a project proposal on community involvement in health planning. This proposal will be tested in practice and pilot areas have already been selected in the districts.

Two health education officers had been in Finland to study video editing. Discussions with the Programme management indicate that seniority, work performance and capability to follow further training, had been the main criteria in selecting the staff members for in-country and overseas training.

According to available information, there are local resources for training of management, administration, clerical staff etc., such as the Kenya Institute of Management. Furthermore, relevant training resources are available in the region e.g. Zimbabwe. Most of the staff training goals can be achieved in large part by in-country training, short courses and on-the-job training.

COMMUNITY DEVELOPMENT

Objectives

With introduction of Primary Health Care, the government identified community involvement as a precondition in meeting the national goal. The approach is an integral part of the overall social and economic development of the community. Communities will be responsible for identifying their own health needs and developing solutions for them.

According to Project Document, Community participation and involvement will be given more emphasis during phase III in order to improve sustainability of the activities:

- the communities will be involved in the activities of the programme at all stages of the implementation;
- the actual mobilisation of the communities will be done in collaboration with the respective District Social Development officers, District Primary Health Care Core Teams, Rural Health Centre staff and Water Project.

The above objectives are in very general terms. Regarding specific roles that the community is expected to play as a partner, the following are identified:

- community participation in defining their own priorities in health-related matters;
- role of village development committees to be activated: selection of CHWs, TBAs by the community, ensuring material compensation for their work;
- provision of land, fencing, mobilising the labour for construction, maintain the component and general cleanliness of the environment;
- community participation in spring protection.

Implementation

In terms of actual implementation of the programmes, the Provincial development planning structure consists of various committees at different levels: village/sublocation/location/division/district. How the village proposals and priorities get incorporated into the planning process is a question which is not easily assessed. Furthermore, at the sublocation/village level there are various committees existing like village development, health committee, health centre committee, well committees. According to the information gathered during the Mission, the well committees are more active, while most of the other committees are not functioning actively. Theoretically they are existing. The expected role of the committee members is not always clearly defined and a question was raised regarding the need to re-establish/activate village committees. To implement and sustain any community-based health care programme, there has to exist functional community-level organisations with proper leadership. The Health Centre Committees

have an important role in supporting the maintenance of the health centres.

The level of community participation in Primary Health Care is an issue where considerable scope of further development was identified both districts and programme staff.

However, the Programme has achieved positive progress and supported in initiating the community participation. It has been agreed that community will be prepared before any construction/renovation will take place in the programme area. A social Development officer was recruited two months back, preliminary for a period of four months. She had initiated community mobilisation activities at Bumala location, where the programme intends to renovate the health centre by the end of 1990 or early 1991. So far the response from the community has been positive.

There is a project proposal prepared by the staff members regarding community involvement in Health Planning. The proposal has been discussed with district teams and four pilot areas have been selected to implement the project proposal. This experiment will give useful experience in relation to community involvement in Health planning.

Major Issues

1. The preparation of the basic strategies and guidelines to identify more specifically the role of the community/committees/district/programme in community-based health care programme.

2. To strengthen the function of Health Centre Committees in collaboration with district/health centres in order to support the maintenance of the facilities constructed/renovated.

3. Close cooperation with the Water Project in order to utilise the well committees in the implementation of community level activities.

Recommendations

Training

1. The programme should consider the establishment of a position of training coordinator to strengthen the coordination between the programme components and between the programme and external training organisations. He/She should have access to all components, work in close relation with the Health planning officer.

2. A working group should be established representing the programme and provincial and district levels to assess the present training activities and to draw up an overall training plan and strategy in relation to the annual operational plan. In particular,

the assessment of training needs should be given special attention and monitoring and evaluation procedures should be established.

3. It is recommended that a short-term training consultant visit the programme and advise in preparing the overall training plan and strategy.

4. The programme should strengthen cooperation with the Medical Training Centre in Kakamega. Special attention should be given to the utilisation of the model health centres as a practical training field for the students and sharing of training resources. The practical aspects of this collaboration can be planned jointly between the programme management and the Medical Training Centre.

5. Improved cooperation with Moi University and Nairobi University would improve the training and research activities - as an example, university graduates could be involved in field research relevant to the needs of the programme.

6. Regarding training approach and methodology, the following is recommended:
   - training should be carried out at places as near as possible to the homes of trainees;
   - practical training in field setting should be given priority over class-room teaching and seminars;
   - regular supervisory visits should be made within the Project area by the Health and Programme staff to assess the performance of trained groups such as TBAs, CHWs, etc.

7. The programme should attempt to integrate the Community Health Workers' training with the DHMT through
   - reducing the direct involvement of the programme staff, unless there is a realistic possibility to increase its effectiveness;
   - continuing to provide financial support to District Health Management Team to continue the programme if they can ensure its sustainability.

8. The programme should pay more emphasis to train the trainers to ensure the sustainability of the activities.

9. In relation to the training of programme staff, overseas training should be closely related to the programme activities and priority should be given to relevant training in neighbouring countries. Concerning the future development of the sanitation component of the programme, visiting the Finnida-supported water supply and sanitation programme in Sri Lanka would be useful. Sarvodaya Programme

Community Participation

10. To ensure meaningful community participation the exact role the community is expected to play as an equal partner in health development should be clearly and specifically defined for various

programme components such as: planning, construction, renovation, maintenance of facilities, sanitation programme, etc.

11. It is recommended that the contract of the Social Development Officer be extended in particular to develop basic strategies and guidelines for community involvement in programme activities.

12. Concentration on the reference health centres is recommended in order to build up workable community participation strategies which could be adopted later on in the other areas as well.

13. The well committees could be used as an entry point for programme activities in the community. Instead of forming and re-establishing new committees, priority should be in utilising the existing committees/organisations at the community level.

14. The output of the sanitation programme could be increased by strengthening community participation in support of latrine construction.

Perspectives for the future

Any continuation of the K-F Programme beyond the present phase should see its final transformation into a true developmental project. During a Phase IV the Programme should shed all its responsibilities for direct service provision. It should transfer these responsibilities to the PHMT and DHMTs as appropriate and along with the responsibilities transfer some of its resources (eg. personnel, vehicles). This would be simply the culmination of the process of integration with the province's health services that we have spoken of already in connection with Phase III. This process calls for a greater level of coordination between the Programme and the PHMT than exists at present.

The project - at a reduced level of resources - should then turn itself into a 'Health Research and Development (R&D) and Training Centre'. With this truly developmental role, it would be able to undertake R&D activities in such areas as:

- health planning and management
- health information systems and management
- community involvement in health
- health intervention strategies

and promote pilot developmental projects with the province's health service using the methods of action-research. The project would thereby play a catalytic role and constitute a resource centre that would be able to respond flexibly to the priority health needs of the province. At the same time, the centre should provide post-basic training in health systems management and research. There is also no reason why, once it is established, this resource should not become a national centre for rural health systems R&D and training, being located appropriately in a rural province.

Being, in this form, a purely developmental project, the problem of long-term sustainability is largely solved and we recommend that FINNIDA should continue to support such a project in at least the medium term, although at a lower level of resources than at present.

Recommendation 9.3.

FINNIDA should continue to support the project in at least the medium term provided its character becomes truly developmental along the lines of a R&D and Training Centre for health systems management and research.

themselves. These should include some measures of service output (e.g. immunisation coverage rates) and others of health status (e.g. selected mortality and morbidity rates). The selection and introduction of indicators should be included in the 1991 Operational Plan. The next support mission to the Programme can give some help in this area.

Recommendation 9.1.

The 1991 Operational Plan should provide for the selection and introduction of a limited number of measurable indicators to monitor impact of the Programme's work.

Effective management also calls for the ability to appriase outputs and impact in relation to inputs, i.e. to make an assessment of cost-effectiveness. This is not possible currently with the Programme, because the budgeting system is not broken down according to its component structure. A system of component by component budgeting should be introduced, so it will be possible to compare total resource inputs (including salaries) against outputs/impact. The inputs should include both Finnish and Kenyan expenditures although, since these reflect different amounts of real resources (e.g. because of different salary levels), the two types of expenditure should be kept separate.

Recommendation 9.2.

The Programme should introduce a budgeting system broken down according to the component structure, so it will be possible to compare inputs against outputs/impact for each component.

4. Balance between training and follow-up/support activities

The third phase is seeing a general movement away from formal classroom teaching towards more emphasis on follow-up, on-the-job support and supervision, and assessing the impact of training. There was consensus at the Review Workshop on the necessity to continue and extend this trend.

The detailed review of training in Chapter 8 highlights the need to:

-- assess training needs in relation to priority PHC activities and develop an overall training strategy for the Programme
-- only train where it is the most appropriate response to an identified need
-- improve teaching methods and reduce the proportion of teaching in the form of seminars and courses
-- increase all types of follow-up of training.

When the DHMTs start preparing their own annual operational plans they should also assess their priority training needs and draw up a plan for the year's different training activities.

Annex 1: Terms of Reference

TERMS OF REFERENCE FOR THE MID-TERM REVIEW OF THE III PHASE OF KENYA-FINLAND PRIMARY HEALTH CARE PROGRAMME IN WESTERN PROVINCE OF KENYA (OCTOBER 16 - NOVEMBER 2, 1990)

1. BACKGROUND

It has been agreed between the Governments of Kenya and Finland that the development of health care in Kenya is one of the fields of Finnish support. Subsequently, a Primary Health Care Programme in Western Kenya was initiated. The first phase of the programme was implemented in the Western Province in 1984-1985, and the second phase in 1986-1988. Phase III covers the years 1989-1992.

The development objective of the programme is to improve the health of the rural population in Western Province through improved services according to the guidelines set by the national health policy in Kenya.

The programme is integrated within the existing Kenyan organizational structures through the District Focus Strategy and community participation. The programme strategy also emphasises improvement of planning and reseach activities, support to health cadres both on the district and health centre level, transfer of knowledge and sustainability of all the activities.

The programme works in close collaboration with the Kenya-Finland Western Water Supply Programme, which also endeavours to improve the preconditions of health in Western Province.

The programme is implemented by the Ministry of Health of Kenya, and supported by Finnish experts provided by Plancenter Ltd. The programme is led by a Kenyan Project Manager. The programme is organised into the following components: rural health services, environmental health and sanitation and construction and maintenance. The three components are served by the project management, planning and administrative unit.

The main activities for the development of the rural health services take place through support to the District Health Management Teams by providing training and professional consultation on all fields of primary health care. In addition the programme started action in AIDS-prevention and studies the aspects of occupational health in the area.

The environmental health and sanitation component

improves the hygienic latrine coverage by providing technical know-how, materials and training for latrine constructions, also developing sanitation technology. The health centres are supported in environmental health activities, such as bacteriological control of food and water, mosquito control, spring protection and demonstration of healthy households, carrying out preventive aspects of occupational health in the area, etc.

The construction component continues the renovation and/or replacement and maintenance of existing facilities.

Programme is financed 90 % by FINNIDA and 10 % by the Government of Kenya. The total amount of the FINNIDA programme budget for the four year period 1988-1992 is FIM 75 million.

2. TASKS OF THE MID-TERM REVIEW MISSION

In annual consultations on the Finnish-Kenyan Development Cooperation, held in Nairobi in January 1990, it was decided to carry out a Mid-term Review of the programme in October-November 1990.

The Mid-term Review shall concentrate on reviewing the long-term sustainability (both institutional and financial) of the project activities, when assessing the overall progress and success of the programme. It will also assess the progress made and prospects for integration of the programme into the Kenyan PHC-network, and give its views on measures needed for consolidation after Phase III.

It will also pay special attention to the progress made in community involvement in planning and decision making, following the approach of the Government of Kenya in development of primary health care.

The review shall be based on an assessment of progress made and success achieved in meeting the objectives in different project components, which are described in the Project Document (December 1988), keeping in mind the National Guidelines for Implementation of Primary Health Care in Kenya as the general framework for development of health care in Kenya. In assessment of the Programme the Mission shall analyze the progress made and success achieved, and need for adjustment in objectives and activities of the project and in their implementation within the remaining project period. The mission should consider the project objectives as described in the Project Document, and the project activities listed below, but should not limit

its work on those:

2.1. Rural Health Services

- support to/and link with DHMT (District Health Management Teams) and programme health centers;
- community mobilization and involvement;
- strengthening of MCH (Maternal & Child Health Care) in PHC;
- promotion of improved nutritional status of the target population, and intersectoral collaboration in this respect, especially with MOA;
- promotion of school health programmes, incl. dental care;
- support to the districts in their AIDS-programmes; continuation of the AIDS-component in the programme should be assessed together with the National AIDS-committee;
- assistance to CHWs (Community Health Workers)and TBAs (Traditional Birth Attendants) in support of mental health care in the villages;
- adequacy of the areal coverage of the programme;
- support to improvement of the health status of the most vulnerable groups (women and children).
- development of health indicators and an information system (data collection & analysis).

2.2. Environmental Health and Sanitation

- design & testing of sanitation technologies adoptable to the communities;
- progress in coverage and usage of V.I.P. latrines; affordability to the target population;
- community involvement;
- cooperation with the Finnish supported Water Project and support to the districts in development of environmental health & sanitation;
- progress in related health education; and the appropriateness of the "healthy households" demonstration concept;
- surveys conducted together with the water project on water & sanitation and analysis done on the environmental impact of the programme;
- improvement of spring water quality (in cooperation with the Water Project);
- reduction of malaria and preventive measures applied;
- support to DHMT's in promotion of occupational health.

2.3. Construction and Maintenance

- present strategy and progress;
- survey results & utilisation studies;
- establishment of a self-sustained recurrent maintenance system;

- support to the decision makers in the province & districts in development of a health facility strategy for the Western Province;
- improvement of people's accessibility to health facilities.

2.4. Training

- present strategy and approaches in training in different components, incl. selection of target groups and training of trainers and community involvement;
- coordination with existing training organizations

2.5 Research

- plans and priorities;
- links to programme activities;
- current progress;
- cooperation with national research institutes and universities

2.6. Management , planning and administration

- strengthening district health planning and organisation:
  --implementation of 1989 survey and provincial seminar
  --functioning of district and provincial teams and committees
  --support and supervisory activities;
- financial and economic sustainability of project activities;
- the planning process of the K-F PHC Programme:
  --1991 operational plan: proposals, structures and procedures;
- personnel management and staff training;
- financing and accounting procedures and activities;
- procurement and tendering procedures and activities.

3. MISSION'S SCHEDULE AND MODE OF WORK

The mission will take place in Kenya from October 16, 1990 to November 2, 1990. In Kenya the mission will hold consultations with the Director of Medical Services, the Programme staff, and the Provincial and District Health Management Teams of Western Province, and FINNIDA staff in the Finnish Embassy in Nairobi. It will also hold a joint workshop with all these parties on November 29 - 31 in Kakamega (draft agenda for the Workshop attached). On November 1, 1990 the Mission will hold a final meeting in Kakamega, and on November 2, 1990 a "wrap-up meeting" with MOH in Nairobi. After November 2, 1990 the mission will leave Kenya, and submit its report to FINNIDA and MOH of Kenya by November 25, 1990.

4. COMPOSITION OF THE MISSION

The mission members will be Mr. Malcolm Segall, and Mr. Bryan Haddon of the Institute of Development Studies (IDS) Health Unit, University of Sussex, Mr. Lasse Topo, project economist, and Ms.Tuulikki Hassinen Ali-Azzani, training specialist. Mr. Ilkka Pirinen, Advisor on Health Care, and Ms. Anna-Liisa Kaukinen, Programme Officer, FINNIDA, will join the mission as resource persons. The Government of Kenya will nominate its representatives to the mission.

Mr. Malcolm Segall will act as the mission leader, and will be responsible for the mission's work in Kenya and the final report, to which the other members of the mission will contribute. In the absence of Mr. Segall in Kenya, Mr. Haddon will act as the mission leader.

KENYA-FINLAND PRIMARY HEALTH CARE PROGRAMME PHASE III/
MANAGERIAL AND SUPPORT SERVICES BY INSTITUTE FOR DEVELOPMENT
STUDIES AT THE UNIVERSITY OF SUSSEX

TERMS OF REFERENCE

1. Background

Finland has supported the development of Primary Health Care Services in the Western Province of Kenya since April, 1984.The first phase of the programme was completed in the end of June,1986 and the second phase in the end of December 1988,accordingly.The activities of the Phase III will be carried out during 1989-92.

The programme activities have been revieved in 1984,1985 and 1987.A thorough evaluation was carried out in May 1988.The general progress has been good and the integration into the health care system of Kenya is developing well.

The programme is implemented in accordance with the district focus policy.The main objective is to strengthen the capacity of the local districts in developing the rural health services and improving the environmental health and sanitation in the area.The programme works in close co-operation with the health care personnel of the districts.However there have been problems due lack of adequately trained personnel in planning and management skills.

2. Purpose of IDS services

IDS has supported the programme since its beginning by providing professonial consultancy and revieving the activities.The emphasis has been on the strengthening of the rural health services by analysing the possible hindrances in the programme implementation,finding out solutions to the problems and training the project personnel.The co-operation has been found very useful by all the parties involved and will continue in the phase III.

3. Main tasks

The IDS will support the programme in its overall planning and implementation and carry out following tasks:

1. follow up the overall development of the programme taking into account the objectives of the programme and the emphasis being in the development of the rural health services and environmental health and sanitation components

2. provide the programme with analysis,comments and proposals for the improvement of the activities.
The analysis should mainly be based on the Programme Document,Progress Reports and Annual Operational Plans and support missions to be carried

out as specified in the time schedule attached hereto as an annex.

3. support the programme in carrying out the staff development programme and

4. assist FINNIDA in preparing the Terms of References for the future review and evaluation missions.

4. Personnel

The services of following IDS personnel will be available:
- Dr Malcolm Segall,Senior Expert and
- Mr Bryan B. Haddon,Junior Expert.

Any change in the personnel shall be discussed with FINNIDA.

5. Timetable and reporting

The exact timing of the activities as speciefied in the Plan of Operation will depend on the progress of the project and will be determined by agreemnet between the parties concerned.The IDS shall submit a report to FINNIDA and the Government of Kenya within four weeks of completion of each mission.Also the comments on the operational plans shall be given in the written form.A financial statement on the use of FINNIDA funds shall be submitted by the end of each calendar year.

IDS is not authorised to make any commitments or comments on behalf of FINNIDA.Any solutions arrived at by IDS are subject to further discussion.

David Johansson
Director General

Annex 2: Itinerary and Main Persons Met

14 October - 2 November 1990

	Activities	Persons Met
14/15 November		
	Arrival of T. Hassinen and L. Topo in Nairobi Meeting at Finnish Embassy (TH, LT)	Heidi Serve, M-L. Kiljunen
Tuesday 16		
0700	Arrival of B. Haddon inNairobi	
0800	Meeting at Finish Embassy (BH)	Heidi Serve
1030	Mission meeting, Hilton Hotel	
1330	Meeting at Finnish Embassy	M-L. Kiljunen
1700	Departure for Kisumu and Kakamega	
Wednesday 17		
0800	K-F Programme Meeting	R. Walukano,Project
Mgr		
1000	Joint meeting (BH)	Prov. HMT with K-FPgm
	Interviews (LT)	M. Wahlros,S. Sidaros, M. Blanco
	Interview (TH)	Mrs Kanyoro, Social Planning Officer
1430	K-F PHCP Co-ordinating Committee	R. Walukano and Component Heads etc
Thursday 18		
All Day	Sirisia, Chwele, Bungoma andKabuchai:- community mobilisation activities (TH)	H. Centre Staff, CHWs, TBAs
All Day	Interviews, Main Stores (LT)	R. Walukano,S. Sidaros
1000	Review: Kakamega Report (BH)	Kakamega DHMT
1400	Construction component Report (BH)	K. Lompari, Constr. Mgr J. Efraimsson
Friday 19		
	Moding: Graduation of CHWs (TH)	F. Khanali
	Bungoma: Discussion of Report (BH)	Dr. Odongo &Bungoma DHMT
	Visit to Bukoli, Sirisia and Moding Health Centres (BH)	Health Centre Staff
	Administration component meeting, interviews with Project Manager(LT)	Finance Staff R. Walukano

Annex 2 Mission Itinerary and main persons met

	Activities	Persons Met
Saturday 20		
1000	Mission Meeting (BH, TH)	
1400	Interview(TH)	M. Blanco
Sunday 21		
1000	Mission Meeting (BH, TH)	
Monday 22		
0800	Discussion of sanitation Report (BH)	D. Ogutu and other Component Staff
0800	Interviews: Training Activities (TH)	E. Sagala, S. Walumbe
0800	Interviews: Construction (LT)	K. Lompari
1400	Discussion of Research Report (BH)	Mrs Kanyoro, G. Miriti
1500	Discussion of Planning Report (BH, LT)	G. Miriti
Tuesday 23		
All Day	Busia: Review District Report, Visit to Matayos Health Centre (BH, LT)	Dr. Onyango and Busia DHMT
0800	Medical Training Centre, Kakamega (TH)	S. Ambogo, Tutor, B. Mangera, PNO
0900 Committee	Visit to Bumala Health Centre (TH)	Health Centre
Wednesday 24		
0800	Review of Finance Report (BH, LT)	Finance Staff
	K-F Water Supply Pgm (TH)	T. Tuominan, PM
0900	Family Planning Assoc, Kakamego (TH)	
1100	Planning and Organisation Report (BH)	G. Miriti
1400	Contruction Report (BH)	K. Lompari
1500	Discussion of Project Manager's Report (BH)	R. Walukano
1700	Rural Health Services Component Report	M. Blanco and Component Staff
Thursday 25		
0800	K-F Water Supply Pgm (TH)	R. Häkkinen
1100	PHMT Meeting and review of provincial report	Dr. M. Kayo, PMO, and prov. and Pgm Staff
1300	Visit to Kakamega Prov. Hospital (TH)	Dr. Gondo and Staff
1400	Review Katamega Report (BH)	

Annex 2 Mission Itinerary and main persons met

	Activities	Persons Met
Friday 26		
1200	Arrival of M. Segall in Nairobi Meeting, Ministry of Health Headquaters (MS)	Prof. J. Oliech, Director Medical Services
of		
0800	Visit to Busia District and Matayos Health Centre (TH)	DHMT members and Health Centre Staff
0800	Sanitation Component Interview (LT)	Component Staff
1100	K-F Coorination Group Meeting (LT, BH)	
1400	Visit to District Accountant, Kakamega (LT)	
1400	Project Managers Report (BH)	R. Walukano
Saturday 27		
0800	Mission Meeting	
1000	Meeting of Mission & FINNIDA	A-L. Kaukinen, Dr. I. Pirinen
1500	Interview on Training (TH)	R. Walukano
1700	Interview on Sanitation (TH)	D. Ogutu
1500	Meeting with Financial Staff	M. Wahlroos, S. Sidaros
Sunday 28		
1000 Pirinen	Meeting of Mission & FINNIDA	A-L Kaukien,Dr. R.
Sunday 28 - Wednesday 31	Review Workshop: see Agenda, Annex 4.	
Thursday 1 November		
0900	Interviews: Health Education, TBAs (TH)	J. Kener, S. Walumbe
	Interviews: Financial Accounting (LT)	S. Sidaros, M. Wahlroos
1400	Final meeting with Coordinating Committee	R. Walukano and members
1700	Depart for Nairobi	
Friday 2		
1030	Debriefing with Finnish Ambassador and Staff	D. Johansson
	Meetings, Ministry of Health (MS, TH) B. Haddon and L. Topo depart	
3/4	Departure of M. Segall and T. Hassinen	

Annex 3: Mission Preparatory Documents

PROPOSALS FOR THE

1990 K-F PHC PROGRAMME SUPPORT MISSION

From Bryan Haddon and Malcolm Segall, IDS Health Unit, September 1990

Mission Objectives

Suggestions for the main objectives of the Support Mission are as follows:

-- To review the current activities and progress of the KFPHCP

-- To make recommendations for the remainder of Phase III and put forward some perspectives for the next phase

-- To hold consultations with the Director of Medical Services, Finnida officials, the Programme staff and the Provincial and District Health Management Teams of Western Province, including holding a joint workshop with all these parties.

In the course of its review, the Support Mission will concentrate on examining the Programme's components; training and research activities; and progress in strengthening district health planning and organisation. It will cover the following issues, but not be restricted to them:

1. Rural Health Services:
   -- Programme health centres
   -- target areas
   -- community involvement and CBHC
   -- links with DHMTs.
2. Sanitation:
   -- progress with V.I.P. latrines
   -- affordability
   -- community involvement
   -- cooperation with Water Project
   -- joint health education.
3. Construction:
   -- present strategy and progress
   -- survey results
   -- utilisation studies.
4. Training of personnel:
   -- present strategy and approaches.
5. Research:
   -- plans and priorities
   -- links to programme activities
   -- current progress.
6. Strengthening district health planning and organisation:
   -- implementation of 1989 survey and provincial seminar
   -- functioning of district and provincial teams and committees
   -- support and supervisory activities
7. The planning process of the K-F PHC Programme
   -- 1991 Operational Plan: proposals, structures and procedures.

Mode of operation of the Mission

It is proposed that the Support Mission aim for an active involvement of Programme staff plus the Provincial and District Health Management Teams (HMTs) in reviewing progress and developing proposals and strategies.

The first stage of the Mission would be to assist Programme staff and HMTs to prepare reports on each of the above topics. These reports would analyse objectives, achievements

and constraints over the past 20 months; identify items for discussion; and make proposals for the future (see attached report guidelines).

The reports would be presented at a three-day workshop to review the K-F PHC Programme and consider its future. This workshop should be a consequential event for the Programme. It is proposed that the Director of Medical Services and FINNIDA officials should attend and participate, as well as Programme staff and the Provincial and District HMTs (a draft workshop agenda has been prepared).

Finally the Support Mission would synthesise the workshop results and its own conclusions.

Proposed Timetable

Dates	Days	Activities	Place	Mission members
Tues.16-Fri. 26 Oct.	11	Help the Programme Components and HMTs to prepare reports	Kakamega	Bryan Haddon Ilka Pirinen*
Sat 27, Sun. 28 Oct.	2	Review reports, prepare for workshop	Kakamega	Bryan Haddon Ilka Pirinen Malcolm Segall
Mon.29-Wed. 31 Oct.	3	Workshop to review the Programme and consider its future.	Kakamega	Bryan Haddon Ilka Pirinen Malcolm Segall
Thur.1 Nov.	1	Finalise Mission's conclusions; wrap-up meeting with Programme	Kakamega	Bryan Haddon Ilka Pirinen Malcolm Segall
Fri. 2 Nov.	1	Discussions with Finnish Embassy and Ministry of Health officials	Nairobi	Bryan Haddon Ilka Pirinen Malcolm Segall
up to 25 Nov.	10	Preparation of Mission's report	Sussex	Bryan Haddon Malcolm Segall
*Ilka Pirinen would join the initial preparations as soon as he was available.				

Time requirements for the Mission would be as follows:
Bryan Haddon: 28 days plus 2 days travelling and 5 days preparation
Malcolm Segall: 7 days plus 2 days travelling and 6 days before and after the Mission
Ilka Pirinen: up to 18 days plus travel time.

Prior Preparations

Once the objectives , procedures and timing of the Mission have been agreed upon, it will be necessary for the Programme in Kakamega to:

-- Identify persons who will be responsible for preparing reports and provide them with copies of the report guidelines and workshop agenda.
-- Send invitations to the workshop well in advance to all participants, on behalf of the Support Mission. Participants could include:
  -- Director of Medical Services
  -- FINNIDA officials
  -- PMO and other members of the PHMT
  -- Executive of Kakamega Provincial Hospital
  -- members of the 3 DHMTs
  -- members of the K-F Programme
  -- representatives of the Water Project (for Sanitation session).

GUIDELINES FOR WRITTEN REPORTS

1990 K-F PHCP SUPPORT MISSION

Introduction

A review will take place in October-November 1990 of the Kenya-Finland Primary Health Care Programme in Western Province, to assist the Ministry of Health and FINNIDA to decide on the future of the Programme. This review will be coordinated by a Support Mission, consisting of Dr. Malcolm Segall and Mr. Bryan Haddon of the Institute of Development Studies, UK, and Dr. Ilka Pirinen, Health Adviser to FINNIDA.

Two major parts of this review will be:
- written reports from Programme officers and the Health Management Teams (HMTs) of the province and districts
- a 3 day workshop where the reports will be presented and discussed, attended by the Director of Medical Services, FINNIDA staff, the Support Mission, plus Programme and HMT officers.

Reports required

Seven reports are required from the K-F PHC Programme on the subjects listed below. Under each subject there are proposals for some (but not necessarily all) of the issues that the reports need to cover.

1. Rural Health Services:
   - -- Programme health centres
   - -- target areas
   - -- community involvement and CBHC
   - -- links with DHMTs.

2. Sanitation:
   - -- progress with V.I.P. latrines
   - -- affordability
   - -- community involvement
   - -- cooperation with Water Project
   - -- joint health education.

3. Construction:
   - -- present strategy and progress
   - -- survey results
   - -- utilisation studies.

4. Training activities:
   - -- present strategy and approaches
   - -- impact of workshops and other training.

5. Research:
   - -- plans and priorities
   - -- links to K-F PHC Programme activities
   - -- current progress.

6. Planning:
   - -- implementation of 1989 Planning Survey and provincial seminar
   - -- 1991 Operational Plan proposals, structures and procedures.

7. Programme Overview:
   - -- Overall priorities and strategies
   - -- Component spending compared to budget for 1989 and January to June 1990 (summary sheet of financial analysis).

A report is needed from each DHMT and the PHMT on the following subject:

Strengthening health planning and organisation:
-- implementation of 1989 survey and provincial seminar
-- functioning of district and provincial teams and committees
-- support and supervisory activities

Structure of the reports

Each of the reports should be 4 to 5 pages long and consist of 5 sections:
1. **Plans and objectives** for the past 20 months (from January 1989).
2. An analysis of **achievements and shortcomings**.
3. **Problems and constraints** encountered.
4. **Items for discussion** on the subject at the workshop.
5. **Proposals for the future**.

Preparation and presentation of reports

One person should be responsible for writing and presenting each report (e.g Component Heads, Project Manager, Medical Officers for the Districts and PMO).

A first draft should be finished and at the K-F PHCP offices by 12th October.

From 16th to 26th October two members of the Support Mission (Bryan Haddon and Ilka Pirinen) will review the drafts and give assistance with preparing the final reports.

At the Workshop there will be about 20 to 30 minutes to present a report, followed by an hour or more for discussion (see the agenda).

PROPOSED REPORTING FORMAT FOR THE MID-TERM REVIEW MISSION WORKSHOP TO BE HELD AT GOLF HOTEL KAKAMEGA ON 28\10\90 TO 31\11\90.

The emphasis should be on your analysis of strategic issues, such as the impact and usefulness of different activities, key constraints and ideas for the future.
Reports should be a maximum of 5 typed pages and must be at the K-F offices by 26th October.
Use the following format for your reports:

A. INTRODUCTION.
- Short summary of main objectives and plans.

B. TRAINING.
- Main areas to be analysed include

1. Achievements - include the number of workshops and total participants for
   a. community and intersectrol level
   b. Health personnel

2. Impact (measurable if possible) and usefulness

3. Constraints

C. STUDIES AND SURVEYS.
(Format as per training above: 1.Achievements; 2.Impact and usefulness; 3. Constraints)

D. LATRINE CONSTRUCTION.
Use same format. For 1.Achievements : report totals of:
a. slab and ventilation pipes
b. demostration latrines
c. percentage of households covered

E. CONSTRUCTION/ RENOVATION AND MAINTANANCE.(use same format)
F. OTHER [illegible]PING ACTIVITIES(use same format)
G. PLAN[illegible]NG AND ORGANIZATION.(use same format) This section should be longer. For 1.Achievements include:
a. meetings planned, meetings held
b. committees planned, committees started
c. support and supervision(visits/followups/checklist
e. planning activities

H. FUTURE FOCUS.
1. 3 top constraints for organising district activities and getting health services to work properly
2. 2-3 key strategies for improving health services:
   a. To do yourself
   b. From K-F Programme
   c. From Ministry of Health

Please be realistic!

Annex 4

Agenda for the

1990 REVIEW WORKSHOP OF THE K-F PHC PROGRAMME

28th - 31st, October 1990, Golf Hotel, Kakamega

CHAIRMAN: Dr. Malcolm Segall, Head of the 1990 Review Mission

WORKSHOP OBJECTIVES: To review the current activities and progress of the Kenya Finland Primary Health Programme and to develop proposals for the future.

SUNDAY 28TH OCTOBER

1800 Opening Reception

- Official Opening by Mr. Francis Lekolool, Provincial Commissioner for Western Province
- Workshop participants and invited guests
- Snacks and refreshments.

MONDAY 29TH OCTOBER

0800 Construction Activities of the KF-PHC Programme

- Presentation of report (20 minutes) — Const. Comp.
- Plenary discussion

1000 TEA/COFFEE

1030 Sanitation Activities of the KF PHCP

- Presentation of report (20 minutes) — Sanitation Comp.
- Plenary discussion

1230 LUNCH

1400 Kakamega District Activities with KF-PHC Programme

- Presentation of report (20 minutes) — D.H.M.T
- Plenary discussion

1530 TEA/COFFEE

1600	Bungoma District Activities with KF-PHC Programme	
	- Presentation of report (20 minutes)	D.H.M.T
	- Plenary discussion	
1730	End of Day One	

TUESDAY 30TH, OCTOBER

0800	Busia District Activities with KF-PHC Programme	
	- Presentation of report (20 minutes)	D.H.M.T
	- Plenary discussion	
1000	TEA/COFFEE -	
1030	Support for District Planning and Organization	
	- Presentation of report (20 minutes)	K-F PHCP
	- Plenary discussion	Planning Officer
1230	LUNCH	
1400	Provincial Activities with KF-PHC Programme	
	- Presentation of report (20 minutes)	P.H.M.T.
	- Plenary Discussion	
1530	TEA/COFFEE	
1600	Research Activities of the KF-PHC Programme	
	- Presentation of report (15 minutes)	K-F PHCP
	- Plenary discussion	Dev. Officer
1730	End of Day Two	

WEDNESDAY 31ST, OCTOBER

0800	Rural Health Services Activities of the KF-PHCP	
	- Presentation of report (20 minutes)	R.H.S Comp.
	- Plenary discussion	
1000	TEA/COFFEE	
1030	Overview of KF-PHC Programme	
	- Presentation of report (20 minutes)	Project Manageme
	- Plenary discussion	
1230	LUNCH	
1400	Plenary Discussion: Observations on the Workshop and Policy Issues	
1530	TEA/COFFEE	
1600	Plenary Discussion continued	
1530	*** CLOSING OF THE WORKSHOP ***	

/EK.