PD-ABF-583

MIHV

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January 20, 1993

Rose M. Robinson, Chief
Child Survival and Health, PVC/FHA
1515 Wilson Blvd., Room 729
Arlington, VA 22209

Dear Ms. Robinson:

Enclosed are one original (unbound and one-sided) and four copies double-sided and bound) of Minnesota International Health Volunteer's First Annual Report for our project in Dagoretti. Included with the report are the pipeline analysis, and response to technical comments of the DIP. The A.I.D. Health and Child Survival Questionnaire-1992 was mailed under separate cover in October, 1992.

Your office advised that the report and pipeline analysis be sent together rather than in two separate mailings. As I informed our Project Officer last fall, our accountant in the home office was diagnosed with terminal cancer in September. Our new accountant, who started in October, worked very hard to learn our financial system, continue the day-to-day work of our financial operations, and complete the pipeline analysis (one of the most difficult reports we have to complete for AID). As you know we are a small office with only a part-time accountant; when that accountant is disabled, there is no one who can readily take over the responsibilities.

I apologize if the delayed submission inconvenienced you or your staff in any way. The project is going extremely well, and I believe you will be pleased with the results which are reported herein. Please call if I can provide any additional information.

Sincerely,

Angie G Nelson

Angie Guggenberger Nelson, Ph.D.
Executive Director

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MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS

FIRST ANNUAL REPORT

for

DAGORETTI CHILD SURVIVAL PROJECT

Cooperative Agreement No. PDC-0500-G-00-1076-00
September 1, 1991 to August 31, 1994

Submitted to the
PVO Child Survival Grants Program
Office of Private and Voluntary Cooperation
Bureau for Food and Humanitarian Assistance
United States Agency for International Development

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October 1992

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EXECUTIVE SUMMARY

Steady progress consistent with the strategies outlined in the DIP was made towards project objectives in promotive, preventive, and curative health during the past year. In addition to focusing on children under five and women of reproductive age, concentrated educational efforts have been initiated toward community youth who are perceived to be particularly at high risk for AIDS and STDS. Presentations to school groups especially the critically important pre-teen group have begun. Special video messages are being planned for the Health Center waiting room in the very near future. Additional educational and outreach efforts have been targeted toward men, particularly about AIDS, STDS, and family planning.

Attention to sustainability is a constant theme in project planning and decision-making. Development of new linkages with such organizations as the JSI Inc. Family Planning Private Sector Program, and strengthening of existing relationships with such agencies as the Kenya Ministry of Health have continued to receive project emphasis. In an effort to enhance both the general level of community economics, and the ability of individual Community Health Workers to generate income, the project has been actively involved with the private sector in exploring the construction of jua kali sheds and sanitary markets in the local area. The intent is to apply rental income from these buildings toward ongoing expenses of the community-based health care program. Discussions have been held with other NGOs regarding the introduction of a micro-enterprise loan scheme as well.

The following are highlights of our achievements so far:

ACHIEVEMENTS

1. Eighty additional Community Health Workers completed their initial training making a total of 200 trained CHWs.

2. The Health Center celebrated its first full year of operation serving over 17,000 different individuals.

3. 6000 preventive care visits occurred in the first year averaging 300 family planning visits/month, 227 antenatal visits/month, and 186 child welfare visits/month.

4. By the end of the first year, condom distribution increased from 2000 to 9000/month; over 5000 home visits/month were being made; referrals to the Health Center increased from less than 100 to over 1000/month; and distribution of ORT packets averaged 700/month.

5. Two business volunteers conducted a community needs assessment and local resource analysis for the development of a micro-enterprise development program.

6. A contract was signed with Family Planning Private Sector Program to receive additional family planning personnel, supplies, equipment, and

training for an oral contraceptive community-based distribution training program.

7. A donor has been found to assist with the construction of jua kali sheds (literally meaning "hot sun" or small workshops in the open air) and sanitary market in the community.

8. Ongoing discussions with the Joint Health Committee regarding training for committee members culminated in a formal request from the Joint Health Committee to the Project Director for a "crush (sic) program of training the people who will be able to take over the running of this project after the MIHV's agreed period has expired."

9. Volunteer health workers in the community have organized themselves into small groups, registered with the government, and requested allocation of plots of land on which they are developing small enterprises.

CONSTRAINTS

1. A nutritional and growth study revealed that mothers stop bringing their babies and children for well-baby visits towards the end of the babies' first year. CHWs are being encouraged to track these mothers and refer them to the Health Center.

2. The project often fails to receive the amounts of medicines and supplies which have been specified in the agreement with the Ministry of Health. All too often, personnel and supplies are received which bear little relationship to actual needs. A strategy for meeting regularly with appropriate people in the Ministry of Health and Nairobi City Commission will be continued. Many factors may change in the wake of the imminent multi-party national elections.

3. Power rationing and sporadic power outages have constrained efficient work at the Health Center and project office. Solar energy is being explored as an alternative energy source.

4. Water rationing has also been a problem--it is not uncommon to not have any running water for a week at a time. Additionally, the Health Center has no hot water system of any kind. Rain water catchment tanks have been installed which are filled when the tap is running. Funding is being sought to install gravity-feed roof top water storage tanks and a solar hot water system.

5. The clinic component will not be able to support the community-based health component in its present form as was originally planned. We believe that the curative care can financially carry preventive care services at the Health Center so we can continue to provide free antenatal, family planning, immunization, and growth monitoring services. Discussions with the community will be continued to identify an effective structure or approach to sustain an entrenched community

commitment to maintain and promulgate certain health sustaining ideas and practices.

SUMMARY

The project has developed a self-sustaining core service component, the Health Center, which the community not only strongly supports but retains active involvement in its management. This core service component achieves sustainability through a carefully nurtured public/private partnership, through the support of the Nairobi business community, through good management practices, and through the collection of affordable fees for curative care services. In addition to covering the costs of free preventive care, the collected revenues for adult curative care subsidize the provision of low-cost curative care to young children, and cost-free services to those who are unable to pay. The Health Center provides a continuing resource which can encourage and support community-based health care activities. This focal point combined with the strong health committee network established in the community will be the infrastructure which sustains the project's positive effects in the long-term.

MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS
DAGORETTI COMMUNITY HEALTH PROJECT
1992 ANNUAL REPORT

1. Results in Year One

1.1 Major Results - Please describe the major results (community activities, training workshops, service delivery, etc) the project has achieved in year one. If possible, relate these results to project objectives and intermediate targets.

During year one over 100 Community Health Workers (CHWs) were actively educating families in the Dagoretti community while another 80 CHWs completed their initial training and began providing services. Late in the project year the Health Center completed its first full year of operation during which over 17,000 different individuals were served. During this project year there were nearly 33,000 clinical encounters at the Health Center. Over 6,000 of these were for preventative care. Preventative care visits increased substantially throughout the year. Family planning visits, which totalled over 2,500 for the year, increased from an average of 125 per month during the first quarter to over 300 per month in the last quarter. Antenatal visits averaged 93 per month during the first quarter and 227 during the last quarter for an annual total of over 2,000 visits. Child welfare (immunization) visits, which totalled over 1,800 throughout the year, averaged 122 per month during the first quarter, and 186 per month in the fourth quarter. Monthly totals for preventative and curative visits are presented in Appendix A.

CBHC activities increased dramatically throughout the year. Condoms distributed per month increased from less than 2,000 at the beginning of the year to over 9,000 at year's end. Similar increases were seen in the distribution of foaming tablets and oral rehydration packets. Home visits increased from a few reported each month at the beginning of the year to over 5,000 per month at the end of the year. The same was true for referrals to the Health Center (from 100 to over 1,000 each month) and a variety of other CBHC activities including followups by Community Health Workers, and youth education sessions. Some of these increases can be attributed to a vastly improved reporting system which was developed and implemented over the course of the year.

1.2 Change in Approach to Individual at Higher Risk - During the first year projects should have refined their strategy for reaching high risk individuals. Please indicate any changes that your project has made this past year in the way it identifies and provided services to individuals at higher risk (that is - women with high risk pregnancies, malnourished children or those with chronic diarrhoea or who have incomplete immunization for age).

Basic strategies for reaching high risk individuals have not changed during year one. However, the project's capabilities for reaching high risk individuals have expanded significantly during the past year. The following measures are now being implemented:

The greatly increased number of trained Community Health Workers has enabled us to identify, track, counsel, educate, and refer more high risk individuals. At the Health Center, in addition to increasing the referrals and follow ups by CHWs, a volunteer nurse/midwife has been added to the Antenatal and Family Planning departments. She has been able to significantly increase the range, quality, and quantity of services in these areas.

The CHWs track families who have been identified by Health Center staff or community members as having underweight children and/or low rates of immunizing their children. Outreach is particularly important in our area for measles immunizations because of its relatively low rate of coverage. We are exploring the possibility of an outreach, or mobile immunization program, especially in one sublocation which is farthest from the Health Center.

Children seen at the Health Center with severe or persistent diarrhoea are referred for follow-up by the CHWs. CHWs also supply families with ORT packets (averaging 700 per month) and education as to how to use them. In addition, we are exploring plans with the Ministry of Health for a "diarrhoea corner" at the Health Center. The Ministry would provide the extra equipment and personnel necessary to provide this service, giving more comprehensive care to those babies and children with severe diarrhoea and furnishing health education for mothers at a time when they are most receptive to the diarrhoea prevention and control instruction.

Youth in our communities are particularly high risk. They are in need of education, especially about AIDS/STD, condom use, drug use and general health information. We have begun an educational effort targeting them. CBHC staff and community volunteers (CHWs and TOTs) have begun making educational presentations to school groups. These presentations will especially target the critically important pre-teen group. Additionally, we will include special video messages about youth health issues which will be shown in the Health Center waiting room in the very near future.

We want to increase the number of referrals that clinicians make to the CHWs. Several strategies are being adopted to accomplish this objective. Increased contact between clinicians and the community (including CHWs) will occur as we begin implementing mobile immunization clinics. Clinicians will be given regular feedback on the actual number of referrals per week which have been made to CHWs and encouraged to increase the number. In-service education sessions will highlight specific cases and common situations in which referrals would be appropriate and helpful. CHWs are trained to follow up and assist high risk families who suffer from psychological distress, environmental difficulties and/or physical problems. With emotionally distressed families, the CHWs role includes counselling of family members, visiting them frequently, and giving moral support when necessary. These families are considered as at special risk of experiencing health problems and are particularly targeted for monitoring, health education, and support. We are also educating clinicians about the needs of emotionally disturbed family members, and how their impact on families may cause them to become high risk.

1.3 Staffing - Organizational charts and job descriptions are important demonstrations of (a) good management, and (b) suitable staff selection. List names of senior staff who joined your project in the past year. Attach job descriptions and resumes. Provide an update organizational chart, showing names of key or senior staff, and supervisory relationships.

One new position, an Administrative Assistant, has been added. A job description is attached. As an organization which emphasizes voluntary service, MIHV as a matter of policy and practice rotates most of its senior expatriate staff frequently. Continuity is provided by permanent Kenyan staff and by an expatriate Project Director, Michael Graf, Ph.D. Dr. Graf joined the project in September, 1991. His resume is attached. American physicians serve the program as volunteer Medical Director for periods ranging from three months to one year. Physicians who have served in this capacity during the past year include James Sanders, M.D., Jean Chin, M.D., and William Manahan, M.D. Loyce Jones, RN, Health Center Administrator and Deputy Director for Administration, is a two-year volunteer. Position Descriptions, resumes, and an organizational chart are attached as Appendix B.

1.4 Continuing Education - List all continuing education activities for project managers and staff this past year, including participation in national or regional workshops, or international conferences.

Project managers and staff have attended the following continuing education activities during the past year:

Deputy Director, Administration:	Training of Survey Trainers Baltimore, Maryland (2 weeks)
Medical Director:	International Conference on Infectious Disease Nairobi, Kenya (1 week)
Community Nurse:	Family Practice Training, Nairobi (8 weeks)
Clinical Officer:	Diarrhoeal Disease, Nairobi (1 week)
Laboratory Technician:	Advanced Course, General Lab. Nairobi (8 weeks)
Assistant Administrator:	Certified Public Secretaries Course Nairobi, Kenya (3 hours/week for one year)
Deputy Director Programs:	NCIH Conference Washington, D.C. (3 days)
	Child Survival Conference: Maternal Health Shiprock, New Mexico (1 week)

We have ongoing continuing education for the clinical staff each Tuesday. A complete listing of continuing education topics presented during the past year is found in Appendix C. Presenters at these sessions are nurses, doctors,

medical students, clinical officers, and nutritionists. The clinical staff members also present at these one hour conferences.

1.5 Technical Support - List all technical help the country project received for child survival field activities this past year, including from PVO headquarters or regional office, local for A.I.D sponsored technical assistance.

Connie Johnson and Kate Coleson of the USAID Kenya mission were primary sources of technical support throughout the year. MIHV's Executive Director and Medical Director worked with project staff in the development of the Detailed Implementation Plan during spring of 1992. Lois Miano, Deputy Director for Programs and Project Officer for the CBHC program, attended a USAID-sponsored Child Survival conference in Shiprock, New Mexico and the National Council for International Health (NCIH) conference in Washington, D.C., where she received valuable technical assistance as well. Two business volunteers conducted a community needs assessment and local resource analysis during the summer of 1992 for the development of a micro-enterprise development program. Late in the year the project began to receive some advice and technical assistance from the JSI Inc. Family Planning Private Sector Program (FPPS). As an outgrowth of these contacts, the project expects to become an FPPS sub-grantee during the coming year. Loyce Jones, Deputy Director for Administration, attended a Training of Survey Trainers (TOST) workshop presented by PVO Child Survival Operations Support in Baltimore.

1.6 Community Participation - Identify the number of active community health committees and describe the committees' work this past year to support the CS project. Have these committees met at least once in the past 90 days?

There are three active area health committees, in three locations, who have been meeting at least once every month. The three join together and form one large area-wide health committee, the Joint Health Committee, which also meets once each month. Both individually and collectively, the committees' work during the past year has included:

Discussions of health development issues from their respective areas

Assisting the community in selection of the CHW volunteers

Linking the community and the health project by carrying messages to and from the community and providing feedback

Giving support to the CHWs

Assisting with decision making processes, e.g., fee increases at the Health Center

Discussions of income-generating activities which may contribute to future sustainability of the project

Participating with the CHWs in village health campaigns on environmental sanitation and AIDS

Participation in distribution of condoms in the villages.

1.7 Linkages to Other Health and Development Activities - Please show how the project actually linked child survival to other in-country health and development activities this past year. How does the project cooperate with the government and other groups?

Child survival is fully integrated into a comprehensive community health project which itself is linked to and supported by both the government of Kenya and a variety of other groups. Some of these linkages include:

Ministry of Health. The project receives all family planning supplies and devices, Essential Drug Kits, and clinical staff without charge from the MOH. Deployed staff as of August 30, 1992 included one Clinical Officer, three Laboratory Technicians, and six Enrolled Community Nurses. The number of clinical staff has varied during the year and has included one nutritionist and a maximum of seven enrolled community nurses in addition to the laboratory technicians and Clinical Officer.

All immunization supplies are given to the program at no charge. Immunization activities are coordinated with the Kenya Expanded Program of Immunization

The project has developed linkages with Family Planning Private Sector Program and in October, 1992 signed a contract to receive additional family planning personnel, supplies, equipment and training from them. Under this agreement the project will receive resources to provide an oral contraceptive Community-based Distribution training program for the project area, training resource materials for the Health Center for both staff and patient education, training for clinical staff on family planning methods, and birth control devices and commodities for distribution by the Health Center and the community-based program.

Meetings have been held with the Nairobi City Commission to coordinate health care facility activities in the project area. Three NCC clinics exist within the project area and an offer has been made by MIHV to help in the management of these facilities. Visits have been exchanged and discussions held, but no further progress has been made at this time. It should be noted that the project Health Center was the first in Kenya to employ MOH seconded clinical staff, receive Essential Drug Kits, and still charge fees for curative care. After carefully monitoring the project's success in these cost sharing efforts, all MOH and NCC clinics have now instituted fees for some services.

In an effort to enhance both the level of economic activity and the ability of the Community Health Workers to generate income, the project has been actively involved with the private sector in exploring the construction of jua kali sheds (literally meaning "hot sun" or small workshops in the open air) and sanitary markets in the local area. A donor is available to assist with the construction of such enterprises and the Area Health Committees and Joint Health Committee are working on obtaining appropriate plots of land.

A plan to collaborate with Program for Appropriate Technology in Health (PATH) on an expanded ARI program did not materialize because the PATH grant request was not approved. However, the project continues to consult regularly with PATH representatives and to explore other areas for cooperation. Discussions are continuing with the United States Peace Corps regarding the possible placement of Peace Corps volunteers in the Dagoretti Community.

The project maintains close cooperative working relationships with the African Medical and Research Foundation (AMREF) and with World Vision, frequently calling on representatives of these organizations for consultation and technical assistance. Project staff are active participants in the NGO Network and NGO Coordinating Committee, two organizations with extensive health-related NGO memberships.

2. Constraints, Unexpected Benefits, and Lessons Learned

2.1 Constraints - Identify any problems and/or constraints to implementation encountered since October 1991. Discuss the strategies the project uses, or plans to use, to overcome these constraints.

One constraint, recognized through a nutritional and growth study done nearly a year ago, was that mothers stop bringing their babies and children for well-baby visits towards the end of the babies' first year. This serves as a barrier to completing their immunizations series (measles is the last one administered and has the lowest coverage) and in maintaining appropriate growth monitoring. We are encouraging our CHWs to track these mothers and refer them to the Health Center. They are also following high risk families which are identified by the clinical staff; the clinical staff has increased its referrals to the CHWs. We will strive for 10 referrals per day from the clinicians to the CHWs.

We have a good condom distribution program through the CHWs, but have not had a good way of tracking how often or how appropriately they are used. Through the University of Nairobi Medical School, we have arranged with an OB/GYN resident to complete a study on these factors in partial fulfilment of his residency requirements. We will use the information generated to assist us in addressing the possible incorrect use of condoms.

There is endemic corruption and inefficiency in the governmental and public sector organizations with which we must collaborate and cooperate for comprehensive care. As a result, we often fail to receive the amounts of medicines and supplies that we need. This has sometimes been the case with condoms, foaming tablets, and other supplies as well. All too often, the personnel and supplies which we do receive bear little relationship to our actual needs. Duplicative personnel for whom we have no real need may be seconded to the Health Center, but other critically important positions go unfilled. These problems are exacerbated by the confusing, overlapping, and ever-changing relationships between the Ministry of Health and the Nairobi City Commission.

Our strategy has been to meet as often as we can, and with specific plans, with the appropriate people in the MOH and NCC. We maintain cooperative working relationships with the Nairobi business community (both the Project

Director and the Deputy Director for Administration are members of local Rotary clubs) and with the Member of Parliament from the Dagoretti area. We will continue this strategy, with the awareness that many factors may be changed or influenced by the imminent multi-party national elections.

We have sporadic electricity outages, and have had one long (several months) period of power rationing in which, for alternating weeks, the power was off for entire mornings or afternoons. This obviously constrains efficient work at the Health Center. Our strategy is to explore the use of solar energy equipment, and to concurrently explore possible funds for procurement.

Nairobi continues to experience a severe water shortage. Our water is off frequently. Additionally, the Health Center has no hot water system of any kind. It is common to not have any running water for a week. This is a great inconvenience and deterrent to quality health care. We have installed rain water catchment tanks (which we also fill from the tap when it is running) to help us with this problem, but they are not adequate for our needs, nor do they provide drinking water. Our strategy is to look for funding to install gravity-feed rooftop water storage tanks and to add a solar hot water system.

2.2 Unexpected Benefits - Identify any strategies or methods that have yielded unexpected benefits this past year.

A volunteer midwife has provided unexpected benefits for our community and Health Center by expanding the antenatal and family planning components of our services. This has resulted in a word-of-mouth fuelled increase in the number of mothers and women requesting this service. This increase has also prompted a need for another family planning trained nurse. Increased activity and greater awareness of need levels in this area has lead to the development of a formal subcontractual agreement with the Family Planning Private Sector program which will provide valuable new resources. We are now training another nurse in this area.

An unexpected benefit resulted from an unfortunate incident early in the summer of 1992. A man with many wounds came to our Health Center requesting care and protection. A mob, which eventually swelled to several hundred people, followed him to the Health Center, saying that he had killed someone; they demanded that he be turned over to them so they could kill him, and threatened to burn down the Health Center. Project personnel were able to hold off the mob, eventually get police assistance, and transport the patient to the hospital without loss of life or property. The unexpected benefit from this was twofold: We have increased our security consciousness and security measures including fire escapes. The Health Center and its personnel received much media attention for their quick thinking, courage, and good care. This has resulted in increased confidence in the Health Center from the community, which is now better known throughout Nairobi.

Our cost sharing program and public/private partnership has become a suggested model for Kenya's failing public clinics. We have responded to inquiries from government officials and representatives of donor agencies as to the specifics of our cost recovery activities as well as how our collaborative system might be applied to other health center settings.

2.3 Institutionalization of Lessons Learned - List any lessons the project learned this year. Describe what the PVO is doing to institutionalize those particular lessons.

We have learned to have more specific and measurable goals for our maternal care, as well as the comprehensive services which we already provide. These are outlined in Section 3.2.

We have learned that we have to do better in increasing the percentage of measles vaccinations for our community's children. Ideas of how to implement this objective are listed in Section 1.2.

Our educational and outreach programs need to reach more men. This is particularly important for AIDS/STD education as well as family planning issues. This is already being addressed within the Community Health Program, using staff people and the CHWs in a more individualized way within their neighborhoods. Health education sessions, especially on AIDS/STDS are presented in local centers, both primary and secondary schools, chiefs' offices, and social halls. Men of all ages are already involved in the distribution of condoms, ORT packets, foaming tablets, and other materials, as well as in community education sessions on family health topics. The male youth, however, have not been reached as effectively as we would like.

We need to target the youth in these communities. The CBHC program has already begun this effort by going to area schools and presenting educational programs, teaching the teachers about health issues, and by distributing condoms at the local teenage hangouts.

Our environmental health interventions have been minimal, limited primarily to digging garbage pits, garbage disposal education, encouraging the construction of improved pit latrines, and teaching families to purify their water. The project does not currently have anyone on its staff with needed expertise in the area of environmental health, e.g., protected water supplies, water storage, etc. We are exploring the possibility of having a volunteer spear-head additional efforts in this area. A formal proposal for the placement of such a volunteer has been submitted to Visions in Action, and discussions have been held with the United States Peace Corps Kenya office regarding the possibility of a Peace Corps volunteer filling this role.

We have learned that we do not have the most efficient process for tracking the Tetanus Toxoid immunizations for expectant mothers. We have already reviewed our chart procedures on this matter, and are amending the form so that the immunizations, or lack thereof, are clearly indicated.

We continue to learn and be aware that the programs and relationships that make the biggest difference are initiated and/or requested by the community members. In fact, activities need to come from the community to make those programs meaningful and to ensure ownership by the community. We can continue to improve this area by assisting the communities' leaders to organize, become trained in how to generate income, and work collaboratively with the Health Center in the community. The project provides a high level of non-intrusive support for the health committees. At the time this report was being written,

ongoing discussions with the Joint Health Committee regarding training for committee members culminated in a formal request from the Joint Health Committee to the Project Director for a "crush (sic) program of training the people who will be able to take over the running of this project after the MIHV's agreed period has expired."

The Project Director replied in part:

> "As I pointed out in my contribution to the committee discussion, at least two distinctly different kinds of training are needed in order for the project to be sustained and well managed. One kind of training is that needed by Kenyan employees and adminstrators to enable them to carry out the project's actual day-to-day program administration. Another is the training needed by members of the Board of Management and Joint Health Committee to enable them to oversee and monitor the actions taken by project employees. A third kind of training which may be needed would focus on the management of income-generating projects developed by the Health Committees, Community Health Workers, or other health volunteers."

He went on to note:

> "It is my hope and expectation that by the time U.S. Government funding ends, project management will be carried out entirely by Kenyan administrators. In order for this to occur, it is vitally important that the Joint Health Committee and especially its representatives on the Board of Management, be fully able to carry out their policy-setting, program monitoring, and fiscal oversight functions. This may require additional training for the membership of these bodies. However, I need your help to determine just what training may be needed by the Joint Health Committee and the Board of Management."
>
> "I am well aware that many Joint Health Committee members have extensive experience in leadership, management, and administration. With a membership which boasts the presence of successful businessmen, a former City Commissioner, numerous Ruling Party office bearers, and many others who possess relevant experience, the Joint Health Committee has available to it a considerable reservoir of experience, talent, and expertise. I am hesitant to impose on so august a body my own assumptions as to what training may be needed or wanted by your membership. It would be helpful to me if the Joint Health Committee could indicate the areas in which training is particularly desired. I will be happy to then seek out the resources to make such training available."

Possible topics suggested for the Joint Health Committee's consideration include: functions of advisory and governing boards; community health development policies, principles, and practice; approaches to program

monitoring; understanding and analyzing budgets; starting a small business; and small business management.

The Trainers of Trainers that we originally trained are not working as originally planned. We have learned that for trainers, rather than having politically appointed elders whose interests are in policy direction and control, the TOTs from now on need to receive basic training as CHWs and to have an interest in direct community intervention and care. At the same time, we have come to appreciate the value of and need for training community policy makers.

A hard lesson we are learning is that, in fact, our clinic component will not be able to support the community-based health component in its present form as we had originally hoped and predicted. The financial constraints of Kenya's economy and rate of inflation makes this impossible. We need to be preparing for other means of sustainability for that program. Already the community people are investigating some income-generating activities. We believe that the curative care can financially carry preventive care services at the Health Center so we can continue to provide free antenatal, family planning, immunization, and growth monitoring services. Further, we have learned that with appropriate community support, adult curative care can subsidize care for young children. Although we charge for children's curative care, these charges don't cover the full costs. Higher adult fees help make up the difference.

A principal which requires frequent reminders and reiteration is that our goal is to sustain the project's positive effects, not its personnel or the program itself. Ideally, we would like to leave an effective self-sustaining primary health facility and an entrenched community commitment to maintain and promulgate certain health-sustaining ideas and practices. The former is clearly much easier to achieve than the latter. Ultimately, we need to identify with the community an effective structure or approach which it is willing and able to maintain.

3. Changes Made in Project Design

3.1 Changes in Perceived Health Needs - Please indicate any changes in identification of local health problems since the project submitted its DIP. Cite source of data.

It has been only a few months since the DIP was submitted. There has been no change in the identification of local health problems during that time.

3.2 Change in Project Objectives - Please indicate whether the project has changed any measurable objectives, or set any new intermediate targets since the Detailed Implementation Plan (DIP).

The project is concerned that although comprehensive maternal services are offered, we should have more measurable goals. Intermediate goals that are being added are:

Increase the percentage of women, who had been pregnant in the last 24 months, receiving antenatal care.

Increase the percentage of women of childbearing age who know that they should gain weight during pregnancy.

Increase the percentage of women, who do not wish to get pregnant, who will use modern contraceptive methods.

The need for a mid-term survey has been extensively considered. At present, we do not expect to conduct this expensive and time-consuming exercise. As a continuation and expansion program, the project area has already been extensively surveyed during the last several years. Completing yet another duplicative survey so soon after the last one would divert scarce human and financial resources. However, some consideration has been given to requesting a final one-year extension. Doing so would require that the survey be carried out. The key question before us is whether perpetuation of the project's effects can be reasonably assured by the end of year three and, if not, whether investment of an additional year's resources would appreciably improve those prospects. We are still examining these difficult questions.

3.3 Change in Planned Interventions - Please describe changes from the DIP in the type or scope of the project's child survival interventions, including new services that the project may have phased in this year.

It has been only a few months since the DIP was submitted. There has been no change in planned child survival interventions during that time.

3.4 Changes in Potential and Priority Beneficiaries - Please indicate any changes made by the project in the location, or number, or prioritization of services to potential beneficiaries of project services (infants 0-11 months, children 12-59 months, women of reproductive age) since the project submitted its DIP.

It has been only a few months since the DIP was submitted. There has been no change in primary potential beneficiaries of project services during that time. However, in addition to focusing on infants 0-11 months, children 12-59 months, and women of reproductive age, the project has increased its focus on young men. This is especially the case with regard to family planning messages and to the prevention of HIV/AIDS and other STDs. This change is justified both by the influence that these young men have on the behaviour (and resultant health status) of women of reproductive age, and by the threat posed to women and children by the unchecked spread of STDs in the community.

4. Progress in Health Information Data Collection

4.1 Characteristics of the Health Information System

4.1.1 What is the health information system at the community or clinic level to maintain records on the family or on the individual?

At the clinic level, each individual has a card which is kept in the Clinic. The antenatal patients also are given a copy of their card after each visit so they have an up to date copy with them in case they need to go to a hospital or other provider. At the community level, there are 220 Community Health Workers who have unwritten records on the health status of the ten families of whom they are in charge. If each family averages just seven people per household, the CHW's have information on the health status of over 15,000 individuals in the community.

4.1.2 Is the system useful for identifying and directing services to the high risk women or child? Has the project made any changes in the system this year?

The health information system for the children includes the "Road to Health" Ministry of Health cards which graph weight for age. Any abnormality is then logged for follow up by the nutritionist and by the CHW. Each patient room also has a form allowing the nurse or Clinical Officer to refer any child (or woman) to the CHW for follow up of any other problem such as illness, social, or economic problems. Also, with regard to women, our antenatal and family planning rooms are adjoining so the pregnant women work with the same staff that will be seeing them after the pregnancy regarding family planning. The family planning information is introduced to the women during their antenatal visits. The most significant change in the health information system this past year is about to occur now. Many months have been spent obtaining audiovisual equipment and appropriate films which will be shown in the waiting room to all of our patients. These films will focus on women's and children's health problems. Another change in the record system (which is not quite completed) is to have a more comprehensive antenatal card. This card will include questions to help identify the high risk pregnant women, and help assure more comprehensive antenatal care (with blanks for such things as tetanus shots, urines, blood pressures, weights, and hemoglobins).

4.1.3 Does the project report clinic activity, such as type and number of clinic sessions held? Has the project made any refinements in the clinic activity reports this past year?

Yes, the project does monthly reports on the type and number of clinic sessions held. Most of these reports are sent to the Ministry of Health via the Provincial Nursing Officer. Specialized reports, such as those relating to immunizations, are routed to Kenya Expanded Program on Immunization offices. Additionally, copies of some clinic activity reports are forwarded to the local USAID office. Some refinements in the reports this year have included a monthly analysis of the distribution of patients by age, disease, reason for visit, and whether the visit is for curative, preventive, or follow

up care. This data has been helpful for future planning regarding staffing distribution, ordering supplies and drugs, and budgeting.

4.1.4 What is the system for reporting the activities of Community Health Workers? How has project management used these data this past year?

Once each week CHW team leaders, known as CHW Representatives, report to the CBHC program head or her assistant. The data they collect from their CHW team members and report to the project includes: number of home visits, referrals to the Health Center for treatment and preventive services, new births in the community, deaths, especially those under two years of age, and any new antenatal referrals.

This data is used to determine who needs continued follow up, how many visits and referrals are actually being made, what CHWs may be in need of encouragement or especially deserving of praise, how many condoms, foaming tablets, and ORT packets are actually being distributed through the visits, and any possible trends that may be detectable.

4.2 Special Capacities of the Health Information System

4.2.1 Does the project monitor service standards such as number of schedule clinic sessions actually held? Please give examples.

The project offices are located in the clinic building so there is constant though unofficial monitoring of all clinic sessions. Every week a one hour meeting is held which includes the Medical Director, the Clinical Officer, and the nurses. The discussions held are intended to update nursing skills and improve patient management.

Every morning fifteen minutes are spent discussing work distribution and any professional issue which might have arisen the previous day. A more extensive senior staff meeting is held weekly, and the senior staff meets monthly for consideration of specific topics which require extended discussion. There are also monthly general staff meeting held which offer an overview of the month's activities.

4.2.2 Does the project monitor any sustainability indicators such as percent of trained community health volunteers still active? Please give examples.

A wide variety of sustainability indicators are monitored through supervisory reporting, attendance at regular CHW meetings, continuing education sessions for the CHWs, and the monthly CBHC activity reports. These measures indicate that around 80% of the originally trained CHWs still identify themselves as CHWs and carry out community health activities.

4.2.3 Does the project detect and investigate cases of acute paralysis in children less than age 15? Do any carry out other case-finding, or active surveillance activities?

The MOH requires reporting of the following conditions: Meningitis, Poliomyelitis, Measles, Whooping Cough, Tetanus, Diphtheria, and Tuberculosis. The MOH is then responsible for follow up.

Cases of marasmus and kwashiorkor detected in the clinic are logged and followed by the Community Health Workers. When necessary, the CHWs refer back to the Clinic. Community Health Workers also monitor and refer severe diarrhoea cases to the Health Center.

4.2.4 Does the project monitor hours of pre-service and continuing education training of Community Health Workers?

Scheduled meetings of selection, orientation, and training are all monitored in the Community Health Education Office. Continuing Education training is also recorded as to how many hours and subjects covered.

4.2.5 Which data have been the most difficult for your project staff to collect this past year, and why?

The most difficult area to track is our referral systems from CHWs to the Health Center and from the Health Center to Community Health Workers. Many times this is done by word of mouth and not always written, though Health Center referrals are supposed to be on the patient's chart. We have mentioned this area in other sections of this annual report and we will work on this mutual referral system during the next year.

4.3 Management of the Health Information System

4.3.1 What proportion of your expenditures since October 1991 has been spent on the project's health information system? What did the costs cover?

Data collection and dissemination are so deeply integrated into all aspects of the program that specific cost allocations are essentially impossible. A reasonable estimate, however, might be around 10%. These costs would cover the printing of health cards, employment of Health Center clerks, a portion of all administrative salaries and expenses, postage, copying, etc.

4.3.2 Please give the date of the last time your project reviewed its indicators. Did the management make any decisions based on these data?

The Health Center Board of Management meets once every month and reviews the month's financial and daily attendance records as well as the activities of CHWs and CBHC staff. The attendance records provide a breakdown and analysis of curative visits, child welfare, family planning, and Antenatal visits on a monthly basis. The Board of Management recently used this financial and patient flow data to make decisions on adjusting the Health Center fee structure for the 1992/93 fiscal year. The Joint Health Committee meets

monthly as well. At each meeting, the Joint Health Committee receives a report which includes many of the project indicators. Many of the indicators listed below must be reported to the Ministry of Health or some other agency as well.

The following indicators are reviewed and reported monthly:

Number of sessions and participants and topics covered at youth education sessions.

Number of sessions and participants and topics covered at patient education sessions.

Number of home visits by CHWs.

Number of Supervisory home visits by TOTs.

Number of Supervisory Home visits by CHW representatives.

Number of supervisory home visits by the health team.

Number of patient referrals to the Health Center by CHWs.

Number of patient referrals by Health Center staff to CHWs.

Number of meetings and attendance by CHWs.

Number of meetings of Joint Health Committee.

Number, location and attendance at area Health Committee meetings.

Number of ORT packet distributed by sub-locations.

Number of condoms distributed by sub-locations.

Number of foaming tablets distributed by sub-location.

Number of curative, child welfare, antenatal and family planning visits to the Health Center by day and total for month.

Pharmacy activity.

Income and expense statement for the Health Center including year-to-date information exclusive of CHW program expenses.

Mortality and morbidity report for all visits to Health Center.

Type and volume of laboratory tests performed at Health Center Lab.

Type and volume of immunizations given, including tetanus toxoid.

Type and volume of family planning devices and supplies utilized or dispensed at the Health Center.

Number of children weighed and those needing follow up.

Number of patients new to the Clinic.

The various sub-location activity reports are used by the Community-based Program Directors to plan strategies for community involvement. The Health Center income and expense reports and attendance indicators are shared with the Board of Management monthly to aid in both short and long term planning. Types of procedures, immunizations, etc are shared quarterly for review and decision making.

4.3.3 Please give the date(s) of the last time(s) your project shared health information with the people who collected the data, with health workers, with the MOH, and with community members.

The project provides regular (monthly) reports to the MOH and to community members via the health committees and the Health Center Board of Management. However, the project has failed to regularly and systematically share the health information it collects with the clinical staff, support staff, and community volunteers who collect it. This oversight will be addressed and corrected in the coming year.

Ministry of Health - 15 October, 1992

Community members:

Board of Management representatives - 8 October, 1992
Joint Health Committee - 25 September, 1992

4.3.4 Who are the persons responsible for collecting, compiling, analyzing, and monitoring the quality of data?

Health Center staff share in data gathering with each nurse, Clinical Officer, nutritionist, and lab technician responsible for keeping daily activity records. Clinic management has the overall responsibility to monitor and analyze the data. Appropriate information is shared with the Board of Management and the Joint Health Committee.

Community-based activities are collected by CHW team leaders and CBHC staff. It is compiled by the CBHC Assistant Project Officer. Analysis and quality monitoring are carried out by the entire senior staff with the Project Director and Deputy Director for Programs assuming primary responsibility.

4.3.5 What is your project doing to improve the staff's skills in data collection and management?

Clinic staff have recently been included in a review of all data collected to understand how it is used and the necessity for collecting accurate data. Administrative staff are learning to use desktop computers, starting with

basic word processing. Project computers include Lotus 1-2-3 and other software which key staff members will learn to use. At a more basic level, data management training has included the introduction of filing systems and standardized reporting practices.

5. Sustainability

5.1 Recurrent Costs

5.1.1 What specific recurrent costs will continue after A.I.D Child Survival funding ends? Please note the total amount in dollars needed to cover such recurrent costs.

Recurrent costs for the program as a whole which will continue after A.I.D. Child Survival funding ends include personnel costs, facility expenses, vehicle expenses, supplies, and miscellaneous. By far the largest proportion of these costs are associated with the Health Center operation: the facility itself, a full cadre of clinical, administrative, and support staff, medications, immunization and family planning commodities, medical and non-medical supplies, insurance coverage, etc. Costs associated solely with community screening, education, outreach, referral, follow up, distribution of family planning commodities and oral rehydration preparations, and other CBHC activities are relatively modest by comparison. However, virtually all recurrent costs associated with the Health Center operation are currently being met through cost recovery mechanisms (fee-for-service curative care) or by well established supports from the Kenyan Ministry of Health, e.g., provision of seconded clinical staff, immunization supplies, Essential Drug Kits, etc. By contrast, there are few Kenya government inputs into the program's community aspects and cost recovery efforts for CBHC activities would not be justified by the revenues likely to be produced. Finally, it does not appear likely that the Health Center can generate sufficient revenues to cover both its own costs and those of the CBHC program as well.

Recurrent program costs will include the following:

DAGORETTI COMMUNITY HEALTH PROJECT
PROJECTED MONTHLY RECURRENT EXPENDITURES

COSTS (PER MONTH) WHICH ARE AND WILL BE PAID (IN-KIND) BY THE MOH

Employee Expenses			
Clinical Officer	Ksh	7,000	
Community Nurses (6)		24,000	
Laboratory Technicians (2)		8,000	
Nutritionist		3,500	
Total Employee Expenses			**Ksh 42,500**

Medical Expenses			
Essential Drug Kits	Ksh	44,000	
ORT Packets		2,000	
Condoms		7,500	
Spermicidal Foaming Tablets		????	
Total Medical Expenses			KSH 53,500

TOTAL MOH RECURRENT MONTHLY (IN-KIND) CONTRIBUTION	KSh 96,000
TOTAL MOH MONTHLY CONTRIBUTION @ KSh 32 per dollar	$ 3,000
PROJECTED ANNUAL MOH CONTRIBUTION	$36,000

MONTHLY RECURRENT COSTS WHICH ARE AND WILL BE PAID BY THE COMMUNITY VIA HEALTH CENTRE CURATIVE CARE FEES

Employee Expense			
Salaries	Ksh	30,000	
Payroll Tax		5,000	
Transport Allowance		11,500	
Other Allowances		4,500	
Total Staff Expense			51,000
Office Expense			
Office Supplies	Ksh	2,500	
Telephone & Fax		2,000	
Insurance		1,500	
Bank Charges		100	
Sm Eqpmt, Furniture		200	
Total Office Expense			6,300
Staff Expense			
Uniforms	Ksh	1,000	
Tea Break		1,500	
Other		500	
Total Staff Expense			3,000
Medical Expense			
Consum, Non-drug	Ksh	16,000	
Drugs		25,000	
Sm Equipment		200	
Rprs, Maintenance		200	
Other		600	
Total Medical Expense			42,000
Laboratory Expense			
Consumable Supplies	Ksh	2,000	
Total Laboratory Expense			2,000

Facility and Grounds			
General Supplies	Ksh	2,400	
Small Equipment		100	
Electricity		2,300	
Rprs and Maint		1,300	
Water		100	
Insurance		1,500	
Total Facility Expense			7,700

TOTAL RECURRENT MONTHLY COSTS COVERED BY HEALTH CENTRE FEES	KSh 112,000
TOTAL MONTHLY HEALTH CENTRE FEE CONTRIBUTION @ KSh 32 per dollar	$ 3,500
PROJECTED ANNUAL HEALTH CENTRE FEE-FOR-SERVICE CONTRIBUTION	$42,000

RECURRENT MONTHLY COSTS, CURRENTLY PAID WITH USAID FUNDS, FOR WHICH A SOURCE OF SUPPORT HAS NOT YET BEEN IDENTIFIED

CBHC Staff Salaries/Benefits			
Wages	Ksh	25,000	
Payroll Taxes		5,000	
Total CBHC Salary Expense			30,000
Office Expenses			
Office/Gen Supplies		20,000	
Repairs/Maint.		500	
Printing		1,000	
Total Office Expense			21,500
Staff and Training Expenses			
Workshop		600	
Training Supplies		600	
Uniforms		400	
Training, Other		8,000	
Total Staff Trng Expense			9,600
Vehicle Expenses			
Petrol, Oil		10,000	
Parking		500	
Repairs, Maintenance		3,000	
Insurance		3,000	
Total Vehicle Expense			16,500

TOTAL UNMET RECURRENT MONTHLY EXPENSES (CURRENTLY PAID BY USAID)	KSh 77,600
TOTAL UNMET MONTHLY EXPENSES @ KSh 32 per dollar	$ 2,425
PROJECTED UNMET ANNUAL PROGRAM EXPENSES	$29,100
TOTAL PROJECTED RECURRENT ANNUAL PROJECT COSTS	$107,100
RECURRENT ANNUAL COSTS TO BE BORNE BY THE COMMUNITY AND MOH	$ 78,000
PROJECTED UNMET ANNUAL PROGRAM EXPENSES	$29,100

5.1.2 Which of these costs will the target community likely pay, which costs will the government pay, and which costs are unlikely to continue being paid?

COSTS WHICH THE TARGET COMMUNITY WILL PAY:
With the exception of a volunteer expatriate Medical Director and volunteer expatriate Clinic Administrator, all administrative and support staff at the Health Center are entirely supported by fee-for-service revenues (See Appendix D). Fee-for-service revenues also cover the purchase of medications in the expanded formulary and both medical and non-medical supplies which are not part of the government-supplied Essential Drug Kits. They are also used to purchase medications and supplies contained in the Essential Drug Kits where the amount supplied is inadequate to meet patient needs. Through these fee-for-service revenues, the target community will continue to support the Health Center and its associated costs, including the costs of free preventative care services and subsidized services for young children. In doing so, the revenues will provide some indirect support for CBHC activities by maintaining a facility with its classroom, office equipment, and other resources and by supporting a project administrator who will be responsible for the administration of the entire community health project.

The community is committed to attempting to pay other costs of the CBHC program through various income-generating activities (IGAs). However, the probability of successfully developing IGAs which can produce sufficient income to sustain the involvement of participants and to support the CBHC program is open to question.

COSTS WHICH THE GOVERNMENT WILL PAY:
Personnel costs for clinical staff at the Health Center are currently borne by the Ministry of Health. According to Mr. Mbiti, the Permanent Secretary for Health, this situation can be expected to continue for the foreseeable future. However, uncertainty engendered by a financial crisis in the country and by upcoming multi-party elections leaves open the possibilities for policy changes in the future. In addition to clinical personnel, the Ministry of Health provides Essential Drug Kits, immunization and family planning supplies, and various other materials and supplies. It is expected that the government will continue to supply these goods and services, although disruptions in supply are expected to continue and perhaps worsen as the country experiences financial and political crises.

COSTS WHICH ARE UNLIKELY TO CONTINUE BEING PAID:
The project is not expected to sustain the involvement of expatriate volunteers, whether physicians, administrators, nurses, or other specialists. Similarly, those expenses which are heavily or primarily related to the support or involvement of expatriate volunteers are unlikely to continue being paid. These expenses include volunteer housing, international travel expenses, visa costs, and local vehicle expenses. Significant resources are currently devoted to the production and distribution of monthly, quarterly, and annual narrative reports, mid-term evaluations, and other materials which are required by involved donor agencies. The costs of creating and disseminating this documentation are unlikely to continue being paid.

5.2 Strategies for Increasing Post-Project Sustainability

5.2.1 Please describe the project's approach to creating sustainable health programs, outputs, or benefits in your local communities. For example, if your project includes community health volunteers, how will the project supervise, supply, pay or motivate the volunteers in other ways after the project ends?

The project has developed a self-sustaining core service component, the Health Center, which the community strongly supports. This core service component achieves sustainability through a carefully nurtured public/private partnership, through the support of the Nairobi business community, through good management practices, and through the collection of affordable fees for curative care services. The revenues collected for curative care services cover the costs of free preventative care services at the Health Center. In addition, adult curative care charges subsidize the provision of low-cost curative care services to young children and cost-free services to those who are unable to pay.

The Health Center provides a focal point around which other services are organized. The community retains both interest and active involvement in its management. At the same time, the Health Center provides a continuing resource which can encourage and support CBHC activities.

Active efforts are under way to develop income-generating activities (IGAs) which can support and motivate community health activities in the future. Major projects under consideration include a large sanitary market facility and a complex to house very small scale "jua kali" businesses. Discussions have been held with other NGOs regarding the introduction of a micro-enterprise loan scheme as well. Volunteer health workers in the community have organized themselves into small groups, registered with the government, and requested the allocation of plots of land on which they are developing various small enterprises as well.

5.2.2 Please describe any activities your project has taken this year to cut recurrent costs, by increasing efficiency.

The Health Center formulary is reviewed frequently for clinical and cost effectiveness. Unnecessary and ineffective medications are eliminated from the formulary and, whenever possible, less costly substitutions made for expensive medications. Improved inventory control has reduced operating costs by virtually eliminating expensive "rush" orders for medications and supplies. A major focus of continuing medical education for and supervision of clinical staff is to reduce over-prescribing of medications. More accurate diagnosis and targeted treatment could substantially reduce recurrent medication purchase costs.

Recent activities undertaken to cut recurrent costs include purchasing and packing unsterile gauze for autoclaving rather than purchasing expensive prepacked sterile gauze, increased monitoring of drug usage and expiration dates, and teaching the enrolled nurses techniques to reduce the number of sterile gloves used.

5.3 Cost Recovery

5.3.1 Describe what the project has done to recover costs this past year. How much did it recover (in U.S dollars)? How did the project use these revenues?

With continued inputs of seconded staff and Essential Drug Kits from the Ministry of Health, the Health Center is intended to be self-supporting. The Health Center charges fees for curative and pharmacy services. In the 12 months from October 1991 to September 1992, the Clinic collected $39,154 (using an average exchange rate of 30 Kenya shillings per U.S. dollar). All clinic income has been used to pay salaries, supply, and facility costs for the Health Center. For the 12 months reported above, there was a net loss of $6,134. There was an excess carried forward from the prior months operations, so no additional grant funds have been required to support the Health Center. However, in response to these operating losses pharmacy fees were increased on 1 October 1992, and a charge for dressing changes was instituted. There continues to be no charge for preventive care including child welfare, antenatal care and family planning.

5.3.2 How does the community react to cost recovery activities? Do the activities create inequities in service delivery?

The community feels a strong sense of ownership for the Health Center and is kept fully informed as to the costs of its operation. There is widespread awareness that fees are necessary to support and maintain its services. Community members on the Board of Management are actively involved in establishing both the fee structure, e.g., higher adult fees which subsidize children's services, and the actual amounts charged. Input is always solicited from the Joint Health Committee as well before any changes are made in the fees charged. The Health Center has kept its fees below those of other private facilities. During the past year Ministry of Health and Nairobi City Commission clinics began charging fees for services rendered. The Health Center has a policy for treating the indigent and will always see patients requiring emergency care without regard to ability to pay. Recent Health Center fee increases have not affected attendance records.

5.3.3 Describe any training your PVO has undertaken this year to improve the project staff's understanding and skills in cost recovery and price setting.

The volunteer Clinic Administrator has worked closely with the Kenyan Associate Administrator throughout the year to enhance his financial management skills. This will continue in the second year of the project but with the Associate Administrator taking the lead on Health Center management activities with oversight by the volunteer administrator. Additionally, in year two the Deputy Director for Programs will assume increasing amounts of financial management activities for the project while the (volunteer) Deputy Director, Administration is still on site. All Kenyan project staff are included in discussions on financial matters so that they can be aware of the financial impact of decisions made.

6. Project Expenditures and Justification for Budget Changes

6.1 Pipeline Analysis - Every project should complete a pipeline analysis. The attachment shows the required format (1992 Annual Report Form A). Please produce this format on the project's own spreadsheet system, if it simplifies reporting.

See attached.

6.2 Justification of Budget Changes - Projects can make certain budgetary changes within the parameters of its cooperative agreement with A.I.D. In the case the project has made budget revisions this fiscal year, provide justification for any major changes from the budget the project submitted in the DIP.

Total AID expenditures are 90 percent of budget for the first year. Some line items are significantly over budget and these are explained below.

I.A. Procurement of Supplies is over-budget due to clinic expenditures for medical supplies and pharmaceuticals. The Ministry of Health has not distributed the medical kits according to the agreed schedule requiring the clinic to purchase the supplies privately. Fee revenues were not sufficient to cover the additional expenses and therefore the project subsidized purchase of supplies that were needed to maintain inventory. Clinic fees have been increased to compensate for these shortages in the future.

II.C. Evaluation-Other is over budget due to added expense of home office visits to monitor the project. In September, MIHV's past President accompanied the new Project Director to Kenya to introduce him to key individuals associated with the project, and assist in the transition to new management. In February, MIHV's Executive Director and new Medical Director both visited the project to assist with the DIP. This was the Medical Director's first visit to the project, and considered critical to his ability to fulfill his responsibilities. Later in the year, MIHV's new President also visited the project to better enable him to fulfill his role. The budget had included only two home office visits in the first year.

IV.B. International Travel is over budget due to added travel expenses of a new Project Director and his wife in September, and a series of 3-month physician volunteer terms in 1991. Although MIHV's policy specifies that volunteer terms are 6 months to two years, when a qualified volunteer is not available, shorter terms are accepted. Such was the case during the project's first year, however, two physician volunteers served six month terms in 1992, and starting in January, 1993, a physician volunteer is serving a 12 month term.

IV.C. Other Direct Costs includes staff housing, telephone and fax, insurance, training expenses for the community health workers, improvements to the clinic and grounds, volunteer services, and expenses for two vehicles. The older vehicle has incurred unexpected repair

costs totaling nearly $5000. The loss on a vehicle which was stolen exceeded $7000. The salaries and benefits of Ministry of Health staff are included here as well; their value was not known at the time the original budget was constructed.

7. **1992/1993 Work Schedule and Budget**

Attach the project's work plan and budget for fiscal year 1992/1993.

There is no change in the project's work plan since the DIP was submitted. See attached work schedule and budget from the DIP.

RESPONSE TO CONCERNS AND RECOMMENDATIONS OF THE TECHNICAL REVIEW OF CSVII; MIHV/KENYA

Immunizations

Vaccinations are only given at the Health Center and not in an outreach program.

In Year 2 an outreach program will be started to give immunizations in the sub-location of Ruthimitu/Uthiru. It is farthest from the Health Center and presents the most difficulty in obtaining public transportation. Two buses must be used if the patients cannot walk the 6 kilometres to the Health Center. Initially four sessions will be scheduled at 4 week intervals. Enrolled Community Health Nurses who staff the Health Center will be used and the clinics will be held in the afternoons when the patient load at the Health Center is lightest. Assuming a reasonable turnout, other outreach immunization clinics will be held in the other two sub-locations served by the project. This will be an ongoing annual activity.

MIHV must make registration of newborns an active function of the EPI program.

This activity is underway and will be documented in future reports.

Dropout between DPT3 and measles is high. MIHV must investigate further.

The recent graduation of an additional 80 Community Health Workers who live throughout two of the three sub-locations served by the project will help us address this concern in those locations. Additionally, the health messages presented to existing active CHWs in the three locations includes the need to complete the vaccinations. The outreach clinics described above will provide an additional opportunity to complete the immunization series.

Tetanus toxoid recording is not clear. Discuss how MIHV will ensure mothers have TT records.

Currently, antenatal tetanus toxoid injection is recorded on the antenatal card which is created by using a rubber stamp on a regular medical record card. Within one month new preprinted antenatal cards will be in use that include a labelled space for recording the TT. A review of the EPI records of total tetanus toxoid injections given and antenatal cards indicates that nurses in the antenatal unit are faithful in questioning and giving appropriate tetanus toxoid injections.

Management of Diarrhoeal Diseases

Forty-three percent of mothers interviewed used antidiarrheal medicines in the baseline survey. MIHV must discourage.

The health message used in training Community Health Workers is for the mother to use available fluids in the home including porridge, water, and juices if there is no ORS package available. All CHWs distribute ORS packets and a

ready supply of additional packets is always available at the Health Center. The community health nurses at the Health Center routinely prescribe ORS treatment. ORS packets are available at the Health Center pharmacy without cost to the patients.

A specific health message against the use of commercial antidiarrheal products will be added to the CHW training.

Maternal Health

Measurable objectives as listed below are added to the plan.

> Increase the percentage of women, who had been pregnant in the last 24 months, receiving antenatal care.
>
> Increase the percent of women of childbearing age who know that they should gain weight during pregnancy.
>
> Increase the percent of women, who do not wish to get pregnant, who will use modern contraceptive methods.

The health message to encourage pregnant women to rest more and work less in order to conserve calories is part of the routine health counselling for pregnant women. Its implementation may be difficult for most women to achieve, however, in a society where women work the gardens and small farms, tend the livestock, carry the water and firewood, care for the children, do the laundry, cook and do the marketing. Additionally, many also maintain small roadside shops. We will make additional efforts to carry this important health message to males who may be in positions to lighten the work loads of pregnant women.

AIDS/STDS

Need to include men in AIDS education.

Though the DIP failed to include them, actual practice is to include men in AIDS education. A special effort has been made and will continue to target young men just becoming sexually active.

DIP does not discuss to whom or how condoms are distribute or how those people who receive condoms will learn to properly use what is distributed.

Condom distribution is carried out primarily through the Community Health Workers although a smaller number are dispensed without cost at the Health Center. In the first 9 months of 1992, 4000 to 5000 condoms were distributed each month. At this writing a study to ascertain actual use has been approved by the project staff and is awaiting final approval by the University of Nairobi officials for implementation by an OB/GYN resident.

The health messages given in HIV/AIDS education intervention is not given nor how they will be communicated. How often will they be given?

The health messages are as follows:

HIV/AIDS is incurable
Unprotected sex is not safe.
Stick to one partner
Injection with an unsterilized needle or syringe is dangerous.
Women with AIDS should avoid becoming pregnant
All parents should tell their children how to avoid getting AIDS

These messages are taught to the Community Health Workers during initial training and reviewed at least annually. Community Health Nurses and Community Program Directors are available to give presentations to any size group including schools.

Environmental Health

Plans for improving water quality are not stated. How will community get a more constant supply of tap water? Discuss the constraints to a constant supply of fresh water and how MIHV will overcome the constraints.

Currently, tap water is provided through pipes from the City of Nairobi. The major constraint to a constant supply of tap water is a region-wide drought, explosive growth of the city which has outstripped available water supplies, and the general breakdown of the infrastructure of the city. All this is exacerbated by endemic corruption and inefficiency. It is unlikely that MIHV can have a significant impact on the situation. The Joint Health Committee and the Chiefs of the locations are already bringing whatever pressure they can to obtain a stable source of water for Dagoretti. In view of the major constraints which exist, it is realistic to emphasize the health messages that are being conveyed to the community to treat river and pond water. We are attempting to obtain human and material resources to assist in environmental health projects which might include protection of existing water supplies, development of water storage tanks, conservation of supplies, etc.

What are health messages for treating river and pond water.

Illnesses can be prevented by boiling drinking water if it is not from a safe piped supply.

If unable to boil water for drinking, store in a closed or covered container of clear plastic or glass and leave it standing in sunlight for two days before using it.

Does not address storage of water and prevention of contamination.

Keep buckets, jars or other containers to store water as clean as possible.

Keep waste water away from any water used for cooking, drinking, bathing or washing.

Keep animals away from drinking water.

Store drinking water in a clean, covered container.

Take water out of container with a clean ladle or cup.

Do not allow anyone to put their hands into the container or to drink directly from it.

What are alternatives to garbage pits. Has composting been considered.

Because Dagoretti is a peri-urban squatters settlement and not a high-density slum, space for garbage pits has not been a problem nor is it expected to be for some time to come. The concept of composting is known only in a general sense in the community. The soil in Dagoretti is highly fertile and many feet or meters deep because of the volcanic nature of the terrain. Composting is a concept that will be introduced in the environmental sections of the next CHW training program. Since the lifestyle of our target population already recycles virtually everything of any value, most items in the individual pits are just organic waste and decompose rapidly in the pit; in essence, each pit is like a mini-compost pile.

Human Resources

How will the project try to prevent volunteer drop-out.

Volunteers are carefully chosen. Volunteers willing to spend six months or more in Kenya do not do so without serious consideration of the implications. Except for one volunteer who returned home at the death of a family member, there have been no drop outs. The in-country staff is currently compiling a comprehensive orientation manual designed to ease the transition to both the project and to living in Kenya.

The sustainability of our project is based on the community supporting the clinic and its programs. This support includes financial fees and time commitments. A review of how we select, train, and incorporate our CHWs from and into the community will show that we place a lot of energy into creating a sustainable volunteer program. CHWs gain respect within the community by being volunteers, and being a part of the health program. Community volunteers and elders also have significant feedback into the operation of the clinic and the community-based health care program. We feel that our links to the community is one of the things that will make the program sustainable--and it appears to be working in our Kasangati project in Uganda four years after outside funding stopped.

In addition, both CHWs and project staff are actively engaged in a search for appropriate, sustainable incentives which can be made available to CHWs and other community volunteers. Involvement of community volunteers in small

group income-generating activities shows some promise in this regard even though the actual income which is likely to be realized promises to be quite small and certainly insufficient to actually support project activities as such.

How will inexperienced expatriate staff with no or limited experience in developing countries benefit this project.

The competencies of our staff are second to none. Two benefits are derived from their use in this project. First, the project receives services from highly trained and skilled people who essentially give their time for free. Many of the project personnel we have had on this project are beyond the pay levels possible in a project such as this. Present staff, though having limited experience in developing countries, have a great deal of training and experience which has proven essential to the project. This includes medical training and many years of medical practice, extensive clinic and financial management experience, extensive grant administration and community health experience, and in some cases experience as Peace Corps or other types of volunteer service. All have provided valuable benefits for the project.

Second, project volunteers experienced in such a setting become advocates for others to donate time and financial support. Many volunteers have returned to the States and become active in promoting health care among disenfranchised communities, both domestic and international. Almost all volunteers have indicated that their experience has fundamentally changed their life and their attitude.

Sustainability

Is the project tracking too many indicators of sustainability. What are the priorities.

Many of the indicators being used are requirements of the Ministry of Health. They are routinely reviewed monthly. Additionally, with two major program components different staff review and react to different indicators. The staff does not feel the indicators used are cumbersome or excessive.

MIHV should study the performance of a single cost-recovery mechanism before instituting a second.

The cost recovery mechanism consists of fees for certain services performed. Fees are charged for curative care and for pharmacy only. There are no charges for preventive services or for family planning supplies. The comments on the technical review are perhaps not understood since we have only one cost recovery mechanism in place, i.e., fees for curative care.

The two fee structure is a revenue-generating scheme as well as an educational tool. In a culture where it is believed that medical care is incomplete without a prescription, this fee structure begins to tell people that they can see a health professional and get information and treatment. A course of treatment does not always include a prescription.

The Clinic Administrator and Medical Director frequently review the cost recovery with the Board of Management. These fees are not something that are set and forgotten for a year but are constantly monitored. Also, absent of additional resources, the project could not forgo these revenues and still provide its present level of services.

1992 COUNTRY PROJECT PIPELINE ANALYSIS – REPORT FORM A

PVO/COUNTRY PROJECT PDC-0500-G-00-1076-00

COST ELEMENTS	Actual Expenditures to Date (9/1/91 to 8/31/92)			Projected Expenditures Against Remaining Obligated Funds (9/1/92 to 8/31/94)			Total Agreement Budget (Columns 1 & 2) (9/1/91 to 8/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	10,113	53,892	64,005	17,887	(19,972)	(2,085)	28,000	33,920	61,920
B. Equipment	—	3,742	3,742	—	7,258	7,258	—	11,000	11,000
* C. Services/Consultants									
1. Local	—	—	—	3,750	14,000	17,750	3,750	14,000	17,750
2. Expatriate	—	—	—	—	5,000	5,000	—	5,000	5,000
SUB-TOTAL I	10,113	57,634	67,747	21,637	6,286	27,923	31,750	63,920	95,670
II. EVALUATION									
A. Consultant/Contract	—	—	—	14,500	1,500	16,000	14,500	1,500	16,000
B. Staff Support	—	—	—	—	3,000	3,000	—	3,000	3,000
C. Other	4,500	4,893	9,393	15,500	5,107	20,607	20,000	10,000	30,000
SUB-TOTAL II	4,500	4,893	9,393	30,000	9,607	39,607	34,500	14,500	49,000
III. INDIRECT COSTS									
HQ/HO Overhead ____(%)									
SUB-TOTAL III	—	—	—	85,712	2,498	88,210	85,712	2,498	88,210
IV. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical	26,705	17,965	44,670	32,335	12,715	45,050	59,040	30,680	89,720
2) Administrative	24,221	—	24,221	91,169	—	91,169	115,390	—	115,390
3) Support	2,850	—	2,850	5,350	420	5,770	8,200	420	8,620
B. Travel (Short Term)									
1) In country	95	—	95	3,155	—	3,155	3,250	—	3,250
2) International	10,155	12,089	22,244	12,445	(12,089)	356	22,600	—	22,600
C. Other Direct Costs (utilities, printing rent, maintanance, etc)	54,891	51,999	106,890	14,119	(51,999)	(37,880)	69,010	—	69,010
SUB-TOTAL III	118,917	82,053	200,970	158,573	(50,953)	107,620	277,490	31,100	308,590
TOTAL FIELD	133,530	144,580	278,110	295,922	(32,562)	263,360	429,452	112,018	541,470

* Excludes Evaluation Costs

1992 COUNTRY PRC T PIPELINE ANALYSIS – REPORT FORM A
PVO/COUNTRY PROJECT PDC-0500-G-00-1076-00

COST ELEMENTS	Actual Expenditures to Date (9/1/91 to 8/31/92)			Projected Expenditures Against Remaining Obligated Funds (9/1/92 to 8/31/94)			Total Agreement Budget (Columns 1 & 2) (9/1/91 to 8/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	2,200	3,561	5,761	3,320	(2,231)	1,089	5,520	1,330	6,850
B. Equipment		2,385	2,385		3,585	3,585		5,970	5,970
*C. Services/Consultants									
1. Local	3,400	7,787	11,187	6,700	(5,267)	1,433	10,100	2,520	12,620
2. Expatriate									
SUB-TOTAL I	5,600	13,733	19,333	10,020	(3,913)	6,107	15,620	9,820	25,440
II. EVALUATION									
SUB-TOTAL II									
III. INDIRECT COSTS									
HQ/HO Overhead ____(%)									
SUB-TOTAL III	677	1,840	2,517	19,523	3,210	22,733	20,200	5,050	25,250
IV. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical									
2) Administrative	15,000	28,956	43,956	29,470	(20,976)	8,494	44,470	7,980	52,450
3) Support	7,600	16,069	23,669	14,950	(10,439)	4,511	22,550	5,630	28,180
B. Travel/Per Diem									
1) In country	1,173		1,173	6,727		6,727	7,900		7,900
2) International									
C. Other Direct Costs (utilities, printing rent, maintanance, etc)	3,920	49,691	53,611	5,888	(47,239)	(41,351)	9,808	2,452	12,260
SUB-TOTAL IV	27,693	94,716	122,409	57,035	(78,654)	(21,619)	84,728	16,062	100,790
TOTAL HEADQUARTERS	33,970	110,289	144,259	86,578	(79,357)	7,221	120,548	30,932	151,480

*Exludes Evaluation Costs

Table 1

1992 COUNTRY PR(CT PIPELINE ANALYSIS – REPORT FORM A

PVO/COUNTRY PROJECT PDC-0500-G-00-1076-00

	Actual Expenditures to Date (9/1/91 to 8/31/92)			Projected Expenditures Against Remaining Obligated Funds (9/1/92 to 8/31/94)			Total Agreement Budget (Columns 1 & 2) (9/1/91 to 8/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
TOTAL HEADUARTERS	33,970	110,289	144,259	86,578	(79,357)	7,221	120,548	30,932	151,480
TOTAL FIELD	133,530	144,580	278,110	295,922	(32,562)	263,360	429,452	112,018	541,470
TOTAL	167,500	254,869	422,369	382,500	(111,919)	270,581	550,000	142,950	692,950

CSVII DIP TABLE B: COUNTRY SCHI 'LE OF ACTIVITIES (disk filename: WP5-1\DIPB

(Check box to specify Quarter and Year)

PVO: MIHV

Country: Kenya

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position												
a. Project Manager	X	X	X	X	X	X	X	X	X	X	X	X
b. Technical Coordinator Volunteer physician & Project Officer	X	X	X	X	X	X	X	X	X	X	X	X
c. Health Information System Manager Proj. Director	X	X	X	X	X	X	X	X	X	X	X	X
d. Community/Village health workers	X	X	X	X	X	X	X	X	X	X	X	X
e. Other Support TOTs & CHWRs	X	X	X	X	X	X	X	X	X	X	X	X
2. Health Information System												
a. Baseline Survey done with Final Eval of previous funding period												
- Design/preparation												
- Data collection and analysis												
- Dissemination and feedback to community and project management												
b. Consultants/contract to design HIS												
c. Develop and test HIS	X	X	X	X								
- Implementation	X	X	X	X	X	X	X	X	X	X	X	X
- Development and feed back to community and project management	X	X	X	X	X	X	X	X	X	X	X	X

Table 2

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CSVII DIP TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES (disk filename: WP5-1\D!PB)

PVO: MIHV

Country: Kenya

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
3. Training												
a. Design Completed under previous grant												
b. Training of trainers	X	X	X	X	X	X	X	X				
c. Training sessions			X	X			X	X				
d. Evaluation of knowledge of skills	X	X	X	X	X	X	X	X	X	X	X	X
4. Procurement of Supplies	X	X	X	X	X	X	X	X	X	X	X	X
5. Service Delivery to be initiated												
a. Area 1												
- ORT	X	X	X	X	X	X	X	X	X	X	X	X
- Immunization	X	X	X	X	X	X	X	X	X	X	X	X
- Nutrition:												
Breastfeeding	X	X	X	X	X	X	X	X	X	X	X	X
Maternal Nutrition	X	X	X	X	X	X	X	X	X	X	X	X
Vitamin A N/A												
Growth Monitoring/Promotion	X	X	X	X	X	X	X	X	X	X	X	X
- ALRI/Pneumonia N/A												
- Family Planning/Maternal Care	X	X	X	X	X	X	X	X	X	X	X	X
- Other Env. Hlth. AIDS/STDs Curative Care	X	X	X	X	X	X	X	X	X	X	X	X

CSVII DIP TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES (disk filename: WP5-1\DIPB)

PVO: MIHV

Country: Kenya

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
b. Area 2 N/A												
- ORT												
- Immunization												
- Nutrition:												
Breastfeeding												
Maternal Nutrition												
Vitamin A												
Growth Monitoring/Promotion												
- ALRI/Pneumonia												
- Family Planning/Maternal Care												
- Other												
6. Technical Assistance												
a. HQ/HO/Regional office visits	X	X		X		X		X		X		X
b. Local Consultants	X	X	X	X	X	X	X	X	X	X	X	X
c. External technical assistance								X	X			X
7. Progress Reports												
a. Annual project reviews				X				X				X
b. Annual reports				X				X				X
c. Mid-term evaluation								X	X			
d. Final evaluation												X

CSVII DIP TABLE C: COUNTRY PROJEC" UDGET (disk filename: LOTUS\DIPC.wk1)

BUDGET: In thousands of dollars ($000)

Place dollar amounts in shaded areas only

PVO/COUNTRY _____

	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
I. PROCUREMENT									
A. Office Equipment (specify)									
1. Office	0	8,000					0	8,000	8,000
2. EPI									
3. ORT									
4. Other	0	3,000					0	3,000	3,000
SUBTOTAL	0	11,000	–	–	–	–	0	11,000	11,000
B. Supplies									
1. Office	4,000	0	4,000	0	3,000	0	11,000	0	11,000
2. EPI	1,000	1,000	1,000	0	1,000	0	3,000	1,000	4,000
3. ORT	1,000	0	1,000	0	1,000	1,000	3,000	1,000	4,000
4. Other	4,000	10,670	4,000	10,770	3,000	10,480	11,000	31,920	42,920
SUBTOTAL	10,000	11,670	10,000	10,770	8,000	11,480	28,000	33,920	61,920
C. Consultants (exclude evaluation costs)									
1. Local	1,250	6,000	1,250	6,000	1,250	2,000	3,750	14,000	17,750
2. External	–	1,000	–	2,000	–	2,000	0	5,000	5,000
SUBTOTAL	1,250	7,000	1,250	8,000	1,250	4,000	3,750	19,000	22,750
D. Services (exclude evaluation costs)	–	–	–	–	–	–	–	–	–
1. Manpower Services									–
2. Lectures/Talent Fees									–
3. General Contractual Services									–
SUBTOTAL	–	–	–	–	–	–	–	–	–

Table 3

CSVII DIP TABLE C: COUNTRY PROJECT BUDGET (disk filename: LOTUS\DIPC.wk1)

BUDGET: In thousands of dollars ($000)

Place dollar amounts in shaded areas only

PVO/COUNTRY _____

	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
II. EVALUATION (specify)									
A. Baseline Survey									–
1. Consultant/Contract									–
2. Staff Support									–
3. Other (Home Office Visits)	4,500	1,500					4,500	1,500	6,000
SUBTOTAL	4,500	1,500	–	–	–	–	4,500	1,500	6,000
B. Mid-term									–
1. Consultant/Contract			3,000	2,000			3,000	2,000	5,000
2. Staff Support			1,000	1,000			1,000	1,000	2,000
3. Other			6,000	6,000			6,000	6,000	12,000
SUBTOTAL	–	–	10,000	9,000	–	–	10,000	9,000	19,000
C. Final									–
1. Consultant/Contract					11,000	0	11,000	0	11,000
2. Staff Support					1,000	0	1,000	0	1,000
3. Other					8,000	4,000	8,000	4,000	12,000
SUBTOTAL	–	–	–	–	20,000	4,000	20,000	4,000	24,000
III. PERSONNEL									
A. Technical	21,010	11,050	20,140	10,430	17,890	9,200	59,040	30,680	89,720
B. Administration	38,300	–	42,140	–	34,950	–	115,390	–	115,390
C. Clerical	3,800	420	2,000	–	2,400	–	8,200	420	8,620
D. Temporary	–						–	–	–
SUBTOTAL	63,110	11,470	64,280	10,430	55,240	9,200	182,630	31,100	213,730

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CSVII DIP TABLE C: COUNTRY PROJECT BUDGET (disk filename: LOTUS\DIPC.wk1)

BUDGET: In thousands of dollars ($000)

Place dollar amounts in shaded areas only

PVO/COUNTRY Kenya

	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
IV. TRAVEL/PER DIEM									
A. Domestic	1,250		1,000		1,000		3,250	–	3,250
B. International	9,000		9,000		4,600		22,600	–	22,600
SUBTOTAL	10,250	–	10,000	–	5,600		25,850	–	25,850
V. COMMUNICATIONS									
A. Printing/Reproduction	1,000		1,000		1,000		3,000	–	3,000
B. Postage/Delivery system	1,000		1,000		1,000		3,000	–	3,000
C. Telephone	2,000		3,000		3,000		8,000	–	8,000
D.FAX/Telex	4,000		3,000		3,000		10,000	–	10,000
SUBTOTAL	8,000	–	8,000	–	8,000	–	24,000	–	24,000
VI. FACILITIES									
A. Equipment Rentals									
B. Facilities Rentals									
C. Other									
SUBTOTAL	–	–	–	–	–	–	–	–	–
VII. OTHER DIRECT COSTS									
SUBTOTAL	15,750	–	15,750	–	13,510	–	45,010	–	45,010
VIII. INDIRECT COSTS									
A. Overhead/Administration 20.0%	35,280		30,880		22,050		88,210	–	88,210
B. Other									–
SUBTOTAL	35,280	–	30,880	–	22,050		88,210	–	88,210
TOTAL	148,140	42,640	150,160	38,200	133,650	28,680	431,950	109,520	541,470

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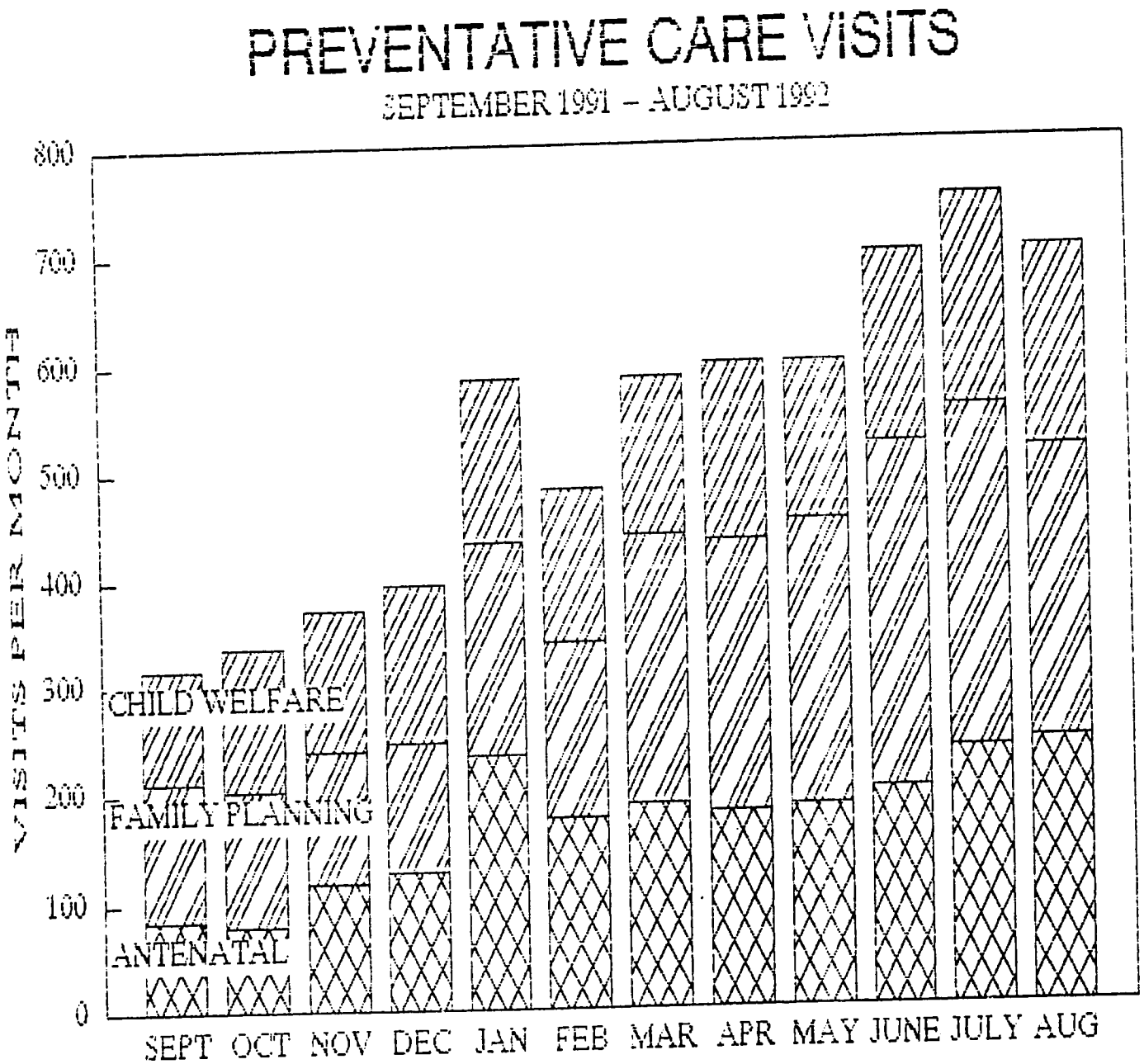
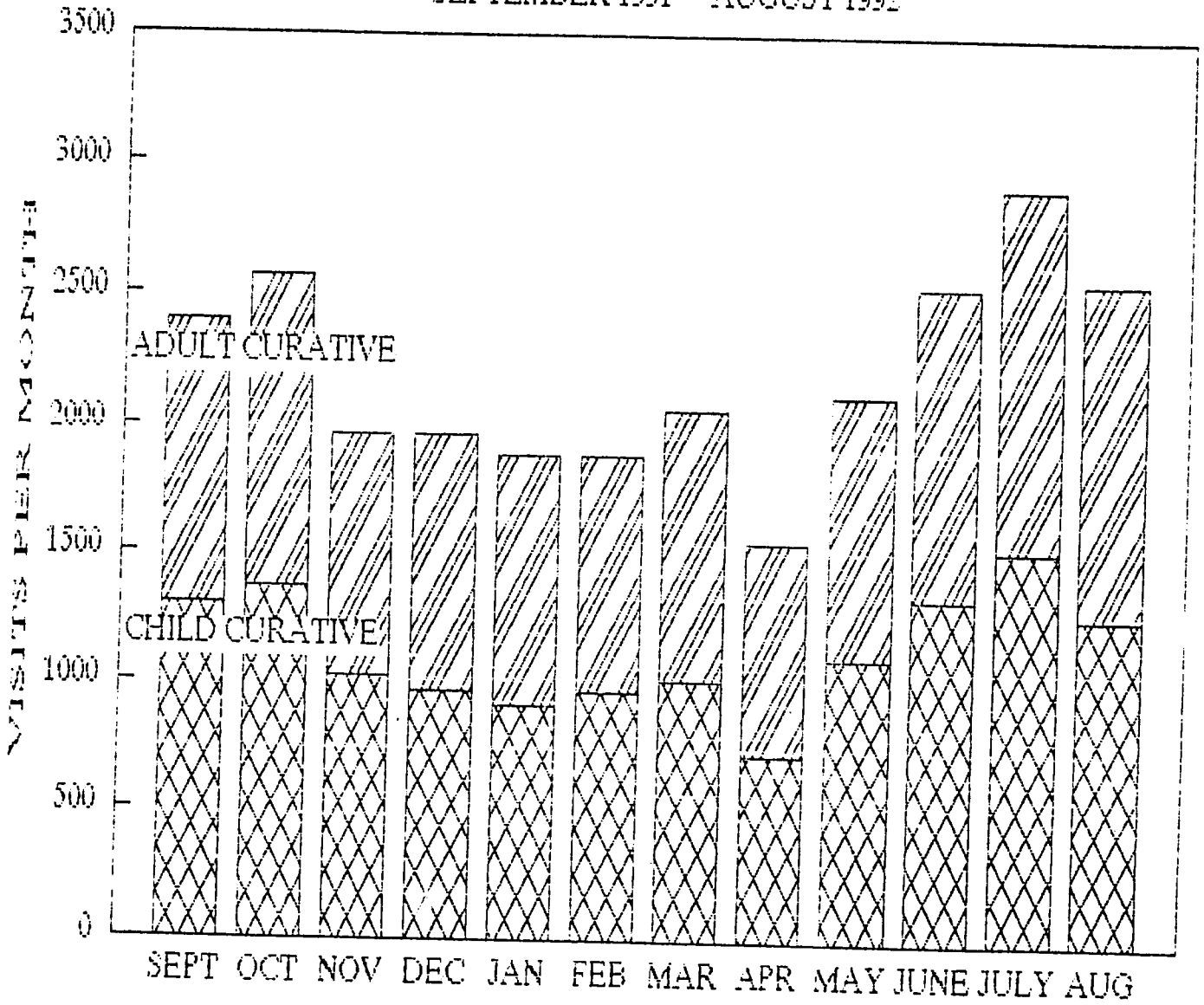
Appendix A: Figures for Health Center's Preventive and Curative Visits



CURATIVE CARE VISITS

SEPTEMBER 1991 – AUGUST 1992



Appendix B: Position Descriptions, Resumes, and Organizational Chart

RECEIVED NOV 2 1 1991

PHYSICIAN/CLINICIAN VOLUNTEER - - JOB DESCRIPTION

QUALIFICATIONS:

1. Licensed physician or mid-level practitioner
2. Experience in primary health care
3. A commitment to community-based health care

ACCOUNTABILITY:

Reports directly to the Kenya Project Director (KPD) or the Project Director's designee.

TASKS AND RESPONSIBILITIES:

The main function of the clinician volunteer is to serve as medical director and provide technical assistance in the clinical affairs of the health center. This takes the form of assisting, supporting, observing, advising, guiding, and, if needed, training the clinical officer and other clinical staff. The clinician volunteer serves as a resource person for the clinical officer and oversees the health center's clinical activities for MIHV.

Although the clinical officer and clinical staff may already have extensive experience working in Kenyan health centres, the clinician volunteer plays a special role in quality assurance activities, such as monitoring drug use to insure proper prescribing practices, reviewing lab results (e.g., malaria smears, AFB slides), reviewing charts to assess quality of care delivered, and suggesting innovations that may improve the efficiency or quality of services provided.

Some of the specific activities of the clinician volunteer:

1) Monitoring and Assisting the Clinical Officer - in the diagnosis and treatment of ill and injured patients. The clinician volunteer monitors the work of the CO through direct observation and review of medical records and treatment, and (if the volunteer is a physician) is available for consultation on difficult cases. Reviewing medications dispensed, especially the appropriate prescribing of antibiotics, is particularly important. This must be done in a non-threatening cooperative fashion by fostering a close working relationship with the CO who, unlike the volunteer, is well versed in the common medical problems encountered in Kenya.

2) Monitoring and Assisting the Nurses, especially in the provision of curative services. Community health nurses or a second clinical officer provide diagnosis and treatment for routine illnesses and injuries. The clinician volunteer monitors her work and provide her with assistance and support as well.

3) Providing or organizing ongoing medical education sessions for the clinical staff, which may include presentations by different staff members and guest presentations. Regular clinical "mini-rounds", especially case presentations, can be invaluable in helping to have the clinical staff work as a team and also to bring up general medical policy issues (ie. appropriate indications for antibiotic use; treatment of various sexually transmitted diseases, clinical presentation of HIV infection, etc). Because nearly all government health facilities are grossly understaffed and clinical staff are overworked, efforts to provide staff with ongoing medical education are greatly appreciated and definitely help to foster positive morale in the clinic team.

4) Overseeing the operation of the pharmacy - supervise, along with the clinical officer and pharmacist, the stocking, storing and dispensing of medication. Investigate and recommend formulary changes based on current practices. Final responsibility for formulary changes rests with a committee consisting of the medical director, clinic administrator, and project director.

5) Incorporation of the laboratory technician into the clinical team - Since many clinical officers and most nurses are not used to having laboratory facilities available on site, the appropriate use of the laboratory and results thereof must be incorporated into the clinical decision making process. Dr. Jane Carter, of the AMREF Laboratory Services Department, and her team, are available to assist with the lab, the laboratory technician, and training of medical staff as necessary. Assuring that the laboratory is used effectively and for the greatest benefit possible requires ongoing supervision.

6) Assisting the Kenya Project Officer with ongoing CBHC activities, especially in supervision of the CHW's and their integration with the community health nurses at the health center. Clinical issues arise as a result of home visits, and as health problems in the community are identified.

7) Providing input into clinic flow and "triage" - While the clinical officer and clinic administrator may have had the greatest experience in working in a health center in Kenya, the volunteer clinician can suggest different ideas and strategies for addressing patient flow issues, room usage, equipment needs, etc.

8) <u>Developing a system within Nairobi for the referral of patients</u> - Patients need to be referred to various health facilities for hospital-based services in and around Nairobi. (ie. for those who can afford it, Kikuyu Hospital, for those who cannot, Kenyatta). Patients may also require referral to speciality Nairobi City Commission (NCC) Clinics (ie. NCC Chest clinic for TB, NCC Special Treatment Clinic for some STD's), and of course prenatal patients will require referral to centers for delivery. In addition to developing a good working relationship with such centers, close interaction with the two nearest NCC clinics, the Waithaka Health Center and the Karen Health Center, are very important as they are serving members of the communities in our project area.

Since MIHV's goal is to ultimately shift responsibility to the Kenyan staff, the clinician volunteer must nurture the clinical officer in her role, and be discreet and tactful in supervising her activities. Eventually the clinician volunteer should become less visible in supervisory activities but remain active in the promotion of quality assurance.

JOB DESCRIPTION - VOLUNTEER CLINIC ADMINISTRATOR

The overall responsibility of the Volunteer Clinic Administrator is to provide leadership and management guidance for the operations of the MIHV Health Centre(s).

As a representative of MIHV and the United States, the volunteer is expected to act in a responsible, ethical and socially acceptable manner in all activities that are directly or indirectly related to MIHV and it's operations. S/he is accountable for building and maintaining positive relationships with appropriate community, government and health care personnel.

The Volunteer Clinic Administrator takes her/his primary direction from the Kenya Project Director, the Project Director's designee or in his/her absence from the Executive Director of MIHV.

DUTIES:

1. Oversee health centre operations to include facility management, accounting and bookkeeping functions and employment of local professional and ancillary personnel.

2. As necessary, hire, train and supervise the activities of H.C. Administrator including bookkeeping, required monthly reporting to Ministry of Health, payroll withholding and taxes, inventories of pharmacy, medical equipment and supplies, facility equipment and supplies, and MIHV/BOM monthly reports.

3. With the Assistant Health Centre Administrator establish/maintain policies, procedures and operating systems for the Health Centre that are consistent with the laws of Kenya and reporting requirements of the Ministry of Health, MIHV and Board of Management.

4. With the Project Director and Assistant Health Centre Administrator prepare an annual budget for the Health Centre.

5. Supervise/assist in hiring, discipline and evaluation of Health Centre employees.

6. With the Clinic Administrator develop/update Health Centre personnel policies consistent with community standards, the laws of Kenya and the regulations of the Ministry of Health.

7. With the Clinic Administrator and subject to approval by the Project Director and Board of Management, maintain staffing patterns and job descriptions appropriate to the project.

8. Develop, maintain and supervise a performance evaluation process for all Health Centre staff.

9. With the Clinic Administrator, provide cost information on proposed formulary and treatment modalities.

10. With the Volunteer Medical Officer, Clinical Officer, and/or the Charge Nurse oversee the work flow of all Health Centre staff consistent with good medical practice and efficient patient flow.

11. Provide support, training and technical assistance to Board of Management members as they assume their roles and responsibilities.

12. Develop, maintain, and prepare regular reports for an MIHV Kenya Project petty cash system and accounts receivable, accounts payable, check registers, income and expense reports, and other necessary fiscal reports for the MIHV Kenya Project.

13. Prepare/oversee preparation of monthly Health Center activity report on areas of responsibility.

14. Be knowledgeable of the Community Based Health Worker program and provide support and technical assistance as appropriate to the CBHW Project Officer and Assistant Project Officer.

15. Support ongoing interaction and service integration between Community Based Health Worker leadership, clinician volunteer and clinical/technical staff.

16. Assist with the preparation and maintenance of an orientation manual for MIHV volunteers new to Kenya and/or the Project.

17. Assist the Project Director to explore the feasibility of additional Health Centre sites and projects.

18. Assist the Project Director in developing and reporting quarterly MIHV goals and objectives.

19. Assist with mid-term and final evaluations of the project consistent with donor agency requirements.

20. Other duties as assigned.

Revised 16 October 1991

JOB DESCRIPTION

PROJECT DIRECTOR--KENYA

The Project Director is the primary representative of MIHV in Kenya. The overall function of the Project Director is to provide leadership and management for MIHV's current and future programs in Kenya. As such, s/he is responsible for representing MIHV regarding all in-country issues, operation of the clinic and community-based health care program, training programs, human resources and financial transactions.

As MIHV's representative, the Project Director must act in a responsible, ethical and socially acceptable manner in all dealings that are directly or indirectly related to MIHV and its operations. S/he will be responsible for building and maintaining relations in Kenya with appropriate community, government and health care personnel.

The Project Director will take his/her primary direction from the Executive Director and the Project Committee. All communications between the project and the home office will be generally available to all project members and home office volunteers and staff. The principle exception ~~are~~ is communications regarding human resource issues.

The primary goals of the Project Director will be 1) to develop sufficient program structure, volunteer incentives, and income-generating projects to make the Dagoretti program sustainable, and 2) to train a Kenyan to take over the Project Director position. Our experience has indicated that the following items are the current components of the Project Director's position. These are listed as indicative of typical requirements but, as the project develops, are subject to change and addition.

REPORTING

Report to and take direction from MIHV's Executive Director.

Inform Minneapolis office of problems and emergencies in an expeditious fashion.

PROGRAM PLANNING, DEVELOPMENT, & EVALUATION

Assume a leading role with and through counterparts, MIHV team members and members of the community in assessing health problems within the population, identifying areas to be benefitted through improved planning, health education, and primary care.

Plan and implement community-based health care (CBHC) program in those locations approved by MIHV's Executive Director and recruit and train country nationals to take over management and operations.

Support, promote, and guide community-developed income generating projects in consultation with the Minneapolis office to sustain the CBHC program and health center.

Establish and maintain ongoing monitoring and evaluation systems for the CBHC.

Start up and manage health center operations and recruit and train country nationals to take over management and operations.

Oversee the administration and financial accountability of the local management board advising the health center.

Establish project goals and objectives with the Minneapolis office, including CBHC program and the health center.

Do program planning to schedule the achievement of project objectives on a month-by-month basis.

With counterparts, develop and establish a system of recording and reporting project activities and measuring results of program efforts against project goals and objectives and send quarterly report regarding same to Minneapolis office.

Supervise and assist mid-term and final evaluations of project consistent with USAID guidelines.

Write reports required by funding agencies such as AID.

FINANCE & ADMINISTRATION

Obtain all appropriate registrations and licensures required to operate in Kenya and file all required forms to continue operating as registered legal entity in Kenya.

Establish annual budget for CBHC and health center and report actual versus budgeted results fifteen days after the close of each month according to established reporting guidelines.

Procure materials and services necessary to the success of the project.

Authorize and account for all project expenditures and payments of MIHV funds.

Maintain and reconcile all MIHV in-country bank accounts.

Prov[illegible]ject financial reports required by funding agencies such as AID.

Submit monthly activity reports to Minneapolis office in a timely fashion including summaries of activity reports submitted by country national staff and U.S. volunteers.

PERSONNEL

Establish administrative systems and personnel policies consistent with the laws of Kenya, including payroll and all required employee withholdings.

Define staffing needs for CBHC and health center including country nationals and U.S. volunteers.

Hire and supervise country national employees and establish goals and objectives that can be used in evaluating their performance.

Conduct annual performance evaluations of country national employees.

Where the need is indicated, assume a leading role in upgrading the health planning, community health education, and primary care skills of the local health staff.

Participate as a leading team member in the initial and ongoing training of trainers-of-trainers and community health workers for the CBHC.

Direct and support activities of U.S. volunteers and student interns.

Secure required visas, entry permits, registrations for U.S. volunteers, and for country national staff traveling overseas.

Do a performance evaluation (written and verbal) of each volunteer team member at the end of his/her tour of service and send same to Minneapolis to use in de-briefing volunteers.

Hold regular meetings with U.S. volunteer and country national staff and report thereon to the Minneapolis office.

FUND RAISING

Develop grant proposals for expanding and extending the current project as well as initiating new projects, including budgets.

Develop host country fund raising sources and refer contributions of any funds, collaborative effort, or payment-in-kind to the Minneapolis office for Board approval prior to acceptance.

Supply resource material for eventual extrapolation into fundraising material as produced by the MIHV home office upon request. Usually patient-type stories and/or photographs and video tape of project, personnel and community.

LONG-RANGE PLANNING

Identify and evaluate development of possible new projects for MIHV in East Africa.

OUTSIDE CONTACTS

Establish and maintain relationships with, and build rapport with Chandaria Foundation, Rotary club, USAID country mission office, U.S. Peace Corps, other maternal and child health PVOs and NGOs in the country, the country national, provincial, and city governments, particularly the Ministry of Health, the medical community, particularly the university's medical school, community chiefs and elders, community health committees.

September, 1991

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MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS

P.O. Box 43678 Nairobi, Kenya . Telephone

Michael Graf Ph.D
Project Director

VACANCY ANNOUNCEMENT

ASSISTANT TO PROJECT DIRECTOR

DUTIES:
Serve as assistant to the Project Director and provide office support for other administrative staff. Perform secretarial functions such as typing copy on a computer, filing, taking notes at meetings, performing mathematical computations of average difficulty, and keeping an office calendar. Serve as Project Office receptionist for visitors and telephone calls. Compose letters and documents in good business English and in Kiswahili or Kikuyu. Substitute for absent clerical staff in patient registration office. Conduct Project business in locations other than Project office. Carry out other duties as assigned. Perform all of the above jobs in a professional manner under minimal supervision.

QUALIFICATIONS:
FINALISTS FOR THIS POSITION WILL BE REQUIRED TO DEMONSTRATE THEIR PROFICIENCY IN WRITTEN AND SPOKEN KISWAHILI OR KIKUYU, WRITTEN AND SPOKEN ENGLISH, TYPING, AND MATHEMATICS.

Must demonstrate typing speed of 40 WPM on manual typewriter or 50 WPM on word processor keyboard with minimal errors. Word processor/computer experience will be an advantage but is not required.

Must demonstrate good command, both written and spoken, of English and of Kiswahili or Kikuyu.

Must demonstrate ability to perform mathematical computations of average difficulty.

Preference will be given to applicants residing in the Dagoretti Community Health Project areas of Mutuini, Ruthimitu and Waithaka.

APPLICATION PROCEDURES:
Applications MUST include all of the following:

- Details of previous employment and experience
- Details of education; list but DO NOT SEND COPIES OF CERTIFICATES
- Estimated typing speed
- A one page letter explaining why you think we should hire you
- Your residential location
- Your mailing address and telephone, if any, so we may reach you if you are chosen for an interview

APPLICATIONS LACKING ANY OF THE ABOVE ITEMS WILL NOT BE CONSIDERED.
Send application to: MIHV, P.O. Box 43678, Nairobi
Or deliver to the Chandaria-MIHV Dagoretti Health Centre upstairs offices

SALARY: Will be determined according to your experience and qualifications.

USA Tel: 612/871 - 3759 122 West Franklin avenue, Suite 621, Minneapolis, MN 55404, U.S.A.

Michael Graf, Ph.D.
Community Health Administrator
Community Clinical Psychologist

P.O. Box 70096 Fairbanks, Alaska 99707 U.S.A.
[redacted] (907) 452-2446 - Work

Marital Status: Married [redacted]
Languages: English, Spanish

Health: Excellent
Height: 5' 8"
Weight: 160 lbs.

LICENSURE AND CERTIFICATION

Alaska Psychologist License #AA 161
Listed in National Register of Health Service Providers - Psychology
Alaska Business License #018826

ACADEMIC AND CLINICAL TRAINING

Bachelor of Arts	Psychology - University of Oregon, Eugene, Oregon; 1970
Bachelor of Science	Public Administration - University of Oregon, Eugene, Oregon; 1970
Master of Arts	Clinical Psychology - Arizona State University, Tempe, Arizona; 1974
Pre-doctoral Internship	University of Washington School of Medicine, Seattle, Washington; 1976
Doctor of Philosophy	Clinical Psychology - Arizona State University, Tempe, Arizona; 1977
Post-doctoral Fellowship	University of Washington School of Medicine, Seattle, Washington; 1977

HONORS AND AWARDS

1966	National Merit Scholarship	Letter of Commendation
1968	University Tuition Scholarship	University of Oregon
1970	Ford Foundation Fellowship	Federal Executive Institute
1972-1974	University Tuition Scholarship	Arizona State University
1975	Herman E. DeMund Scholarship	Arizona State University
1975	NIMH Traineeship	Univ of Washington School of Medicine
1988,1991	Peer Reviewer	Federal Office of Substance Abuse Prevention
1989-1990	Adolescent Health Advisory Panel	Congressional Office of Technology Assessment
1990	Peer Reviewer	Federal Office of Treatment Improvement

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PROFESSIONAL EXPERIENCE

1987 - Present **Community Health Director**, Tanana Chiefs Conference, Fairbanks, Alaska. Responsible for the planning, development, funding, and direction of behavioral health programs in 43 predominantly Alaskan Native communities throughout northern interior Alaska. Supervise 50+ professionals and paraprofessionals. Urban and rural programs managed include health and safety education, AIDS and toxic fetal effects prevention, community mental health, substance abuse treatment and prevention (including three remote site Athabaskan alcohol recovery camps and a 16-bed adolescent residential substance abuse treatment program for Alaskan Natives), paraprofessional training, and maternal/infant nutrition.

1985 - 1986 **Assistant Professor and Internship Coordinator**, University of Alaska, Fairbanks. Taught graduate classes in community psychology and cross cultural counseling, developed internship opportunities, placed and supervised graduate students in community internship placements. Conducted and supervised research. Participated in the development of an innovative community psychology graduate program curriculum.

1984 - Present **Self-employed Clinical/Community Psychologist**. Major contracts have included grant and proposal preparation, social services research, program management, evaluation, psychotherapy, clinical supervision, and consultation. Under contract with the Alaska Division of Mental Health and Developmental Disabilities and Weisenbach Inc. oversaw the development of residential, day treatment, and other specialized services for emotionally disturbed adolescents and mentally ill adults.

1977 - 1983 **Assistant Professor of Medical Sciences**, University of Alaska, Fairbanks (adjunct).

1977 - 1983 **Director, Tanana Chiefs Mental Health Programs**, Fairbanks, Alaska. Developed and directed behavioral health programs serving northern interior Alaska. Implemented treatment, training, and prevention programs in mental health substance abuse, infant learning, and other areas. Provided clinical services in Fairbanks and at satellite clinics in remote villages; recruited, trained, and supervised professional and paraprofessional staff; wrote successful grant applications and contract proposals and assisted communities in the development of locally based behavioral health services. Innovative projects included a regional children's newspaper, a widely acclaimed fetal alcohol syndrome prevention project, a summer survival camp for troubled youth, and a regional village arts program.

1974 - 1975 **Psychological Consultant**, Maricopa County Juvenile Court Center, Phoenix, Arizona (half time). Assessment, program development, staff training, consultation, individual and group therapy.

1974 **Drug Abuse Counselor**, Community Organization for Drug Abuse Control, Phoenix, Arizona. Served poly-drug abusing clients of all ages at a short term behavioral evaluation and holding unit and at the central intake facility. Emphasis was on individual and family interventions.

1973 - 1974 **Psychology Trainee**, Social Learning Division of Arizona State Hospital (half time). Assessment, consultation, staff training, and treatment including individual and group psychotherapy and ward management activities in a token economy setting.

1972 - 1973 **Teaching Assistant**, Arizona State University (half time). Taught experimental and developmental psychology in a supervised teaching experience.

1968 - 1972 **Research Assistant**, University of Oregon Human Neuropsychology Laboratory. Under the direction of Dr. Peter M. Lewinsohn, administered Halstead-Reitan Battery and other psychometric tests to brain injured clients and research subjects. Conducted and reported research in depression and neuropsychology, supervised support staff.

GRANT WRITING AND MANAGEMENT

A strong record of consistently funded proposals and professionally managed grants is reflected in successful projects funded by the University of Alaska, National Institute of Mental Health, State of Alaska Divisions of Mental Health and Developmental Disabilities, Alcoholism and Drug Abuse, Family and Youth Services, Public Health, and Vocational Rehabilitation, National Endowment for the Arts, Alaska Humanities Forum, Federal Office of Substance Abuse Prevention, and U.S. Public Health Service.

PUBLICATIONS

"A follow-up study of patients who have suffered brain injury." With Peter M. Lewinsohn. Journal of Community Psychology, 1, (1), 57-62, 1973.

"Pleasant activities and depression." With Peter M. Lewinsohn. Journal of Consulting and Clinical Psychology, 41, (2), 261-268, 1973.

"Negative self-evaluation and depressed mood." With Randy Frost and Joseph Becker. Journal of Consulting and Clinical Psychology, 48, (1), 1979.

"Community mental health in rural Alaska -- A joint report." With Nettie Scott, Susan Soule, Daniel Bill, Jeff Friedman, Boy Collier, Sharon Walluk, and Evelyn Wiszinckas. Coping, Winter, 1982.

Our First Baby -- But Love Wasn't Enough With Maxine Thibedeau, Tanana Chiefs Conference, Fairbanks, Alaska, 1982. (A "tragic romance" fetal alcohol syndrome prevention comic book aimed at a high risk rural population).

"When more isn't necessarily better -- Program proliferation and the plight of rural services." Coping, Spring, 1983.

"I think we'll do better next time." Coping, Fall, 1988.

Village With Steve Crosby and Maxine Thibedeau, Tanana Chiefs Conference, Fairbanks, Alaska, 1990. (A community development/substance abuse and suicide prevention comic book aimed at a high risk rural population).

"Freighters -- Travel for the unhurried adventurer." Accepted for publication, Rider.

PROFESSIONAL ASSOCIATION PRESENTATIONS

A follow-up of brain injured clients referred to Vocational Rehabilitation. With Peter M. Lewinsohn. Presented at Western Psychological Association Convention, 1973, in Portland, Oregon.

Depression, anxiety, and altruism. Presented at Western Psychological Association Convention, 1975, in Sacramento, California.

The use of a mood-related activities schedule in the treatment of depressed persons. Presented at Western Psychological Association Convention, 1976, inn Los Angeles, California.

Innocence and experience - Social skill training for developmentally disabled children. With Eric Trupin and Lewayne Gilchrist. Presented at 9th Annual International Conference on Behavior Modification, 1977, in Banff, Alberta.

The contribution of neuropsychology to the assessment and treatment of children's social skill deficits. With Lewayne Gilchrist. Presented at Western Psychological Association Convention, 1977, in Seattle, Washington.

Rural internships: A solution to problems you may not know exist. Presented at Western Psychological Association Convention, 1978, in San Francisco, California.

Velten's depressed mood induction -- Self-devaluation or somatic suggestion? With Randy Frost and Joseph Becker. Presented at Western Psychological Association Convention, 1979, in San Diego, California.

Prior stress and the induction of depressed affect. With Pamela Woods and Charles Geist. Presented at Western Psychological Association Convention, 1980, in Honolulu, Hawaii.

Ethical issues, patient rights and effective treatment in a rural transcultural setting -- The Alaskan bush. Presented at Western Psychological Association Convention, 1981, in Los Angeles, California.

Creating and maintaining children's services networks. Presented at National Indian Child Conference, 1981, in Albuquerque, New Mexico.

Strangers in estranged families -- Cultural barriers and disoriented interventions. Presented at Child Welfare League of America Convention, 1981, in Anchorage. Alaska.

Only the best for this baby -- A multiple-impact prevention program. Presented at Behavioral Sciences Conference of the North, 1985, in Anchorage, Alaska.

Alaska's forgotten people -- the invisible Athabaskans. Presented at the Alaska Anthropological Association convention, 1986, in Fairbanks, Alaska.

Patient rights in remote culturally distinct settings. Presented at the American Psychological Association Convention, 1986, in Washington, D.C.

Why recreational/alternative activity and education/prevention programs fail. Round table presented at the Second National Learning Community Conference on High Risk Youth, 1988, in Washington, D.C.

Identifying mental health issues for interpersonal violence and substance abuse workers. Presented at 15th annual School on Addiction Studies, 4th annual Mental Health Conference, and the Alaska Interpersonal Violence Conference, 1989, in Anchorage, Alaska.

PROFESSIONAL AFFILIATIONS

Member		**American Psychological Association**
Member		**National Association of Rural Mental Health Providers**
Member		**Society of Indian Psychologists**
President	(1982)	**Alaska Psychological Association**
President	(1980)	**Alaska Mental Health Program Directors Association** (V.P. 1979, 1981)

COMMUNITY SERVICE

Member	(1991)	**Governor's Mental Health Trust Resolution Task Force**
President	(1990-)	**Alaska Mental Health Board** (V.P. 1987-1989)
President	(1982-1983)	**Fairbanks Youth Services Board of Directors**
Chairman	(1978)	**Fairbanks Community Mental Health Advisory Board**
Vice-chair	(1985-1990	**District 20 Democrats**
Vice-chair	(1987-1990	**Interior Democrats**
Member	(1979)	**Fairbanks Rehabilitation Association Board of Directors**
Member	(1978-1982)	**Statewide Health Coordinating Council**
Member	(1985-1986)	**Fairbanks Community Mental Health Governing Board**
Member	(1972-	**American Civil Liberties Union**
Member	(1987-	**Advocacy Services of Alaska Board of Advisors**
Member	(1990)	**Fairbanks - Yakutsk Sister Cities Delegation**

CONTINUING EDUCATION

1977	Medical Aspects of Alcohol and Alcoholism (3-day seminar).
1978	Rational Emotive and Other Cognitive Approaches (2-day).
1979	Pain: Mechanisms and Management (2-day).
1979	Biofeedback Seminar (3-day).
1979	Hypnosis, Psychosomatics and Human Potential (2-day).
1980	Ericksonian Approaches to Hypnosis and Psychotherapy (5-day).
1983	Support Systems for the Chronically Mentally Ill (3-day).
1983-1984	Sabbatical year riding a motorcycle around the world, visiting 29 countries on 5 continents.
1985	Concepts of Mental Illness: Implications for Legislative Process (3-days).
1985	New Directions in Mental Health (3-days).
1986	Reaching Out to Forgotten Populations (2-day).
1988	Psychosocial Rehabilitation (9-day).
1988	Hazelden Professional in Residence (5-day).
1988	National Conference on Alcohol Abuse and Alcoholism (3-day).
1988	Mental Health Housing Symposium (3-days).
1988	National Learning Community Conference on High Risk Youth (3-day).
1989	National Learning Community Conference on High Risk Youth (3-day).
1989	Domestic Violence/Mental Health/Substance Abuse Cross Training (3-day)
1990	National Conference on Children of Dysfunctional Families (4-day).
1990	IHS National Mental Health Training Conference - Building Strong Indian Families (4-day).
1991	Using Telecommunications/Distance Learning in M.H. Human Resource Dev. (3-day)

HOBBIES

Frequent Traveler, Amateur Musician and Juggler, Shade Tree Mechanic, Avid Outdoorsman, Lifelong Motorcyclist, Old Car Enthusiast, Antique Tool Collector, Political Activist, and Voracious Reader.

REFERENCES

Will be sent on request.

Revised 5/91

CURRICULUM VITAE

William David Manahan, M.D.
Wellness Center of Minnesota
Good Counsel Drive
Mankato, Minnesota
(507) 345-7898

PROFESSIONAL EXPERIENCE

Medical Director of Quality Assurance, 1989 - present
Immanuel-St. Joseph's Hospital, Mankato, Minnesota

Visiting Faculty, 1988 - 1989
Community-Oriented Primary Care Teaching Program
Carney Hospital, Boston, Massachusetts (one year sabbatical)

Director, 1982 - present
Wellness Center of Minnesota, Mankato, Minnesota

Private Practice, 1973 - present
Mankato, Minnesota

Assistant Professor of Family Medicine, 1977 - 1986
Mayo Medical School, Rochester, Minnesota

Private Practice, 1978 - 1979
Kahuku, Hawaii (one year sabbatical)

Instructor, 1974 - 1978
Department of Family Practice and Community Health
University of Minnesota Medical Center, Minneapolis, Minnesota

Clinical Instructor in Family Medicine, 1972 - 1973
Department of Community Health and Family Medicine
University of Oklahoma

U.S. Peace Corps, 1967 - 1970
Patient care, health programming and administration
Ghana and Malaysia

PROFESSIONAL SOCIETIES

American Public Health Association, 1988 - present
American Holistic Medical Association, 1980 - present
Minnesota State Medical Association, 1973 - present
Minnesota Academy of Family Physicians, 1973 - present
Blue Earth County Medical Society, 1973 - present
American Academy of Family Physicians, 1967 - present

OFFICES AND ORGANIZATIONS

President, American Holistic Medical Association, 1990 - 1992
Advisory Board, School District 77 Drug Abuse Prevention Group, 1989 - present
Health Action Council, Mankato, 1987 - present
Board of Directors, American Heart Association, Mankato Division, 1986 - 1989
Advisory Board, Mankato Lutheran Home Care, 1986 - present

Board of Trustees, American Holistic Medical Association, 1985 - present
Member, Just Peace and Physicians for Social Responsibility, 1984 - present
Co-Founder and Director, Wellness Center of Minnesota, 1982 - present
Board of Directors, Minnesota Heart Health Program, Mankato, 1981 - present
Advisory Committee, Headstart Health Services, 1977 - present
President, Blue Earth County Medical Society, 1986 - 1987
Advisor, American Red Cross, Blue Earth County Chapter, 1979 - 1987
Board of Editors, *Patient Care* magazine, 1975 - 1987
Advisory Committee, Mankato Gay Group, 1976 - 1986
Task Force on Substance Abuse in School District #77, 1979 - 1984
Task Force on Early Periodic Screening for School District #77, 1977 - 1984
Advisory Board, Region Nine Human Services, 1977 - 1978
Advisor, Blue Earth County Public Health Nurses, 1976 - 1978
Advisory Committee, Rape Crisis Center, Mankato, 1976 - 1978
Chief, Department of Family Practice, Immanuel-St. Joseph's Hospital, Mankato, 1976 - 1978
Adjunct Faculty, Mankato State University, 1974 - 1978
Curriculum Committee, Department of Family Medicine, Mayo Medical School, 1974 - 1978

EDUCATION

Carney Hospital, Boston, Massachusetts, 1988 - 1989
Fellowship in Community-Oriented Primary Care

University of Oklahoma Health Sciences Center, 1970 - 1972
Resident in Family Medicine

Santa Barbara County & Cottage Hospitals, 1966 - 1967
Santa Barbara, California; Rotating Internship

University of Minnesota Medical School, 1964 - 1966
Minneapolis, Minnesota; Medical Doctor

University of South Dakota Medical School, 1962 - 1964
Vermillion, South Dakota; Master of Science in Medicine

University of Minnesota, 1960 - 1962
Minneapolis, Minnesota; Bachelor of Arts in English Literature

College of St. Thomas, 1958 - 1960
St. Paul, Minnesota

CERTIFICATION AND LICENSURE

Diplomate of the American Board of Family Practice, 1973
Recertification by exams: 1979 and 1986

M.D. License in Minnesota, by exam, 1966

GRANTS AND FELLOWSHIPS
1991

Minnesota Department of Public Safety, Office of Drug Policy.
Governor's Program Grant for Multi-disciplinary Chemical Abuse Prevention Teams. Awarded to the Wellness Center of Minnesota for $11,000. Director: William Manahan.

1989 - 1992	W.K. Kellogg Foundation, Hospital Research and Educational Trust, and National Rural Health Association. Community-Oriented Primary Care National Rural Health Demonstration Grant. Awarded to the Wellness Center of Minnesota for $75,000. Director: William Manahan
1988 - 1989	Bush Foundation, St. Paul, Minnesota. Bush Clinical Fellows Program. Community-Oriented Primary Care Fellowship at Carney Hospital, Boston, Massachusetts, for $36,000. Awarded to William Manahan.
1988	Southwestern Minnesota Initiative Fund. Grant to train "Rural Pastors in Facilitating Change". Awarded to the Wellness Center of Minnesota for $24,000. Director: William Manahan.
1988	Southeastern Minnesota Initiative Fund. Grant to train "Community Leadership in Times of Change". Awarded to the Wellness Center of Minnesota for $23,160. Director: William Manahan.
1987	Southeastern Minnesota Initiative Fund. Grant to train "Rural Pastors in Facilitating Change". Awarded to the Wellness Center of Minnesota for $30,000. Director: William Manahan.

PUBLICATIONS AND MAJOR PRESENTATIONS

1. Manahan, W.D.: American Holistic Medical Association President's Message. "Holistic Medicine." Bimonthly publication, January - December 1990.

2. Manahan, W.D.: The Marriage of the Community and the Primary Caregivers in Rural America. Presentation at the American Public Health Association Annual Meeting, New York City, October 3, 1990.

3. Manahan, W. D. : Can a Physician Survive Financially in a Wellness-Oriented Medical Practice? "The Bulletin of the Society for Professional Well-Being". Vol. 2, No. 3, Mar. 1990.

4. Manahan, W. D. : The Community As The Patient. "Minnesota Medicine". Vol. 72, 703-704, December 1989.

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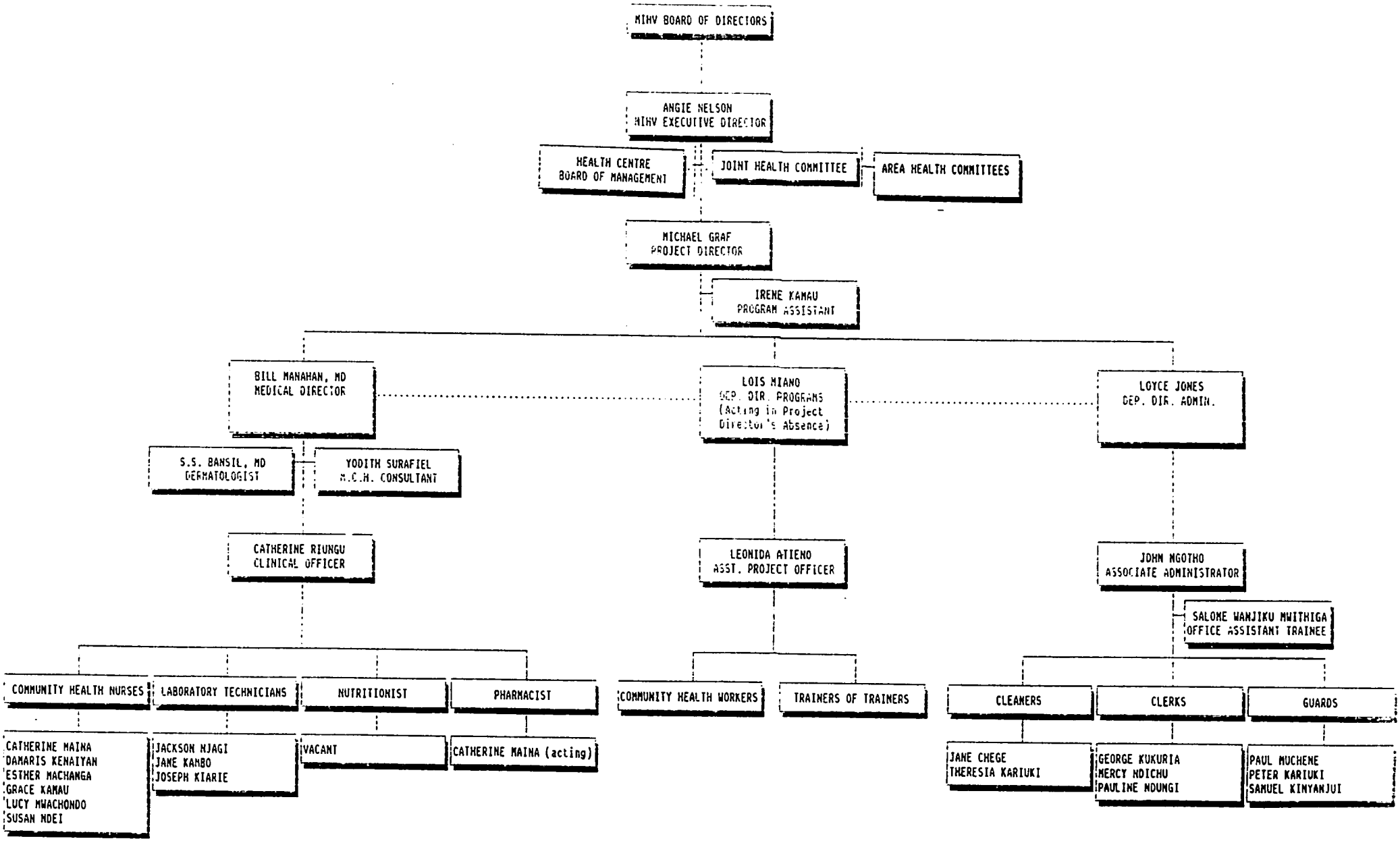
17. Manahan, W. D.: Cox, B. G.: The Status of Family Medicine in Oklahoma. "The Journal of the Oklahoma State Medical Association." Vol. 66, No. 4, April, 1973.

MIHV DAGORETTI COMMUNITY HEALTH SERVICE

ORGANIZATIONAL CHART



Loyce Y. Jones
1239 Eleanor Avenue
Saint Paul, MN 55116

RESUME

EMPLOYMENT

1982-Present CLINIC MANAGER, GROUP HEALTH INC.; Minneapolis, MN
Currently manage 24,250 member primary care clinic with $5,000,000 budget. Responsible for laboratory, radiology, pharmacy and optical services as well as all nursing and clerical support staff to physicians. Experienced in union environment and on negotiating team. Recognized for ability to develop management team members. Experienced in facility management including renovation and expansion. Year end expense budgets consistently at or below target. Management of change a strong ability Have managed three different Group Health, Inc clinics.

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1957-1966 STAFF AND CHARGE NURSE, VETERANS ADMINISTRATION AND MADISON GENERAL HOSPITALS; Madison, Wisconsin and MARSHFIELD CLINIC; Marshfield, WI.
Surgical, medical, and geriatric in-patient unit and orthopedic outpatient clinic experience. Evening and night charge nurse responsibilities.

PROFESSIONAL ACTIVITIES

ISP Alumni and Student Association Council, President 1987-88, Member 1987-Present

Minnesota Medical Group Management Association, 1983-Present.

Medical Group Management Association, 1977-80, 1989-Present.

Member, Bloomington Chamber of Commerce, 1988-Present, Member, Business Executive and Education Exchange Program, 1990-Present.

Coulee Region Business and Professional Women, President Elect and Program Chair, 1981-82.

American Academy of Ambulatory Nursing Administration, 1979-80.

American, Wisconsin, and District Nurses Associations, 1976-80. District Board of Directors, 1977-80; Wisconsin Commission of Nursing Administration, 1978-80; WNA House of Delegates, 1978-80; WNA Program Committee, 1979.

PRESENTATIONS AND PUBLICATIONS

"Physician-Nurse Interaction: Conflict, Compromise, or Cooperation?" Group Practice Journal, 1981.

Speaker, various fraternal and educational organizations, Minneapolis/St. Paul metropolitan area, 1985-87.

Speaker, ISP Student Orientation, University of Minnesota, "The Role of the Health Care Manager", 1986

Speaker, American Academy of Ambulatory Nursing Administration, Orlando, Florida. "Physician-Nurse Interaction: Conflict, Compromise, or Cooperation?", 1980.

Panel Member, National Annual Workshop for Nursing Administrators in Ambulatory Care. Champaign, Illinois. "Use of Allied Health Professionals", 1976.

EDUCATION

University of Minnesota. School of Public Health, Master in Public Health, 1990.

University of Minnesota, ISP Program in Health Services Administration, 1985-87, 1989-90. Credential of Advanced Studies in Ambulatory Care Administration.

Metropolitan State University, 1987-89. BA in General Business, 1989.

Madison General Hospital School of Nursing, 1954-57. Registered Nurse, State of Wisconsin. (Currently inactive)

REFERENCES

Available on request.

CURRICULUM VITAE

William David Manahan, M.D.
Wellness Center of Minnesota
Good Counsel Drive
Mankato, Minnesota
(507) 345-7898

PROFESSIONAL EXPERIENCE

Medical Director of Quality Assurance, 1989 - present
Immanuel-St. Joseph's Hospital, Mankato, Minnesota

Visiting Faculty, 1988 - 1989
Community-Oriented Primary Care Teaching Program
Carney Hospital, Boston, Massachusetts (one year sabbatical)

Director, 1982 - present
Wellness Center of Minnesota, Mankato, Minnesota

Private Practice, 1973 - present
Mankato, Minnesota

Assistant Professor of Family Medicine, 1977 - 1986
Mayo Medical School, Rochester, Minnesota

Private Practice, 1978 - 1979
Kahuku, Hawaii (one year sabbatical)

Instructor, 1974 - 1978
Department of Family Practice and Community Health
University of Minnesota Medical Center, Minneapolis, Minnesota

Clinical Instructor in Family Medicine, 1972 - 1973
Department of Community Health and Family Medicine
University of Oklahoma

U.S. Peace Corps, 1967 - 1970
Patient care, health programming and administration
Ghana and Malaysia

PROFESSIONAL SOCIETIES

American Public Health Association, 1988 - present
American Holistic Medical Association, 1980 - present
Minnesota State Medical Association, 1973 - present
Minnesota Academy of Family Physicians, 1973 - present
Blue Earth County Medical Society, 1973 - present
American Academy of Family Physicians, 1967 - present

OFFICES AND ORGANIZATIONS

President, American Holistic Medical Association, 1990 - 1992
Advisory Board, School District 77 Drug Abuse Prevention Group, 1989 - present
Health Action Council, Mankato, 1987 - present
Board of Directors, American Heart Association, Mankato Division, 1986 - 1989
Advisory Board, Mankato Lutheran Home Care, 1986 - present

Board of Trustees, American Holistic Medical Association, 1985 - present
Member, Just Peace and Physicians for Social Responsibility, 1984 - present
Co-Founder and Director, Wellness Center of Minnesota, 1982 - present
Board of Directors, Minnesota Heart Health Program, Mankato, 1981 - present
Advisory Committee, Headstart Health Services, 1977 - present
President, Blue Earth County Medical Society, 1986 - 1987
Advisor, American Red Cross, Blue Earth County Chapter, 1979 - 1987
Board of Editors, *Patient Care* magazine, 1975 - 1987
Advisory Committee, Mankato Gay Group, 1976 - 1986
Task Force on Substance Abuse in School District #77, 1979 - 1984
Task Force on Early Periodic Screening for School District #77, 1977 - 1984
Advisory Board, Region Nine Human Services, 1977 - 1978
Advisor, Blue Earth County Public Health Nurses, 1976 - 1978
Advisory Committee, Rape Crisis Center, Mankato, 1976 - 1978
Chief, Department of Family Practice, Immanuel-St. Joseph's Hospital, Mankato, 1976 - 1978
Adjunct Faculty, Mankato State University, 1974 - 1978
Curriculum Committee, Department of Family Medicine, Mayo Medical School, 1974 - 1978

EDUCATION

Carney Hospital, Boston, Massachusetts, 1988 - 1989
Fellowship in Community-Oriented Primary Care

University of Oklahoma Health Sciences Center, 1970 - 1972
Resident in Family Medicine

Santa Barbara County & Cottage Hospitals, 1966 - 1967
Santa Barbara, California; Rotating Internship

University of Minnesota Medical School, 1964 - 1966
Minneapolis, Minnesota; Medical Doctor

University of South Dakota Medical School, 1962 - 1964
Vermillion, South Dakota; Master of Science in Medicine

University of Minnesota, 1960 - 1962
Minneapolis, Minnesota; Bachelor of Arts in English Literature

College of St. Thomas, 1958 - 1960
St. Paul, Minnesota

CERTIFICATION AND LICENSURE

Diplomate of the American Board of Family Practice, 1973
Recertification by exams: 1979 and 1986

M.D. License in Minnesota, by exam, 1966

GRANTS AND FELLOWSHIPS
1991

Minnesota Department of Public Safety, Office of Drug Policy.
Governor's Program Grant for Multi-disciplinary Chemical Abuse Prevention Teams. Awarded to the Wellness Center of Minnesota for $11,000. Director: William Manahan.

1989 - 1992	W.K. Kellogg Foundation, Hospital Research and Educational Trust, and National Rural Health Association. Community-Oriented Primary Care National Rural Health Demonstration Grant. Awarded to the Wellness Center of Minnesota for $75,000. Director: William Manahan
1988 - 1989	Bush Foundation, St. Paul, Minnesota. Bush Clinical Fellows Program. Community-Oriented Primary Care Fellowship at Carney Hospital, Boston, Massachusetts, for $36,000. Awarded to William Manahan.
1988	Southwestern Minnesota Initiative Fund. Grant to train "Rural Pastors in Facilitating Change". Awarded to the Wellness Center of Minnesota for $24,000. Director: William Manahan.
1988	Southeastern Minnesota Initiative Fund. Grant to train "Community Leadership in Times of Change". Awarded to the Wellness Center of Minnesota for $23,160. Director: William Manahan.
1987	Southeastern Minnesota Initiative Fund. Grant to train "Rural Pastors in Facilitating Change". Awarded to the Wellness Center of Minnesota for $30,000. Director: William Manahan.

PUBLICATIONS AND MAJOR PRESENTATIONS

1. Manahan, W.D.: American Holistic Medical Association President's Message. "Holistic Medicine." Bimonthly publication, January - December 1990.

2. Manahan, W.D.: The Marriage of the Community and the Primary Caregivers in Rural America. Presentation at the American Public Health Association Annual Meeting, New York City, October 3, 1990.

3. Manahan, W. D. : Can a Physician Survive Financially in a Wellness-Oriented Medical Practice? "The Bulletin of the Society for Professional Well-Being". Vol. 2, No. 3, Mar. 1990.

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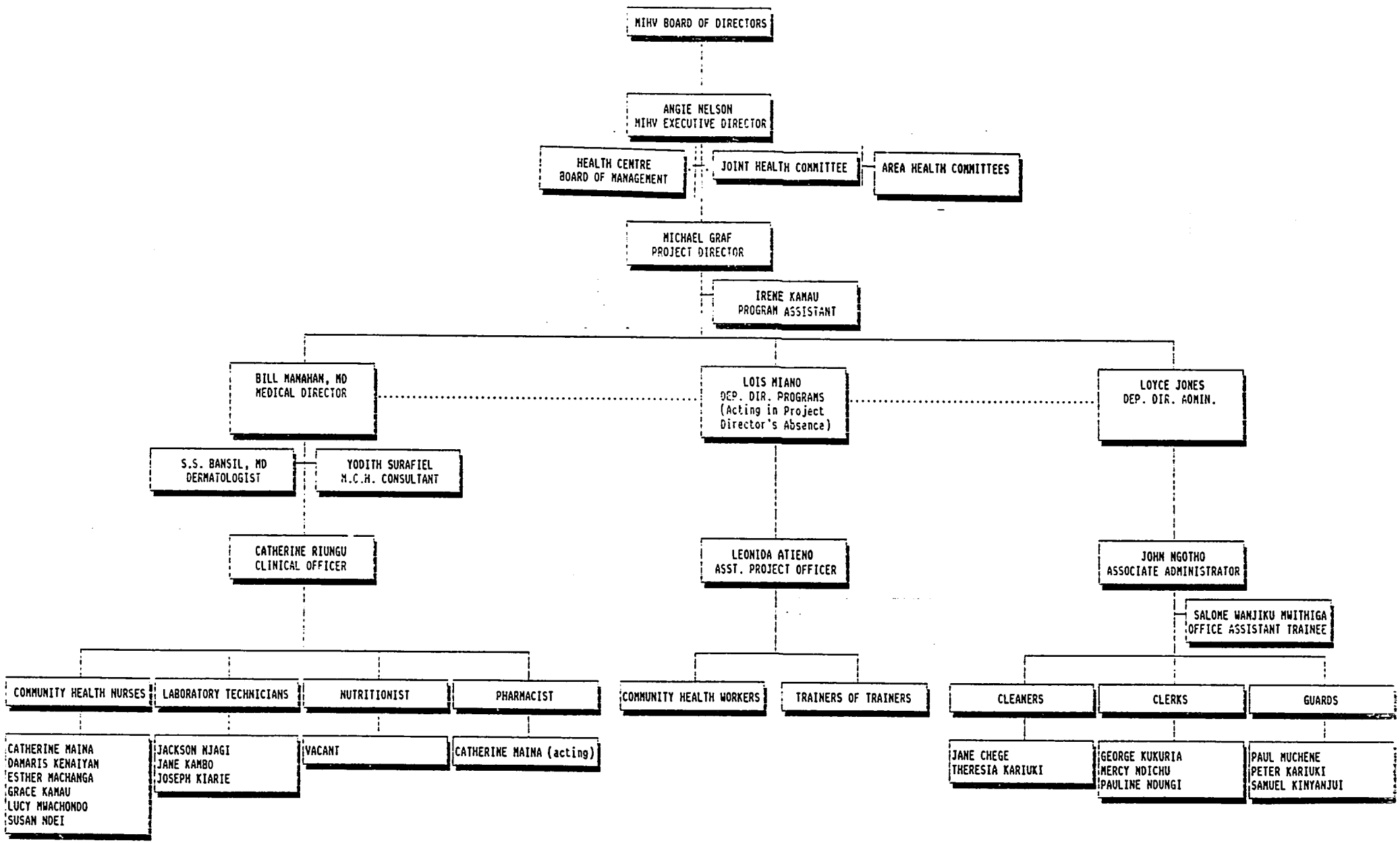

74

Medical Group Management Association, 1977-80, 1989-Present.

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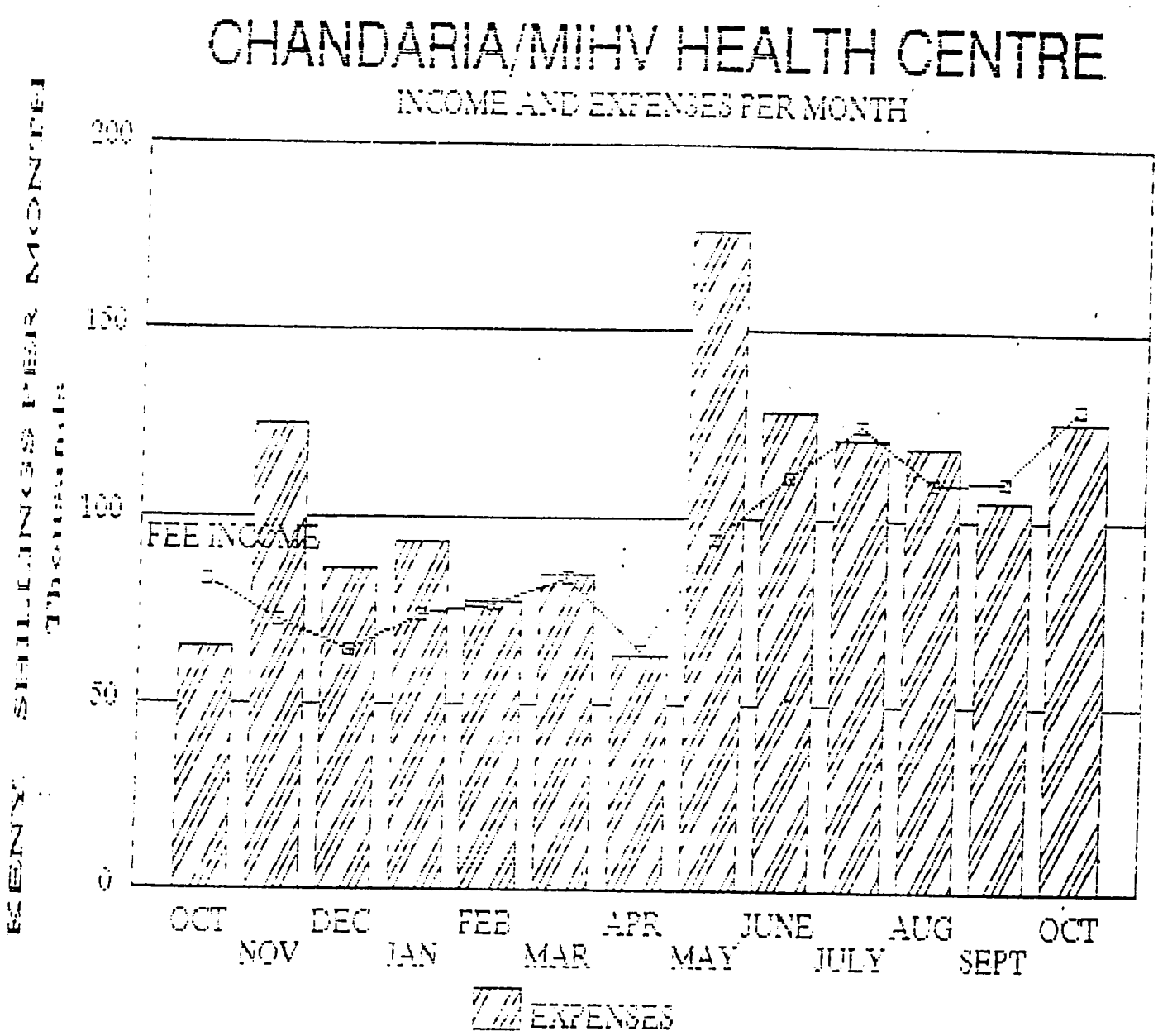
Appendix C: List of Continuing Education Topics for Health Center Clinical Staff

DATE	TOPIC OF LECTURE	NAME
14/11/91	Acute Respiratory Information	Jim Sanders
21/11/91	AIDS	Michael Mbogo
26/11/91	Diarrhea in Children	Jim Sanders
3/12/91	Ulcers and Bloody Stool	Patrick M.
10/12/91	Family Planning	Susan Kibue
31/12/91	Scabies and other Common Skin Disease	Grace K.
17/12/91	Sexually Transmitted Disease	Jim Sanders
19/12/91	Concepts of Primary Health Care	Mary Muthinja
7/1/92	CBHC in Dagoretti	CBHC Staff
9/1/92	Vaginal Bleeding	Lucy Mwachondo
14/1/92	Rabies and Tetanus	Mary Muindi
16/1/92	Malaria	Jane W. Kambo
21/1/92	Jaundice in Newborns	C. Riungu
28/1/92	Rabies	M. Muindi
30/1/92	Burns	C. Maina
6/2/92	Hepatitis B	J. Chin
11/2/92	Diabetes - Part 1	P. Mbugua (Med student)
13/2/92	Diabetes - Part 2	P. Mbugua
18/2/92	Child Development Ages 1 mo.- 1 year	J. Chin
27/2/92	Vaginal Discharge and Vaginitis	L. Mwachondo
3/3/92	Child Development Ages 1-5 yrs.	S. Kibui
5/3/92	Arthritis	J. Chin
12/3/92	Common Skin Diseases	J. Chin
17/3/92	HIV - A Patient's Perspective	Michael Mbogo
19/3/92	Tetanus, Neonatal	C. Riungu

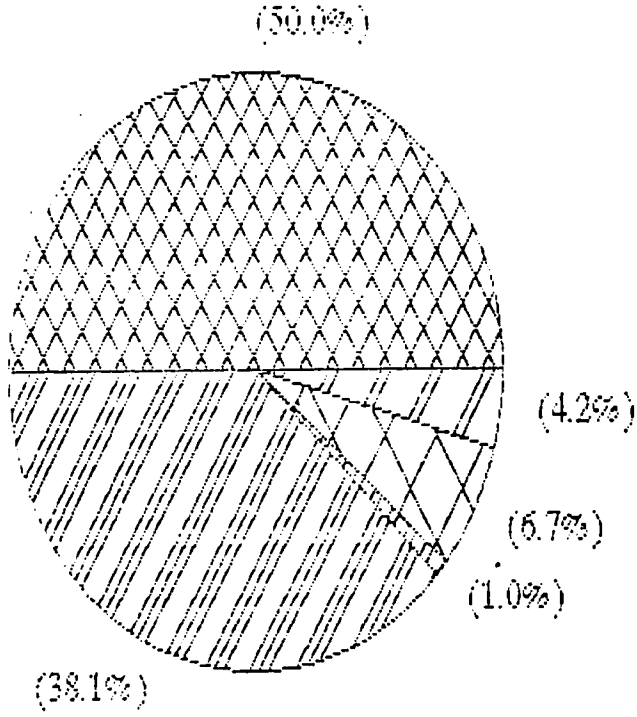
24/3/92	History of Family Planning	Y. Surafiel
26/3/92	AIDS	G. Kamau
31/3/92	Diff. Diagnosis of Abd. pain	J. Chin
7/4/92	Hypertension-post-poned	E. Machanga
16/4/92	Worms	J. Kambo
21/4/92	Iron Deficiency Anemia	M. Muthinja
28/4/92	URTI	A. Joplin (Med student)
5/5/92	Stomatitis	C. Maina
14/5/92	Hypo/Hyeprthyroidism	L. Mwachondo
28/7/92	Introductions; general format	Group Discusssion
4/8/92	Adolescent Pregnancy	Yodith Surafiel
11/8/92	Clinic charges	General Staff meeting
18/8/92	Malaria in Pregnancy	Esther Machanga
25/8/92	Mental Health Issues	Diane Manahan
1/9/92	Intestinal Worms	Jane Kambo & Joseph Karugu
8/9/92	General Discussion	General Staff meeting
15/9/92	Common Skin Problems	Bill Manahan
22/9/92	How clinical care and community health can connect	Lois Miano & Leonida Atieno
29/9/92	Evaluation of chest and abdonimal pain	Bill Manahan
6/10/92	Acute allergic (naphylactic) reaction.	Walter Juma
13/10/92	Maternity study analysis plus General Staff meeting	Mary Muthinja
20/10/92	Health Centre is closed	Holiday
27/10/92	Headaches	Catherine Riungu
3/11/92	Trauma (lacerations, abrasions and fractures)	Bill Manahan

Appendix D: Financial Charts for the Health Center



CHANDARIA/MIHV HEALTH CENTRE

1992 SEPTEMBER YEAR-TO-DATE EXPENSES



STAFF MEDICAL LAB FACILITY OFFICE