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**KENYA FOCUSED PROGRAMME REVIEW
PHASE II**

**A Report Prepared by PRITECH Consultants:
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**During The Period:
APRIL 27 - MAY 11, 1992**

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT

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PURPOSE OF VISIT

1. To participate as external consultants in the WHO-sponsored Focused Programme Review of the Kenya National Control of Diarrhoeal Diseases Programme (NCDDP), Phase II.
2. To assist the PRITECH country representative, Karen Blyth, in developing a proposal for a PRITECH initiative for training of NGOs in effective case management including development of monitoring tools to measure progress in implementation of the initiative.

FOCUSED PROGRAMME REVIEW: PHASE II

A. Process. During Phase I of the Kenya Focused Programme Review (see Trip Report of S.Endsley/G. Hirnschall), five priority constraints for the Kenya national control of diarrhoeal diseases programme (KNCDDP) were identified including-

1. home case management is poor
2. monitoring and supervision of district level activities is irregular
3. ORS supply and logistic problems including needs assessment, ORS supply monitoring, delays in ORS procurement and distribution, and over-reliance on external contributions
4. managerial issues confronting the NCDDP needing to be addressed include revision of programme targets, delays in implementation, sustainability of the programme, and the establishment of a DTU
5. quality of operational training at district levels is probably inconsistent and not monitored by central level staff.

During Phase II of the Focused Programme Review, members of the NCDDP were joined by external consultants from WHO/Geneva, WHO/Brazzaville, WHO/Kenya, PRITECH and UNICEF to examine these five priority issues in greater depth (see list of participants in Annex 2). Five working groups were formed consisting of 1-2 external consultants, 1-2 NCDDP staff, and 1-2 resource individuals. These working groups followed the protocol for Phase II of the Focused Programme Review (see Annex 1) which systematically guided the groups through-

1. in-depth analysis of the priority issue,
2. identification of potential solutions,
3. identification of feasible solutions,
4. selection of activities and preparation of a workplan.

The five working groups followed the schedule below:

- Day 1: Introduction to the protocol; formation of working groups; review of documents
- Day 2: Review of data collection instruments (DCIs); key informant interviews
- Day 3-9: Data collection in the field
- Day 9-10: Review of data collected; identification of solutions; selection of activities; preparation of workplan
- Day 11: Presentation of key findings and proposed activities to formal meeting of Ministry of Health, USAID, UNICEF, and invited guests.

The methods used, key findings, identified factors and proposed solutions and activities for each of the five working groups are presented in the draft report in Annex 2.

B. Results of the FPR Affecting PRITECH. A number of key findings and proposed activities were identified which potentially affect current and future CDD activities of PRITECH in Kenya. These findings are in the areas of programme sustainability, ORS commercialization, and home available fluids.

1. **Programme sustainability.** By 1993-94, contributions of UNICEF and USAID to the NCDDP will be substantially reduced. Four activities were proposed to address this problem of funding shortfalls. Among the four, MOH will be asked to include a line item in the budget for CDD which can then be used to propose specific activities to USAID and UNICEF. This may mean that after PRITECH II, USAID/Kenya may be asked to fund specific activities such as training, communications or operations research. It is unclear if the USAID mission will be able or willing to provide funding, even PL480 counterpart funding. If it does decide to fund specific, time-limited activities, this may be done potentially through a PRITECH III project.

2. ORS commercialization. The FPR team including Hans Faust of WHO concluded that the ORS needs of Kenya are already being met for the most part by current producers, Cosmos and Lab Allied, who should be supported further, including producing on tender from the NCDDP for public sector needs. The Sterling-Winthrop initiative was seen as not a particularly necessary or likely candidate to produce ORS in the near future. The ORS needs assessment done by Hans Faust using a methodology developed by WHO produced a national ORS need significantly lower than the 40 million sachets used by Camille Saade in his analysis of commercialization in Kenya. With the MEDS group providing ORS to the NGOs, central medical stores providing to the hospitals, and the Essential Drug Programme (EDP) providing to health centres and dispensaries, the team felt that ORS access will be adequately addressed.

3. Home fluids. The home case management group facilitated by Dr. Isabelle de Zoysa, the research director of WHO/CDD, concluded informally that uji is not the most appropriate candidate to be promoted as a home fluid. It was felt that uji is a food which is too thick even in the 'light' form to be useful for fluid therapy. WHO-sponsored research in Kakamega district is currently addressing home fluids in diarrhea to better inform the NCDDP on types and volumes of different fluids used by mothers for children with diarrhea which should be used by the NCDDP to review and revise, if necessary, its home fluids policy. The group concluded that more emphasis should be placed on communicating to mothers the need to increase fluids, any fluid, during diarrhea, and to provide adequate nutrition to the child. These messages should be more specific (types, quantities, frequencies). It was further recommended that development of new IEC materials, especially by PRITECH should await the development of these specific messages. Moreover, it was recommended that the NCDDP produce and distribute a clear policy statement on the use of home fluids.

THE PRITECH NGO EFFECTIVE CASE MANAGEMENT TRAINING INITIATIVE

Two days were spent by Agma Prins and Scott Endsley in consultation with Karen Blyth, PRITECH Kenya representative, on developing a NGO training proposal (see Annex 3). This proposal describes a six step process which includes-

1. a workshop to review and better organize the NCDDP operational/ effective case management training courses as recommended by the Focused Programme Review. Members of the NGO community would be invited to participate in this workshop with the view that the NGOs would use the resulting training course with minor adaptations for NGO training.
2. selection of NGO facilities to be included in four provincial NGO training workshops. One of these facilities per province would be utilized as a DTU site for these trainings. Participants for the workshops as well as potential trainers to attend the training of trainers course would also be selected. Facilities would be selected using a facility checklist (see Annex 4).
3. NGO curriculum meeting in which the NCDDP curriculum will be reviewed and adapted, if necessary, for the NGO training. It was agreed that a 'new' curriculum would not be the desired outcome, but modifications in terms of emphasis would be considered.
4. NGO training of trainers course
5. Effective case management workshops in each of four provinces at a pre-selected NGO DTU site.
6. CDD Community Outreach and Prevention Workshop for NGO outreach coordinators would be planned using the CEDPA-developed NGO materials.

Included in the NGO training course would be emphasis on monitoring of on-going activities using a supervisory checklist with optional case observation forms (see Annex 5). It was felt that a large-scale 'evaluation' of NGO training would be unwarranted.

The developed proposal will be submitted to PRITECH for approval of funding by the Karen Blyth following continued discussions with the three NGOs proposed for the PRITECH NGO initiative.

ANNEXES

- Annex 1: Focused Programme Review, Phase II Protocol**
- Annex 2: Phase II FPR Report**
- Annex 3: PRITECH NGO Proposal (draft)**
- Annex 4: Facility Selection Checklists (2)**
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**GUIDELINES TO CONDUCT A
FOCUSED PROGRAMME REVIEW
(FPR)**

**Phase II:
Finding solutions for priority issues**

**DRAFT
APRIL 1992**

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Use of this manual:

This manual, in section A, outlines the objectives of the review, the major steps of the process, and schedule and the expected outcome. In section B, the process is outlined in detail, the rationale for each step is described, examples are provided, and notes for the facilitator how to moderate the group process are made.

A copy of this manual should be distributed to each team member of phase I well in advance. The manual is meant to assist the national programme manager and his team to successfully plan the activity (in reference to section A) and to be used as a guide throughout the process (section B).

Short "process" descriptions are provided at the beginning of each task. It is recommended that the facilitator asks all participants to first read these descriptions, and to then provide additional verbal explanations, if required. The "notes for the facilitator" are naturally directed towards the person who is facilitating the group process, and they outline suggestions how the various tasks may be organized in an efficient and dynamic group process.

A. OVERVIEW:

a) Objectives:

The Focused Programme Review (FPR) is a **two-phase process** (see diagram 1):

In **phase I**, achievements and constraints of the programme have been identified. Constraints have then been prioritized. For the selected priority issues, additional data requirements (to better characterize the issue and to identify solutions) have been specified and a plan has been developed for the data collection efforts to be carried out in phase II.

The overall objective of **phase II** of the review is to analyze the priority issues, to collect relevant data and information and to identify solutions (sets of activities) which should, when appropriate, be integrated in the overall work-plan.

Specific objectives of phase II are to guide a process to:

- identify important factors that contribute to the constraint and to allow an analysis of the priority issues
- to generate, assess and select potential solutions for implementation
- to develop a plan to implement feasible solutions and to monitor their implementation

Diagram 1: Phases of Focused Programme Review

	Activity	Duration
Phase I:	Identification of Achievements and Priority Issues Planning for Phase II	1 week
Interval:	Preparations for Phase II	6-8 weeks
Phase II:	Identification of solutions to Priority Issues Development of work-plan	2 weeks

PHASE II

b) Format:

The objectives of phase II will be achieved by a team of reviewers (see c.) during a two week period (see e.). A structured process will be applied (see h.). A facilitator moderates the process. The expected outcome of the exercise (see g.) will be solutions (sets of activities) for the priority to be integrated into overall CDD work-plans.

In some countries, the integration of the work-plan suggested by the FPR team into the existing overall work-plan will require substantial re-planning. In such situations, overall re-planning of the national CDD programme might have to follow the FPR (it is evident that the time to conduct a FPR needs to be carefully considered and planned).

c) Team composition:

The review team for this phase should consist of national CDD programme managers, programme managers from other programmes and representatives of relevant donor agencies. It is desirable that all team members of phase I will also participate in phase II. The function of external consultants is not only to guarantee external validity for the review process, but also to provide specific technical expertise related to the identified priority issues. The size of the review team will mainly depend on the number of priority issues that have been selected for phase II (normally 4 - 5), overall not more than 15 persons should be involved in phase II. The review team is divided into working groups, each priority issue is assigned to a working group which consists of three individuals:

- one team member from the national CDD programme, with sound knowledge of the programme in general and the specific priority area
- one external (international) reviewer with expertise related to the priority issue (from WHO, UNICEF, or other relevant donor agencies)
- one local resource person (outside the NCDDP) who has good knowledge of CDD activities and the specific priority issue (e.g., from the Division of Education, Family Health, Epidemiology, the Bureau of Statistics, EPI or other child survival programmes, etc.)

Decisions on the team compositions are made during phase I. It is crucial that all team members are briefed thoroughly prior to phase II on the outcome of phase I and the suggested process and expected outcome of phase II. All team members should receive a copy of the report of phase I which outlines data needs and proposed data collection methods and instruments for phase II.

Certain responsibilities should be assigned:

- the national CDD Programme manager should supervise all administrative and logistic arrangements throughout the review;
- one participant familiar with the review process should function as facilitator;
- one team member should be the rapporteur whose task is to summarize the team's findings and to finalize the report.

d) **Prerequisites for phase II:**

It is the responsibility of the national programme manager and his team to make necessary preparations for the review, in particular (use Annex 1: check-list for programme manager):

- notification (invitation) of suggested team members and confirmation of their participation
- Briefing of team members:

relevant programme documents have to be made available to all review participants. Each participant should receive a copy of all documents in advance. It will be of great advantage if all participants familiarize themselves with these documents before the beginning of phase II. It is suggested that a folder be prepared with a copy of all key documents and forwarded to all team members before phase II. If this is not possible due to time constraints, the folder should be distributed to participants upon arrival.

List of documents: all documents which have been reviewed during phase I should be prepared for phase II, specifically:

- national CDD Plan of Action (or Operation)
- national CDD policy statements
- previous review reports
- country profile
- survey reports (household case management, health facility, mortality, etc.)
- consultants' reports
- routine reporting data
- supervisory and monitoring reports
- relevant research papers, etc...

In addition to these programme documents, each review participant should receive a copy of the "Guidelines to conduct a Focused Programme Review" to have the opportunity to familiarize him(her)self with the process.

- Preparation of data collection forms:

during phase I and in the interval between phases decisions on data needs and on data collection methods are made by national and external review participants. For certain priority issues, data collection forms will be prepared for use in phase II. It is important that a sufficient number of copies of data collection forms is prepared for phase II.

- Selection of districts (health facilities, etc..) to be visited:

information might have to be obtained at different places and institutions, such as regional or district public health offices, different types of health facilities, households, drug vendors, pharmacies, ORS production plants, and others. Given the limited amount of time for data collection, only a limited number of facilities can be visited. It is obvious that collected information might not be representative for the whole country, where the review is being conducted. However, it is important that districts are chosen that are somewhat typical (representative) for CDD implementation and performance. It is also possible, if a team visits two districts, to choose one district where CDD efforts have been strong and another one where less emphasis has been given to CDD; hereby a range of information could be obtained which represents the two ends of the spectrum of CDD performance.

- logistic arrangements (meeting room, provision of flip-chart, overhead projector, writing materials, transport, etc.):

a meeting room will have to be made available for the two week period.

travel arrangements to the field need to be made in advance, and transport in the district has to be arranged.

- appointments with key informants:

interviews will be conducted with certain key informants at central level. Their availability should be confirmed in advance and appointments be made.

e) **Schedule:**

The activity will last two weeks. Scheduling within these two weeks can be handled rather flexible and according to each subgroup's perceived needs. For some priority issues additional data needs might be very limited and therefore the time allocated for data collection will be short (e.g., if a priority issues is "to set targets and sub-targets", then data needs might be rather limited). In other instances, very incomplete information might be available to the review team and the respective working group will have to go through a more extensive data collection exercise that will naturally require longer time periods (e.g., if a priority issue is "no ORS is available in the periphery", then the team might require more time to gather appropriate and specific information).

If a working group manages to complete their task of developing solutions to priority issues early, the remaining time can be utilized to test the feasibility and acceptance of their suggested activities.

Suggested schedule:

- Day 1: - Opening
 - Briefing of review team:
 objectives
 procedure
 brief presentation of results (phase I)
- Day 2: - Review of relevant documents and data within working groups
 - Interviews with key informants (optional)
- Day 3: - Continuation of interviews with key informants at central level
 - travel to field (as required by working groups)
- Day 4 - 9: - field visits (or continuation of interviews at central level, as required)
 - preliminary drafting of solutions by working groups
- Day 10: - Working groups return from field visits
- Day 11: - finalization of working group reports
 - presentation to review team and discussion, preparation of final report
- Day 12: - preparation of final report (contd.)
 - presentation to MoH and donors and interested parties

f) Venue:

Initially 2-3 days will be held mostly in group sessions among the whole review team, on days two and three some team members might be conducting interviews with key informants. The team will then be divided in working groups, and will conduct the interviews at central levels and the field visits. Towards the end of the review, all working groups will meet in the capital city again. A conference room that comfortably accommodates the review team (about 8 review persons, 1-2 support staff) and that provides the necessary equipment (overhead projector, flip-chart, etc..) will have to be arranged for the duration of the review. It is essential that all team members attend all sessions and consider the review a **full-time activity**.

g) Outcome of phase II:

Report

Throughout the process of phase II the working groups analyze priority issues, investigate reasons for their occurrence and develop solutions. Each working group will have to prepare a report in regard to their assigned priority issues that contains:

- an exact statement of the priority issue
- reasons and factors affecting the area under investigation
- results from field visits
- a summary of potential solutions to address the priority issue
- the solution that appears to be the most feasible and effective
- a detailed summary of activities that constitute the solution to the priority issue
- a work-plan that incorporates all the suggested activities, and specifies the time-frame, the responsibilities and the budget sources.

The working group reports will then be synthesized into an overall report that contains the work-plan.

h) Major Steps of phase II:

The following steps will be performed for each priority issue:

- I. In-depth analysis of the priority issue
- II. Identification of potential solutions
- III. Identification of feasible solutions
- IV. Selection of activities and preparation of workplan

i) Use of work-sheets:

The following work-sheets will be used:

- 1A: Identification of reasons (factors)
- 1B: Construction of causal tree
- 2: Potential activities
- 3: Estimated input for potential activities
- 4: Activities for work-plan

B. DETAILED OUTLINE OF PROCESS:

STEP I: IN-DEPTH ANALYSIS OF THE PRIORITY ISSUE:

Notes for facilitator:

Before the tasks 1-4 can be performed by the working groups, the facilitator should:

- welcome and introduce the review team members and briefly outline the review process:*
- describe the objectives of the FPR, Phase II*
- outline the schedule, and expected outcome of Phase II*
- ask the national programme manager to present the results of Phase I (in particular the achievements and constraints, and the priority issues that have been selected)*
- announce the composition of the working groups and their assigned priority issues.*

At the end of this introductory session, all team members should have a sound understanding of the objectives and the process of the FPR. The flow-chart which outlines the steps and tasks of Phase II will serve as a teaching aid.

TASK 1: Review of relevant data and programme documents:

Process:

During phase I various documents have been reviewed that lead to the identification of priority issues. These documents will be briefly reviewed by the respective working groups. All team members should familiarize themselves with essential programme documents, such as the "National CDD Plan of Operation", the "National CDD policy statements", and the report of Phase I.

Notes for facilitator:

The following tasks will be done by the working groups (WG). It might be advisable that each working group nominates a working group chairman who will later on present the WG findings to the rest of the team.

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- ask each WG to briefly review relevant programme documents. Phase I participants should be helpful to identify which documents should be reviewed by their WG.

TASK 2: Discussion of additional data needs / suggested data collection instruments:

Process:

To better characterize a priority issue and to identify solutions, in most cases, additional information will be required.

During Phase I, these additional data needs have been identified and data collection methods have been suggested. During the interval between the two phases data collection forms should have been finalized to be used during Phase II.

The WGs will have to review and, if necessary, modify, the plans and instruments for data collection. Each WG should carefully familiarize themselves with the suggested data collection methods and instruments.

It is important that the following elements are well specified and discussed

- exact details of information to be collected
- place, time-frame, sample size

In some instances, it will be necessary to develop additional simple instruments (e.g., check-lists, questionnaires,...) which would guide interviews with key informants.

Notes for facilitator:

- ask each WG to review the suggested data collection methods and instruments, and to familiarize themselves with respective data collection forms.
- for the interviews at central level: ask each WG to prepare
 - a list with all persons that will be interviewed
 - an appointment schedule
 - prepare a brief check-list containing the major pieces of information to be asked for each planned interview
- ask each WG to present briefly their terms of reference, the data collection methods and instruments to the whole review team; it is important that all team members are

aware which information and data will be collected by each WG in order to avoid duplication of efforts.

It is probably helpful to note on a flip-chart:

- the working group topic (priority issue)*
- which types of data will be collected (e.g., information on health worker performance)*
- where this information will be collected (e.g., in 6 health centres in districts X and Y)*
- the expected schedule of each WG (leaving on ... returning on...)*

- who will be interviewed at central level (in order to coordinate interviews among working groups)*

- interviews at central level will be conducted at day 2 and/or three of the review (for some priority issues even more time might be needed at central level)*

- discuss the logistics of the field visits. It is expected that the national programme manager and his time have arranged transports to the field before the arrival of the review team. As facilitator, make sure that the following items are arranged for each WG:*
 - transport at central level to conduct interviews*
 - transport to respective districts (tickets, ...)*
 - transport at the districts*
 - notification of district level staff*
 - per-diem for field visits*

TASK 3: Collection of data:

Process:

The WGs will then conduct the interviews at central level and the field visits according to plan. It is expected that each WG prepares a summary of their findings and suggests solutions upon return from the field, which will be presented to the other WGs.

It is essential that all team members have a good understanding of the concept of how priority issues will be analyzed and solutions be developed. Therefore, it is necessary that the facilitator outlines the process that should be followed for the identification of solutions by each WG (task 4 and steps II and III).

Notes for facilitator:

- *explain task 4 and steps II and III as outlined on the following pages of this document. Use examples and work-sheets. Choose a "hypothetical" problem, and discuss "hypothetical" solutions with the team.*
- *make sure that a sufficient number of copies of the work-sheets is available for each WG to be taken into the field.*
- *outline in detail what the WC report (to be presented after return from the field, presumably on day 11) should contain:*
 - *situation analysis of the priority issue, stating factors and reasons that cause or contribute to the existence of the priority issue*
 - *statement of potential solutions*
 - *statement of feasible solutions (set of well defined, specific activities) will be incorporated into work-plan*
 - *completed work-sheets*

TASK 4: Identification of reasons/Analysis of priority issue:
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Process:

Before solutions can be developed, logically, reasons (factors) for the occurrence of a constraint will have to be identified. These factors, once established and ordered in a causal sequence, will then be addressed, when potential solutions are prepared.

In many instances, more than one factor will contribute to the existence of the priority constraint. It may be that

- all factors directly relate to a problem
- factors are causally interrelated (there is a causal chain of factors)

All considerations and decisions made during this task should be guided by data previously or currently collected. Sometimes, of course, in the absence of reliable information, it might be tempting for the team to simply speculate on possible factors for the occurrence of a constraint. Such speculations based on certain individuals' personal experience are valuable, and should, however, stimulate a process in which the WG attempts to identify information on which such suggested factors can be based on. In any case, factors included in work-sheets 1A and 1B should be justifiable by data as much as possible.

The review team should be aware that constraints occur because:

- activities have not been carried out according to plan
- some crucial activities have not been carried out in a timely fashion
- the plan did not specify the appropriate activities
- there was no plan

- a combination of these items

Notes for facilitator:

- *explain the objective and process of the current task and the format of work-sheets 1A and 1B as follows:*

Explanations to worksheet 1A:

On top of the page, the priority issues is stated. All reasons (factors) that cause or contribute the priority issue should be listed in whatever order in the rows below.

Explanations to worksheet 1B:

In the box in the centre of the worksheet the priority issue will be stated. The team should attempt to design a diagram of reasons where causal links are taken into account. Arrows should indicate how these factors relate to each other (see attached the completed sample worksheet). Ideally, the construction of a causal tree should be the outcome of this exercise. Once all reasons have been listed, a number should be assigned to each of them (which will be needed later). An example of a completed worksheet is attached in the annex.

- *ask the WGs to consider the following questions when analyzing the priority issue:*
 - *Why has a constraint occurred? What are the reasons that a certain activity has not been performed according to plan?*
 - *Why has an activity been delayed? What are the factors that caused the delay?*
 - *Who is responsible for the inadequate performance or delay? Which factors inhibited the persons-in-charge to perform according to plans (expectations)?*
 - *where has the constraint occurred? Have activities been carried out in all places (at all levels) according to plan? If not, what are the reasons for differences in performance in different places (geographical units, institutions, health facilities)?*
 - *Have activities been well specified in existing plan of action? Is the current work-plan specifying the appropriate activities?*

STEP II: IDENTIFICATION OF POTENTIAL SOLUTIONS

Process:

Once all factors contributing to the priority issue have been identified, solutions will have to be developed.

A solution to the issue will normally be the result of a number of well specified and successfully implemented activities.

Theoretically each factor can be "removed" (or alleviated), if one or several activities are implemented:

Example:

Factor: the national CDD training officer is not energetic enough to initiate training activities as planned

Potential activities:

- *replace the training officer with a more energetic person*
- *stimulate (give incentives) to the training officer by ...*
- *assign a dynamic assistant to the training officer*

Each factor should be considered separately and activities which would address this factor and hereby solve the constraint partially, be identified.

The solution itself (the combination of activities), and its components (single activities) need to fulfil certain requirements. They have to be:

- logical
- effective
- feasible

Example:

In the above-mentioned example (training officer...) the three potential solutions will have to be ranked according to the criteria. The activity that gets the highest score in the ranking will later be incorporated into the work-plan.

Description of criteria:

a) logical:

Logical means that it "makes sense" to carry out a certain activity to address a specific factor. In other words, a logical activity has to be causally linked to the factor it is supposed to influence. A "very logical solution" should "make sense" to all members of the team.

Annex 2

FOCUSED PROGRAMME REVIEW
KENYA NATIONAL CONTROL OF DIARRHEAL DISEASES PROGRAMME

Phase I: March 13 - 17, 1992

Phase II: April 27 - May 11, 1992

Final Report

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I. EXECUTIVE SUMMARY

A review of the national Diarrhoeal Diseases Control Programme (NCDDP) was carried out by the Government of Kenya with the participation of the NCDDP, WHO, UNICEF and PRITECH/USAID. A new process recently developed by WHO, the Focused Programme Review (FPR), was conducted in two phases: Phase I from March 16-20, and Phase II from 27 April to 8 May 1992.

Throughout the review key persons from the Government of Kenya (GOK), in particular within the Ministry of Health (MoH), and other relevant institutions were visited and interviewed.

Relevant programme documents were used to identify the programme's progress towards its targets and subtargets and to obtain information on the status of the CDD key indicators. In particular, findings of a household case management survey and a small scale health facility survey, previously conducted by the NCDDP in collaboration with WHO, were useful to identify gaps and areas for improvement related to diarrhoea case management practices in the home and at health facility level. During phase I, major findings were used to identify the following priority areas for the review team to focus on during phase II:

1. Home case management practices of diarrhoea
2. Supervision and monitoring of district level activities
3. ORS procurement and distribution, sustainability of ORS supplies
4. Management issues, such as the revision of targets and subtargets, the analysis of implementation delays, the overall programme sustainability and the feasibility of establishing a Diarrhoea Treatment Unit (DTU).
5. Quality of training activities conducted at district level.

During phase I, programme documents were reviewed and a limited number of interviews was conducted with key personnel to identify the programme status related to its targets, its achievements and major constraints. During phase II, the above mentioned priority areas were analysed in-depth by the review teams by collecting specific additional information. Site visits were conducted at all levels of health facilities (major hospitals, provincial and district hospitals, and health canters), at Provincial and District Health Management Teams, at ORS manufacturers and distributors, at pharmacists and at private sector practitioners. Structured questionnaires and check-lists were used to collect specific data in convenience samples of facilities. The obtained information was then used by the review teams to identify the major factors that influence successful programme implementation, and to recommend specific solutions. These recommendations were discussed with major decision makers and representatives of donor organisations. The NCDDP is committed to incorporate these solutions into the new CDD Plan of Operation which will be finalized in June 1992.

The major achievements of the NCDDP are:

- the national CDD policy statement on case management of diarrhoea
- ongoing training activities in case management and supervisory skills
- the establishment of 240 ORT canters/corners in health facilities
- ongoing communication activities, including the production and distribution of various educational print materials, and the dissemination of radio programmes
- the implementation of evaluation activities and research projects

Summary of major recommendations

1. Home case management practices of diarrhoea

- The CDD Programme should focus on key areas (such as increased fluid intake, preparation and use of ORS, etc.) in ongoing and any future IEC activities.
- The CDD Programme should ensure that IEC materials developed are effectively distributed.
- The CDD Programme should prepare a summary of its policy statement on case management in the home, and distribute this to all health facilities for easy reference.
- The CDD Programme should continue its training activities with increased emphasis on interpersonal communications to improve the ability of health workers to counsel caretakers on case management in the home.
- The CDD Programme should incorporate the control of diarrhoeal diseases, including effective case management and the rational use of drugs, within existing curricula for pre-service and in-service training of selected categories of health workers.

2. Supervision and monitoring of district level activities:

- The CDD programme manager should assign one CMU staff member the responsibilities of managing monitoring activities.
- The CMU staff responsible for monitoring should, as part of the monitoring plan, establish a CMU supervisory schedule which identifies dates and participants for all districts over the next two years.
- The CMU staff member responsible for monitoring should ensure the expeditious production and distribution of reporting forms and supervisory checklists to all districts in sufficient quantities.
- The NCDDP should budget for 1 follow-up visit of trainees of the mid-level supervisory course.

3. ORS procurement and distribution:

- Define the role of the national CDD programme with respect to the responsibility for assuring sufficient ORS in the country
- Establish a clear policy on the use of ORS which is a prerequisite for careful planning of ORS supplies in the coming years.
- Improve and intensify cooperation and collaboration with providers and distributors of ORS at all levels (EDP, CMS, UNICEF, MEDS, ORS manufacturers, etc.).
- Calculate the need of ORS for each of the coming years and assure its availability through monitoring of other ORS providers.
- Advocate the inclusion of ORS in CMSs' drug supply list and remind the hospitals of their responsibility to assure availability of ORS in their facilities.

4. Programme management:

- The NCDDP staff should finalize a detailed Plan of Operation for 1993-1997 and a mit-term Plan for 1993-94 within two months after the Focused Programme Review.
- The NCDDP Programme Manager and the Director of the Division of Family Health should submit this new Plan of Operation to key decision makers within the MOH to negotiate a budget line for CDD in the next forward budget.
- The NCDDP should submit this new Plan of Operation to current and prospective donor agencies including WHO, UNICEF, USAID and others in the next quarterly donors meeting (July 1992).
- The NCDDP Programme Manager should arrange advance consultations with donors and finance officials in MOH at least 1 month prior to planned activities.
- The NCDDP Programme Manager should closely monitor the timely implementation of planned activities by staff, enforce scheduled field visits, and ensure that trip reports are submitted within one week following field activities.
- The Director of Family Health should negotiate with the Department of Health Financing a proposal to increase the use of cost-sharing funds for CDD activities.
- The Bamako Initiative ("Community Financing of Health Care Services Initiative") should be enforced as a strategy for increasing community participation and funding of local CDD activities.

Efforts to establish a DTU at Kenyatta National Hospital (KNH) should be reinforced. Kisumu Provincial Hospital should be considered at a later stage as an appropriate site for a regional DTU in Western Province. Certain ORT canters should be upgraded to function as provincial or regional DTUs.

5. District level training:

- The NCDDP should organize workshops for revision of operational course content, methods and procedures.
- NCDDP should include funds in operational course budgets for one follow-up visit to each participant by trainers within three months of the completion of the course.
- During supervisory visits, the district health management team should continue to assist the establishment of ORT corners and identify potential trainees.
- NCDDP should send out technical update materials including a newsletter on regular basis to trained health workers.
- NCDDP should designate a clinical officer in each district to be responsible for content and practical training during operational courses.
- NCDDP should request of WHO/AFRO sufficient quantities of training materials well in advance of expected training activities and should also consider reprinting materials locally.

II. INTRODUCTION

The review of the national Diarrhoeal Disease Control Programme (NCDDP) of Kenya was conducted a Focused Programme Review (FPR) which was conducted in two phases: Phase one from March 16-20, 1992 followed by Phase II from 27 April to 8 May, 1992.

During phase I, the programme progress towards targets and its achievements and constraints over the last five year were identified. The constraints were then prioritized and priority issues which impeded implementation of planned activities were selected. Base on these identified priority areas, the NCDDP planned the terms of reference for the review teams, prepared the schedule of activities for phase II, selected key informants and sites to be visited during phase II, selected the participants and decided on team compositions.

During phase II, the review team was divided into five working groups which used a problem-solving approach to:

- analyze the priority issues in depth;
- identify potential solutions;
- select feasible solutions;
- attempt to incorporate these solutions into a work-plan

A list of the review team members is found in Annex 1.

The terms of reference for the four working groups (WG) were as follows:

- WG 1: Problem analysis of home case management practices of diarrhoea; assessment of quality and appropriateness of communication efforts and educational materials used.
- WG 2: Problem analysis of supervision and monitoring of district level activities; current activities and constraints to performance of supervision of selected district CDD staff, and to completion of routine reporting forms by district level health workers.
- WG 3: Problem analysis of ORS procurement and distribution, estimation of ORS needs in a "push" logistics system, sustainability of ORS supply.
- WG 4: Problem analysis of outstanding management issues: revision of targets and subtargets; assessment of factors related to implementation delays of various CDD activities; assessment of feasibility of establishing one (or possibly two) Diarrhoeal Training Units (DTU); assessment of programme sustainability.
- WG 5: Problem analysis of quality of district level training and monitoring of district level training courses by central staff

The outcome of the focused programme review is revised national targets and concrete recommendations for the preparation of the Plan of Operation for 1993-1997 and the Mid-term Plan for 1993-1994. The NCDDP foresees to finalize these plans shortly after the FPR.

The implementation of the review recommendations will be evaluated in a mid-term review by the end of 1994.

This report contains a summary of phase I activities and outcome, an overall description of Phase II, and the five working group reports related to the priority issues.

III. BACKGROUND

1. The diarrhoeal disease problem:

Diarrhoea is the second leading killer of children in Kenya. Along with respiratory disease and malaria, diarrhoea is associated with over 50% of all childhood deaths. On average, Kenyan children under five years of age experience four episodes of diarrhoea each year.

2. The National Control of Diarrhoeal Diseases Programme (NCDDP):

To address this important disease and its consequences, the Kenya Ministry of Health established a national control of diarrhoeal diseases programme in 1985 with the aim of reducing morbidity and mortality through five key strategies which include:

1. effective case management at health facilities and in the community,
2. adequate supply and use of safe, clean water,
3. improved personal, domestic and environmental hygiene,
4. improved nutrition through promotion of breastfeeding and proper weaning practices, and
5. measles immunization.

To date, NCDDP activities have been targeted on the first strategy. The initial five year plan (1987-1992) specified activities in training, supervision-ORT centres, ORS supplies and logistics, communications, information systems, and operations research. During this initial five years, the main emphasis has been on training and communications with lesser emphasis in the other programme areas. Two provinces - Western and Nyanza- were initially selected as pilot areas based on their high childhood mortality rates and their high prevalence of diarrhoeal diseases. Currently, the national control of diarrhoeal diseases programmes is operational in 42 districts serving 3.3 million children under five years (approximately 70% of all children under five years in Kenya).

Organizationally, the national CDD programme is situated within the Division of Family Health of the Ministry of Health. It is managed by a Central Management Unit (CMU) comprised of a full-time programme manager and seven full-time staff. Since 1990, efforts have been underway to decentralize CDD activities and their management to the provincial and district levels.

3. Achievements:

By 1992, there have been 240 ORT corners/ centres established in hospitals, rural health training centres, health centres, and dispensaries within the 42 districts. 95% of these facilities are supported by the Government of Kenya. Over 3000 health workers have been trained in diarrhoea case management with over 500 mid-level supervisors trained in supervisory skills by 1990. A computerized national training database has been established at

the Central Management Unit as has a ORT corner/ centre- based CDD information system.

There has been established a supervisory plan which focuses on district level supervision by the district health education officer (DHEO) and members of the provincial health management team. A supervisory checklist and district summary form have been developed and disseminated to the districts. The Central Management Unit provides annual funds to the districts, a portion of which is intended to finance supervisory activities. The Central Management Unit also does supervision. Six visits, principally to Western and Nyanza Provinces, have been done in the past two years.

The national policy on diarrhoea case management recommends use of oral rehydration salts (ORS) for the treatment of dehydration, and for the prevention of dehydration in the home when it is available. It has been estimated that at minimum, ORS needs are in the range of 4-5 million litres per year. To date, 13% of ORS in the country has been supplied through UNICEF donations; local producers have recently expanded production. Distribution to the public sector system is through two channels. The Essential Drugs Programme (EDP) distributes ORS in its kits to health centres and dispensaries. The Central Medical Stores provides ORS to hospitals as a 'loose' drug on request. The MEDS system distributes ORS to the non-governmental organizations (NGOs) in its private sector network.

From programme inception, communication and social mobilization have been integral components of the national CDD strategy. Pilot mass media campaigns were directed at Western and Nyanza provinces, but now cover all 42 districts. Booklets, flyers, posters, flip charts, stick-logos, radio messages and plays have all been produced and distributed. Currently, the Central Management Unit is working with the Kenyan Institute of Education (KIE) to develop a solar cassette programme for distribution to health centres. It also is working with KIE on developing materials for the Kenya school system on CDD.

Evaluation and research has also been an active component of the national CDD programme. Two household morbidity and treatment surveys have been completed (1987, 1990), a health facility survey was piloted in Kenya in 1988, and a recent training impact survey has been done. Numerous operational research studies have been done on information systems, home available fluids, mixing containers and other topics. Information from these surveys and studies have lead the national programme to refine its communication strategies, change the recommended ORS packet size from 1 litre to ½ litre, and to consider adoption of a common weaning porridge called 'uji' as the main recommended home available fluid for early treatment of diarrhoea.

4. Methodology:

Because 1992 is the end of the current five year planning cycle, the national CDD programme in early 1992 asked the World Health Organization (WHO) to assist in conducting a review of the programme. Using a newly developed WHO protocol for Focused Programme Reviews (FPR), the national programme performed a two phase programme review in March and April/May 1992 which is described in this report. The main principle of an FPR is the identification of programme achievements and priority areas which impeded programme implementation (during phase I), and the identification of feasible solutions for these priority areas (during phase II).

IV. PHASE I

The first phase of the Focused Programme Review was held in Nairobi during March 16-20, 1992. The objectives of this phase were to identify achievements and constraints of the NCDDP; to rank these constraints using a set of pre-defined criteria, and to establish a list of priority issues; further to plan the second phase which was scheduled for 27 April to 8 May.

The review team for phase I consisted of the full Central Management Unit including the programme manager and seven staff members. Also on the review team were two external facilitators from WHO and PRITECH.

Using the WHO protocol for Focused Programme Reviews, the phase I review team completed the following steps:

I. Identification of achievements and priority issues:

- 1) Review of programme documents
- 2) Identification of progress towards targets
- 3) Analysis of activities/achievements and constraints
- 4) Ranking of problems/identification of priority issues

II. Planning of Phase II:

- 1) Selection of team members
- 2) Terms of reference of working groups and identification of data needs
- 3) Planning of data collection
- 4) Briefing of interested parties

A selection of key programme documents were reviewed by the review team who reviewed and reported on key findings in the documents. Using information from these documents, a summary of 13 programme indicators was compiled (see Table 1).

Table 1

National CDD Programme Indicators Summary
from evaluations in 1987,88,90

	<u>1990</u>	<u>1987/8</u>
1. Training Coverage Rates*		
case management	452	
mid-level	577	
operational	2554	
MEASURED IN THE COMMUNITY		
2. ORS access rates	65%	
3. ORS use rate	10.8-29%	25.8%
4. ORT use rate**	69.4-93%	41.0%
5. Increased fluid intake rate	4-26%	36.4%
6a. Continued breastfeeding rate	96.2-100%	
6b. Continued feeding rate	46.2-80.5%	
7. Households with correct knowledge of when to seek care outside of home rate	5.8-50%	
8. Households able to correctly prepare ORS	2-41.7%	
9. Households able to correctly prepare RHF	na	
MEASURED AT HEALTH FACILITIES		
10. Cases correctly assessed	25.9%	
11. Cases correctly rehydrated+	50-60%	
12. Mothers who were correctly advised	38.1%	
13. Dysentery cases given appropriate antibiotics	na	

* national health personnel statistics not available to NCDDP

** 1987 estimate is ORS + SSS use rate

+ 50% = correct classification, 60% = correct selection

The team compared program targets and subtargets with the current status of indicators. Conclusions regarding progress towards targets are as follows:

Training: 50-100% of 1992 targets have been met. Information from district-level operational courses have not been fully received which would increase the 50% rate.

Communications: some progress towards targets. Insufficient data on communication 'reach'. Little or no progress was noted in ORS use and increased fluid use during diarrhoea episodes.

- ORS Availability: target reached according to GOK statistics. Insufficient information from districts to confirm this conclusion. ORS monitoring not implemented.
- ORS use rate: no progress noted. Use rates constant between 20-30% during period 1987 to 1990.
- Morbidity Reduction: no progress. Annual incidence remained at 4 episodes per child per year from 1987.
- Mortality Reduction: insufficient evidence to assess progress. Overall childhood mortality has been reduced by 16% during period 1978 - 1988 but no cause-specific data exist of national sample.

18 programmatic achievements were identified by the review team. Table 2 presents a list of key achievements noted.

Table 2
MAJOR ACHIEVEMENTS

1. 50-100% of training target have been met.
2. ORS distribution channels have been streamlined.
3. Communication channels have been utilized including radio and print with new initiatives in solar cassettes in health facilities and school radio programs.
4. Supervision system is organized with supervisory visits done by central staff to the districts with the use of a supervisory checklist.
5. NCDDP has established management structure with full-time staffing and written job descriptions. A plan of operation has been formulated with programme targets, and a national policy established which has been approved by the GOK.
6. 240 ORT centres/ corners have been established in 45 districts.
7. Operational research and evaluations done with results utilized by NCDDP for refinement of home case management policy, communication messages, and change of packet size.

Based upon a thorough review of program documentation and a full discussion by the review team, five priority issues were identified using the scaled criteria in the WHO Focused Programme Review protocol. The following priority areas (see Table 3) were identified to serve as a basis for a more in-depth review during Phase II:

Table 3
List of priority issues

1. Home case management of diarrhoea is poor (low increased fluid use, inappropriate use of drugs, low knowledge levels of when to seek care).
2. Monitoring and supervision of district level activities is irregular
3. There are problems in assessing and monitoring ORS, ORS procurement and distribution show delays and the system is over-reliant on external contributions
4. Outstanding management issues confronting the NCDDP need to be addressed including revision of programme targets, delays in implementation, establishment of a DTU, and programme sustainability in the context of diminishing donor support.
5. The quality of training activities conducted at district level is probably inconsistent and not monitored by central level staff

IV. PHASE II:

Method:

During Phase II, conducted from 27 April to 8 May 1992, the review team, consisting of the staff of the national CDD Programme, resource persons from other programmes and the district level, and international consultants with expertise in the respective areas (see Annex 1), analyzed the priority issues, outlined in table 3. The review team was divided into five working groups (WG), and each WG was assigned one of the priority issues. The following steps were followed by each WG:

1. In-depth analysis of the priority issue:

Relevant programme documents were reviewed and interviews were conducted with key informants at central level.

2. Additional data collection :

Each WG identified additional data needs to better understand the priority issue, and developed simple data collection instruments (questionnaires, check-lists, etc.). Site visits were then conducted (e.g., to health facilities, District and Provincial Health Management teams, ORS manufacturers, Central Medical Stores, etc.) according to the needs defined by the different WGs. Sites were randomly selected, the number of sites (and observations) is limited and obtained data are therefore not representative for larger areas of the country or the country as a whole.

3. Identification of solutions:

After completion of field work, the WGs identified reasons and factors that contribute to the existence of the priority issues. Feasible solutions were developed and, wherever possible, integrated into a preliminary work-plan.

V. WORKING GROUP REPORTS

1. CASE MANAGEMENT IN THE HOME

1.1 PROBLEM STATEMENT

Case management of diarrhoea in the home is poor:

- the rate of increased fluid intake is low;
- the knowledge of caretakers on when to seek medical care is inadequate;
- when caretakers seek medical care, they are not always provided with ORS for use in the home;
- the rate of correct preparation and use of ORS is low;
- the level of inappropriate drug use is high.

1.2 BACKGROUND

1.2.1 *Relevant survey results:*

The Diarrhoeal Diseases Household Case Management Survey conducted in 6 districts (Kwale, Kakamega, Kisii, Nakuru, Kisumu, and Kilifi) in January - February 1990 indicated that:

- Few caretakers offered their children more to drink during diarrhoea (Increased Fluid Intake Rate ranging from 4 to 26%). Caretakers gave on average 317-708 ml of recommended home fluids; ugi was the most commonly used fluid, followed by water.
- The ORS use rate ranged from 11-29%, the most common source of ORS being the government health facilities. The average quantities of ORS given ranged from 288-687 ml in the last 24 hours. However, only 10-42% of caretakers could prepare ORS correctly.
- The drug use rate was high (26-47%). The most frequently used drugs were analgesics, antimalarials, antibiotics and antidiarrhoeals.
- Few caretakers had adequate knowledge on when to take a child with diarrhoea to the health services.

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1.2.2 IEC activities:

The Communications and Social Mobilization Component of the CDD Programme has been active for the last 4-5 years, with the objective of educating health workers and members of the public about the control of diarrhoeal diseases, to maintain awareness through the training of health workers and by using mass media and print materials for the public, and health education for schoolchildren. The following print materials have been produced and distributed, in collaboration with UNICEF and PRITECH:

- posters (1 theme poster, 1 poster on the 4 rules of treatment, 1 poster on the preparation and use of ORS);
- flyers (1 with rules on treatment on one side and preventive messages on the other, and 1 with instructions for the preparation of ORS);
- a booklet about CDD for leaders and extension workers;
- a flip chart about CDD;
- bumper stickers.

Some of these materials have been revised and are being reprinted. New materials are under preparation, in collaboration with PRITECH and PATH, which will focus on case management in the home and are intended for use by NGOs and in schools.

Radio programmes and jingles have also been produced in collaboration with the Division of Health Education of the Ministry of Health, and were on the air in 1989.

1.3 ASSESSMENT METHODS

The team visited Kisumu district in Nyanza, Kakamega district in Western and Embu district in Eastern Province. Three provincial hospitals, 3 rural health training centres, 2 health centres, 2 dispensaries and one mission hospital were visited. A convenience sample of fourteen health workers and 13 caretakers was interviewed using separate interview guides. A few observations of health workers during a consultation for a child with diarrhoea were conducted, guided by a checklist. Another 26 caretakers of young children were interviewed in their homes.

1.4 KEY FINDINGS

The team found that most of the health workers interviewed had adequate knowledge on case management in the home. Of the 14 health workers questioned, the majority said that they advise caretakers to increase fluids (9/14) and discuss recommended home fluids (13/14). Other aspects, such as continued feeding, including breast-feeding, were mentioned less frequently. Antibiotics seem to be commonly prescribed, and some children who present with diarrhoea are diagnosed as having malaria or ARI (especially in Western and Nyanza Provinces) and no treatment (i.e., ORS) or advice is provided for the diarrhoea. A number of caretakers interviewed (13/39) said that no advice had been given to them about case management in the home during a recent consultation for diarrhoea in their child. Very few caretakers (only 3 out of 39) had ever received any print materials about diarrhoea. Most caretakers (27/39), however, could recall messages about diarrhoea that they had heard over the radio. The team could not assess caretakers' knowledge about case management in the home on such a small and selected sample.

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The team observed that IEC materials on CDD were not always available in the health facilities visited, or, if available, were not always displayed in suitable locations or otherwise readily accessible for reference during consultations for diarrhoea. All health workers interviewed expressed satisfaction with the print materials that have been developed by the CDD Programme; they felt that these materials were attractive, clear and helpful, and said that they could use more of them to facilitate their counselling of caretakers. The only criticism received from a few health workers was that the type size of the printed messages on some of the materials was too small. The new flip chart and the leaflet for mothers were felt to be particularly useful for this purpose.

1.5 FACTORS ASSOCIATED WITH THE PRIORITY ISSUE

- IEC messages particularly related to the amounts of fluids required during diarrhoea may not be understood/accepted by caretakers;
- IEC materials intended for caretakers are not available in sufficient quantities; some of the materials contain too many messages;
- health workers offering CDD services have not all received CDD training, and may not be aware of the importance of case management in the home, or may not be able to communicate the key messages effectively to caretakers;
- caretakers are reluctant to seek care because of the high cost and poor acceptability and accessibility of health services;
- ORS is not always available in health facilities;
- ORS is not always provided to caretakers for use in the home; in particular, diarrhoea complicated with other conditions is not always treated with ORS;
- health workers do not always explain and demonstrate the preparation and use of ORS to caretakers;
- IEC activities have not critically addressed the issue of inappropriate drug use;
- health workers often indiscriminately prescribe antidiarrhoeals and antibiotics for the treatment of diarrhoea;
- there is widescale advertisement by drug companies promoting the use of antidiarrhoeals;
- traditional herbs are commonly used for the treatment of diarrhoea in the home.

1.6 SUGGESTED ACTIVITIES:

1.6.1 The CDD Programme should focus on the following areas in ongoing and any future IEC activities:

- increase fluid intake;
- when to seek medical care;
- preparation and use of ORS;
- appropriate use of drugs.

Requirements:

- The CDD Programme should ensure that messages on the above are included in the new materials that are under preparation in collaboration with NGOs and the Kenya Institute of Education. This seems appropriate as it is already planned that these materials will emphasize case management in the home. Messages on fluid intake and care-seeking should be developed that are simple, acceptable and specific. Extensive pre-testing of these messages will be required. The development of easy-to-follow take-home materials for caretakers on the preparation and use of ORS is encouraged.
- IEC activities related to drugs should be closely linked to the planned training for pharmacists.

1.6.2 The CDD Programme should ensure that IEC materials developed are effectively distributed.

Requirements:

- The CDD Programme should further investigate the mechanisms that are used for distributing IEC materials, to assess their relative effectiveness and identify bottlenecks. In particular, the Programme should explore the use of the production and distribution mechanisms used by the Health Education Materials Production Unit of the Ministry of Health.
- On the basis of this information, the CDD Programme should develop as required more effective distribution mechanisms, in consultation with donors (e.g., UNICEF).

1.6.3 When available, the data from the ongoing research project on the use of ugi during diarrhoea should be carefully reviewed by the CDD Programme, which should then consider whether its policies regarding recommended home fluids need to be adjusted.

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- 1.6.4 The CDD Programme should prepare a summary of its policy statement on case management in the home (including guidelines on home fluids to be recommended, amounts to be given, when to seek medical advice, and on appropriate use of drugs), and distribute this to all health facilities for easy reference (it should preferably be a one-page document or poster that can be placed on the wall in the ORT corner).
- 1.6.5 The CDD Programme should continue its training activities with increased emphasis on interpersonal communications to improve the ability of health workers to counsel caretakers on case management in the home. Such training should also emphasize that diarrhoea, even when complicated with other conditions such as malaria, should be treated with ORS.

Requirements:

- The CDD Programme and PRITECH should finalize the planned communication module and incorporate it into future training activities.

- 1.6.6 The CDD Programme should incorporate the control of diarrhoeal diseases, including effective case management and the rational use of drugs, within existing curricula for pre-service and in-service training of selected categories of health workers.

Requirements:

- The CDD Programme should continue the ongoing curriculum review, and undertake the necessary modifications to selected curricula, in collaboration with the University of Nairobi (Faculties of Medicine and Pharmacy), the Kenya Medical Training College, and the respective councils and professional associations. It is recognized that this is a long-term activity, which will require substantial resources. During the preparation of its next operational plan, the CDD Programme should examine carefully the priority and phasing of this activity in relation to others, and if appropriate, it should seek additional funding for this purpose from donors.

- 1.6.7 The CDD Programme should make specific recommendations to the Ministry of Health (Director of Medical Services) for regulation and information activities related to drugs advertised and used for the treatment of diarrhoea.

Requirements:

- The CDD Programme should examine the results of the formative research conducted in the context of the Pharmacists' training project, to identify problems areas and possible regulatory and information solutions, and consult with the relevant manufacturers. This activity should be carefully coordinated with the planned training activities, as they are mutually supportive.

2. MONITORING AND SUPERVISION

2.1 PROBLEM STATEMENT

- Supervision is not consistently and systematically conducted both by central and district-level CDD supervisors.
- Routine CDD reporting is not performed in a timely, accurate and complete fashion by health workers and district CDD supervisors with little use of information for programme improvement by district or central staff.

2.2 DATA COLLECTION METHODS

A team of five reviewers visited three districts in Western, Eastern and Central Provinces. The following interview instruments were used:

- Mid-Level Manager Structured Interview Guide
- Health Worker Interview form
- Structured Key Informant Guides (HIS & Supervision)

A convenience sample of 9 health facilities (4 hospitals, 3 health canters, 2 dispensaries) in Western, Eastern and Central provinces was visited and 6 district level supervisors and 19 health workers were interviewed in these facilities using the above mentioned instruments.

Key informant interviews were also conducted with representatives of the Health Information Systems (HIS) unit, MOH, and the Kenya Expanded Programme on Immunization (KEPI).

2.3 SUPERVISION

2.3.1 *Background:*

The National Control of Diarrhoeal Diseases Programme (NCDDP) has since programme inception trained 557 mid-level supervisors which exceeds the 1992 target. Moreover, supervisory funds have been allocated since 1990 to the districts for supervision. The strategy proposed in the CDD workplan calls for monthly supervisory visits by the district health education officer using a structured checklist. However, a recently completed training impact assessment found that 63% of health workers had never received a supervisory visit. Since 1989, less than 10 supervisory visits have been made by central NCDDP staff.

2.3.2 Findings:

- 6/6 of supervisors had been trained in supervisory skills. 5/6 felt that the course adequately prepared them to perform supervision.
- 3/6 of supervisors do not use supervisory checklist.
- Average number of supervisory visits by interviewed DHEO is 1 per year.
- 3/6 of district supervisors stated that the district health management teams (DHMT) were not supportive of CDD supervisory activities, especially in arranging transport (6/6 reported this as problem).
- Only 2/19 (10%) of health workers stated that they were observed managing a case of diarrhoea by the district supervisor. Most common activity was checking ORT corner/supplies.
- Only 1/19 (5%) of health workers stated that they received feedback on their management of diarrhoea cases from district supervisor.
- Average time spent doing supervision by the district supervisor was 30 minutes (includes supervision of other non-CDD activities).
- 5/6 of district supervisors had not been visited by Central Management Unit staff in the last year.

2.3.3 Factors

The key factors influencing the deficiencies noted in supervision are summarized below:

- Insufficient personnel for adequate supervisory coverage.
- DHMT does not provide sufficient support in terms of prioritization of activities, funds, and transport.
- Supervisory staff (DHEO/DPHN/DCO) are responsible for a wide variety of activities outside of CDD which limits their time to perform supervision.
- Due to lack of transport and staff, CDD supervision is often added to other supervisory responsibilities which compromises thoroughness of supervision.
- CDD supervisory checklists are rarely available which leads to less structured supervision.
- Lack of follow-up of mid-level managers following supervisory skills training which leads to decay in motivation and skills to perform supervision.

2.4 CDD REPORTING

2.4.1 Background

Since 1988, the NCDDP has actively sought to develop a functional CDD reporting system. Through the Information and Planning Systems (IPS) Project, the NCDDP investigated the possibility of combining a KEPI/ CDD sentinel surveillance system. This attempt was abandoned following field trials in Muranga district. In 1991, the routine reporting form was revised and distributed to the district supervisors for reproduction and distribution to health facilities. The NCDDP has hired two full-time information system staff who compile submitted reports and enter them into a computerized database. This computer system is capable of generating reports but is not currently used for such, and there is no data analysis carried out. To date, the district ever-reporting rate is only 11% and the timely reporting rate is less than 1%.

2.4.2 Findings

- 13/19 of health workers stated they did not have CDD reporting forms. Only 4/19 (21%) have ever had forms.
- Only 12% of the 42 districts have ever sent in CDD report forms. 1% of these had been sent within one month of completion.
- None of the 6 district supervisors who were interviewed have ever received feedback on reports from Central Management Unit.

2.4.3 Factors:

The main factors which were found in this review to possibly influence the deficiencies noted in the NCDDP routine reporting system are as follows:

- Insufficient supply of forms or materials available at district level and in health facilities.
- Lack of training of health workers and district supervisors in the use and interpretation of reporting forms and the information they solicit.
- Lack of feedback from central and district supervisors on reports submitted.
- Lack of central and district supervision of reporting activities.
- Lack of routine mechanism for distribution and collection of forms.
- Routine reporting seen by health workers and supervisors as impinging on normal daily tasks.

2.5 RECOMMENDED ACTIVITIES

Monitoring of NCDDP activities, both centrally and in the districts optimally involves timely and accurate collection of relevant data with systematic analysis of results leading to specific, problem-oriented actions. Routine reporting and supervisory visits provide mechanisms of data gathering which if effectively utilized for analysis and planning, provide a means for information-based program management. This applies, as noted above, to both central and district-level CDD managers. The activities outlined below represent an integrated approach which seeks to improve the flow and use of program-relevant information. Table 4 presents budget requirements and suggested timelines.

2.5.1 The CDD programme manager should assign one CMU staff member the responsibilities of managing monitoring activities. Specific sub-activities might include:

- development of job description
- development and presentation of monitoring strategy
- organization of annual programme reviews
- manage monitoring activities including negotiation of central monitoring schedules with other CMU members
- ensure that supervisory reports are submitted and reviewed, and information obtained disseminated to all CMU staff

2.5.2 The CMU staff responsible for monitoring should, as part of the monitoring plan, establish a CMU supervisory schedule which identifies dates and participants for all districts over the next two years. Key sub-activities should include:

- The director of the Division of Family Health and/or the CDD programme manager should be included in team
- The supervisory schedule should be disseminated to all districts through an announcement from the DFH director.
- The CMU checklist should be routinely used.

2.5.2 The CMU staff responsible for monitoring should participate in these supervisory visits in order to:

- distribute forms
- collect reports
- facilitate discussions with the DHMT to assist development of district supervisory plans including specific agreements on logistics (transport, funds, participants, writing of reports)
- assist in solving problems related to district supervision and reporting

2.6 The CMU staff member responsible for monitoring should ensure the expeditious production and distribution in bulk of the following forms to all districts:

- 7,500 (24 copies per facility) CDD reporting forms
- 45,000 supervisory checklists
- 200 quarterly supervision summary forms

2.7 The NCDDP should budget for 1 follow-up visit of trainees of the mid-level supervisory course.

Table 4.

<i>BUDGET AND TIMELINE FOR RECOMMENDED ACTIVITIES</i>			
<i>ACTIVITY</i>	<i>BUDGET (KSh)</i>	<i>SOURCE</i>	<i>TARGET DATE</i>
1.Appointment of CMU staff responsible for monitoring. a. job description b. monitoring plan	0	--	July 92 July 92 Aug. 92
2.NCDDP Supervision Visits	285,000 (95,000/yr. x 3yr)	MOH	13 districts/year 3-5 visits
3.Materials Production and Distribution a. 7500 CDD report forms b. 45000 Sup.Checklists c. 200 Quarterly Report	75,000	MOH PRITECH/ USAID UNICEF	Sept. 92
4.Follow-up visits to graduates of mid-level courses	200,000	MOH	to be scheduled
TOTAL	560,000		

3. ORS PROCUREMENT AND DISTRIBUTION

BACKGROUND AND FINDINGS

3.1 The requirement of ORS

3.1.1 *Situation*

A market survey for Sterling Health Ltd. conducted in 1992 showed that up to 53% of mothers use household fluids in the early treatment of diarrhoea (of which 37% is SS-solution) in selected districts. The survey also reported that 80% of the interviewed mothers get medical care through public health facilities. From available data it can also be concluded that, given the very limited availability of anti-diarrhoeal drugs, public health staff seem to have no other choice than giving mothers ORS. This situation seems to have a beneficial effect on ORS use.

3.1.2 *Estimating the need of ORS*

To warrant regular ORS availability in public health facilities it is important to estimate ORS requirements for each of the coming years. Such figures are currently not made available by the NCDDP. Calculating the need for ORS is a complex matter and can be done in various ways. The most appropriate way of calculating needs entails the following data:

- the policy on ORS, for example when and by whom ORS is to be used and distributed. These details are not specified in the policy of the Kenya CDD Programme; it only indicates that the packets should contain doses for the preparation of 500 ml solutions
- the average number of diarrhoea episodes per year,
- the access rate to the public health system, and
- the ORS use rate, a criteria which should reflect the progress made by the CDD programme in terms of promotion and training

As some of these elements were unavailable during the review, it was decided to establish at least an indicative estimate for the global need in the country, based on parameters which are currently known:

Population of children below the age of 5 years:	5.0 million
Average diarrhoea episodes per year:	4.0 episodes
Total estimated diarrhoea episodes per year:	20.0 million
Estimated percentage of episodes associated with dehydration, thus requiring ORS:	10 %
Total number of episodes requiring ORS:	2.0 million
Number of packets given per episode (nat.Policy)	2 packets
Total requirement in packet for 500 ml:	4.0 million packets
10% Contingency for older children and adults:	0.4 million packets

Theoretical amount of packets needed at national level per year

4.4 million packets

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Estimated percentage of population covered by the public health system	65 %
Estimated ORS need in the public health system	2.9 million packets
Estimated percentage of this system covered by the CDD programme	10 %
Estimated annual ORS need by the CDD programme	0.4 million packets

A more accurate estimate can be done for each of the coming years by taking into account progress and status of the CDD programmes in the various districts. More accurately this should be done by taking into account the ORS use rate, thus replacing the above estimated 10% of cases with dehydration. The CDD programme has such data only from 6 districts (Kisumu, Kakamega, Kilifi, Kisu, Kwale and Nakuru); they were obtained during a household-survey early 1990. The rates vary from a low of 10.8% in Kisumu to a maximum of 29% in Nakuru. As they are not representative for the overall situation in the country they were not used to calculate the national estimate.

3.2 Source of ORS supplies

Until 1988, large quantities of ORS packets were imported by donor agencies such as SIDA and DANIDA, mainly for use by the National Essential Drug Programme (EDP). This situation changed considerably after the external support for this programme was reduced and the management of the National CDD programme decided to adopt an ORS packet with a dose for 500 ml. The import of ORS dropped and the local manufacture of ORS began to increase so that by 1991 about 87% of all ORS available were produced in the country. As a consequence of the smaller packet size, however, the availability of ORS in terms of liters dropped by 50% and has remained at that level since 1989:

SOURCE	1987	1988	1989	1990	1991
UNICEF	380 200	343 000	765 600	61 800	371 400 (13%)
SIDA	4 564 000	5 000 000			
ECHO	1 000	1 000		650	1 000
IDA	189 050	479 000	545 150	1 250	
Local prod.	200 000	202 280	875 000	2 861 386	2 476 250 (87%)
Total (lit.)	5 134 250	6 025 280	2 186 400	2 925 436	2 847 650 (100%)

The quantities of ORS provided in 1987/88 seem to have been overestimated and considerable quantities remained unused. While some were retained in the district stores, others were returned to the KEPI stores for destruction when they reached the expiry date. A considerable number of these packets are still available at the KEPI store in Nairobi. These packets are for a one-liter solution. A re-validation of these packets could allow to make them available in cases where such packets would be useful, for example for the treatment of patients with cholera or for the preparation of ORS solution in Hospitals for treating in- and out patients.

3.3. Distribution of ORS

The Central Medical Store (CMS) distributes all ORS in the public health system, including those provided by UNICEF for the CDD programme. The procurement, however, covers only those ORS packets which are an integral part of the essential drug kits. In addition to the EDP kits, CMS also distributes five different kits designed for hospitals (for in-patients and out-patients) which do, however, not contain ORS. Unfortunately ORS is not included in CMS's drug supply list and therefore also not available to hospitals as a "buffer" or "loose" drug. This gap is currently filled by the CDD programme with ORS provided by UNICEF.

3.3.1 The Essential Drug Programme (EDP)

ORS is a standard component of the EDP's essential drug kits. There are two different drug kits, one for health centers containing 38 drugs, called "Rural Health Center Ration Kit" and one for dispensaries containing 32 drugs, called "Rural Health Dispensing Ration Kit". The one for health centers is designed for 3 000 patients each and that for dispensaries for 2 000 patients each. As the regularly provided number of packets in these kits proved to be excessive it was felt appropriate to maintain the same number of packets after the change to the 500 ml packet, thus supplying only half of the original quantity if measured in liters. Despite this reduction the packets kept accumulating in the field and further reductions were required in each of the following years. The details, provided by EDP, are given below:

1989	H/Center	4 660 kits x 300 packets of O. S	=	1 398 000
	Dispens.	8 042 kits x 200 packets of ORS	=	<u>1 608 400</u>
		Total ORS packets in 1989	=	3 006 400
1990	H/Center	5 206 kits x 150 packets of ORS	=	780 900
	Dispens.	8 654 kits x 100 packets of ORS	=	<u>865 400</u>
		Total ORS packet in 1990	=	1 646 300
1991	H/Center	4 891 kits x 100 packet of ORS	=	489 100
	Dispens.	10 711 kits x 50 packets of ORS	=	<u>535 550</u>
		Total ORS packets in 1991		024 650

While in some facilities the regularly provided quantity of ORS is still excessive, it remains insufficient in others. EDP sees this problem in the way ORS is dispensed. It is observed that the number of packets which are given to patients vary from 2 to 40 packets.

The essential drug kits are distributed monthly, thus on a "push"-system. However, faced with transport problems in certain districts from the district store to the rural health facilities (availability of trucks, poor road conditions, seasonal constraints, etc.), the kits are not distributed on a regular basis. It was reported that the kits are often collected by rural health facilities when they receive their salaries at the district office. Therefore, a combination of "push" and "pull"-system of essential drugs exists in Kenya.

3.3.2 *The National CDD Programme (NCDDP)*

ORS provided by the CDD programme is primarily for use in hospitals. The hospitals have received ORS free for a number of years, and do therefore not routinely include this item in their drug procurement lists and allocate funds for it.

Currently ORS supplies through the CDD programme are donated by UNICEF. ORS is stored at the Central Medical Stores and distributed alongside the essential drug distribution system. It is further distributed to the zonal stores for distribution to the hospitals.

The amounts issued to the zonal stores are predetermined by the CDD unit, based on past experience of ORS consumption. A distribution list specifying the amounts to be distributed to each hospital is forwarded to all zonal stores by the central level. This distribution system was established in June 1991 and since then the distribution of ORS has greatly improved. A remarkably close collaboration exists between CDD/EDP and Central Medical Stores.

3.3.3 *UNICEF*

UNICEF has so far obtained ORS through their procurement system from abroad. Only on a very few occasions packets have been purchased locally, usually in response to a short-fall of ORS for CDD. The reason for limited local procurement is the relatively high price of ORS produced in Kenya. Historically, about half of the provided packets has been for use by the CDD programme, the other half being a component of UNICEF's contribution to the Bamako Initiative communities' projects. In 1992 UNICEF procured 4 million packets for Bamako Initiative projects. On special requests, UNICEF has also provided limited quantities of ORS to NGO's (for example MEDS), private hospitals (e.g. Gertrude's Garden Childrens' Hospital) and to UN agencies, such as UNHCR.

Procurement through UNIPAC takes 6-9 months from the time of order to arrival in Nairobi. Delays in the UNICEF ordering system have in the past resulted in insufficient supplies at the Central Medical Stores.

3.3.4 *Use and monitoring ORS supply at national level*

As mentioned above, the distribution of ORS through EDP kits has decreased over the last three years. Also the availability of ORS in terms of liters has decreased. From the example given below (1991) it appears that the availability of ORS is far above its actual use:

ORS packets made available by UNICEF	742 800	
ORS packets produced locally	5 722 772	
Total ORS packets made available	6 465 572	100%
Total distributed through EDP kits	1 024 650	
Approximate number distributed by CDD	700 000	
TOTAL DISTRIBUTED	1 724 650	26.7%
BALANCE	4 740 922	73.3%

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It is obvious that a) sufficient ORS is currently available and b) the commercial sales have increased significantly. Although no clear evidence was found, it is suspected that a large quantity of locally produced packets find their way into neighboring countries. This would explain the totally unbalanced proportion between supply and distribution.

While the distribution system for ORS has been streamlined, there exists still a substantial problem in monitoring ORS supplies at the central level. The reporting system for ORS is either irregular or incomplete. Secondly, the NCDDP does not receive reports from the Zonal stores, EDP, and other distributors/users of ORS like the Primary Health Care programme-Bamako initiative.

3.4 Funding of ORS procurement

ORS for the EDP programme was initially funded by SIDA and later by DANIDA in the overall process of the drug procurement for the essential drug kit. DANIDA's assistance to EDP for the procurement of drugs ended in July 1991, and the purchase of the required drugs for the EDP kits is now totally covered by the government.

The funding of ORS which is purchased by UNICEF is included in their budget a) in the context of the Bamako Initiative (vertical pilot project) and b) for the support of CDD activities, of which part is used for the procurement of ORS. The CDD programme decided to include funds for the procurement of ORS in the budget proposal for 1992. The budget was approved by the GOK, but the required funds of 4 mio Ksh for the purchase of 4 mio packets have not yet been released.

3.5 The cost of ORS

The cost of imported ORS, including sea-freight, is currently between US\$ 0.05 and 0.06, or Ksh 1.5 - 1.8 per packet for a 500 ml solution. The import of ORS is exempt of duty and VAT (a liter of ORS solution is therefore around Ksh 3.3 -3.5). The ex-factory price of ORS produced in Kenya is currently around Ksh 3.5, thus the cost for a one-liter solution a cost of about Ksh 7.0, a price which cannot compete with that of imported ORS.

In contrast to the import of ORS, the import of raw and packaging material for its local manufacture is submitted to rather high import duties and value added taxes, of which the details are given below:

	Custom Duty	VAT	Total
Dextrose anhydrous	35%	18%	59.30%
Sodium Chloride	35%	18%	59.30%
Postassium Chloride	35%	18%	59.30%
Trisodium Citrate, dihydrate	-	5	3.15%
Aluminium Laminate	45%	18%	71.10%

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These taxes, excessive handling charges, high financial costs for credits, and the devaluation of the local currency were mentioned by local manufacturers as the main reasons for the high price of ORS.

The CDD programme, UNICEF, PRITECH, USAID, as well as the pharmaceutical industry have repeatedly communicated this problem to the local authorities, and tax exemptions for dextrose and printed aluminum laminate have recently been introduced. Given this new situation it may be possible for the manufacturers to reduce the price of ORS to make it competitive to imported ORS.

3.6 Local ORS manufactures

3.6.1 *Situation*

In the past at least 9 different commercial products were available in the market. In the meantime, unfortunately, two companies have stopped the manufacture of ORS and two others gave up its import. As a result only two companies currently produce ORS: Cosmos Ltd. and Laboratory & Allied Ltd. These two manufacturers have been able to increase their production considerably over the last two years. Annex 3 provides a list of manufacturers of ORS in Kenya.

At least two other companies are known that currently evaluate the manufacture of ORS; Rhône-Poulenc Ltd. and Kenya Sterile Supplies Ltd. They are primarily interested to make ORS commercially available and to compete with those products already on the market.

3.6.2 *Expanding ORS commercialization in Kenya*

In 1990, UNICEF and PRITECH agreed with the Ministry of Health that the development of the commercial production and the distribution of ORS were very important goals. After a review of the relative advantages and disadvantages of the various companies in the field, UNICEF and USAID (PRITECH) agreed that Sterling Health was the company most likely to develop the market rapidly and viably. Sterling produced ORS some years ago in doses for 200 ml. They later changed to the international standard dose for 1000 ml and discontinued when the dose for 500 ml was adopted in Kenya. Sterling indicated the intention of re-entering the ORS market in Kenya if UNICEF and PRITECH were willing to fund their communication activities and a part of the production costs. A market survey was considered the first requirement for the development of a marketing plan. The results of this survey were presented during the review and shall be further studied by the management of Sterling before a final decision will be taken.

3.6.3 *Manufacture of ORS in hospitals*

In order to assure the availability of ORS in hospitals, Prof. Okello, the Director of Medical Services, suggested that ORS be manufactured in hospitals. This is definitely possible where hospital pharmacies exist which have the necessary installations. Its operation, however, will only be of value if the funds for the needed raw and packaging material is available and the goods are regularly supplied. Currently, the ingredients are not on the supply list of the CMS and special arrangements may therefore be required in order

to assure the distribution of the goods to all the hospitals. Such an option involves more work, possibly even more staff and funds for a product which is currently provided for free. The staff and the managements of hospitals may therefore not consider an "in-house" manufacture of ORS a specific advantage. In addition, such an option will raise the question of quality assurance, quality control and finally the liability in case of problems. Considering all these aspects the usefulness and cost-effectiveness of manufacture of ORS in hospitals seems to be very limited.

3.7 The national standard of ORS

Currently the national standard covers only the composition and the dose. The CDD Programme has developed a special label design with illustrations for the ORS packets which are used in their activities. The EDP programme does not specify a country-specific label for their ORS and so the labels vary all depending from where the ORS is purchased. In one case it was observed that the text was given in English, Arabic and Portuguese. Commercial manufacturers, in addition, have their own label design and brand name. With this inconsistency the mothers cannot get accustomed to a specific product and possibly get confused.

3.8 Summary

- The role of the CDD programme with respect to assuring sufficient ORS in the country has so far been unclear.
- In the absence of a clear policy on the use of ORS, the programme has remained unable to calculate/estimate accurately the requirement of ORS for the CDD programme, in the public health system in general and finally at national level.
- While ORS is distributed through the EDP it is not on the general drug list of the Central Medical Stores (CMS). This is one of the reasons why hospitals do not have ORS in their pharmacies, and the CDD programme has to fill this gap with packets provided by UNICEF.
- The decision to adopt an ORS dose for 500 ml and the programme's recommendation to give only two packets per episode have reduced the requirement of ORS by half. The number of packets in the EDP essential drug kits has therefore been gradually reduced. Yet the local production of ORS has increased to four times the actual amount of ORS distributed in the public health system. Where and by whom the balance is distributed and used remains unknown.

3.9 Recommendations

- Define the role of the national CDD programme with respect to the responsibility for assuring sufficient ORS in the country
- Establish a clear policy on the use of ORS; a prerequisite for careful planning of ORS supplies in the coming years
- Improve and intensify cooperation and collaboration with providers and distributors of ORS at all levels (EDP, CMS, UNICEF, MEDS, ORS manufacturers, etc.), so that the availability of sufficient ORS and its proper use are assured in the public health system and if possible more widely also through commercial channels. In particular, close

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contact with UNICEFs' group involved in the Bamako Initiative should be established to coordinate supplies and CDD activities

- Calculate the need of ORS for each of the coming years and assure its availability through monitoring of other ORS providers.
- Advise EDP on CDD progress and activities in the districts so that the standard number of ORS packets in the kits can be adjusted periodically. Advocate use of the ORS label used by the CDD programme. Monitor ORS supply and redistribute those packets which are unused in other facilities.
- Advocate the inclusion of ORS in CMSs' drug supply list and remind the hospitals of their responsibility to assure availability of ORS in their facilities so that the CDD supplies can be gradually phased out. This would not only be beneficial for CDD to become less dependant from external support, but it would also reduce the programme's logistic burden and be a step towards "cost-sharing" in the public health system.
- Keep regular contacts with local ORS manufacturers and follow-up on the cost issue. The price of the locally manufactured ORS currently also includes a number of the companies general overhead costs, for example promotion and distribution, which would not apply if large quantities (for example boxes of 100 packets) are ordered for delivery to the central medical stores. Minimal overhead charges should therefore be negotiated and the details clearly described in the tender specifications.
- Consider the use of the returned ORS packets for a one liter solution in hospitals; for example for the treatment of cholera patients. Establish inventory of packets and re-validate, if required with assistance of CDD/WHO in Geneva.

4. MANAGERIAL ISSUES

4.1 PROBLEM STATEMENT

- Targets and subtargets for the next five year plan of operations need to be set.
- Planned activities have encountered delays in implementation.
- There is uncertainty regarding sustainability of the National CDD Programme.
- There is a perceived need to establish one or more Diarrhoea Training Units.

4.2 DATA COLLECTION METHODS

Interviews were conducted with key informants within the Ministry of Health, relevant donor agencies (UNICEF, WHO, USAID), non-governmental organizations (NGOs), provincial and district level staff, and hospital administrators and chief pediatricians in three major hospitals.

Three examples of delayed implementation of CDD activities (training courses, radio programmes, and supervisory visits from central level staff) were selected, and analyzed through review of documents and discussions with key informants.

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Site visits were conducted at three hospitals previously identified by the Central Management Unit as potential candidates for the establishment of a Diarrhoea Training Unit (DTU) including Kenyatta National Hospital (Nairobi), Provincial Hospital (Kisumu), and the District Hospital (Kisumu).

4.3 BACKGROUND

A. Target Setting. The National Control of Diarrhoeal Diseases Programme (NCDDP) was established in 1986 within the Division of Family Health of the Ministry of Health. A five year plan of action was written in 1987 which outlined major strategies and activities, and set targets and subtargets. Progress towards targets was critically assessed during Phase I of the Focused Programme Review. It was clearly evident during this Phase of the programme review that the NCDDP will need to redefine its strategies with targets and subtargets and incorporate them into mid- and long-term plans.

B. Implementation Delays. One of the major constraints to achievement of programme targets and subtargets identified during Phase I of the Focused Programme Review was the delay or cancellation of planned programme activities. Specific examples of important delays in implementation of planned activities identified in Phase I are:

- four clinical management courses which had been planned for Mombasa in 1992 were delayed and subsequently cancelled.
- an radio programme on CDD which was planned to be aired during 1990/91 was despite preparatory work, not implemented.
- 6 out of 12 supervisory visits to districts which were planned to be conducted by central level staff during 1991/92 were cancelled.

C. Sustainability. Since inception of the national programme in 1986, external donors (UNICEF, USAID, DANIDA, WHO) have been significant contributors through financial contributions and technical assistance to the efforts of the NCDDP. The government of Kenya (GOK) has contributed mainly through provision of salaries of programme staff, provision of office space, and maintenance of vehicles. These recurrent costs provided by the GOK are essential, yet have not been included as a separate line item in the MOH budget. In addition, some donors have discontinued their contributions, and others are projecting major reductions in assistance to CDD in the near future. For example, DANIDA suspended support in 1988, and USAID through the PRITECH Project will terminate support in August 1993.

Table 5: Funding Levels & Projections (KSh)

	<i>USAID</i>	<i>UNICEF</i>	<i>WHO</i>
1989/90	9,000,000	360,000	
1990/91	10,000,000	560,000	
1991/92	10,000,000	560,000	
1992/93	10,000,000	560,000	
1993/94	1,000,000	0	

D. *Establishment of A Diarrhoeal Training Unit (DTU)*. Training of health workers of all levels in effective case management has been a primary focus of national CDD efforts since programme inception. However, to date there has not been a DTU established which would serve as a center of excellence in diarrhoea case management, and a center for training of physicians and nurses. In 1987, efforts to start a DTU at Kenyatta Hospital were unsuccessful for a variety of reasons.

4.4 KEY FINDINGS AND MAIN FACTORS FOR FINDINGS

4.4.1 *Target Setting* (see Table 8, progress towards targets, p.35)

4.4.2 *Implementation Delays*

- Release of funds by finance section of MOH
- Earmarked CDD funds are diverted for other activities within the MOH
- No CDD budget line with MOH budget
- Inadequate per diems for field visits leading to poor motivation
- Unavailability of transport due to:
 - lack of maintenance
 - MOH withholds vehicles until bills are settled
- Reluctance of certain groups of professionals to attend training
- Inadequate provisions made by central staff for anticipated delays
- Inadequate numbers of trained trainers
- Cumbersome tendering system at provincial and district levels which often does not give preference to CDD

4.4.3 *Sustainability*

- Lack of dynamic communication between NCDDP and donors
- PRITECH is ending bilateral project in August 1993
- unsatisfactory collaboration between departments of MOH, Ministry of Education, Water and Sanitation, as well as between NCDDP and NGOs
- no CDD budget line within MOH budget
- lack of reliable funding source for certain program materials including ORS, ORT corner equipment etc.

4.4.4 *Establishment of A Diarrhoeal Training Unit*

- Kenyatta Hospital: adequate patient load, treatment in casualty not good, hospital administration seems committed, and out-pt department has adequate space for DTU.
- Kisumu Provincial Hospital: adequate patient load, treatment practices are poor, hospital administration seems enthusiastic, and out-patient department has ample space for DTU.
- Kisumu District Hospital: adequate patient load, trained staff present, staff is committed and enthusiastic, building would have to be constructed.

4.5 RECOMMENDED ACTIVITIES

4.5.1 *Target Setting*

- The NCDDP staff should finalize a detailed Plan of Operation for 1993-1997 within two months after the Focused Programme Review.
- A mid-term Plan of Operation for 1993-94 should also be drafted.
- WHO/HQ Geneva should provide one consultant to assist in the development of these plans.
- These plans should incorporate the strategies and targets/subtargets outlined in Tables 6 and 7.
- The NCDDP Programme Manager and the Director of the Division of Family Health should submit this new Plan of Operation to key decision makers within the MOH to negotiate a budget line for CDD in the next forward budget.
- The NCDDP should submit this new Plan of Operation to current and prospective donor agencies including WHO, UNICEF, USAID and others in the next quarterly donors meeting (July 1992) to discuss commitment of these agencies during next several years.

4.5.2 *Implementation Delays*

- The Permanent Secretary for Health, in consultation with donors, should establish "pay master general accounts" for CDD.
- The NCDDP Programme Manager should arrange advance consultations with donors and finance officials in MOH at least 1 month prior to planned activities.
- The NCDDP Programme Manager should closely monitor the timely implementation of planned activities by staff, enforcing scheduled field visits, and ensure that trip reports are submitted within one week following field activities.
- The Director of Family Health should consult with the Permanent Secretary for Health regarding an increase of imprest for vehicle maintenance.

4.5.3 Sustainability

- The MOH should reconsider budget allocations to those public health programmes, including CDD, which have cost-effective interventions from which large segments of the population would benefit.
- The NCDDP should more actively communicate with the donors and also serve as catalyst to enhance coordination among them. Bimonthly meetings should be organized to discuss workplans and budget requirements.
- The Director of Family Health should negotiate with the Department of Health Financing a proposal to increase the use of cost-sharing funds for CDD activities.
- The Bamako Initiative ("Community Financing of Health Care Services Initiative") should be enforced as a strategy for increasing community participation and funding of local CDD activities.

4.5.4 Establishment of A Diarrhoea Training Unit

- Efforts to establish a DTU at Kenyatta National Hospital (KNH) should be given priority. The NCDDP should hold further discussions with the hospital administrators and chief pediatricians of KNH to assess the feasibility of establishing a DTU and consequently of developing a detailed plan.
- Kisumu Provincial Hospital should be considered at a later stage as an appropriate site for a regional DTU in Western Province. The NCDDP should discuss the structural changes needed and obtain a local budget from the hospital administration for these required renovations.
- Certain ORT centers should be upgraded to function as provincial or regional DTUs (examples: Alupe or Kakamega Hospitals).

Table 6

REVISED PROGRAMME STRATEGIES

- to continue training of health care providers in all public and private health facilities in effective case management of diarrhoea.
- to increase access to effective case management by including additional providers (ie. private practitioners, pediatricians, pharmacists, NGOs) in training activities.
- to increase knowledge of effective case management and diarrhoea prevention in the community through effective use of media and interpersonal communication channels.
- to ensure the production and distribution of oral rehydration salts (ORS) in sufficient quantities for wide access through public and private sectors.
- to improve monitoring and supervision of district level activities along with continued transfer of responsibilities for CDD activities to districts and provinces.
- to intensify intersectoral collaboration with Ministry of Water Development to improve access and availability of safe water.
- to improve nutrition through promotion of breastfeeding and proper weaning practices.

Table 7

REVISED PROGRAMME TARGETS

By the year 1997, the mortality associated with diarrhoea in children under 5 years should be reduced by 20%

Assumptions:

1. current ORT use rate of 40% and,
2. expected increase of ORT use of 30% over next 5 years

REVISED PROGRAMME SUBTARGETS

- the proportion of population with access to effective case management at public health facilities should be 50% by 1994

Data source: revised WHO health facility survey, central training data base

- the proportion of all diarrhoea cases seen at health facilities to be correctly rehydrated should be 70% by end of 1994

Data source: health facility survey

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- the proportion of all pharmacists trained and supplied to provide ORS should be 15% by the end of 1994.

Data source: central training data base, ORS monitoring reports

- the proportion of all (public and private) health facilities expected to offer ORS should be 80% by the end of 1994.

Data source: records from NCDDP and EDP

- the proportion of cases of diarrhoea in children under 5 years expected to be given increased amounts of fluid should be 50% by the end of 1994.

Data source: household case management survey

- the proportion of diarrhoea cases in children under 5 years expected to receive ORS should be 35% by the end of 1994

Data source: household case management survey

- the proportion of districts returning completed CDD report forms in a timely fashion to the central level should be 60% by the end of 1994

Data source: central monitoring data base

- the proportion of districts receiving a supervisory visit from central staff should be 70% by the end of 1994

Data source: central monitoring data base

5. DISTRICT LEVEL TRAINING

5.1 PROBLEM STATEMENT

The quality of operational-level training in the districts is uneven and inconsistent.

5.2 DATA COLLECTION METHODS

The team visited 3 districts in Western Province (Kakamega, Bungoma and Busia). Five (5) hospitals, six (6) health canter, and two (2) dispensaries were visited. Health workers were and operational course facilitators were interviewed using a structured interview form, and two days of a four day operational course in Busia district were observed using structured observations checklists. During this course, the team observed reading and group discussion/ exercises of the modules and practical case management training in a local hospital. The NCDDP Training officer was a member of the review team and was interviewed in depth.

5.3 BACKGROUND

The NCDDP began implementing operational level courses in 1987. Initially, the courses were conducted using the Treatment of Diarrhoea, Community Involvement, and Monitoring modules of the WHO Mid-level Supervisory Skills course. In 1989, the course was simplified by the NCDDP to use only the Treatment and Prevention modules. In 1990, the NCDDP switched again to using the Management of Diarrhoea module from the revised WHO Supervisory Skills course which is now used along with the WHO Guidelines for Conducting Clinical Training Courses at Health Canter and Small Hospitals. From 1987 to 1991, 2552 health workers have received operational level training. In the three districts visited, a total of 20 courses have been held with training of 459 health workers. Forty-two (42) health workers and thirteen (13) course facilitators were interviewed.

Concern regarding quality of operational training arose as a result of a 1991 training assessment which suggested that training quality might have problems. The NCDDP does not receive sufficient and regular information from districts about these courses or about post-training follow-up.

5.4 KEY FINDINGS

5.4.1 *Strengths*

Overall, the team concluded that good progress was being made in operational training. Specific observations to support this were:

- the ORT corners at Kakamega and Alupe Hospitals were functioning as de facto DTUs providing good case management and operational training. Similar but smaller facilities are reported to exist in Nakuru and Mombasa Provincial Hospitals;
- functioning ORT corners were found in all health facilities visited except Busia District Hospital and Mumias Dispensary in Kakamega district;

- the large majority of health workers interviewed are using the skills acquired during operational training
- most of the health workers interviewed were knowledgeable about the assessment of dehydration, and the major components of case management.
- operational level courses were being carried out by district training teams as planned when the funds were available.
- two-thirds of the health workers interviewed reported training other colleagues in ORT.

5.4.2 Weaknesses

- the interviewed health workers had inadequate knowledge of some key areas of diarrhoeal case management including the quantity of ORS to be given, and advice to mothers concerning feeding of the child with diarrhoea.
- some course participants are not establishing ORT corners upon return from training.
- insufficient numbers of health workers have been training in operational level courses nationally.
- practical training in case management was either absent or inadequate in terms of time allocated.
- key areas are neglected in operational courses including organization and management of ORT corners, health education, and record-keeping.
- methodologically, the operational level courses put emphasis on reading modules and small group discussion. Role plays, demonstrations, exercises and practical work are used infrequently, if at all.

MAIN FACTORS

5.5.1 Participants have inadequate knowledge in some key areas:

- inadequacy in training content and methods. Too little practical and role plays, too little emphasis on health education, record-keeping, management.
- the duration of the training course is too short to allow for adequate practical training.
- training courses do not always take place during peak diarrhoea season.

- training courses take place at a considerable distance from a functioning ORT corner, making practical training logistically difficult.
- training agenda is not standardized. Each facilitator established their own objectives (rarely written) and session plan. This is particularly true for topics not covered in modules including management of ORT corners and health education.
- lack of written participant selection criteria leading to selection of participants who would not be able to use their acquired skills upon return to home facility.
- occasionally, course materials are in insufficient quantity meaning that participants must share or return home without materials to use as references and memory aids.
- participants get inadequate support following training:
 - follow-up and supervision after training are infrequent
 - many "in-charges" have not yet received CDD training and are therefore not supportive of the trained staff
- the designation of the district health education officer (DHEO) as sole organizer of operational courses may not be effective, especially in the area of case management.

5.5.2 Some participants do not establish ORT corners after training:

- this topic is not emphasized practically in the training.
- health workers believe that an ORT corner needs "a lot" of space and equipment. They are not always ready to improvise with what they have available.

5.5.3 Many more health workers need training in case management

- Missions and private hospitals are sometimes reluctant to send participants.
- training materials and funds are not always sent on time so there are delays in implementing courses.

5.5.4 The operational courses have some weaknesses in content and methodology:

- not all trainers have themselves been trained in diarrhoea case management.
- insufficient emphasis in training of trainers (TOT) courses on acquisition of pedagogical skills.
- lack of national standardization of curriculum objectives and content.

5.6 RECOMMENDED ACTIVITIES

- 5.6.1 The NCDDP should organize workshops for revision of operational course content, methods and procedures with the objectives to:
- to review and identify solutions to the problems of the current approach, including selection criteria, course duration, lack of standardized content, insufficient emphasis on practical and role-play/exercises, and insufficient attention to some key content areas
 - to design standardized procedures and tools as necessary, including objectives and content of training sessions not covered by existing modules, check-lists for follow-up visits and observation of practical sessions, etc.
- 5.6.2 All district level trainers and supervisors (in-charges) of MCH clinics, health canters, and dispensaries which have CDD trained staff should be given priority in operational level training. Mission and NGO staff should be included.
- 5.6.3 clinical management training should be held during peak diarrhoea season if possible.
- 5.6.4 existing DTUs in Kakamega, Alupe and elsewhere should be used more consistently as training venues for their districts.
- 5.6.5 NCDDP should include funds in operational course budgets for one follow-up visit to each participant by trainers within three months of the completion of the course.
- 5.6.6 NCDDP should review the distribution system of course certificates.
- 5.6.7 during supervisory visits, the district health management team should continue to assist the establishment of ORT corners and identify potential trainees.
- 5.6.8 NCDDP should send out technical update materials including a newsletter on regular basis to trained health workers. These materials should include a one or two page newsletter prepared by the NCDDP staff as well as appropriate copies of Diarrhoea Dialogue, Technical Literature Update or other available materials.
- 5.6.9 NCDDP should designate a clinical officer in each district to be responsible for content and practical training during operational courses.
- 5.6.10 NCDDP should establish a yearly award for the best ORT corner.
- 5.6.11 NCDDP should request of WHO/AFRO sufficient quantities of training materials well in advance of expected training activities and should also consider reprinting materials locally.

Review team members

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Annex 2.

Schedule of activities during Phase II:

- 27.04
 - Opening
 - Briefing of review teams
- 28.04
 - Review of relevant documents within working groups
 - Discussion and finalization of data collection instruments
 - interviews with key informants
- 29.04
 - travel to the field
- 30.04.- 05.05
 - continuation of interviews with key informants at central level and field visits (as required by working groups)
- 06.05.
 - return to Nairobi
- 07.05.
 - finalization of working group reports
 - discussion and preparation of final report
- 08.05.
 - preparation of final report (contd.)
 - presentation to MoH, donors, and interested parties

Annex 3.

TRADENAMES AND MANUFACTURERS OF ORS IN KENYA.

TRADENAME	VOLUME	MANUFACTURERS
ORS	500	Laboratory & Allied Ltd
DTS (COSMOS)	500	Cosmos Limited
OARES	500	Kenya Sterile Supplies Ltd
ORALITE	300	Beecham of Kenya Limited
REHYSAL	1000	Westco Laboratories
WINHYDRAN	1000	Sterling Products Int.
WINHYDRAN	1000	Sterling Products Int.
WINHYDRAN	200	Sterling Products Int.
DIORALYTE	200	Rhône-Poulenc Ltd
REDIDRAT	250	Searle Limited
SERVIDRAT	250	Ciba-Geigy Ltd
PEDIALYTE	240	Abbott Laboratories

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Annex 3

**CDD TRAINING FOR NGO AND CHURCH RELATED HEALTH FACILITIES
IN KENYA**

A PROJECT OUTLINE

GOALS:

1. To develop a cadre of CDD trainers within the NGO/Church Health community in Kenya with the skills, materials and experience to allow them to carry out good CDD case management training for health workers as well as to train community outreach workers to provide good education to mothers in the area of home case management and diarrhoea prevention.
2. To train 10 - 15% of NGO/Church related health workers in four Provinces in good clinical management of diarrhoeal diseases.
3. To train 20 community outreach health professionals from the NGO/Church community in the areas of home case management and prevention of diarrhoeal diseases.

OBJECTIVES:

1. To improve clinical case management of diarrhoeal diseases in NGO/Church related health facilities in Kenya.
2. To improve community level education of child care takers by NGO/Church related outreach workers concerning home case management and prevention of diarrhoeal diseases.

STRATEGIES:

1. Refine existing CDD Clinical Management training materials currently being used in the public sector to more closely meet the expressed needs of the NGO/Church based health community.
2. Train a cadre of NGO/church based trainers in clinical and home case management and prevention of diarrhoeal diseases
3. Train approximately 80 NGO and Church based health personnel in clinical management of diarrhoeal disease in existing public sector ORT Corners or "Provincial DTUs"
4. Identify four potential NGO health facilities which could serve as future DTUs for the NGO and Church based health community.

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5. Develop a simple monitoring/evaluation strategy and tool which could be used by the NGO/Church based trainers and supervisors to monitor progress in improved case management at health facilities.
6. Train approximately 20 outreach workers in home case management and prevention of diarrhoea.

ACTIVITIES:

1. *Sponsor a 4-5 day NCDDP Workshop as recommended by the MOH Program Review Team to review and revise the current public sector operational/clinical case management training.*

The objectives of this workshop would be:

1. To review and identify solutions to the problems of the current approach, including selection criteria, course duration, lack of standardized content and content of curriculum, insufficient emphasis on practicals and role-play/exercises, insufficient attention to some key content areas (amount of ORS, feeding, practical health education/communications skills, setting up an ORT corner, etc.);
2. To design standardized procedures and tools as necessary, including objectives and content of training sessions not covered by existing modules, checklists for follow-up visits and observation of practical sessions, etc.;
3. To provide some basic training/pedagogical skills to course facilitators.

This proposed curriculum development workshop will be funded by PRITECH/Kenya pending USAID/Kenya approval. The twenty invited participants will include public sector trainers (health educators, clinical staff from each selected district) and three to four NGO staff.

Proposed Date: August, 1992

Approximate Cost: \$6,000

2. Preparatory Information Gathering for CDD Training:

A core staff comprised of members from the CDD Unit PRITECH, Catholic Secretariat and CHAK will visit the four targeted provinces (Western, Nyanza, Eastern and Coast Provinces) to:

- a. To identify government hospital facilities to serve as sites for the PRITECH-sponsored NGO effective case management workshops.
- b. To identify one NGO facility per province which could serve as a future DTU for clinical management training.
- c. To identify from these facilities potential participants for the PRITECH-sponsored TOT training. These participants would then serve as future trainers for the PRITECH-sponsored clinical management training.
- d. To identify three additional facilities per province and appropriate participants from these facilities who will attend the PRITECH-sponsored clinical management training workshops.

Please see Annex 1 for facility checklists which will be used during this information gathering period from July-August, 1992.

Approximate Cost: \$2,000

3. NGO Curriculum Development Meeting, September, 1992

- a. The CDD Unit, PRITECH and core NGO staff will review the revised MOH Clinical Management Training Curriculum to ensure that the curriculum meets their objectives, incorporating minor modifications as needed.

Date: September, 1992

Approximate Cost: \$300

4. NGO Training of Trainers (TOT) in CDD:

- a. ***Phase One:*** One Week TOT Preparation including clinical update of clinical management co-facilitators by Dr. Larry Casazza, PRITECH. Meetings will be held at the Conference Room at CHAK, Christian Health Association of Kenya and clinical review will take place at a local NGO hospital. October 12-16, 1992

- b. ***Phase Two:*** Training of Trainers Workshop for the NGO Trainers. (6 to 8 days)

The TOT will consist of the same content of the clinical management training, upgrading of pedagogical training skills and planning of training activities. The Clinical management curriculum will be pre-tested during the TOT. Minor revisions will be incorporated

accordingly. A model CDD monitoring tool will be proposed during the TOT. This tool will be introduced during the clinical management workshops to allow the NGO staff to monitor their progress. See Annex 2 for the draft instrument.

Date: October 19-28th, 1992
Approximate Cost: \$10,000

5. *Clinical Management Training Workshops:*

There will be four clinical management workshops one per province to be carried out by the NGO training staff. Four facilities per province will be selected as proposed in Step One, totaling 20 participants per workshop.

Date: November, 1992, January, February, March, 1993
Cost; \$10,000

6. *CDD Community Outreach and Prevention Workshop:*

This workshop will be targeted for hospital-based community outreach coordinators. Materials will be adapted from the CEDPA Community-Based Regional Workshop held in Nairobi in March, 1992. Emphasis will be on existing CDD materials and newly designed outreach materials for home case management of diarrhea and prevention. Approximately 20 participants will be invited to the workshop.

After the workshop the community-based coordinators will train community health worker in CDD home case management messages and prevention. Costs for this activity will be incurred by the NGO's.

Date: April, 1993
Cost: \$3,000

**FACILITY CHECKLIST
NGO HOSPITALS**

Hospital Name: _____

- | | |
|---|-----|
| 1. Are they interested in establishing an ORT unit | |
| a. hospital administrator | Y N |
| b. head of paediatrics | Y N |
| c. MCH head nurse | Y N |
| 2. Are they willing to release selected staff for
7-10 days for CDD training? | |
| a. hospital administrator | Y N |
| b. head of paediatrics | Y N |
| 3. Are they willing to make selected staff available
to act as trainers for CDD course? | Y N |
| 4. Does this facility use ORS to treat children with
diarrhoea? | Y N |
| 5. Does this facility have 5-10 cases of diarrhoea
per day? | Y N |
| 6. Does this facility see children with dehydration
of all severity (none, moderate, severe) | Y N |
| 7. Does this facility do training in other areas? | Y N |
| 8. Does this facility have adequate space for an
ORT unit large enough to conduct training? | Y N |
| 9. Does this facility have teaching facilities? | Y N |
| 10. Is there affordable lodging nearby? | Y N |
| 11. Is there available/willing to obtain- | |
| a. cups and spoons | Y N |
| b. measuring container(s) | Y N |
| c. benches and tables | Y N |
| d. ORS | Y N |
| 12. Does facility have regular source of ORS? | Y N |

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13. What population/area does this hospital serve?

14. Comments:

FACILITY CHECKLIST
Public Site for NGO Course

Hospital Name: _____

- | | |
|--|-----|
| 1. Does this hospital have an ORT unit | Y N |
| 2. Is the hospital administrator willing to allow ORT Unit at his hospital to be used for NGO CDD training without compensation? | Y N |
| 3. Does the ORT unit see 5-10 children with diarrhoea each day | Y N |
| 4. Does the ORT unit see children with diarrhoea of all severity (none, moderate, severe) | Y N |
| 5. Is there CDD trained staff in ORT unit available to act as trainers? | Y N |
| 6. Does this ORT unit host CDD training? | Y N |
| 7. Is there adequate space in ORT unit for 4-5 trainees? | Y N |
| 8. Is there teaching facilities here? | Y N |
| 9. Is there affordable lodging nearby? | Y N |
| 10. Are there adequate materials/ facilities- | |
| a. regular ORS supply | Y N |
| b. diarrhoea treatment chart(s) | Y N |
| c. IEC materials | |
| - flipcharts | Y N |
| - mothers handouts | Y N |
| d. cups and spoons | Y N |
| e. measuring container(s) | Y N |
| f. classroom | |
| - blackboard | Y N |
| - audio-visual equipment | Y N |
| - writing tables and chairs | Y N |

11. Comments:

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HEALTH FACILITY MONITORING TOOLDate: / /

Health Facility: _____

Name of Monitor: _____

1. Is there a functioning ORT corner/ unit at this facility? Y N
2. Is there regular supervision for this ORT corner/ unit? Y N
3. Are there children with diarrhoea in the ORT corner/ unit today? Y N

STAFFING

STAFFING OF THE ORT CORNER/ UNIT			
CATEGORY	NB Per Shift	Total Number	Total Number Trained in Effective Case Management
Doctors			
Nurses			
Clinical Officers			
Other (list)			
-			
-			
-			
-			

COMMENTS ON STAFFING AND SUGGESTIONS FOR IMPROVEMENT:

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ORT EQUIPMENT

EQUIPMENT AND SUPPLIES	PRESENT	
	YES	NO
Benches for mothers & children		
Tables for mixing ORS		
2-3 cups and spoons		
a mixing container(s) for ORS		
a water container or functioning tap		
a diarrhoea register book		
diarrhoea assessment forms		
Diarrhoea treatment chart a. in assessment area b. in treatment area		
functioning weighing scale		
CDD posters on wall		
CDD flipchart		
Mothers' handouts on CDD		

COMMENTS ON EQUIPMENT AND SUGGESTIONS FOR IMPROVEMENT:

ORS SUPPLY

Is ORS stored in clean and dry place?	Y N
Do any packets feel 'caked'?	Y N
Is there an ORS Supply log book?	Y N
<hr/>	
Nb. of packets in store today	_____
Nb. of packets used in last month	_____
For last 10 cases, avg. number of packets dispensed/ prescribed	0 1 2 3 4 5 6 6+

COMMENTS ON ORS SUPPLY & USE AND SUGGESTIONS FOR IMPROVEMENT:

CASE PATTERN

(select 10 records from register or assessment forms)

Nb. OF WATERY	NB. WITH BLOOD IN STOOLS	NB. LASTING TWO WEEKS OR LONGER

COMMENTS ON CASE PATTERN:

CONSTRAINTS NOTED		YES	NO
1.	Acceptance of ORT by hospital authorities (administrator, head of paediatrics, chief matron)		
2.	Acceptance of ORT by medical/nursing staff		
3.	Lack of training in diarrhoea case management		
4.	Lack of adequate and effective supervision		
5.	Lack of adequate space for ORT activities		
6.	Management of ORT activities		
7.	Lack of supplies (cups, spoons, education materials, treatment charts)		
8.	ORS supplies (regularity and/or quantity)		
9.	Staffing patterns of ORT unit		
10.	Number of diarrhoea cases		
11.	Record-keeping and use of information for improving diarrhoea services		

COMMENTS ON CONSTRAINTS AND SUGGESTIONS FOR IMPROVEMENT:

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CASE OBSERVATION FORMDate: / /

Health Worker: _____

ASSESSMENT

DOES HEALTH WORKER ASK-	YES	NO
how many days of diarrhoea?		
is there blood in stool?		
does child have other illnesses?		
number of stools in last 24 hours?		
if the child has vomited and how many times?		
is the child drinking more than usual? (thirsty)?		
has the child passed urine in the last 8 hours?		

DOES HEALTH WORKER EXAMINE-	YES	NO
child's general appearance		
look for presence of tears		
look for sunken eyes		
look for dryness of mouth & tongue		
do skin pinch to assess skin turgor		

DOES HEALTH WORKER	YES	NO
take temperature of child		
weigh child		
make nutritional assessment using growth chart or table		

Health Worker uses diarrhoea assessment form?	YES	NO
Health Worker uses diarrhoea assessment chart?	YES	NO

CONCLUSION ABOUT DEGREE OF DEHYDRATION	NONE (Plan A)	SOME (Plan B)	SEVERE (Plan C)
Health Worker			
Your Conclusion			

COMMENTS ON ASSESSMENT AND SUGGESTIONS FOR IMPROVEMENT:

TREATMENT

TREATMENT	HEALTH WORKER SELECTS	YOU SELECT
home with no ORS, no advice		
home with only advice on ORS or home fluids		
give ORS in facility		
admit or refer for IV rehydration		
other - - -		
Volume of Fluid correctly calculated and administered	YES	NO

DRUG PRESCRIBED		
Antibiotic Prescribed/Given	YES	NO
Reason for Antibiotic	blood in stools suspected cholera	— —
	other illness - - -	—
Antidiarrhoeal Prescribed/Given	YES	NO

COMMENTS ON TREATMENT AND SUGGESTIONS FOR IMPROVEMENT:

gl

ADVICE TO MOTHER

MESSAGE	YES	NO
How to prepare ORS		
How to give ORS		
Increase fluids at home		
Continue to feed during episode		
Increase feeds after episode		
When to seek care		
Ways of preventing diarrhoea		

COMMENTS ON ADVICE GIVEN TO MOTHERS AND SUGGESTIONS FOR IMPROVEMENT:

FEEDBACK

Comments and Suggestions Given to Health Worker?	YES	NO
Comments and Suggestions Given to Health Worker's Supervisor?	YES	NO