

CLASSIFICATION
PROJECT EVALUATION SUMMARY (PES) -- PART I

Report Symbol U-447

1. PROJECT TITLE Health Planning and Information Project			2. PROJECT NUMBER 615-0187	3. MISSION/AID/W OFFICE HNP/USAID/Kenya
5. KEY PROJECT IMPLEMENTATION DATES A. First PRO-AG or Equivalent FY <u>79</u> B. Final Obligation Expected FY <u>81</u> C. Final Input Delivery FY _____			6. ESTIMATED PROJECT FUNDING A. Total \$ <u>3,272,000</u> B. U.S. \$ <u>2,450,000</u>	4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) <u>615-83-02</u> <input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION
7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>7/79</u> To (month/yr.) <u>7/82</u> Date of Evaluation Review _____				

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAH, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Extend project PACD by 2 years		March 1, 1983
2. Extend DREW Host Country - 2 years		March 1, 1983
3. Revise project and contract budgets as appropriate		March 15, 1983
4. Amend Project Authorization to delete Section 5.3 of Article 5 Special Covenants in ProAg		Feb 15, 1983
5. Assignment of 2nd Health Planner under Host Country Contract		May 1, 1983
6. Resolution of formal establishment of Planning Unit as called for in Section 5.2 Article 5 Special Covenants		Feb 10, 1983
7. Formalization of biweekly Min./USAID project meetings		Feb 10, 1983
8. Preparation for Implementation Plan for the remainder of project to include: a) Plans for: Short term consultants Reimbursement of funds Data management and research studies Monitoring project progress b) Scheduling joint management conference to develop, review Implementation Plan		March 15, 1983

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Financial Plan	<input checked="" type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A. Continue Project Without Change

B. Change Project Design and/or
 Change Implementation Plan

C. Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Charles J. Mantione, USAID Health Officer

HNP: R Britanak: RB PRG: R Crist: RC PRJ: S Shah: _____
 D/DIR: B Riley: BR

12. Mission/AID/W Office Director Approval

Signature _____

Typed Name ABH
 Allison B. Herrick

Date 10 Feb 83

CHAPTER 1

1.0. EXECUTIVE SUMMARY

1.1. Introduction

Between July 12 and August 19, 1982, the USAID assisted Kenya Health Planning and Information Project underwent a mid-term evaluation.

Quoting from the project's logical framework, the project goal is "To enhance the GOK capability to develop health sector plans, programs and policies that will achieve a more efficient use and a more equitable distribution of health sector resources."

The project was initiated on August 30, 1979 through a Grant Agreement between USAID and the GOK with total U.S. funding amounting to \$2,450,000. Earlier on, U.S. technical assistance was provided by USAID/K and HRA/DHHS.

On October 1, 1980, the GOK entered into a three year host country, \$1,712,000 contract with the Charles R. Drew Postgraduate Medical School (Drew) to provide technical assistance, and to secure and deliver a computer, vehicles and other commodities related to planning and programming the delivery of health services. To carry

out the evaluation a two person team was sent from the U.S. to Kenya during the period July 10 through August 7, 1982. The proceeding week, the team visited Drew in Los Angeles and held meetings with project-related AID and HRA/DHHS staff in Washington, D.C.

While in Kenya, the team studied documents, examined files, visited a provincial and a district medical establishment including their facilities and senior health staff, and conferred with responsible officials in the Ministries of Health, Economic Planning and Development, Finance and other Kenyan agencies and the key staff of USAID/K.

A representative from the Ministry of Economic Planning and Development joined the evaluation team between July 19 through 31, 1982.

The administrative basis of the evaluation is the logical framework in the Project Paper. The method of evaluating the HPIP was primarily open ended interviews with key decision-makers by a team of three people. While the team found constraints to the evaluation, its significant aspects were accomplished within the allotted time frame.

1.2. Background

General

Kenya has demographic characteristics which point to a great need to adequately plan for health services and improved rural health care delivery. The high birth and fertility rate, coupled with a low death rate have given the country a large proportion of dependent population under the age of 15. These factors will put further strains on the health system and will demand systematic planning to meet health needs.

Health Planning Environment

In previous years, health planning in Kenya has been primarily the responsibility of one individual who aggregated Ministry headquarters, provincial and district plans. These were then reviewed and frequently modified by the Ministry of Economic Planning and Development.

Recently the environment for health planning has become increasingly favorable. Several aspects of that environment are described: (a) The President's Mandate for decentralized planning has aided the purposes of the project; (b) the detailed specification for the preparation of the fifth Year Development Plan by the Permanent Secretary and (c) the "Strategy for Health" by the Director of Medical Services have proved to be key aspects in the

environment which are used to develop the infrastructure of planning.

Project Related

The project was designed to provide for increased institutional capacity to plan and implement as well as to expand and evaluate health services and policies. It provides for the training of Kenyan health professionals to: (a) improve the rationality, (b) establish criteria and policies for evaluating public and private programs, (c) develop alternatives for uses of resources, and (d) establish an information system to assess the needs for services.

Design of the project seems to have been centered on the assumption that a free standing health planning structure, elevated and independent, is necessary to perform health planning. Such an entity as well as a Planning Policy Coordinating Committee and a scheme of service for health planners are called for in the Project Paper.

1.3. Issues and Problems

A number of issues and problems are discussed under conclusions and recommendations. Two areas requiring specific comment are addressed here.

The Health Planning Structure in the MOH

A review of the inputs to the planning process suggests that one area has plagued the project, i.e, the structure of the health planning entity. That issue has consumed much of the effort of project participants and slowed or adversely affected the relationships between the GOK and USAID/K. We feel it should be deemphasized but resolved.

There seems to be three streams of activities within the Ministry of Health which are planning related. These deal with health facility planning, health services planning, and the health information service. Each of these areas has a significant and integral relationship to successful planning. Each have a different organizational home.

There seems to be a deliberate reluctance to focus the power to plan in a single central unit. That, we feel, is due to an attempt to distribute involvement to various units within the Ministry of Health. A partial remedy has been to design a Health Planning

Steering Committee, which develops policy, and a Health Planning Working Group to implement that policy. That structure seems to be a necessary evolutionary step towards involving the entire power structure of the MOH in the decision-making.

A Scheme of Service for Health Planners

Under existing GOK public service regulations a scheme of service or career ladder for specific skill categories is located in a single ministry or government agency. Thus all planners fall under the scheme of service of the Ministry of Economic Planning and Development. No scheme of service for health planners presently exists or can exist in the MOH without changing public service regulations. This fact apparently was not appreciated when the project was designed.

1.4. Conclusions and Recommendations

Seven areas are addressed in this section. These are goals and purposes, project outputs, project inputs and assumptions, which are all key elements of the logical framework, and project management, financial aspects and the health information component which apply to the project in general.

Goals and Purposes

- . The broad goals and purposes of the project are being met. However, even with the changes and improvements discussed below, the MOH will not achieve an institutionalized health planning capability in three year project period.

We recommend that the project be continued and that it be extended two additional years.

- . We further recommend that greater attention be given to policy analysis and formulation. We also recommend that a consistent approach to the review of provincial and district plans be developed so that these plans can be incorporated smoothly into an overall health sector plan.

Project Outputs

- . Although a formal planning entity, with the context of the Project Paper, has not been established in the MOH, the Planning Steering Committee and the Health Planning Working Group are actively involved in health planning at all levels of the Ministry. Hopefully the HPWG will evolve into the formal planning entity.

The thrust of the planning to date has been on the health

sector portion of the next five year development plan. The impact of the HPIP on this process was evaluated. Our findings indicate that there is indeed a big difference in the awareness of planning issues and more involvement in the planning process at all levels of the Ministry than there was in years past. We feel that this is directly attributable to this project. Indeed much excellent work has been done on the development of the planning process. The process is well conceived, deliberate and is considered by us to be effective, its impact documentable.

To enhance the work of the HPWG, we recommend that a suitably trained Kenyan physician be posted full time to the Working Group. This physician would work in a counterpart relationship with the Drew COP. Failure to post this physician will directly handicap the institutionalization of the planning process in the MOH.

Also to strengthen the HPWG and its activities we recommend the posting of a second health planner as part of the Drew team. This individual, trained at the M.P.H. level, should

have direct health planning experience, preferably in Africa. This planner would assist the organizational development of HPWG, assist in training and workshops and provide administrative support to the Drew COP.

- . Participant Training both long and short term, and planning workshops and seminars have been carried out essentially as specified. However, the obstacles for the staffing of planners in the MOH and their retention must be resolved. Not all Kenyans trained at the masters level were sent to appropriate U.S. institutions. Future trainees should include more non-physician health workers and training institutions selected more carefully.
- . Equipment Procurement, particularly vehicles, has not gone smoothly. Hopefully with the strengthening of Drew's project management this problem will be rectified.

Project Inputs

- . Only one of the two called-for long-term technical advisors, the COP, has been posted in the field. The health information specialist is still being sought. A third long term advisor, the health planner described above, is also recommended.
- . Short term consultants have not been used sufficiently.

The areas where consultants could provide valuable assistance are in training, organizational development, data management, project administration, etc.

. Assumptions

The logical framework discusses assumptions in relation to project goals and purpose, outputs and inputs. These are discussed in detail in the body of the report. Our general conclusions are that the goals purpose are laudible but that they cannot be achieved within the project time frame. Further, while suitable institutions are available in the U.S. to provide training in health planning, those selected in this instance were not totally appropriate. We feel that the project outputs are somewhat over ambitious within the time frame of the project. However, the GOK is certainly moving in the direction called for by the project and is supplying people and funding to further the project.

Project Management

Drew

While an extremely competent and resourceful COP has been posted by Drew, his effectiveness has been limited by lack of adequate professional and administrative support and by the ongoing difficulties related to the task of resolution of contract issues between the GOK and USAID.

Drew's financial management of the project leaves much to be desired. For example, vouchers for payment are not submitted in a timely fashion. This makes tracking project performance as against expenditures difficult.

Drew needs to deploy senior technical staff in Kenya for short periods on a regular basis to review project progress and to resolve technical and administrative issues and problems. And it needs to improve various aspects of project management in the home office.

The Ministry of Health

While the Ministry of Health is making significant strides in developing the planning process at various levels, undoubtedly to a considerable degree because of the HPIP

project and Drew assistance, the MOH has not developed a formal mechanism to review progress of the project and the performance of various parties to the contract. This it should do.

USAID/K

USAID/K has shown flexibility in living with the unresolved issues of contract compliance, recognizing that progress toward program goal achievement was being made.

To move the project forward USAID/K, the MOH and Drew must sit down and resolve issues and problems.

Project Finances

To date, project finances have been underutilized. This may in part be due to a particularly ample budget. However, 58 percent of the time of the project has elapsed and only one third of the funds have been used. At least part of the difficulty can be placed on problems in project management. People were not posted as anticipated. The health information component of the project has lagged. To these difficulties have been Drew's delays in submitting its vouchers for payment.

The underutilizations of financial resources to date provides a better opportunity than might otherwise exist to extend the project period.

The Health Information Component

Although most of the data needs for health planning have been identified, these have never been assembled into a cohesive, clearly stated health information base for planning at the district, provincial and other levels of the MOH.

This needs to be done! We recommend that this be a priority item on the upcoming health data workshop.

We concur that the Ministry could manage its data processing better with a computer. However, before the project purchases a computer, we feel that six areas must be addressed. These fall into the areas of data management, the scope of data processing requirements, the bureaucratic control of the machine and its upkeep, the training of users and producers and their involvement in the design of the system.

1.5. Future Directions

Despite the significant contributions the project has made towards goal achievement it also has some short-comings. It does not represent the maximal focussing of resources of the contractor (Drew), the MOH and USAID/K toward the resolution of several issues which have been in need of attention for varying lengths of time:

(a) Resolution of the issue of the covenant between USAID/K and the MOH about the creation of a "free-standing unit of health planning"; (b) The appointment of individuals to implement the health information activities necessary to health planning; (c) The necessary support to the Drew Chief of Party in both programmatic and operational areas; and (d) The appointment of a Kenyan physician to the Health Planning Working Group.

After this evaluation report has been reviewed it is strongly recommended that there be a management conference with all parties related to the project in attendance. The purpose of this conference will be to map the future direction of the project, to resolve issues and problems and to agree on project staffing and management roles and responsibilities.

REPORT OF THE
EVALUATION OF THE KENYA HEALTH PLANNING
AND
INFORMATION PROJECT

Submitted By: Paul Zukin
Z. Erik Farag

EVALUATION OF THE
KENYA HEALTH PLANNING AND
INFORMATION PROJECT

CONTRACT NUMBER 615-0187

CONTRACTOR: THE CHARLES R. DREW POST-GRADUATE
MEDICAL SCHOOL
FOR THE
MINISTRY OF HEALTH, GOVERNMENT OF KENYA

REVISED REPORT SUBMITTED
OCTOBER 10, 1982

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Abbreviations Used

ASU	Administrative Support Unit MOH
CBS	Central Bureau of Statistics
COP	Chief of Party, Charles R. Drew Post Graduate Medical School
DANIDA	Danish International Development Agency
DCAU	Data Collection and Analysis Unit, MOH
DCH/UN	Department of Community Health, University of Nairobi
DDC	District Development Committee
DMO	District Medical Officer
DDMS	Deputy Director of Medical Services, MOH
DMS	Director of Medical Services, MOH
DPS	Deputy Permanent Secretary
DPI	Division of Planning and Implementation
DREW	Charles R. Drew Post Graduate Medical School
GOK	Government of Kenya
HPIP	Health Planning and Information Project
HPPCC	Health Planning and Policy Coordinating Committee
HPWG	Health Planning Working Group
HRA/DHHS	Health Resources Administration, Department of Health and Human Services
IBRD	International Bank for Reconstruction and Development
IRH/FP	Integrated Rural Health/Family Planning Project

KIA	Kenya Institute of Administration
MPH	Master's Degree in Public Health
MCH/FP	Maternal and Child Health and Family Planning
MOF	Ministry of Finance
MOH	Ministry of Health
MOEPD	Ministry of Economic Planning and Development
MOW	Ministry of Works
NFWC	National Family Welfare Center
NORAD	Norwegian Agency for Development
PASA	Participating Agency Service Agreement, between USAID and DHHS
PID	Project Identification Document
PMO	Provincial Medical Officer
PPCC	Planning and Policy Coordination Committee
PS	Permanent Secretary
RHDP	Rural Health Development Project (NORAD)
SIDA	Swedish International Development Agency
SDDMS	Senior Deputy Director of Medical Services
TA	Technical Assistance
TDY	Temporary Duty Expert Consultation
USAID/K	United States Agency for International Development Mission in Kenya
USAID/W	United States Agency for International Development, Washington HQ
WHO	World Health Organization

ACKNOWLEDGEMENTS

The Evaluation Team wishes to thank the various governmental officials in the United States and Kenya for affording us the privilege to perform this evaluation. In doing so, they and the contractor, the Charles R. Drew Post Graduate Medical School, (Drew) generously gave us their time and opinions and shared with us their records and documents. More importantly all were gracious and open in imparting their opinions and perceptions. They readily acknowledged strengths and weaknesses and willingly gave and discussed their views and ours.

Because mention of all the individuals would be lengthy, as a review of the list of individuals who contributed to our understanding will attest, our special thanks go to those who gave so much of their time. Drs. Haynes and Gipson of Drew, Drs. Kanani and Maneno of the MOH, Drs. Britanak, Slattery and Sheppard of USAID, Mr. Mahoney of HRA/DHHS, and lastly to our team member Ms. A. Khasakhala whose insights and questions were most helpful.

The limitations of this report in no way reflect the hospitality, courtesy and cooperation afforded the team, but must be a reflection of our short stay, and the complexity of the issues we sought to understand.

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CHAPTER 1

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To move the project forward, USAID/K, the MOH and Drew must sit down and resolve issues and problems.

Project Finances

To date, project finances have been underutilized. This may in part be due to a particularly ample budget. However, 58 percent of the time of the project has elapsed and only one third of the funds have been used. At least part of the difficulty can be placed on problems in project management. People were not posted as anticipated. The health information component of the project has lagged. To these difficulties have been Drew's delays in submitting its vouchers for payment.

The underutilizations of financial resources to date provides a better opportunity than might otherwise exist to extend the project period.

The Health Information Component

Although most of the data needs for health planning have been identified, these have never been assembled into a cohesive, clearly stated health information base for planning at the district, provincial and other levels of the MOH.

This needs to be done! We recommend that this be a priority item on the upcoming health data workshop.

We concur that the Ministry could manage its data processing better with a computer. However, before the project purchases a computer, we feel that six areas must be addressed. These fall into the areas of data management, the scope of data processing requirements, the bureaucratic control of the machine and its upkeep, the training of users and producers and their involvement in the design of the system.

1.5. Future Directions

Despite the significant contributions the project has made towards goal achievement it also has some short-comings. It does not represent the maximal focussing of resources of the contractor (Drew), the MOH and USAID/K toward the resolution of several issues which have been in need of attention for varying lengths of time:

- (a) Resolution of the issue of the covenant between USAID/K and the MOH about the creation of a "free-standing unit of health planning";
- (b) The appointment of individuals to implement the health information activities necessary to health planning;
- (c) The necessary support to the Drew Chief of Party in both programmatic and operational areas;
- and (d) The appointment of a Kenyan physician to the Health Planning Working Group.

After this evaluation report has been reviewed it is strongly recommended that there be a management conference with all parties related to the project in attendance. The purpose of this conference will be to map the future direction of the project, to resolve issues and problems and to agree on project staffing and management roles and responsibilities.

CHAPTER 2

2.0 INTRODUCTION

The Health Planning and Information Project (HPIP) is a four-year agreement between the Government of Kenya (GOK) and the United States Agency for International Development, Mission to Kenya (USAID/K) to assist the Ministry of Health (MOH) to develop and train Kenyan staff to plan, implement and evaluate health policies and programs with primary emphasis on expansion of rural health care.

To provide for this project, a Grant Agreement was signed between the GOK and the USAID/K on August 30, 1979, for a total of \$2,450,000. On October 1, 1980 the GOK entered into a host country three-year \$1,712,000 contract with the Charles R. Drew Post-Graduate Medical School (Drew) to provide technical assistance, to secure and deliver certain commodities and to provide or arrange for training in skills related to planning and programming the delivery of health services. Prior to October, 1980, project related activities had been carried out by USAID/K and HRA/DHHS.

2.1 Administrative Basis for the Evaluation

The Project Paper has explicit provisions for evaluations of

this project on an annual basis. Evaluations were tentatively scheduled for June 1981 and July 1982 with a final evaluation in June 1983.

The June 1981 evaluation was not carried out. It was decided that the present evaluation would take the place of the first two annual evaluations.

The specific bases for the project evaluation are the project's logical framework, implementation schedule and the contractor's detailed time-phased work plans (See Appendix I for the projects logical framework).

A systematic and objective framework for the evaluation was prepared by the USAID/K Project Manager in consultation with GOK officials. The evaluation and our report were guided by that framework.

2.2 Objectives and Scope of the Evaluation

Three areas of focus are specified as providing the framework of the evaluation of the project's progress in achieving these goals. These are:

1. Review the proposal to establish a Division of Planning and Implementation, its structure and staffing in light of recent developments in the Ministry of Health.
2. Review the role of the proposed Health Planning and Policy Coordinating Committee (HPPCC) composed of senior health officials and representatives of the Ministry of Works (MOW) and Ministry of Economic Planning and Development (MEPD) vis-a-vis Ministry of Health Management Committee.
3. Assess the functions of the three trained planners in the MOH and their relevance to planning at Headquarters, Provincial and District levels.

In addition, the scope of work calls for assessment of inputs, outputs, working relationships, budget projections, achievement of purpose, validity of assumptions and recommendations. These are addressed in the remainder of the report.

2.3 Methodology of the Evaluation

The World Health Organization (WHO) evaluation methodology guided the evaluators as they reviewed the HPIP. This methodology includes five criteria. They are relevance,

progress, efficiency, effectiveness and impact. These criteria were used because they do not contain any particular country bias.

In carrying out the evaluation a basic open ended interview technique was used. The selection of individuals for interview was based on meeting one or more of the following criteria:

1. They were in positions of responsibility and/or authority vis-a-vis the project in the four loci of the administration of the project: USAID/K, Drew, Ministry of Health of Kenya and AID/W.
2. They were directly involved with the project, such as Dr. Reginald Gipson and those with whom he works and interacts.

3. Others whose influence would impinge on the conduct and effectiveness of the project. These include individuals in the MOH, Ministry of Economic Planning and Development (MEPD), Ministry of Finance (MOF), other donors, WHO, etc. Also included in this group is the Health Resources Administration/U.S. Department of Health and Human Services (HRA/DHHS), which provides consultants to the project.
4. Those who will continue the process of health planning in Kenya once the project runs its course -- the returning Kenyan students from the U.S., and other officials in the MOH.

The interviews were generally structured to facilitate responses around issues identified in the evaluation scope of work or in the reference documents.

A site visit was made to Nyeri Provincial Headquarters and Hospital and the Muranga District Headquarters Hospital and discussions were held with the provincial (PMO) and district medical officers (DMO) in charge and several of their key staff. The discussions centered on issues and problems related to the delivery of health services and planning to meet health care needs. The impact of planning workshops recently held under the auspices of the Health Planning Working Group was probed in detail. Persons contacted and sites visited are

noted in Appendix II.

2.4 The Evaluation Team

The Scope of Work for this evaluation calls for two outside evaluators. In addition the MOH was to provide one disinterested member of the Ministry not associated with the health planning project and the MEPD one officer who works closely with the planning of the health sector by that Ministry.

The evaluation was carried out between July 12 to August 19, 1982. The team consisted of Paul Zukin, M.D., M.P.H., President of Health Management Group, Ltd., Piedmont, California, the team leader, and Z. Erik Farag, Ph.D., M.P.H., Director, Office of Program Development, Health Resources and Services Administration, Washington D.C., and Ms. Ann Khasakhala, M.A., representing the Ministry of Economic Planning and Development who participated in meetings in Kenya through July 30th, the period of her assignment to this project evaluation.

2.5 Constraints on the Evaluation

In the evaluation of any project it is necessary to describe the limitations. With respect to the present evaluation, they fall into the following areas:

- The complexity of the "environment" and the project per se required understanding of nuances and an array of governmental operating systems. This understanding was affected by many factors. The time available to the evaluators, the range of issues involved, the attitudes and perceptions of those interviewed, cultural and social factors, to name a few.
- An attempted military coup which occurred at the beginning of the third week (and last in country) of the evaluation, significantly interfered with the orderly conduct of the last portion of the evaluation. Scheduled meetings with the Senior Deputy Director of the Medical Services responsible for health data and the Director of the Central Bureau of Statistics had to be cancelled. And meetings with other donors such as DANIDA and SIDA did not take place as anticipated.
- Despite these limitations, the evaluators believe they had adequate opportunity to make value judgements on the major

aspects of this project. However, because of time and other constraints the financial aspects of the project were not delved into the degree desired.

CHAPTER 3

3.0 GENERAL BACKGROUND

To adequately describe the activities of this project it is necessary to give the context of the undertaking. Thus an overview of the country, its demographic and health status, the organization of the Ministry of Health and other aspects are briefly touched upon to give the reader a general appreciation of the complex environmental factors which impinge on this project. There is no presumption of originality in the description. It is heavily reliant on readily available reference materials.

3.1. General Overview of the Country

Kenya is a country sovereign over 569,249 square kilometers in East Africa. It is divided into seven provinces and 42 districts with an estimated population in mid 1980 of 16 million people. The overall population density, except for three areas of population concentration, is light (only 28 per square km).

3.2 Demographic Characteristics

The growth rate of the population is 3.9% per annum. This rate

is among the highest in the World. Kenya has a crude birth rate of 53 and an infant mortality rate of 87. There has been a remarkable drop in infant mortality from 148 in 1948 to 114 in 1969 to 87 in 1979. The country is one of only 8 of 52 in Africa with an infant mortality rate below 100. There has been a similar drop in the crude death rate, from 25 in 1948 to 14 in 1979. The decrease in infant mortality has dramatically increased life expectancy and altered the age distribution of the population. Thus Kenya's life expectancy is now 53 years at birth, as compared to 49 years overall in Africa, and its population is young, 50 percent being under 15 years of age.

3.3 Mortality and Morbidity

The overall mortality is primarily related to infectious and parasitic diseases. Malnutrition plays a significant contributory role in deaths of infants and children. In out patient settings respiratory diseases, malaria, diseases of the skin and diarrheal disease are the most common health problems encountered and reportedly make up 80 percent of the cases seen. It is widely reported that the majority of the morbidity and mortality is preventable with simple primary health care.

3.4 Organization of Health Services

As in many less developed countries, Kenya's health service includes a fairly well developed hospital system and more primitive rural health services. There is a large, essentially new, 1200 bed general hospital in Nairobi, associated with a medical school which graduates physicians (100 per year), nurses and other health care workers.

Each province has a provincial hospital of about 350-400 beds. Each district also has a hospital. Some of these district hospitals are as large as the provincial hospitals. Both of these facilities provide mainly basic medical and surgical care with some diagnostic and therapeutic capabilities. Government hospitals are augmented by Mission and private hospitals.

Compared with most African countries the availability of health workers in Kenya is rather good. In 1977 the physician to population ratio was almost 1 in 12,000, and the nurse ratio somewhat over one per 1,000. In the past several years the ratio of doctors to population has increased considerably and now is said to be one physician for 6,000 population.

Rural health care is based on static facilities. Mobile services in Kenya are now in the early stages of developing village based primary health care. A multi-donor Integrated

Rural Health and Family Planning (IRH/FP) project has recently commenced. This is an extremely important and large project since it marks a concerted effort to address the health needs of the underserved rural majority and also aims to strengthen the family planning effort which, to date, has reported limited progress in meeting its targets. The project is also important to the HPIP since HPIP staff played a major role in IRH/FP project planning and implementation.

Over the years Kenya has had considerable assistance from donors - Denmark, Sweden, Japan, Holland, Britain, the United States, etc. These donors have supported a variety of health programs, mostly categorical in nature, although there have been some general efforts to improve the functioning and coverage of the health care system. To a considerable degree these programs seem to work independently of each other.

3.5 The Organization of the Ministry of Health

The Ministry of Health (MOH) one of 23 ministries in the country, is headed by the Honorable Dr. A. Mukasa Mango, the Minister of Health. He has two assistant ministers. The

Ministry has two major components, the administrative and the professional sides. The administrative side is managed by the Permanent Secretary (PS). The professional side is managed by the Director of Medical Services (DMS).

A thorough analysis of the various organizational components and complex organizational, hierarchical, and substantive/technical relationships operative in the Ministry of Health is clearly beyond the scope of this paper. Yet a few central observations regarding the key organization structure must be addressed.

The Permanent Secretary the Honorable Mr. G.R. M'Mwirichia, among other major duties manages the Ministry's budget, finances, structure and staffing.

The Director of Medical Services the Honorable Dr. W. Koinange, manages the technical operations of the Ministry. Some eleven divisions report to him. They have operational responsibilities for programmatic areas such as Curative Services, Preventive Services, Public Health, Nursing, and Administration and Planning. Each of these divisions has major responsibility for programs and staff. These have critical relationships to the HPIP.

The MOH headquarters controls most of the administrative,

policy and programmatic decisions as well as the fiscal, personnel and operations at the central level and in the provinces and the districts.

Each of the seven provinces has a Provincial Medical Officer (PMO) who also represents the Ministry on the Provincial Development Council. These councils have considerable impact on the formulation of the Provincial Development Plan including facilities development, and other health-related activities of the government including public works, water, and sanitation etc.

The seven provinces have 42 districts and in each district is a parallel District Development Council. The District Medical Officer sits on this council. The districts are also divided into sub-units where health services are delivered. There are 254 sub-districts in the country.

CHAPTER 4

4.0 PROJECT BACKGROUND, PURPOSE AND DESCRIPTION

4.1 Background

The evolution of the present project has its origins in Kenya's shift from a strategy of rural health services supported mainly by local authorities to a centralized system of rural health care delivery as a responsibility of the MOH. This shift, which occurred in 1970, produced strains on the management and planning capabilities of the Ministry's central staff. With the assistance of external donors, a number of health planning-related activities emerged to remedy some of these recognized weaknesses.

In 1972, the Ministries of Health and Finance, in cooperation with WHO and the Ministry of Social Services undertook a health sector assessment. This led to a "Proposal for the Improvement of Rural Health Services and the Development of Rural Health Training Centers." This proposal was accepted and in 1974 evolved as the Rural Health Development Program. NORAD played a significant role in the training and facility implementation for the RHDP from 1973-76.

A National Five Year MCH/FP Program also commenced in 1974. This was developed with the assistance of the IBRD and five donors, including USAID.

In April, 1976 a USAID/K staff paper pointed to the need for planning assistance to the GOK in the delivery of rural health services.

Other significant donor involvement by DANIDA in management and administrative functions followed in 1977.

In February 1977 the Haynes-Gipson team sponsored by the USAID, worked with the MOH to draft a scope of work to assist the MOH in the development of the next five year health development plan with emphasis on rural health care delivery.

The next step of USAID assistance was to recruit planning experts. This was accomplished through a PASA agreement between the HRA/DHHS, and USAID. Under this agreement, several short-term consultants were initially posted in early 1978.

Among them was a health economist, Dr. James Jeffers, who subsequently commenced a long term health planning consultancy in June 1978. Working with USAID, the MOH, the MEPD and other organizations, Dr. Jeffers produced a number of papers. These include a Health Sector Assessment (1979) and a later paper which critiqued previous health sector plans.

All these activities, plus national pressures, spawned the development of this project.

4.2 Project Purpose

The documented purpose of the project is two fold:

- 1) To strengthen the GOK institutional capacity to plan, implement and evaluate health sector policies and programs, and by so doing;
- 2) To expand rural health services delivery.

4.3 Project Description

Quoting from the Project Paper "The project will establish within the MOH and the MOP (now MEPD) headquarters and in selected provinces and districts a small cadre of trained Kenyans who can:

- 1) Establish rational (concrete, practical and achievable) objectives and plans; relating these to precise health programs, costs, manpower and implementation capacities.
- 2) Establish both the criteria and capacity through which existing and proposed ministry and private sector health programs and policies can be evaluated.
- 3) Examine health policy alternatives, weighing anticipated results in relation to alternative used of resources and the feasibility of implementation.
- 4) Conduct or direct and oversee forward planning studies and research into important health policy issues and health program problems on behalf of ministry management.
- 5) Establish a health information system which can deliver, in a timely fashion, the minimum amount of information necessary for national comprehensive health planning and short-term needs.

The project provides for many inputs. Among others, these include 79 1/2 person months of intermediate term and long term health planning and information consultant services, 50 person months of short-term consultant services, 180 person months of masters level training and 50 person months of short-term seminar of observational tour training. Training at the masters and other levels, and the holding of seminars and conferences are to be conducted continuously throughout the course of the project.

The project also provides support for 9 health planning, policy and information seminars; \$200,000 of support for the acquisition of library materials, equipment and vehicles; and \$400,000 of support for action research (using Kenyan consultants and institutions), baseline information field trials and evaluation studies.

Prior to the involvement of Drew, the training of Kenyans under this project was arranged for by USAID/K. Subsequently Drew took over this responsibility. Drew in conjunction with GOR/MOH and USAID/K now selects the training institutions, facilitates student applications and their acceptance and from project funds, handles financial arrangements both with institutions and for trainees.

Technical assistance began in September 1979 with the services

of Dr. James Jeffers, a health economist.* A Drew two member long-term technical assistance team was scheduled to arrive in Kenya on or about June 15, 1980. However, delay occurred in the signing of the MOH-Drew Contract until October 1, 1980 and Dr. Reginald Gipson, the Drew Chief of Party (COP) arrived in Kenya the end of November 1980.

In the original project design it was anticipated that Dr. Gipson's term would overlap with Dr. Jeffer's for several months but this did not occur. A critical structural change which still affects the project occurred during the interim period between Dr Jeffer's departure and Dr. Gipson's arrival. Some background concerning that change is necessary to understand the evolution of the project.

The Ministry of health, as described above, has a Permanent Secretary (PS) who is the administrative head of the Ministry, a Director of Medical Services who directs the technical or

*Dr. Jeffers initial assignment was under the sponsorship of HRA/DHHS

professional aspects of the Ministry. Each of these two sides has its own staff and organizational structure. Each depends on the other in that services delivery controlled by the DMS requires finances and budgets, and a schedule of services and disbursement mechanisms which are under the control of the Permanent Secretary.

During Dr. Jeffer's tenure, the Director of Medical Services and the Permanent Secretary posts here held by one man. Therefore, agreement that there should be a "free standing agency"* for planning which was highly placed in the ministry and structurally "independent" did not seem to pose a problem. After signing of the Drew contract but before the arrival of Dr. Gipson that structural unity in the MOH was split with separate individuals holding the PS and DMS positions.

Historically, there have been several reversals in this aspect of the structure of the MOH. The causes or reasons for these changes can only be speculated on, and are beyond the scope of this evaluation. Yet the split in the structure has constrained the achievement of a key aspect of the contract requirements, i.e., that a planning unit be established in the MOH with the specifications described in the Jeffers paper.

*These were the terms used by Dr. Jeffers in his health sector assessment (1979).

Several aspects of this problem deserve special comment. First, the schedule of duties of the Ministry allocates staff positions under the PS side for Health Planning, Health Information Systems and Health Facility construction. Yet the professional side of the Ministry feels that performing these functions cannot be done without the services delivery staff involvement.

Second, the GOK-USAID Agreement specifies that a "division of planning and implementation" and a "planning and policy coordinating committee" with the necessary authority to implement the project will be established within 90 days of the signing of the project agreement. To date, the division called for has not been established. The Planning and Policy Coordinating committee has recently been established.

Over the months, USAID has insisted that the contractual obligation concerning the planning and implementation division be honored. Numerous letters (about 12) regarding this matter have been sent to the Ministry by USAID/K. To date the Ministry has not responded and this has proven to be a source of concern for USAID/K.

The Drew Chief of Party tried to resolve this issue by proposing modifications to the contract with the MOH. The intent was to change the requirements for a defined planning

unit as specified in the contract, and substitute other entities and planning mechanisms which were on going and which functionally were directed at accomplishing the planning function.

The first of these such draft revisions was submitted by Dr. Gipson to Drew and the MOH in February 1981, shortly after his arrival in Kenya. Soon thereafter, Dr. M. Alfred Haynes, Dean and President of Drew and Dr. Alfred Cannon, then Director of International programs arrived in Kenya. In a visit of around ten days they attempted to negotiate changes and modifications to the Drew-MOH contract. However, no contract modifications ensued.

The provisions of the first proposed modification were clearly of concern to all the parties. Yet while no solution was entered into, no urgency for action seemed to develop from the session. Subsequently, Dr. Gipson drafted two additional modifications of the Drew/MOH contract, the last in December 1981. To date, none of the parties appear to have made successful efforts to resolve the issues except those suggested alternatives drafted by Dr. Gipson. We saw no written critiques of those drafts by Drew or the MOH. There was none by USAID/K, since they had not officially received the drafts.

There seems to be evidence that the impasse in resolving the issues, while of much concern to USAID/K, was not seen as critical issue since the MOH appeared to be making progress in developing a planning mechanism within its organizational structure and its functional inter-relationships. Recognizing this progress, the first year project evaluation was postponed.

Despite the absence of project revision, Dr. Gipson has used other strategies to enhance the Ministry's planning function. These are discussed later in this report.

There is another aspect of the project that has been a source of concern between the MOH and USAID/K.

The project in essence calls for the establishment of a career ladder or "scheme of service" for health planners in the MOH. Yet under present Public Service Commission policies, a separate scheme of service for planners in the MOH does not and cannot exist. Therefore a career ladder for planners in the MOH does not seem to be possible at this time. To qualify as a planner an individual is required to have had a formal graduate education in economics at a university which has a curriculum acceptable to the civil service, and MEPD. These individuals all serve under the scheme of service of the MEPD and are seconded to work in other ministries.

CHAPTER V

5.0 FINDINGS, ANALYSIS AND DISCUSSION

5.1 Planning Environment

The planning process in the Government of Kenya is highly institutionalized in the Ministry of Economic Planning and Development. In 1980, some financial responsibilities were separated from the MEPD and were placed under the Ministry of Finance. Both of these ministries now have a vital role in the planning and budgeting process of the government.

The MEPD has developed the national five year development plans since independence in 1962. To do this, the sectoral plans prepared by various ministries and other agencies are aggregated into a cohesive, national plan. Not all of the sectoral plans are adequate, however, and the MEPD may prepare its own plan for a sector under these circumstances. This is said to have occurred in past years with respect to the health sector. Because of the events described below, it is anticipated that the MOH will not be found lacking this time.

5.1.1. President's Mandate

Recently, the President of Kenya the Honorable Mr. Daniel

Toroitich Arap Moi, established as policy that the districts will be the hub of development in the country. This has had direct impact on the planning and administration of health services in Kenya. It reflects a deep interest in local development, and has shifted the focus of health planning from the central level to the districts.

5.1.2. Preparing for the Fifth National Development Plan (1984-88)

On January 20, 1982, the Ministry of Economic Planning and Development issued a circular implementing the President's decentralization mandate. The schedule for plan completion and publication is December 12th, 1983, Kenya's 20th independence anniversary.

To prepare the health portion of the Fifth Development Plan, a detailed outline and schedule of events were laid down by the Permanent Secretary of the MOH on December 2, 1981. Early in 1982, the Director of Medical Services issued a health strategy statement which emphasized that greater attention and resources would be paid to primary care and to meeting the needs of the underserved rural

population. New hospital construction will be delayed and rural health facilities will be pushed. The PS' schedule of events and the DMS' statement are outlined in Appendix III.

Both of these documents have led to the following preliminary work being completed or being undertaken to prepare the Fifth Development Plan:

1. Reviews of performance under the present plan to be prepared, down to the districts level;
2. Plan-related research projects to be identified and work initiated;
3. Phased workshops on health planning at the provincial and district levels;
4. Monitoring systems to be established;
5. Development of priorities in districts to be identified, and
6. A draft of development strategy and supporting policies with respect to the health sector to be prepared and submitted to Cabinet.

5.1.3. Relationship of the Ministry of Health to Other Ministries and Organizations

Other than MEPD whose influence we have discussed above, there are three ministries which affect health planning in Kenya.

The MOH relates to the Ministries of Works and Water Development in the planning and implementation of health services and construction of facilities. Delays or problems in the relationship with these ministries directly impact the MOH operations and service delivery capability.

The third ministry which impacts the MOH's planning environment is the Ministry of Finance which approves its developmental and recurrent budgets. These ministries therefore have an important ongoing effect on the MOH and its planning capability.

Over the years, various donors have provided planning assistance to the MOH. For example, DANIDA and SIDA have directly supported planning and management related

activities. DANIDA assisted the development of the Administrative Support Unit under the DMS and SIDA has long supported health facility planning and implementation which fall under the purview of the PS. These donor efforts are not always well coordinated. Although an effort is made to accomplish this through a Deputy DMS, donor requests and interests may block the process.

5.2 MOH Functions in Relationship to Health Planning

In its schedule of duties, the MOH has a list of functions which deal with planning. Three principal areas will be discussed. These are facilities planning, health services planning and the health information service.

5.2.1. Facilities Planning

Feasibility of, planning for, and development and construction of health facilities is an activity, generally conducted in a complex relationship with the Ministry of Works. This activity traditionally has been under the PS side of the MOH. This function is not performed by a single unit but has several loci in which the various activities which deal with facilities development and construction are performed.

It was not clear to this team what relationship health

facilities planners have with the staff who plan health services. So far as we are aware, no one yet has been assigned to be the Health Planning Working Group (HPWG) from the area of facilities development. This situation should be remedied.

Additionally, in the area of decision making, the roles and functions seem unclear between the facilities development activities of the MOH and those of the Ministry of Works. That the interface is not what it needs to be, is exemplified in the length of time that constructed facilities may stand idle, awaiting the placement of needed support systems. The complex issues involved in that interface and the working relationship which must exist between the MOH and the MOW were clearly beyond the scope of this review. That they need to be studied and operational problems resolved was indicated to us as being beyond question.

5.2.2. Health Services Planning

The activities which deal with health services planning have had an uncertain and varied organizational home. While in the schedule of duties, the locus for services planning is placed on the PS side of the MOH, the function presently falls under the SDDMS, Director of the Division of Administration and Planning, Dr. S. Kanani. Indeed that seems to be where the locus of control of HPIP resides in the MOH.

Health services planning is integrally tied to the five year development planning system and is very closely related to the budgeting system. It has two aspects which have separate process streams: The developmental budget which deals with the financing and construction of health facilities and the recurrent budget which deals with staffing, operations and related costs.

In a critique of the relationship of the developmental budget and the recurrent budget, Dr. Jeffers suggests that this is probably the greatest single step in need of health planning action. That the MOH is aware that this is a central planning problem is amply demonstrated in paper written by the Secretary of the HPWG who stated this in a frank presentation to a National Workshop on Health

Planning.

The complex process, both political and decisional, which deals with the policy issues involving the expenditures and recurrent aspects of the budgeting system but among the provinces, and the relationship of those expenditure to the health problems, be a central theme in the development of the next plan. Evidence of that was clear from our discussions with key staff, both central as well as those in the provinces and districts.

5.2.3. The Health Information Service

A third group performing a function related to planning is the Health Information Systems Unit. It, too, has had the same ambiguous placement as health services planning, with the schedule of duties placing it under the DPS but with its staff functioning under the SDDMS for Public health, Dr. Ottete.

Our evaluation of this activity unfortunately was interrupted before its conclusion. Thus some historical or developmental steps may not have been fully grasped by the evaluating team.

The World Bank as part of its study for the IRH/FP project, in November 1980 (that is, simultaneously with the development of HPIP) wrote an extensive report which analyzed the Ministry's information and data systems. The report costed the subparts, its staffing, and made a thorough review of components required by those subsystems in the MOH. This report provides a detailed analysis of the data needs of MOH.

Dr. Robert Winshall, an epidemiologist, spent six weeks as an HPIP short term consultant in the fall of 1981. His task was to develop the data base for planning and to outline a schedule for implementing the health information aspects of the project. Unfortunately, little came from his consultancy.

Mr. Joel Henderson, a computer systems expert has contributed about five months toward the development of a data processing system for the Ministry. His plan was reviewed. It deals with the implementation of some of the recommendations of the World Bank Team, but also provides for the computerization of the data.

Some features of the plan include:

1. The purchase of an IBM 4321 computer and to install it

in the MOH;

2. A shift from the present system of disease identification to ICD/9 and to shift some data processing into the field;
3. To establish a computer committee within the Ministry; and
4. To develop Ministry-wide on-line information systems.

It is clear that this area has received a great deal of thought by the Ministry management over the years. Indeed each district and province has defined system of patient and vital statistics record keeping.

While a similar track is evolving along the management and control functions of the Ministry, these are not as systematic nor as developed as the patient care and vital statistics records.

5.3 The MOH Strategy for Planning

From the above descriptions of the three streams of activity related to planning it is safe to conclude that there are several organizational units which play a significant role in the performance of the health planning function in the MOH. There seems to be a deliberate attempt by the MOH to distribute the power and responsibility to various power loci. The strategy appears to be more a seeking of major divisional involvement in the planning process than to establish or concentrate it in freestanding agency isolated from the operating units of the Ministry.

The planning structure which now exists seems to be designed to focus the power, that a central unit might have, in the Health Planning Steering Committee (HPSC). The HPSC is thus the functional head of planning in the MOH. That Committee is composed of the five key decision-makers of the MOH. The committee functions as a policy setting group for health planning issues. Reporting to the HPSC is the Health Planning Working Group. At this writing that group is composed of three full time staff performing the health planning functions. All were trained at Johns Hopkins University under funding of this contract. Dr. Gipson, the Drew COP, nominally serves as the "Resource Person" to this group but fully participates in its activities.

This organizational arrangement, whose permanence we were not able to ascertain, has some advantages to the successful working of a planning apparatus in the Kenyan MOH. Since the Ministry staff has had experience with a centralized MEPD/MOH managed process they seem to perceive planning as more of a constraining/managing function, than a policy-analytic-options-formulating process. However, the choice of the current arrangements appears to be enhancing an evolutionary change towards the latter view. That evolution will need to be nurtured and fostered.

5.3.1. The Structure and Terms of Reference for Planning

Thus the Ministry of Health has a complex but defined structure for planning, which is spelled out in the schedule of duties enunciated in the most recent such document. That structure seems to be carefully thought out and designed to serve the purposes of key MOH decision makers. An effort by the evaluators to understand those purposes and their fundamental philosophical underpinnings was attempted. The following observations sketch the key areas uncovered.

There seems to be a very strong feeling in the Ministry that a "free standing agency" for planning would be too big a power base which, when combined and interacting with extra-ministerial influences (e.g., other ministries such as MEPD AND MOF), would diminish the role of key MOH staff with respect to the direction and nature of Ministry of Health decision making. Hence the need for the current structure which requires the involvement of the key decision-makers.

A second key observation which appeared to influence the planning structure is the often repeated statement that planning must be one of the several functions of management and not an isolated activity "doing its own thing." The interpretation we give to this complex distinction is that the nature of planning for the Ministry must be perceived as the cumulative sum of the planning of its several units. It is the evaluators opinion that to short-circuit such an evolutionary and necessary step which the Ministry is seeking to develop, would be a critical error. Indeed the process of planning by the key units or divisions must precede the decision makers reconciliation of their combined activities. In short, national health planning, it seems to us, must evolve as a function of increased rationality in planning by the subparts of the Ministry.

Should that sequence of development be nurtured it would impel the growth of the planning process. This would assist the development of consistent policies in both the developmental and recurrent budgets. The reconciliation of the two budgets to each other would be enhanced. The development of cohesive and integrated policies regarding the nature of the priorities and their net effect on Kenyan society and the weighing of the political, social and societal effects of these priorities on the development of the Kenyan Nation would become the final stage of the planning process.

To expect the process to have evolved in the short duration of the contract period to date is to seriously underestimate the complexity of the change required, the nature of that change, and the speed with which it can take place.

Indeed the Steering Committee seems to be gradually evolving a focus of decisionmaking regarding the planning and implementation of a wide spectrum of activities.

It is in this complex environment that the HPIP must work. There have been various vehicles used by the Drew COP to involve the Ministry components in the planning process. The Kitui and IRH/FP projects served as "test" (as one influential officer of the MOH described the involvement of the Drew COP in the undertaking). The attempt of the Ministry to develop an annual report was another. The fourth strategy in which the Ministry has a large investment and which represents the major existing vehicle towards the implementation of a health planning function is the next five year development plan. While at first glance these attempts seem unrelated they represent to us the aggregation of alternative strategies employed to accomplish the stated purpose of the contract.

At this point it is fair to ask to what extent has the MOH been concerned with health planning in the past, and to what extent it is now concerned with health planning? The questions are not rhetorical. They are designed to answer the central question of the impact of this contract on the MOH.

A review of the historical involvement by the MOH indicates that it has devoted minimal resources and little effort to the production of what has become the health chapter in the previous five year development plans. From interviews, and

the review of a critique of that chapter of the current five year plan, it is evident that there was little effort to reconcile the plan document with projected budgeting or action plans. Indeed, the relationship of the last five year plan to the accomplishments were not viewed, by anyone interviewed, as closely related. The plan was not a guide to action. Many projects planned were not implemented and some that were unplanned became realities.

It is clear that in the past the planning process was entered into to fulfill a governmental requirements rather than as a guide for increasing the rationality in the expenditure of resources or programming. Furthermore, prior to the present project, the planning process was described as delegated to one individual who tried his best, but who did not analyze the relationship of expenditures to future needs. Thus for example, on the developmental side, the budget grew independently of the ability for its support by the recurrent budget.

Another factor which further complicated the current plan's development was that it was prepared with little involvement of the districts and provincial staff of the MOH. Thus there seems to have been an enormous dissonance in the view of the district and provincial development committee assessment of need and that of the central MOH and MEPD. Indeed, few of the district or provincial officers seemed to be aware of the budgetary, facility and service implications of the planning process, and seemed unaware of how it could be impacted.

In sum this project seems to have had a profound effect on beneficially changing some undesirable aspects of this historical direction. A brief description of that evolving new direction is appropriate here.

Under the guidance of the Steering Committee, the MOH is developing a sophisticated process toward the development of the next five year development plan. Indeed the involvement of the Permanent Secretary, the Director of Medical Services and other key officials in setting the timetable and stressing the importance of the various stages of the development plan, seem to define a well articulated and defined process. Their involvement "kicked off" a national meeting and was followed by training sessions in the provinces and districts. These meetings,

as can be ascertained from the written speeches, materials used during the sessions, and the minutes, were frank and self-critical. A clear departure from the past process seems to have evolved during these sessions and an enthusiastic but deliberative attitude prevails in the provinces and districts as well as in the HPWG.

The training workshops utilized detailed guidelines developed by the HPWG and the Resource Person (COP) as the vehicle for the development of the provincial and district plans. This process promises to bring new input into the decision making which will lead to the development of the health chapter, -- the country's Development Plan.

Yet it is not clear to us how and with what criteria the provincial plans will reconcile the various district plans coming to it, or the process of reconciliation of the seven provincial plans into a National Plan. This will have to be done so that the various needs and wants of each sector of the country are reviewed with a consistent set of policies developed to meet those needs. This seems to be the next critical step in the planning process. How that step will be performed may be the key step toward credible review of

provincial and district development in the planning process. It will also be a pivotal step in showing the extent to which the Ministry is moving from the use of the process as an exercise, toward a system of more rational planning which meets the needs of the various sectors of the country equitably.

To achieve the project purpose, the training of Kenyans in planning skills in the United States and elsewhere has been emphasized. However, with the sophisticated local workshops being undertaken in the country, there has been a second stream of long and short term training. This aspect of the contract seems to have been the area which was implemented ahead of schedule. The review of the training and its contributions to this project is discussed in Section 5.4.

5.4 Projects Inputs into the Planning Process

In evaluating, the HFIP it is required that the team review, among other things, the project inputs into the planning process. Essentially, HFIP may be viewed as an institution building project which provides training, technical assistance and related commodities as the primary inputs.

A key input in the planning process as perceived by the project

designers, is that organizational arrangements would have considerable impact on this project. The situation as described above, -- the dual track administrative and professional decision making structure -- has constrained project achievement. It has also slowed down the meeting of some targets envisioned in the agreement between USAID and the GOK, and the contract between the MOH and Drew. However, as noted in the project paper, the "wisdom, perception and competence of the technical assistance team" would largely determine the performance of the planning entity and how it is interacted with other units within the MOH.

5.4.1. DHHS/HRA to Province Technical Assistance

Dr. James Jeffers, who provided technical assistance to the MOH for several years under the auspices of HRA, did in fact remain in Kenya an additional seven-and-a-half months, as called for in the project paper. Some of his analyses and perceptions are valid now and deserve continued consideration.

5.4.2. Drew to Provide Long Term Technical Assistance

The Project design specifies that Drew will provide 70 person months of technical assistance. That a senior health planner will be posted for 35.5 months and a health information specialist for 34.5 months.

In the project proposal, Drew had specified Dr. Girma Wolde-Tsadik, a biostatistician and head of its Community Health Information System as the project information specialist. This individual was not accepted by the MOH who requested that a medical doctor/epidemiologist be posted instead.

Although Drew did not entirely agree with this request it bowed to the GOK's preference. After some delay, Dr. Robert Winshall, an M.D. with an M.P.H. in epidemiology, was identified by Drew. Dr. Winshall arrived in Kenya on August 24, 1981 and remained for approximately seven weeks, serving as a short term consultant to initiate the project health information system. His consultancy is discussed below. Suffice to say, Dr. Winshall was not selected as the long term information specialist.

To date, a health information specialist, as specified in the GOK-Drew contract, has not been posted. However, a

second health information consultant, a data processing specialist, Mr. Joel Henderson was in Kenya during the evaluators' stay, preparing for the installation of an IBM computer in the MOH. If his activities go as scheduled, he will be posted for an additional 18 months as the long term project health information specialist.

This report will next consider the activities of Dr. Reginald F. Gipson, Drew's Chief of Party and to date, the single provider of long term technical assistance, under this \$1.7 million contract. Project needs for technical assistance will then be addressed.

Earlier sections of this report have described the ebb and flow of the project. Shortly after Dr. Gipson arrived at post he pressed the MOH to establish the called for Policy and Planning Coordinating Committee and a Division of Planning and Implementation as specified in the project paper and the USAID/GOK agreement, but without success. It was evident that the MOH was not yet prepared to take these steps.

To push on with the project, Dr. Gipson began to build relationships with various officials and directorates in the MOH and with other organizations related to health planning and health services development. In the view of the evaluation team he has done this with exquisite skill and considerable success. At the same time he became intimately involved in the planning and development of the multi-donor Integrated Rural Health and Family Planning Project. To prepare for this country wide effort, a project data system had to be developed and planning work shops carried out. Dr. Gipson has played a key role in all these activities as well as providing effective linkages to the Medical School in Nairobi, other donors, the Ministries of Finance and Economic Planning and Development.

In December 1981, the government announced its policy of decentralization and called for preparation of the Fifth Development Plan. To prepare for the writing of the plan, the Health Planning Working Group and Dr. Gipson, with other staff of the Division of Planning and Administration of the MOH, are carrying out planning workshops at the provincial and district levels.*

*Despite its name, the Division of Planning and Administration does not constitute a formal planning entity as called for in the project agreement

A major effort went into the preparation of the planning workshops which are phased and sequenced. Training material including planning guidelines were developed, produced and disseminated. Much of the cost for this effort came from the Drew contract, yet some significant expense was also borne by the MOH. Details of the finances are discussed below.

As a result of the First National planning workshop effort, on May 6, 1982, the PS established the Health Planning Working Group which reports to the Planning Steering Committee (See Appendix IV). The Working Group is charged with the responsibility of "coordinating departments and collecting data in order to write a draft health sector plan." In essence, this is the beginning of formalization of a planning process and entity in the MOH.

To date, Dr. Gipson, essentially alone, has had the responsibility to provide long term technical assistance and to carry out the major administrative aspects of the Drew contract in the field. Up to 30% of his time in the field may be spent on non-technical activities. He has recently requested that a second planner be posted for the remainder of the project term. This individual, classified as a planner/management development specialist, would have contract management responsibilities in Kenya but would

function primarily to assist in the development of training materials, participate in planning workshops and other activities, and in general support the activities of the HPWG.

The second Drew long term planning advisor would enhance the operation and capability of the Working Group to perform its present functions and to move on to a planning continuum to assist provincial, district and other MOH entities in the preparation of annual plans. Then the Working Group and the Drew team can evolve as a service organization to the various components of the MOH rather than a decision making body for it. The evaluation team thoroughly supports this proposal.

To summarize, to date, Drew has provided approximately 19 person months of long term technical assistance of a total of 70 person months specified during the project term. An additional long term planner is recommended for the remainder of the project term. Drew also intends to post a health information specialist to improve data processing capability of the MOH.

5.4.3 Drew to Provide of Short Term Consultant Services Related to the Implementation of the HPIP

Drew is required to provide 18 person months of short term training. The following consultants so far have provided to the HPIP:

<u>Name</u>	<u>Dates</u>	<u>Discipline</u>	<u>Person months</u>
Peterson	3/81-8/81	IRA/FP Implementation	5.4
Winshall	8/81-10/81	Health Information	1.5
Henderson	2/82-Present	Computer Programming	5.0

To date approximately 11 persons months of consultant services have been provided through the Drew contract.

Dr. Gipson, and Drew have identified other disciplines which would provide consultant services. These are in the preparation of training materials for planning and assistance with plan formulation at the district level. Up to six months are suggested for these services. Whether or not such services are required would in part be related to the skills of the second long term planner discussed above.

5.4.4. HRA/DHHS Provide 26 Person Months of Short Term Consultant

Services for Assessing Feasibility and Design of USAID and
MOH Jointly Identified New Health Sector Activities.

To date, the largest single expenditure, Dr. Jeffers consultant services, have been provided through HRA/DHHS. As the MOH/Drew identify consultant needs, they presumably will be provided mainly by HRA in collaboration with the USAID/K Mission.

5.5 Financial review of the HPIP

The financial performance of project represents an important factor in considering the project's viability.

In our review of this sector area we were faced with a paucity of information. For example, we did not have a recount of HRA/DHHS' project related expenditures, Drew's records were incomplete and the MOH had to estimate what it had contributed to the project.

Records indicate that the first voucher for payment submitted by Drew was dated eleven months after the project commenced and was for the period from October 1, 1980 through June 30, 1981. The second voucher covered July 1, 1981 through September 30, 1981, and the third from October 1, 1981 through December 31, 1981.

There then occurred an eight month delay in submission of vouchers covering 1982 expenditures. Two vouchers were finally submitted in late August, 1982, covering the first two quarters of the year.

We were unable to ascertain why such delays occurred or were permitted. Some of the delay probably was caused by inadequate staffing support to provide secretarial, accounting and book-keeping services in the field office. More directly we feel it represents managerial inattention by the Drew home office.

Tables I, II and III provide information on expenditures by Drew during the first 21 months of the project. Appendix V details these by project year and whether expended by the home office or field service.

TABLE I

Expenditures by Contractor by Category*

<u>Category</u>	Budgeted Amount, 36 Month's <u>Project</u>	Actual Expenditures Through 6/30/ 82 (21 <u>Months)**</u>	% Budgeted Expended Through <u>6/30/82</u>
Salaries & Wages	401,955	159,732	38.9
Consultants	81,000	29,457	36.4
Fringe Benefits	82,191	19,466	23.7
Overhead	159,749	62,535	39.1
Travel & Transport	173,900	35,967	20.7
Allowances	213,970	41,603	19.4
Equipment & Vehicles	144,236	56,105	38.9
Materials & Supplies	40,764	3,107	7.6
Participant Training and Conferences	302,955	166,215	54.9
Other Direct Costs	<u>102,280</u>	<u>34,135</u>	<u>33.4</u>
TOTAL	\$1,712,000	\$558,322	32.6

*Source, USAID/K and Drew

**21 months represents 58% of the total project period

TABLE II

21 Month Expenditures by Home and Field Offices

<u>Total</u>	<u>Home</u>	<u>Field</u>	<u>%Home</u>	<u>%Field</u>
558,322	122,144	434,177	22.2	77.8

TABLE III

21 Month Expenditures by Home and Field OfficesExcluding Equipment, Vehicles and Participant Training

<u>Total</u>	<u>Home</u>	<u>Field</u>	<u>%Home</u>	<u>%Field</u>
386,001	122,603	263,398	31.8	68.2

Although billings cover 58 percent of the Drew contract time frame, only in the case of training have expenditures kept pace with the project flow. Approximately \$300,000 was budgeted for this activity and with the majority of training now completed only somewhat over half the budget amount for the activity has been used. Less than ten percent of funds budgeted for materials and supplies have been used.

This under-utilization of the full availability of resources is due to many reasons. In some cases more money than was necessary was budgeted. In the case of equipment and vehicles the computer is yet to be purchased. And with respect to human

resources the under-utilization of funds has been due to lack of closure on staffing, particularly on the data issues, and also on the under-use of consultants to assist in the project development (only about \$30,000 were used to date).

Another significant observation can be made. Table II shows that for the first 21 months of the project 22% of expenditures were made by the home office and 78% by the field office. The great share of expenditures on vehicles and equipment is charged to the field. Direct training and conference costs, i.e., tuition, transport, living expenses, etc., are charged totally to the field office. The home office has the responsibility of facilitating placement of trainees and administering funds related to training. This is considered as part of project administration and is not separated out as a line item expenditure by the home office.

To get more a realistic picture of the relative value of the contribution by the home office and the field office to the achievement of project purpose we have arbitrarily excluded

training costs and expenditures on equipment and vehicles from total project expenditures. As may be seen from Table III, the ratio of home office expenditures to that of the field office is then 32% to 68%. In the view of the evaluation team this ratio is undually skewed in favor of the home office, not so much in the expenditures themselves, but in terms of relative cost-benefit they represent to achievement of project purpose.

The Ministry of Health also has contributed critical financial assistance to the HPIP. A rough estimate by Dr. Kanani of the GOK/MOH contribution towards its share of the financing of the project places the figure at about \$100,000. No analysis of the relative relationships of this contribution to the contractual levels agreed to has been made made by the evaluation team due to time constraints. It can be stated nevertheless that the ministry has made a considerable investment in health planning and the project. The expected MOH subvote to fund the use of the soon to arrive commodities/vehicles represents an example of this GOK commitment.

The anticipated and planned subvotes in both the Ministry of Finance (for four data systems analysts and other data input personnel at the district, provincial and MOH levels) and at the Ministry of Planning and Economic Development for economists (number unknown at this time) to be seconded to the MOH for planning -- also represent major commitment by the GOK in the

development of planning in the MOH.

CHAPTER 6

6.0 CONCLUSIONS AND RECOMMENDATIONS

To be responsive to the scope of work for this evaluation, the conclusions and recommendations will be presented in the context of the project's logical framework with sections on goals and purposes, outputs, inputs and assumptions. The report will also address specific overarching aspects of the project. These concern the management of the project, financial aspects and the project's health information component.

Some material presented previously may also appear in this chapter in summary form.

6.1 Goals and Purposes

CONCLUSION: Most of the goals and purposes of the project are being met.

Largely through this project the GOK capability to develop health sector plans, programs and policies that will achieve a more efficient use and more equitable distribution of health sector resources is being enhanced. The project purpose is to strengthen the GOK institutional capacity to plan and implement health sector program and policies with primary emphasis on

expanding health services delivery to the rural population.
This is occurring.

6.1.1. Policy Analysis and Formulation

CONCLUSION: The project as yet had small effect on policy analysis and formulation.

However, the recently published Health Strategy Paper by the DMS undoubtedly reflects the impact of planning and policy development.

RECOMMENDATION: The MOH should formulate policies to deal with provincial and district plans consistently.

In preparing the provincial and district plans for inclusion in the Fifth Development Plan, many issues and problems will surface. The key staff of the central level of the Ministry should formulate policies early on, so that when provincial and district plans come in, there is a consistent manner in dealing with them so as to arrive at a cohesive health sector plan.

6.1.2. Continuation of Project and Project Duration

CONCLUSION: We believe that three years is not sufficient time to train staff in planning and to achieve and achieve and institutionalize a decentralized national planning process in a ministry where planning and programmatic decision making historically has been made centrally. Experience in other countries would indicate that a period of five years, given a reasonably receptive environment, is a more realistic time frame in which to train a cadre of planners and to achieve the organizational changes necessary for there to be full awareness of the planning process and for it to be accepted and to function in a productive manner.

Additionally, in the present situation, the timing sequence for the production of the limited number of trained planners who have been or are being trained by this project is such that few of them will have the opportunity to interact adequately with the expatriate advisor(s) prior to the end of the project, as presently scheduled.

RECOMMENDATION: The project should be continued and its period extended.

We suggest that the project and its funding be extended through September of 1985. This will permit the project to

go through the formulation of the health sector portion of the Fifth Development Plan which is due in December 1983. The extension recommended would also provide for an additional year to consolidate the planning process and the planning entity and to develop and implement the first annual plan. This extension would also allow a final period for project termination, closeout, and reporting.

Whether this time frame is sufficient to institutionalize the planning process should be re-assessed at the next project evaluation which should be carried out as scheduled, i.e., mid year 1983.

6.2 Project Outputs

6.2.1. Establishment of a Division of Planning and Implementation in the MOH

CONCLUSION: There is evidence that the CCK/MOH in conjunction with MEPD has embarked on health planning at the national, provincial and local levels. The MOH is also involved with programming of rural health delivery, e.g. the

National Integrated Rural Health and Family Planning Project and the soon to be established Kitui project. The Drew Chief of Party and the Health Planning Working Group were actively involved in the development process of these projects.

However, to date a formal Division of Planning and Implementation has not been established. None the less, we believe the Health Planning Working Group will evolve into a formal planning entity.

The called for Planning Policy and Coordinating Committee has been established with representatives of the main division of the MOH. However, to guide planning a Planning Steering Committee has also been set up. Its members are the five key staff of the Ministry. This Steering Committee meets at least monthly.

RECOMMENDATION: The structure and functions of HPWG should be formalized in a planning entity by the MOH. In order to gain acceptance and to minimize threats to established decision making power, the planning entity should function primarily as a service organization undertaking activities which will develop and support the planning efforts of the Ministry's operating units.

The contract requirement for the creation of the formal

planning entity should be postponed to a time to be agreed upon by the parties to the agreement. A Kenya physician should be assigned full time to the HPWG to serve as Dr. Gipson's counterpart. Unless this is done institutionalization of the health planning process underway will lack the necessary continuity at the end of the project.

6.2.2. Eighteen Planning Workshops or Conferences to be conducted

CONCLUSION: These were carried out with at least two iterations in each of the provinces and their districts, except for the North Eastern Province where travel is restricted.

These workshops are aimed at developing and institutionalizing a systematic decentralized planning process.

RECOMMENDATION: We urge that further workshops which are planned continue. These should address the scheduled areas as well as others such as a minimal needed data set, the reconciliation of local with national plans, research topics for needed health services development, and management controls of the planning process.

6.2.3. Long and Short Term Participant Training

CONCLUSION: Long and short term training was carried out as specified.

6.2.3.1 Kenyans Trained in Health Planning Under the Project Function as Planners in their Return

CONCLUSION: Three Kenyans trained at Johns Hopkins University returned to the MOH and are assigned to the HPWG. However, the issues revolving around the scheme of service were not adequately considered as they impacted on the trainees and the MOH. Specifically, the M.H.S. degree given by Johns Hopkins University to non-physicians was not deemed acceptable by the MEPD as appropriate training for advancing planners in its scheme of service.

RECOMMENDATION: Should future trainees be sent to the U.S., there should be adequate review of the acceptability of their curriculum and the awarded degree in advance with the Public Service Commission or other relevant GOK agencies.

6.2.3.2 Graduate Training in Planning Related Subjects

CONCLUSION: Nine Kenyan physicians are now in the U.S. receiving long term training in public health at the

master's level. Four are at the University of Massachusetts and five are at Loma Linda University.

It is recognized that there is a great need for trained medical doctors in public health to serve at various levels in the MOH. However, there is equal need for training of nurses and other staff who are playing a critical role in the planning and implementations of health services.

While there may be advantages to sending groups of students to the same university, the benefits derived from the diverse strengths of various institutions may have contributed to a greater mix of skills and variety and range of staff competency in the MOH. The timing and selection of students to be trained severely limited the choices of training institutions.

RECOMMENDATION: Should the project be extended, nurses and other categories of health workers, including administrative personnel should be provided training in discipline dealing with health planning.

Greater diversity should be made in selecting institutions to provide the specific planning-related skills required by those being trained.

6.2.3.3 Province Short Term Training For Five Kenyans

CONCLUSION: Five short term trainees representing various disciplines in the MOH, were sent to Drew to develop training materials designed to develop provincial and district health management teams.

The selectees were senior health staff of the provinces and districts and thus represented a significant commitment by the MOH to decentralized planning and to the development of planning and management skills at various levels of the MOH.

This training was well timed to fit into the ongoing planning workshops at the provincial and district levels.

RECOMMENDATION: Some of the funds presently available in the project should be considered to provide further short term training, preferably in Kenya for other areas needing attention such as data selection, its uses for Managers and planners; data processing; sampling and its uses, rural health care facility, minimal requirements and the relationship of administration to planning.

6.2.3.4 Conduct Observational Tours in Africa

CONCLUSION: Observational tours of public health training and services delivery activities in East and West Africa were carried out in a timely fashion and seem to have been of benefit. It had been anticipated that the Kenya participants would prepare a report. This was not done. The Drew COP took the responsibility to summarize the tour activities for the record. The failure to have had a formal presentation and discussion to share the observations, insights, etc. limited the potential value to the MOH. All parties could have benefited from the impressions gained by the observers.

RECOMMENDATION: That a meeting be held, even at this late date, to summarize impressions, lessons learned and their impact on the Kenyan health systems design.

6.2.4. Select and Deliver Commodities

CONCLUSION: There have been delays in the purchase of such commodities as vehicles. Those delays have reduced the total number of vehicles to be purchased due to price escalation during the interim. Yet other equipment and supplies seem to have been made available to the project in a timely fashion. Selection of the most expensive piece of equipment, a main frame computer, is awaiting project action.

RECOMMENDATION: Delays in equipment procurement require corrective action by Drew home office management.

6.2.5. Field Studies and Research Activities

CONCLUSION: Because the process of planning has been delayed, field studies and research activities have not been initiated. Field studies and research activities are expected to be identified and implemented as the need for information for decision making is delineated.

RECOMMENDATION: Suggested topics for field studies and research have been identified in various sections in this report.

6.2.6. Development of a Scheme of Service for Planners in the MOH

CONCLUSION: The technical design of the project appears to have lacked full understanding of the complex bureaucratic relationships and mechanisms which are operative in Kenya and which effect some aspects of the project's implementation. For example, scheme of service restrictions require that each separate skill category of employees be exclusively employed by only one ministry. Thus, an individual qualified as a planner may not be employed directly by the MOH but rather must be seconded from the Ministry of Economic Planning and Development under whose scheme of service all planners presently fall.

RECOMMENDATION: Efforts to remedy or cope with these complex requirements should be made by the MOH if the planning system envisioned is to be effectively established.

6.3 Inputs

6.3.1. Two Long Term Technical Advisors to be Posted

CONCLUSION: Only one of the two long term technical advisors called for to staff the project in the field, has been deployed. A senior health planner was on site within two months after the GOK-Drew contract was signed.

The second long term advisor, a health information specialist has not been posted. The fact is that at least four types of skills are required to accomplish the health information responsibility: health statistics, epidemiology, data processing, and data management. To find all of these skills in one individual is difficult.

The different perceptions on the part of Drew and the MOH with respect to the desired and appropriate qualifications of a single health information specialist have not been adequately resolved. Thus, no long term health information specialist has yet been posted. However, significant progress has been made toward meeting the data processing needs. The short term consultancies of an epidemiologist (Dr. Winshall) and a data processing specialist (Mr. Henderson) have each contributed partial solutions to the total problem.

6.3.2. Provide Short Term Consultant Services

CONCLUSION: These have been only partially provided. This is discussed in the section on management of the project later in this chapter.

6.3.3. Provide Health Planning/Policy/Information Seminars and Conferences

CONCLUSION: These are scheduled to be given following the return of the five short term trainees who are just completing training at Drew. These sessions will be carried at the provincial level with involvement of all district health management teams.

6.3.4. Establish a Library for Health Planning

CONCLUSION: Under project auspices a fledgling of a Health Planning Library, has been developed both at Drew
and partners and in the field office. However, there does not appear to be an organized approach for selecting library materials. The project staffing seems to preclude the adequate development of this activity.

6.4 ASSUMPTIONS

6.4.1. For Achieving Goals and Targets

CONCLUSION: These are laudable and given time and adequate resources they can be reached. There appears to be an evolving planning structure in the MOH, and channels of communication to permit those trained to have impact of the health plans, policies and budgets of the Ministry of Health.

RECOMMENDATION: The goals should not be changed, but the expectations for the timing of their achievement should be lengthened.

6.4.2. For achieving Project Purpose

CONCLUSION: Assumptions for achieving project purposes

should be carefully studied. Procedural difficulties at times have delayed availability of Kenyan funds for some training activities but remedies for these difficulties have been found with the aid of the Drew Chief of Party, USAID and HRA.

RECOMMENDATION: Funding should be extended by USAID and the Government of Kenya to achieve the goals of the project.

6.4.3. There are Suitable Institutions in the U.S. to Provide Necessary Training

CONCLUSION: U.S. training institutions are suitable and available but generally have rigid schedules and only accept students at certain times. This training constraint has limited the number of institutions available at the precise time the MOH has made students available. (See also 6.2.3.1 and 6.2.3.2).

6.4.4. The MOH will Establish a Planning Division

CONCLUSION: The MOH top management has not yet established a planning division within the context of a free standing agency as advocated by Dr. Jeffers in his recommendations concerning the design of the HPIP. The MOH, however, has initiated a planning mechanism with trained planners in place, actively assisting the development of planning at provincial and district levels. A Steering Committee composed of top management of the MOH is seriously involved in policy formation and guides the activities of the Health Planning Working Group.

RECOMENDATION: See Section 6.1.4.

6.4.5. For Achieving Project Outputs

CONCLUSION: These are largely too ambitious. The GOK is gradually moving toward support (both financial and programmatic) of health planning. As note above, a scheme of service has not been established in the MOH. However, there is a subvote in the MEPD to post planners to the MOH and, as of July 1982, there is a subvote in the MOH which will provide support directly for the HPWG.

From discussions with the senior levels of the

administrative and professional branches of the MOH and the chief planner for the MEPD, the evaluation team concludes that there is willingness on the part of both ministries to accept organizational and policy changes in order to make more rational use of resources and to decentralize decision making so as to strengthen rural health care.

There appears to be careful planning and implementation of planning workshops and seminars and these seems to be effective in preparing staff to prepare health plans at provincial and district levels.

RECOMMENDATION: These beginning steps should be strengthened and nurtured by all the parties.

6.4.6. For Providing Project Inputs

CONCLUSION: The assumptions regarding providing inputs require much more attention than they have received to date. Although working relationships between the Drew COP and GOK personnel appear to be very good, there is little

evidence of GOK supervision of the Drew component of the project. Similarly there is evidence that the Drew home office has not provided all of the needed administrative support and technical backup to the project, to the COP, or the MOH.

RECOMMENDATION: See Section 6.5 below.

6.5 Project Management

In presenting this aspect of the report the evaluators have endeavored to separately deal with the parties to the project. Thus the conclusions and recommendations will deal with Drew, the MOH/GOK, AID/K and HRA/DHHS consecutively.

6.5.1. Management of the HPIP by Drew

CONCLUSION: A competent senior health planner as chief of party, sensitive to the needs of the GOK and the contract requirements, was posted in a timely fashion. Drew's attempt to rewrite the contract scope of work in recognition of the delay by the MOH in establishing a PPCC and health planning unit was envisioned in the project design, was laudable. However, to date no resolution has been achieved. Yet there seems to have been no reinvolvement by Drew senior management personnel in resolving this critical

issues.

Drew management appears to have made inadequate effort at drawing upon its own resources to provide substantive support for the conduct of the ongoing project. Except for facilitating training of Kenyans in the U.S. it appears that the COP has had the major proportion of responsibility in the performance of the contractual obligations, including the administrative activities as well as professional activities in assisting the MOH to develop a planning capability.

Despite his obvious competence, the COP has not been able single handed to cope with all of the demands of the project. This is reflected in the sketchy quarterly progress reports which frequently fail to indicate the difference between the activities or work planned for the quarter and what was actually accomplished. Project work plans need to be prepared by the HPWG in conjunction with the Drew COP and these then submitted to the Planning Steering Committee for discussion and approval. This will both increase the legitimacy of the planning entity and its support by the key staff of the MOH.

Project financial reporting by Drew to USAID has not been done in a timely manner.

RECOMMENDATION 1: That the home office of Drew take immediate and special care to improve the quality and timeliness of its reporting and managerial responsibilities. That the following specific areas be considered for improvement:

- a. The presence of senior Drew management personnel on site be deployed for short periods to provide technical consultation and/or to resolve contractual snags and/or impasses in the implementation of the contract and the project.
- b. That backup be provided to the COP in specific areas, such as accounting, vehicle or commodity processing, group dynamics, organizational development and information systems (as distinguished from biostatistical systems design and development, or data management).
- c. That financial reports be submitted in a timely fashion, but no later than 90 days after the end of a quarterly reporting period.

RECOMMENDATION 2: That Drew post a second long term

technical associate in Kenya to assist the development of the planning entity and administration of the project in the field. That person should have had experience in developing a health planning entity. The primary skills would be in management/organizational development and training - e.g., workshops, seminars, etc. This individual would also largely relieve the Drew COP of routine project administrative chores freeing up his time for the more technical aspects of the project.

6.5.2. Management of the HPIP by the MOH

CONCLUSION: The Ministry is making significant strides in institutionalizing the planning process at headquarters, the provinces and districts. It is doing so by utilizing the cadre of trained personnel as well as by other means.

However, the Ministry seems to have only informal mechanisms for reviewing the progress of the contract. The team did not identify or see written reviews of expenditures or technical comments on the performance of Drew.

RECOMMENDATION: The MOH needs to refine its mechanisms for the management of Draw contract compliance and to refine its formal mechanisms for reviewing such compliance. The areas identified above such as financial and quarterly reports should be reviewed plus technical reports on the performance of the contractor submitted to USAID/K.

Furthermore, should issues related to changes, modifications or delays in the project arise, that the methods for resolving these include all of the following:

- a. Periodic meetings and phone calls, with minutes, by the contractor field COP and his headquarter that seek to resolve the issues.
- b. That similar meetings be held by the MOH and the COP on a periodic and regular basis, and also with USAID/K, all with minutes, for the same function. Impasses should be clarified either by contractual services sought from a specialist in the area at issue, or through a neutral other party. These differences should not be allowed to remain unresolved for as long as they have heretofore.
- c. Quarterly reviews of performance of the plan of work should be held and reports of such meetings be sent by the Ministry to USAID/K.

6.5.3. The Management of the HPTP by USAID/K

CONCLUSION: USAID/K has shown flexibility in allowing the MOH additional time to take the steps required to meet the goals and purposes of the MOH and the contract. It has also tolerated short comings of the contract as noted above. However, the relationships which can only come from frequent meetings and systematic personal interaction were not sufficient to build a wide base of trust and understanding between the parties. Furthermore, few apparent alternative strategies were developed to accomplish contractual ends.

RECOMMENDATION: That meetings be held with key decision makers from the GOK, USAID and Drew to resolve the outstanding issues and problems and deal with key recommendations of this mid term evaluation report.

That regularly scheduled sessions be held by the GOK and USAID/K to maintain a productive working relationship.

6.5.4. The Management of the PASA by HRA/DHHS

CONCLUSION: The Health Resources Administration played a constructive role in facilitating the flow of project implementation. The nature of its reactive role seems to limit its ability to bring the considerable resources of the U.S. in general and the PASA in specific to resolve some of the long standing issues. Similarly it too has had a slow reporting mechanism of expenditures against the PASA to the parties who need timely reports.

6.6. Finances of the Project

CONCLUSION 1: The financing of the project has been inadequately militated to fully achieve the project purposes

Fifty eight percent of the time of the project has elapsed and only about 33% of the funds have been used. This fact represents both a problem and an opportunity. It is a problem in that resources should have been expended to resolve some of the issues pointed to in this report, which were known to the parties of this project. It is an opportunity in that the unused funds can, if the project period is extended, be used to finance a part of that extension.

CONCLUSION 2: All parties have not paid sufficient attention to

a review of project finances

RECOMMENDATION: Careful management must be exercised by Drew and MOH management with oversight by USAID/K to ensure that delays in vouchering do not occur. A maximum of 90 days should be sufficient of accomplish the task. Speedy review would ensure that a relationship is made between the expenditure and future needs. These vouchers should be linked to quarterly progress reports so that management can assist the project in meetings its goals.

CONCLUSION 3: Adequate support resources are present only in the home office, while most of the expenditures are incurred and the need is in the field office which does not have the sufficient support services to perform the administrative task.

RECOMMENDATION: A review/comparative analysis of the distribution of support services in the Drew home office vs the field office should be done. Special attention should be given to existing distribution of resources and to the cost benefit of that distribution, now that most of the scheduled training in the U.S has been completed.

6.7 The Health Information Component of the Project

6.7.1. Design the Health Information System for the MOH

CONCLUSION: A key component of this project is the development of a health information system for the MOH. Several, if not most of the data needs have been identified and have been costed in terms of human and other resources. But a data base for health planning has yet to be specified.

What is required is to assemble a suitable team to tackle the job.

RECOMMENDATION: That the chief item on the agenda of the upcoming health data workshop be the design of the MOH health information system. It is suggested that a team approach be used to accomplish this task.

6.7.2. The MOH Secure its own Data Processing Capability

CONCLUSION: As part of this project there is a plan to purchase an IBM 4321 computer and to install it in the MOH. There will be a shift from the present system of disease identification to the ICD/9. Preliminary processing of data will take place in the field rather than at MOH headquarters, as at present. A computer committee will be

established within the Ministry and a Ministry wide general function data processing system will be developed. These and other aspects in the design we feel are very critical for the quality of planning and decision making.

RECOMMENDATION: We would urge that the implementation of the computerization of health information proceed as expeditiously as possible. However, there are issues and questions which the team feels must be clarified and resolved prior to the purchase of the expensive computer. Six main areas will be covered in this recommendation.

1. Data Management

a. It would seem that the formation of an Inter-ministerial Steering Committee as suggested by the World Bank report as the Intra-Ministerial Steering committee proposed in the Henderson report should be implemented and that they be involved in design of the data sets/information needs of their subparts of the Ministry.

b. Further, that they be charged with ensuring that the uses of the data of the data collected are clearly defined before they are collected.

c. That this definitional process should deal with each level of collection and processing of data. it is not clear that such a concept has been developed.

d. Care must be taken to ensure that each management levels' use and need of the data is clearly understood before the data are collected.

e. That the information requirements of planning, programming and managerial processes are clarified. We feel information whose use and value is not defined will not have the effect that it should merely because the information is computerized and speedily returned to current producers and potential users.

f. Information must be accurate. Thus reliability, validity and other related factors must be ensured.

g. Systems should be developed to provide management controls on production of data and similarly on their use in the management of health services delivery.

To suggest that the introduction of a speedier form of

access to the existing data is all that is necessary for an improvement in the planning process to occur may be falacious.

2. Scope of Data Processing Requirements

In our view it is critical that priority needs for computerization must be agreed upon. While discussions with Mr. Mware and Dr. Kanani suggest clear priorities, it seems to this team that other areas of the Ministry will clamor for entry into the system and may overburden it.

3. Bureaucratic Support for the Data Function

The issues of the scheme of service and the schedule of duties should be clarified in a more formal way. It appears that informal arrangements have been made. These should be reflected in the budgetary and personnel systems, if the introduction is to be viable, and the requisite staffing required assembled to perform the task. It is clear that

the entire data processing function cannot be performed under contractual funding or with expatriate staff. Indeed, counterparts must be on board with the wide spectrum of experiential background in planning information systems, biostatistics, research, and evaluation so that the system is adequately and appropriately utilized.

4. Control of the System

It must be established who has clear control of the computer (MOF/MOH/Drew) and who is responsible for its operation, maintenance and ensuring that input systems to it are properly programmed and are credible.

5. Training of Procedures and Users

It is critical that training be done of producers and users at each level. This is a lengthy process which we feel could be done in conjunction with the first issue above, i.e., the definition of the data sets and their uses.

6. The Involvement of Users and Producers of Data in the Design of the System

Finally, the data workshop scheduled to take place in September/October, 1982 hopefully will address the issues

noted above as part of the design of the health information system of the Ministry.

A P P E N D I X I

PROJECT LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1979 to FY 1984
Total U. S. Funding \$2,453,200
Date Prepared: August, 1979

Project Title & Number: Health Planning and Information (615-0187)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To enhance the GOK capability to develop health sector plans program and policies that will achieve a more efficient use and more equitable distribution of health sector resources.</p>	<p>Measure of Goal Achievement:</p> <ol style="list-style-type: none"> 1. Reduction of percentage of MOH development budget spent on curative hospital services. 2. Increase in the percentage of MOH budget allocated to preventive and promotive services on both development and on recurrent account. <p>(Cont. p.2)</p>	<ol style="list-style-type: none"> 1. Analysis of health planning and implementation documents. 2. GOK adoption of new or revised health policies announced by MOH executives and cabinet officials which are based on planning activities, policy studies and analysis performed by health planners in the MOH and related ministries. 3. Analysis of budget and expenditure trends. 	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> 1. Suitable candidates for training can be identified, trained and returned to the MOH and MOP. Health planning officers have appropriate access to MOH and MOP executives. 2. Training in U.S. institutions, Kenya and third countries, imparts appropriate planning, implementation, policy analysis and program <p>(Cont. p.2)</p>
<p>Project Purpose:</p> <p>To strengthen the GOK institutional capacity to plan and implement health sector program and policies with primary emphasis on expanding health services delivery to rural populations.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 1. Establishment of Division of Planning and Implementation staffed with professionally trained Kenyan staff. 2. Establishment of Health Planning and Policy Coordination Committee composed of senior health officials and representatives of MOH and MOP which meets regularly. <p>(Cont. p.2)</p>	<ol style="list-style-type: none"> 1. MOH and MOP organizational charts. 2. Schedules of duties. 3. Trained planners in place in all areas. 4. Minutes of meetings of Health Planning and Policy Coordination Committee. 	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> 1. USAID can provide timely and satisfactory technical assistance and funding. 2. GOK funds and services are available in a timely fashion. 3. U.S. training schools are able to accommodate students and Kenyan students are capable. <p>(Cont. p.2)</p>
<p>Outputs:</p> <p>Measure:</p> <ol style="list-style-type: none"> 1. Establishment of a Division of Planning and Implementation staffed by Kenyan trained professionals. 2. Functioning Planning and Policy Coordination Committee. 3. Planning, policy and information seminars and conferences. <p>(Cont. p.2)</p>	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> 1. Roughly ten person assigned to Division of Planning and Implementation, MOH by end of project. 2. Fifteen M.A. level trained health planners in MOH and MOP headquarters and a selected Province and District 3. Planning and Policy Coordination Committee meeting quarterly and <p>(Cont. p.2)</p>	<ol style="list-style-type: none"> 1. Organization chartes, rosters, appointment papers and schedule of duties of MOH and MOP. 2. Minutes of Health Planning and Policy Coordination Committee. 3. Examination of library data, policy analysis reports and field studies. 4. Seminar and conference reports. <p>(Cont. p.2)</p>	<p>Assumptions for achieving outputs:</p> <ol style="list-style-type: none"> 1. GOK accepts new positions and proposed schemes of service. 2. Recurrent budget availabilities sufficient to cover increased personnel and operating costs. 3. Willingness of MOH and MOP to accept organizational and policy changes. 4. ability of GOK to identify able people to train. <p>(Cont. p.2)</p>
<p>Inputs:</p> <p>Items:</p> <ol style="list-style-type: none"> 1. Long-term and intermediate term technical assistance service. 2. Short-term expert consultant services. 3. M.A. level training. 4. Short-term seminar participant training. 5. Observational tour training. <p>(Cont. p.2)</p>	<p>Implementation Target (Type and Quantity)</p> <ol style="list-style-type: none"> 1. 79½ person months of intermediate and long term technical assistance services including 7½ months of the services of Dr. James Jeffery, HRA/DHEW Health Economist, over the interval January 1 to August 15, 1980. Two additional advisors will serve an additional 36 months each beginning on or about June 15, 1980. <p>(Cont. p.2)</p>	<ol style="list-style-type: none"> 1. USAID and HRA/DHEW financial reports. 2. USAID and HRA/DHEW financial reports. 3. USAID and HRA/DHEW financial reports. 4. USAID and HRA/DHEW financial reports. 5. HRA/DHEW project reports. 6. USAID financial reports and HRA/DHEW project reports. 7. HRA/DHEW project reports. <p>(Cont. p.2)</p>	<p>Assumptions for providing inputs:</p> <ol style="list-style-type: none"> 1. Availability and timely provision of USAID and GOK funds and services. 2. Availability of qualified US technical assistance personnel. 3. Availability of Kenyan personnel to be trained and to staff project components. 4. Smooth administration of project personnel by GOK. <p>(Cont. p.2)</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

Project Title & Number: _____			
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes:	<p>Measures of Goal Achievement: (Cont.)</p> <ol style="list-style-type: none"> 3. Increase in the rate of MOH outlays on rural health services on development and on recurrent account. 4. New and revised Health Sector policies that relieve existing constraints on health sector development. 5. New or revised health plans that state clear and measurable (Cont. p. 3) 		<p>Assumptions for achieving goal targets: (Cont.)</p> <ol style="list-style-type: none"> 3. Organizational structure, reporting mechanisms and communication channels are appropriate for making adequate impact on health plans, policies and budgets.
Project Purpose:	<p>Conditions that will indicate purpose has been achieved: End of project status. (Cont.)</p> <ol style="list-style-type: none"> 3. Trained health planners in MOH and MOP headquarters and at MOH Provincial and District level posts. 		<p>Assumptions for achieving purpose: (Cont.)</p> <ol style="list-style-type: none"> 4. MOH develops and relevant government agencies review and establish an appropriate scheme of service for non-medical personnel in the MOH, particularly for health planners. 5. MOH top management assures leadership in the establishment and functioning of the Division of Planning and Implementation and (Cont. p. 3)
<p>Outputs: (Cont.)</p> <ol style="list-style-type: none"> 4. Health planners in place in selected Provinces and Districts as well as in MOH and MOP headquarters. 5. Completed field studies and data collection activities yielding minimum information required of health planning efforts in MOH and MOP. 	<p>Magnitude of Outputs: (Cont.)</p> <ol style="list-style-type: none"> attended by 10-12 MOH senior officials and representatives of MOP and MOH. 4. 3-6 major field trail and baseline data collection studies completed by end of project. 5. 6-8 action research studies completed by the end of project. (Cont. p. 3) 	<p>(Cont.)</p> <ol style="list-style-type: none"> 5. Scheme of service and letters of submission and approval. 6. Budget reports and audits. 7. Reports on results of observational tours and short-term training supported by expense vouchers and receipts. 8. Copies of policy and plan revision recommendations. 9. Copies of decentralization guidelines. 	<p>Assumptions for achieving outputs: (Cont.)</p> <ol style="list-style-type: none"> 5. Good Planning and management of all training seminars, field study activities. 6. The timely release and appropriate expenditure of funds.
<p>Inputs: (Cont.)</p> <ol style="list-style-type: none"> 6. Health planning/policy/information seminars and conferences. 7. Library, administrative support equipment and vehicles. 8. Studies and action research using Kenyan consultants and institutions. 9. Baseline information studies and field trails and project evaluations. 	<p>Implementation Target (Type and Quantity) (Cont.)</p> <ol style="list-style-type: none"> 2. 50 person months of short-term consultant services during the life of the project. 3. 180 person months of M.A. level training for Kenyan nationals beginning August or September 1979 and continuing over the life of the project. (Cont. p. 3) 	<p>(Cont.)</p> <ol style="list-style-type: none"> 8. USAID and GOK financial reports. 9. HRA/DHEW and USAID financial reports. 	<p>Assumptions for providing inputs: (Cont.)</p> <ol style="list-style-type: none"> 5. Appropriate supervision, coordination and cooperation between U.S. technical assistance team and GOK personnel.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

Project Title & Number: _____

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p>	<p>Measures of Goal Achievement: (Cont.)</p> <p>objectives and targets, rationally ordered priorities, clear implementation strategies and plans, and mechanisms to evaluate results.</p>		<p>Assumptions for achieving goal targets:</p>
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p>		<p>Assumptions for achieving purpose: (Cont.)</p> <p>the conduct of the Planning and Policy Coordination Committee and seriously considers and transmits recommendations and analyses.</p>
<p>Output:</p>	<p>Magnitude of Outputs: (Cont.)</p> <p>6. Nine major policy, planning and health information seminars conducted by end of project.</p> <p>7. Revised or new Scheme of Service for nonmedical professionals in MOH completed by June 30 1981, and adopted by relevant COX agencies within a year.</p> <p>(Cont. p.4)</p>		<p>Assumptions for achieving outputs:</p>
<p>Inputs:</p>	<p>Implementation Target (Type and Quantity)(Cont.)</p> <p>4. Thirty person months of seminar training beginning in March or April of 1980 and continuing over the life of the project.</p> <p>5. Twenty person months of observational training over the life of the project.</p> <p>6. Nine health planning/policy seminars over the life of the project with the first beginning September/October 1979. (Cont. p.4)</p>		<p>Assumptions for providing inputs:</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

Project Title & Number: _____

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Purpose or Sector Goal: The broader objective to which this project contributes	Measures of Goal Achievement:		Assumptions for achieving goal targets:
Project Purpose:	Conditions that will indicate purpose has been achieved: End of project status.		Assumptions for achieving purpose:
Outputs:	Magnitude of Outputs: (Cont.) 8. Completed purchase of all administrative support, vehicles, library materials by end of the project. 9. Completion of observational tour and short-course training involving fifty person months activity by end of the project. 10. A set of recommendations for revision of health sector policies, revision of health sector plan for (Cont. p. 5)		Assumptions for achieving outputs:
Inputs:	Implementation Target (Type and Quantity) (Cont.) 7. Five project vehicles, books; furniture, printing, supplies, books and periodicals and other support items. 8. 6-8 studies and action research projects one year Kenyan consultants up to 5,000 over the life of the project. (Cont. p. 5)		Assumptions for providing inputs:

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY _____ to FY _____
Total U. S. Funding: _____
Date Prepared: _____

Project Title & Number: _____

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes:	Measures of Goal Achievement:		Assumptions for achieving goal targets:
Project Purpose:	Conditions that will indicate purpose has been achieved: End of project status.		Assumptions for achieving purpose:
Outputs:	Magnitude of Outputs: (Cont.) 10. MON and content and methodology for health program and project evaluation by end of the project.		Assumptions for achieving outputs:
Inputs:	Implementation Target (Type and Quantity) (Cont.) 9. 3-6 baseline information studies of and field trials conducted over the life of the project beginning after the arrival of long-term technical assistance team in June 1980.		Assumptions for providing inputs:

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY _____ to FY _____
Total U. S. Funding: _____
Date Prepared: _____

Project Title & Number: _____

PERFORMATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>1. The broader objective is to rehabilitate project communities.</p>	<p>Magnitude of Goal Achievements</p>		<p>Assumptions for achieving goal targets:</p>
<p>2. End of project</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p>		<p>Assumptions for achieving purposes:</p>
<p>3. End of project</p>	<p>Magnitude of Outputs: (Cont.)</p> <ol style="list-style-type: none"> 1. Completed purchase of all administrative support, vehicles, library materials by end of the project. 2. Completion of observational tour and short-course training involving fifty person months activity by end of the project. 10. A set of recommendations for revision of health sector policies, revision of health sector plan for (Cont. p. 5) 		<p>Assumptions for achieving outputs:</p>
<p>4. End of project</p>	<p>Implementation Target (Type and Quantity) (Cont.)</p> <ol style="list-style-type: none"> 7. Five project vehicles, books, furniture, printing, supplies, books and periodicals and other support items. 3. 6-8 studies and action research projects one year Kenyan consultants up to 5,000 over the life of the project. <p>(Cont. p. 5)</p>		<p>Assumptions for providing inputs:</p>

A P P E N D I X I I

Persons Contacted and Sites Visited

Ministry of Health, Kenya

Mr. G.R. M'Mwirichia	Permanent Secretary
Dr. W. Koinange	Director of Medical Services
Dr. S. Kanani	Senior Deputy Director of Medical Services
Dr. J.J. Thuku	Senior Deputy Director of Medical Services
Dr. J. Maneno	Assistant Director of Medical Services
Dr. Mueke	Assistant Director of Medical Services
Mrs. E.M. Kiereini	Chief Nursing Officer
Mr. P. Kariuki	Deputy Secretary
Mrs. E.N. Ngugi	Deputy Chief Nursing Officer, Ministry of Health
Mr. L.K. Ndungu	Administrative Secretary, Coordinator, HPWG
Mr. C. Thube	Senior Planner
Mr. S. Ong'ayo	Economist/Planner
Dr. Minangi	Deputy PMOH, Nyeri Province
Mr. Maretta	Administrator, Nyeri Provincial Hospital
Dr. Mwangi	DOH, Murang'a District
Dr. Ongango	<u>WHO Country Coordinator for Kenya</u>

Ministry of Economic Planning and Development

Mr. L.E. Ngugi	Chief Planner
----------------	---------------

Mrs. A. Vukovich-Brown Planning Officer of Health
Ms.A. Khasakhala Planning Officer

Ministry of Finance

Mr. M'ware Director, Computer Center
Ms. A.M. Kahuri Deputy, Computer Center

University of Nairobi Medical School

Professor J.D. Kagia Chairman, Department of Community Health

Health Resources Administration, DHHS

Mr. J.E. Mahoney Director, Office of International Affairs

AID/Washington, Bureau of Africa

Dr. J. Shepperd	AFR/DR, Health/Nutrition
Dr. J. Stockard	AFR/DR, Health/Nutrition
Mrs. G. DeLuca	AFR/DR, Health/Nutrition
Mr. C. Brown	AFR/DR, Health/Nutrition
Mrs. C. Schoux	AFR/DR, Health/Nutrition
Mr. H. Miles	Director of Evaluation

USAID/Kenya

Mrs. A. Herrick	Mission Director, USAID/Kenya
Mr. W. Lefes	Program Officer/Evaluation
Dr. J. Slattery	HPIP Project Officer
Dr. R. Britanak	Chief, Health Population and Nutrition
Mr. S. Silberstein	Population Officer
Mr. Green	Economic Officer
Mr. J. Greenough	Executive Officer

Charles R. Drew, Post Graduate Medical School

Dr. M.A. Haynes	Dean and President
Dr. J.G. Houghton	Vice President/Finance
Dr. R.F. Gipson	Kenya Project Director, COP
Dr. A. Newmann	Professor, Community Medicine
Ms. D. Fairchild	Acting Director, Officer of International

Health and Economic Development
Ms. M. Pollard Kenya Project Administrator
Mr. J. Henderson Consultant, Data Processing

Kenya Trainees

Dr. R.K.A. Kalya Deputy PMO, Rift Valley
Mr. N.A. Keyonzo Health, Evaluation and Research Division,
NFWC
Mr. F.M. Mworia Senior Hospital Secretary, IRH/FP
Mrs. T.A. Oduori Senior Nursing Officer, MOH
Dr. A.O. Oyoo Deputy/DMS/PMO, Eastern Province
Dr. George Rae District Medical Officer
Dr. Kimutai Bicmndo District Medical Officer
Dr. Newton Kulundu District Medical Officer
Dr. Gabriel Mbugua District Medical Officer
Dr. William Jimbo District Medical Officer

International Monetary Fund

Mr. D. Simpson Officer, Kenya

World Bank

Mr. H. Diaz

IRH/FP Project Officer

Sites Visited

Provincial Medical

Office and Hospital

Nyeri Province

District Medical

Office and Hospital

Murang'a District

A P P E N D I X I I I

Preparation of the Health Sector Portion of the
Fifth National Development Plan

Permanent Secretary's Guidelines:

- | | |
|---------------------------|---|
| December 1981 to May 1982 | - Preliminary work |
| June 1982 | - Approval of basic strategy by
Cabinet |
| July 1982 | - Summary of strategy, tentative
budget ceilings, and district
priorities |
| August 1982 | - First meetings of the health
sector planning groups |
| December 1982 | - Drafts of all macro chapters
to be completed |
| March 1983 | - Drafts of the health sector
chapter with district level
disaggregation where pertinent
to be completed and circulated
to District Development
Committees for comment |
| June 1983 | - Comments by Districts to
be returned and circulated to
Ministry Headquarters |
| August 1983 | - Revisions of all macro and
sectoral chapters to be |

completed and sent to Cabinet

September 1983

- Final approval by Cabinet

Director of Medical Services' Health Strategy Statement

In early 1982, to prepare for the development of the health component of the Fifth Development Plan, the DMS detailed the health strategy for Kenya. Key features of this strategy are to:

1. Increase the share of primary, preventive and promotive health budget;
2. Accelerate construction of more rural health facilities with bias to less served areas;
3. Strengthen and improve rural health programs;
4. Allow only completion of hospitals already under construction and those where funds are committed and freeze all other proposals until 1990. Use the funds made available to construct rural health facilities;

5. After 1990, seek to attain a national target of hospital beds to population of 1.0 per thousand by year 2000. In so doing priority to be given to areas that have less bed population ratios;
6. Expand immunization programs;
7. Launch schistosomiasis control programs with particular attention to the Tana River, Kerio Valley and Lake Basin development projects;
8. Introduce a school of health program focused on hygiene, nutrition and family planning;
9. Expand program on environmental sanitation;
10. Expand and strengthen the mental health program; and
11. Strengthen the health information and education program.

A P P E N D I X I V

MINISTRY OF HEALTH



Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 27351
When replying please quote
Ref. No. 13/11/1/74
and date

AFYA HOUSE
CATHEDRAL ROAD
P.O. BOX 30016, NAIROBI

5th May, 1982

TO: Heads of All Departments
Provincial Medical Officers
Director, Kenyatta National Hospital

RE: WORKING GROUP FOR WRITING THE FIFTH NATIONAL
HEALTH DEVELOPMENT PLAN.

As a result of a Workshop for developing a plan for writing the next National Health Development Plan, it was agreed that a Working Group be formed and charged with the responsibility of coordinating departments and collecting data with a view towards writing a draft plan.

The following were identified as members of the Working Group:

1. Mr. Ouka
2. Mr. Ndungu
3. Mr. Thube
4. Mr. Ong'ayo
5. Dr. Cipson - Resource Person

The identified Working Group will report to a Steering Committee which is composed of the following:

1. Permanent Secretary
2. Director of Medical Services
3. Senior Deputy Director of Medical Services
4. Deputy Secretary
5. Chief Nursing Officer

They will also work closely with the Ministry of Economic Planning and Development, Ministry of Finance and with the various departments and sections within the Ministry of Health.

Your maximum cooperation and assistance will be required to facilitate the activities of this group.


G. R. MUMBI CHILA
PERMANENT SECRETARY

ASAS/012/1

A P P E N D I X V

Project Budget and Actual Expenditures

Project Budget and Actual Expenditures

Drew HPIP Contract	36 Month Project Budget			Year I Actual Expenditures*Year II Actual Expenditures**Expenditures to 6/30/82								
				10/1/80-9/30/81	10/1/81-6/30/82 (10 months)	(22 months)						
Category of Expenditure	Home	Field		Home	Field		Home	Field		Home	Field	
	<u>Office</u>	<u>Office</u>	<u>Total</u>	<u>Office</u>	<u>Office</u>	<u>Total</u>	<u>Office</u>	<u>Office</u>	<u>Total</u>	<u>Office</u>	<u>Office</u>	<u>Total</u>
Salaries & Wages	122422	288533	410955	32277	52614	87891	30021	41819	71840	65298	94433	159731
Consultants	-	81000	81000	-	11734	11734	-	17723	17723	-	29547	29547
Fringe Benefits	24484	57707	82191	5065	4888	9954	4835	4678	9513	9900	9566	19467
Overhead (Indirect Costs)	58762	100987	159749	16933	18799	35732	12749	14054	26803	29682	32853	62535
Travel, Transport & Perdiem	8800	165100	173900	4038	27757	31795	4172	-	4172	8210	27757	35967
Allowances	3420	210550	213970	-	31794	31794	-	9809	9809	-	41603	41603
Equipment & Vehicles	2850	141386	144236	1541	7682	9223	-	46882	46882	1541	54564	56105
Materials & Supplies		31764	40764	922	642	1564	71	1472	1543	993	2114	3107
Participant Training &												
Conferences	-	302955	302955	-	23287	23287	-	92928	92928	-	116215	116215
Other Direct Costs	<u>34700</u>	<u>67580</u>	<u>102280</u>	<u>3891</u>	<u>7841</u>	<u>11732</u>	<u>4629</u>	<u>17774</u>	<u>22403</u>	<u>8520</u>	<u>25615</u>	<u>34135</u>
TOTAL	264438	1447562	1712000	67668	187038	254706	56477	247139	303616	124144	434177	558321

*Source, USAID/Kenya

**Source, Drew Post-Graduate Medical School, Kenya Project Report Detail, 4/1/82 through 6/30/82

BEST AVAILABLE