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HEALTH PLANNING AND INFORMATION PROJECT

PROJECT NO. 615-0187

TECHNICAL SERVICES TO THE MINISTRY OF HEALTH

GOVERNMENT OF KENYA

Annual Report

(for period October, 1981 - September, 1982)

V O L U M E I

Contractor

Charles R. Drew Postgraduate Medical School

Office of International Health and Economic Development

1621 E. 120 Street

Los Angeles, CA 90059

Contractor's Director (Chief-of-Party)

Reginald F. Gipson, M.D., M.P.H.

FOREWORD

September 30, 1982, marked the completion of the first two years of a three-year contract between the Government of Kenya, Ministry of Health, and the Charles R. Drew Postgraduate Medical School, Health Planning and Information Project. This document provides a report on Project achievements to date, with special attention to activities undertaken during the period October 1981 to September 1982.

For a further, more comprehensive overview of the Project, the reader is additionally referred to the Project's first Annual Report covering the period October 1980 - September 1981, and the findings of an independent Mid-term Project Evaluation completed in August 1982.

ABBREVIATIONS USED

AID/K	USAID Mission to Kenya
COP	Chief-of-Party (contractor staff)
GOK	Government of Kenya
HPIP	Health Planning & Information Project (contractor)
HPWG	Health Planning Working Group/MOH
IRHP	Integrated Rural Health/Family Planning Programme
KEMRI	Kenya Medical Research Institute/GOK
M.A.	Master's Degree Study Program
MCH/FP	Maternal and Child Health/Family Planning
MOEPD	Ministry of Economic Planning & Development, Kenya
MOH	Ministry of Health, Kenya
M.P.H.	Master's Degree in Public Health
NCST	National Council on Science and Technology/GOK
PIO/T	Project Implementation Order/Technical Services
USAID	United States Agency for International Development

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BACKGROUND In August 1979, USAID/Kenya and the Government of Kenya (GOK), signed a grant agreement in the amount of $2,453,000, establishing the Health Planning and Information Project (HPIP).

The HPIP was intended to address several concerns related to Ministry of Health (MOH) operations. It was recognized that the GOK/MOH planning functions were organizationally dispersed within the MOH, and that planning decision-making was not adequately supported by health information. The seriousness of these conditions was further complicated by the facts that:

1. New programs/projects were projected to be added each year to the Ministry's system without benefit of comprehensive, data-based planning; and
2. The Ministry's priority policy for redistribution of health resources to meet the needs of rural areas, suggested the need for both consolidation (at the national level) and decentralization (to provincial/district levels) of health planning and management functions.

In response, the HPIP was designed to develop MOH capacity to plan, implement and evaluate health programs and policies, with primary emphasis on expansion of rural health service delivery. Increased "capacity" was to be evidenced by a more equitable distribution of GOK health sector resources, and by development and implementation of future joint USAID/GOK health sector activities.

The bilateral agreement between the GOK/MOH and AID/K included provision of a full-year program consultant (administered through the U.S. Dept. of Health and Human Services), to design one or several programs (for funding) that would address comprehensive long range developmental needs of the Ministry. The Project Implementation Order/Technical Services (PIO/T) for the Kitui District Project (now under negotiation) was a major output of that first year effort. Additional funds were set aside for AID/K use in deployment of ad hoc consultants, and for selected applied research/project development sub-contracting related to HPIP objectives.

The first year of the HPIP (bilateral agreements) also included selection and contracting with a technical assistance agent to provide support to the MOH.

PROJECT PURPOSE

The Drew School, Office of International Health commenced work in October 1980*. The host-country technical assistance contract was funded at a level of $1,712,000 for a three year period. The Contractor was charged with "providing long and short term technical assistance to the Ministry of Health and to a lesser degree, the Ministry of Economic Planning and Development (MOEPD) of the Government of Kenya, with the major aim of strengthening the GOK's institutional capacity to plan and implement health sector programs and policies with primary emphasis on expanding health services delivery to rural populations".

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*Both the bilateral agreements and the Technical Assistance Contract are referred to as the "HPIP".

PROJECT OBJECTIVES

The Project's first annual Report set forth a list of Operational Objectives which effectively re-organized and categorized the seventeen (17) separate Terms of Reference of the contractual agreement into distinct programmatic activity components. For purposes of continuity and comparability, this list of Operational Objectives provides a presentation outline for this Report which will continue to be used for project reporting and future implementation planning.

The Contract Terms of Reference are shown in Figure A. The Project's Operational Objectives (cross-referenced to the Contract Terms) are shown in Figure B.

In reference to those Objectives, the first Project Year was extremely productive. Major progress was made in solidifying HPIP/MOH working relations and developing an understanding of the realistic time frames and approaches needed to achieve Project objectives. Progress was made in activating both the Policy Coordination Committee and the National Planning Unit. Placement of five health administrators for M.P.H. training (two ahead of schedule) was also a noteworthy achievement. Moreover, the MOH's insight in directly involving the HPIP in the developmental planning of the large-scale integrated Rural Health/Family Planning Programme resulted in substantial progress toward defining the strategies by which the MOH's overall institutional capacities to plan, implement, manage and evaluate policies and programs, were to be facilitated during Years II and III of the HPIP.

FIGURE A

HEALTH PLANNING AND INFORMATION PROJECT

Technical Assistance Contract Terms of Reference

A. Assist MOH executives and other Kenya agencies in the establishment of the new Division of Planning and Implementation in the MOH. While a tentative organizational structure and staffing pattern has been developed, this is subject to continuous review, revision and consequent evolution, particularly as concerns relationships with other administrative units within the MOH.

B. Assist in the establishment of the Planning and Policy Coordination Committee composition, charge and duties, authorities and reporting responsibilities.

C. Assist in developing, refining and establishing health planning, implementation, evaluation and policy analysis procedures.

D. Assist in the preparation of guidelines for decentralizing planning, implementation and evaluation activities to the provincial and district levels.

E. Assist in the revision or development of a scheme of service appropriate for health planning personnel, both medical and non-medical, in the MOH and MOEPD. (This will be completed as evidenced by written recommendations by June 1, 1981.)

F. Provide technical assistance in appraising health sector policies and programs, in the form of written memoranda as required by senior officers.

G. Assist in the identification and assembly, from primary and secondary sources, of a minimum base of data needed to support health sector planning, implementation and evaluation activities.

FIGURE A cont'd

H. Assist the MOH/MOEPD in developing a list of research priorities and in developing appropriate procedures and guidelines for the solicitation, review and approval of research contracts.

I. Assist the MOH/MOEPD in identifying the need for baseline studies, and assembling data and institutionalizing the continuous gathering of a minimum base of data needed to support health planning, implementation, policy analysis and health program evaluation.

J. Assist in evaluating the results of action-oriented research studies and in developing procedures for the appropriate distribution of research findings.

K. Assist the MOH in identifying consultant needs to assist in the design of specific projects and assist in preparing appropriate scopes of work for these consultant activities, which will be funded from other sources.

L. Assist in identifying the need for consultant services to implement discrete portions of the projects; develop appropriate scopes of work in consultation with MOH officials and assist in recruiting appropriate experts. (Note: In addition to 18 person-months of consultant services to be fielded by the Contractor, the project will fund approximately 26 person-months of services from the Health Resources Administration in the follow-on project design category and 6 person-months of AID evaluators. The Contractor will work closely with these other consultants.)

M. Assist in the selection of five (5) M.A. and 15 short-course training candidates and assist AID and MOH/MOEPD in making all necessary administrative arrangements for their placement and training. (AID will effect and fund actual placement of an additional 7 M.A. training candidates through its own procedures.)

N. Help organize and make arrangements for observational tour training on behalf of 10 Kenyan officers. This will involve training in other African countries.

FIGURE A cont'd

O. Assist in seeing that M.A. Kenyan Planners (returned participants) are functioning effectively in appropriate positions on the MOH and MOEPD.

P. Assist in organizing, conducting and evaluating eight (8) health planning, policy and information seminars.

Q. Assist in developing an appropriate list of equipment (vehicles, office equipment, commodities) needed and effect timely acquisition and deployment of all such equipment, etc. Procurement will be in accordance with AID regulations.

Figure B - Operational Objectives

OBJECTIVES	CROSS - REFERENCE TO CONTRACT TERMS
I. TO DEVELOP A NATIONAL HEALTH PLANNING SYSTEM	
National Level	
● Establish National Planning Coordination Committee (policy level)	B
● Establish National Planning Unit (operational level)	A
● Design/implement planning functions and procedures	C
● Develop scheme of service for planning personnel	E & D
● Train planning staff (off-site)	
1. M.P.H.	M
2. Short-term	M
3. Observational Tours	N
● Assistance to planning staff (on-job)	O
1. Appraise health sector policies and programs	F
2. Organize operations research	H & J
3. Develop programs/projects	K & L
● Create national health sector dialogue (conduct conferences) on planning/information systems	P
● Develop a strategy to decentralize planning/management functions	D
Provincial/District Levels	
● Conduct assessment/planning workshops	C & G
● Ensure coordination between national planning staff and provincial/district administrators related to implementation of national planning unit activities	O
II. TO IMPROVE THE NATIONAL HEALTH INFORMATION SYSTEM	
● Assist in organizational structuring	I
● Design/implement systems improvements	G & I
● Train Staff	I
III. TO ADMINISTER ACQUISITION OF SUPPORTIVE COMMODITIES	
● Purchase computer, other office equipment and vehicles	Q

SUMMARY ANALYSIS

An independent mid-term evaluation of the Project was completed during Project Year II. Among the major findings of the evaluation was the need to extend the Project to September 1985. At the close of Project Year II, discussions were underway regarding the feasibility of such an extension. The forward planning which relates to contemplation of a Project extension provides an opportunity to more clearly define or redefine the objective outcomes and expectations of the Project. These specifications, in turn, provide for better perspective in terms of reviewing and assessing the Project accomplishments and impact to date.

Figure C is a Detailed Qualitative Analysis of Operational Objectives expressed in quantitative terms. The Analysis summarizes estimated Project achievements to-date, and projects upon the balance of work that could reasonably be accomplished during the term of the Project. Projections are shown for the end of Project Year III -- which under the current contract terms would represent the end of the Project. Projections are additionally shown for a Project that would end in September 1984 and September 1985, respectively. When viewed against these longer range Project designs, the significance of achievements during Project Years I and II can be more fully appreciated.

The ability to draw programmatic inferences from this Analysis will be somewhat hampered for the reader who does not already

possess some understanding of the Project's history and on-going activities. However, quantification of Project achievements and projections, as presented in this exercise, should have intrinsic value as a quick reference overview of the Project.

FIGURE C - DETAILED QUANTATIVE ANALYSIS OF OPERATIONAL OBJECTIVES: ACHIEVEMENTS AND WORK TO BE COMPLETED

	ORIGINAL RELATIVE WEIGHTED VALUE OF TASKS	% OF TASK ACHIEVED END YEAR II	(1)x(2)=(4)	% OF TOTAL PRJT.ACHIEVED END YEAR II	100-(2)=(6)	% OF ORIG. PRJT.TASKS REMAINING	REASSESSED WEIGHTED VALUE OF TASKS	% OF TOTAL PRJT.EFFORT REMAINING	ESTIMATED % FEASIBILITY OF ACHIEVING TASKS, AND ESTIMATED INCREMENT OF PROJECT COMPLETION: YEAR III %	(8)x(10)=(11)	YEAR IV(+4 mos.) %	(8)x(13)=(14)	(additional 8 mos.) YEAR V %	(8)x(16)=(17)
I. DEVELOPMENT OF NATIONAL HEALTH PLANNING SYSTEM	(.65)						(.50)							
A. National Level														
•Est. Nat. Plng. Coord. Comm.	.05	90		4.5		10	.05	.5	.50	.25	.50	.25		
•Est. Nat. Plng. Unit	.08	60		4.8		40	.06	2.4	.50	1.20	.50	1.20		
•Design/imple. Plng. Proced.	.04	50		2.0		50	.07	3.5	.50	1.75	.50	1.75		
•Develop Scheme of Service	.05	5		.25		-0-	-0-	-0-						
•Train Plng. Staff (off-site)														
1. M.P.H.	.05	88		4.4		12	.01	.12	1.00	.12				
2. Short Term	.03	100		3.0		(+) 50	.03	1.5	.20	.30	.80	1.20		
3. Observational Tours	.02	90		1.8		10	.01	.1	1.00	.10				
•Assist Plng. Staff (on-job)														
1. Appraise Health policies/prgms	.03	30		.9		70	.02	1.4	.10	.14	.30	.42	.60	.84
2. Operations Research	.06	10		.6		90	.10	9.0	.20	1.80	.50	4.50	.30	2.70
3. Develop Prgms/Prjts	.10	30		3.0		70	.01	.7	.60	.42	.40	.28		
•Conduct Conferences	.04	100		4.0		(+) 25	.02	.5	.50	.25	.50	.25		
•Develop Decentral. Strategy	.05	100		5.0		(+) 10	.02	.2	1.00	.20				
B. Provincial/District Level														
•Conduct Plng. Workshops														
•Assist Plng. Coordination	.03	100		3.0		(+) 50	.08	4.0	.40	1.60	.50	2.00	.10	.40
	.02	20		.4		80	.02	1.6	.30	.48	.40	.64	.30	.48
II. IMPROVE NATIONAL INFORMATION SYSTEM	(.25)						(.40)							
•Assist Org. Structuring	.05	5		.25		95	.10	9.5	.10	.95	.30	2.85	.60	5.70
•Design/Imple. Systems	.15	20		3.0		80	.20	16.0	.20	3.20	.60	9.60	.20	3.20
•Train Staff	.05	-0-		-0-		100	.10	10.0	.10	1.00	.60	6.00	.30	3.00
III. PROCURE COMMODITIES	(.10)						(.10)							
•Office Equipment	.01	95		.95		5	.01	.05	1.00	.05				
•Vehicles	.04	98		3.92		2	.04	.08	1.00	.08				
•Computer	.05	10		.5		90	.05	4.5	1.00	4.5				
TOTALS	1.00			46.27			1.00	65.65		18.39		33.94		16.32

Explanation of Analytical Method - Figure C

Tasks were first assessed in terms of the relative level of effort needed and their relative significance to achievement of the overall purposes of the Project. (Obviously, delay in an area of high priority would have greater implication for Project performance than would delay in a less significant area). Each task was then assigned a value reflecting an estimate of how much has been achieved to-date. By factoring relative value of a task with its percent of completion, a figure was derived which expresses overall Project achievement.

The balance of work to be done was than subjected to the same analysis. However, it was necessary to reassess the relative significance of the various tasks, since experience into the Project term has necessarily produced re-ordered priorities.

The re-stated balance of work to be done was then analyzed in terms of how much of a given task could reasonably be accomplished (based on an understanding of the expected qualitative outcomes, mediated by constraints operating in the work environment).

Explanation of Terms and Computations - Figure 2

Columnar Notations:

(1) ORIGINAL RELATIVE WEIGHTED VALUE OF TASKS: This is a discretionary value, based on operational staff's understanding of the relative level of effort needed and the relative priority of various tasks as originally agreed by the contracting parties.

(2) % OF TASK ACHIEVED, END YEAR II: This is a discretionary value, based on operational staff's understanding of the total scope of work required to satisfactorily complete the task, compared to what has been achieved to-date.

(4) % OF TOTAL PROJECT ACHIEVED, END YEAR II: This is a computed figure, [column (1) x column (2) = column (4)].

(6) % OF ORIGINAL PROJECT TASKS REMAINING: This is a computed figure, [100% minus column (2) = column (6)].

(7) REASSESSED WEIGHTED VALUE OF TASKS: This is a discretionary value, based on factors such as,

- reduced emphasis on tasks where institutional (MOH) responsibility and momentum have begun to take effect, or;
- increased emphasis on tasks which reflect increased priority within the MOH, or;
- increased emphasis on tasks for which insufficient progress was made during Years I and II.

(8) % OF TOTAL PROJECT REMAINING: This is a computed figure,[column (6) x column (7) = column (8)].

(10-17) ESTIMATED % FEASIBILITY OF ACHIEVING TASKS IN YEAR III, AND OPTIONAL YEARS IV AND V: Columns (10), (13) and (16) show a discretionary estimate of the feasibility of completing tasks in Years III, IV, and V, respectively.

Columns (11), (14) and (17) show a computed figure, [column (8) x column (10), (13) and (16) - columns (11), (14) and (17), respectively].

Discussion of Figure C

(Comments and implications of Figure C are treated from left to right).

1. During Years I and II, approximately 65% of the total Project emphasis was placed on the Planning System. By original design, development of the Health Information System and procurement of commodities were intended to be essential but subsumed aspects of Health Planning Systems development. Their relative values are shown as 25% and 10%, respectively.

2. It will be noted in column (2), that progress on the Health Information System has been far less productive during the first two years of the Project than had originally been intended. The causes for delays and plans for remediation have been previously discussed in various documents, including the Project's First Annual Report and the Project Evaluation. This subject is further treated in the discussion section of this Report.

3. The figure shown in the total for column (4) estimates that 46% of the total Project requirements have been met. It is useful to compare this figure with project time elasped (66% of a three-year contract), and funds expended (approximately 45% to-date).

   One can conclude that the Project is approximately 20% (or 7 months) behind schedule. This is due almost exclusively to short falls in the information systems area (and such related areas as operations research).

   However, a more significant conclusion -- and perhaps a more technically useful way to evaluate Project effort to-date -- is that percent of achievement is roughly comparable to funds expended. This suggests that, in spite of short falls, those resources which have been used, have been applied with considerable efficiency.

4. The readjusted estimate of the amount of effort remaining to satisfactorily complete the terms and expectations of the Project is about 66% [as shown in the total of column (8)].

   When added to the amount already completed (46%), this suggests that the total qualitative expectations (by virtue of MOH requests for Project services and Project staff's interpretation of the level of effort required), have increased by a factor of about 12% over and above the original agreements (46% + 66% = 112% - 100% = 12%). This inference is essentially accurate. HPIP has, and continues to contribute significantly to development of the Integrated Rural Health Programme. Although within the parameters of HPIP's scope of work, the current degree of involvement constitutes a programmatic extension of level of effort.

Similar statements can be made about the training area. Although the Project has essentially met all of its basic requirements for in-country training, it is clear that the overall need is far greater. The Project has succeeded in assisting the MOH in operationalizing its policy toward decentralized management, by introducing the technique of practice-oriented planning and management training at the provincial and district levels. Because of the momentum created in this area, it can be expected that the HPIP will continue to be involved in these activities during the remainder of the Project term.

Neither of the two above described informal expansions of the Project's original contract are negative. Rather, these involvements have facilitated achievement of related HPIP objectives. However, for future planning purposes, these areas of involvement should be formally incorporated into the contract scope of work.

5. Column (7) suggests a current approach to the Project which shifts emphasis relative to the three major components of the Project. It is expected in the future that heavier emphasis will be placed on the information system (40%), and concentration of development of the planning system can now be reduced slightly (from 65% to 50%), owing to the progress and momentum already established in this area.

6. Estimates of the percent of feasibility of achieving increments of the total remaining 66% of project effort, are based on certain assumptions related to the type of staffing that would be appropriate for Years III, IV and V. The following should be noted:

- Year III level of effort assumes COP plus a variety of short-term

consultant (if the Project were, indeed, to terminate on September 30, 1983).

- Year IV level of effort assumes that the COP plus (the desirable level of) two additional full-time long-term consultants (Health Planning/Management Information Specialist and Management Training/Organizational Development Specialist) will be deployed in the field during Year III.
- Year V level of effort assumes that the COP will be deployed for a full twelve months, the HIS Specialist for three months and the Management Training Specialist for five months.

On the basis of these completion estimates, it can be seen that, were the Project to terminate as currently contracted, the total achievement of the Project would probably approach 53% of expectation (Net achievement end Year III = Total achievement (46%) minus additional general level of effort (12%) = 34%; 34% + Project Year III effort of 19% = 53%).

If the Project extended to a fourth year, it would be feasible to achieve 84% of expectation, (34% + 19% + 31% = 84%). However, note that the health information component would be the major activity negatively affected by Project termination at that time. (It is projected that adequate impact on development in this area will require a minimum of 22 months, with the most substantial achievements realizable toward the end of that period.)

Also note that the potential for achieving up to 84% of the Project during this period would be negatively affected if it were necessary because of lack of funds to operate with less than the optimal number of three long-term consultants.

Fairly assessed, it appears that only under the terms of an expanded five year contract would it be possible to achieve total project expectations and provide for an orderly transition and phase-out.

DISCUSSION OF PROJECT ACHIEVEMENTS

The cumulative achievements of Project Years I and II, and the specific activities and outputs of Year II are further discussed below. Discussion is organized into categories consistent with the Operational Objectives listed on page 7 of this document. The bracketed alphabetic notation found next to each discussion title refers to the related item(s) of the Contract Terms of Reference.

Establish National Planning Coordination Committee (policy level) _ _ _ _ _ [B]

With assistance from the HPIP, a National Planning Coordination Committee (policy steering committee) was formed during Project Year I for the purpose of guiding policy direction of all projects within the MOH. During Project Year I, the Committee concerned itself mainly with project design and development of the Integrated Rural Health/Family Planning Programme.

Since January 1982, the Committee has further formalized its structure and operations. The Committee is composed of:

- Permanent Secretary (Chairman)
- Director of Medical Services
- Senior Deputy Director of Medical Services
- Deputy Secretary (two)
- Principal Nursing Officer

During 1982, the Committee met on two occasions to review the progress being made by the Health Planning Work Group (HPWG)*. Of particular concern were activities related to the HPWG assistance to provincial/district health management teams in developing their input to the Fifth National Development Plan.

Within the context of the Project's requirements, the objective of assisting the MOH in establishing a Planning Coordination Committee is considered to be essentially complete. In the future, HPIP's responsibilities in this area will be limited to providing coordinative and administrative support to the Committee, as needed.

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*See discussion page B-1.

Establish National Planning Unit (operational level) _ _ _ _ _ _ _ _ _ _ _ _ [A]

During Project Year I, three health administrators formerly trained at the M.P.H. level under the HPIP were seconded to work along with the Project's Chief-of-Party on various aspects of systems development. On 6 May, 1982, the MOH formally established a Health Planning Working Group. Those indivdiuals previously seconded to the HPIP formed the core of the HPWG's staffing, and the Project has henceforth been integrally involved in the day-to-day operations of the HPWG through the assistance and direct input of the HPIP Chief-of-Party.

The HPWG is considered to be a permanent unit within the MOH with the following responsibilities:

- Coordination of the collection of data and the writing of the Fifth National Health Development Plan and the development of Annual Plans for implementation of the Five Year Plan.
- Assist in developing, refining and establishing planning, implementation, evaluation and policy analysis procedures.
- In consultation with the Steering Committee review policies, objectives and strategies.
- Coordination of the planning process at the national, provincial and district levels.
- Assist in the training of District Health Management Teams in planning and evaluation.
- Collect the necessary data which will facilitate formulation of health policy for the next Health Development Plan.
- Assist in the preparation of guidelines for decentralization of planning, implementation and evaluation activities to the provincial and district levels.
- In liaison with the Ministry of Economic Planning and Development and the Ministry of Finance, work out a plan/program budget which reconciles the health activities to be carried out during the Plan period.

The Health Planning Working Group is currently composed of Mr. L. K. Ndungu, Senior Administrative Secretary; Mr. F. Ouka, Under Secretary; Messrs. C. Thube and S. Ong'ayo, Health Economists; and Dr. R. Gipson, Senior Health Planner (resource person).

The Health Planning Working Group reports to the National Planning Steering Committee. Progress reports related to the activities of the HPWG during Project Year II are attached.

Within the context of the Project requirements, the objective of establishing a national planning unit is considered to be about 60% complete. What remains to be done is to assist the MOH in identifying a qualified counterpart to the HPIP/COP who will assume full leadership of the HPWG once the Project terminates, and to further train and guide the activities of the HPWG to ensure that the momentum created during 1982 is maintained and that the provincial/district planning activities are fully institutionalized.

THE CHAIRMAN,
STEERING COMMITTEE (P.S).

THE DIRECTOR OF MEDICAL SERVICES.

PROGRESS REPORT - HEALTH PLANNING WORKING GROUP

This is the first progress report of the Planning Working Group which was appointed by you on 7th May 1982. The main task of the Group was to facilitate the process of preparation and production of the Health Chapter for inclusion in the 5th National Development Plan which is due to be launched on 12th December 1983, at the Celebration of our 20th Independence Day.

Composition.

The team is composed of five officers. Mr. F. Ouka, Dr. K. Gipson, S. Ong'ayo and C. Thube and Mr. L.K. Ndungu - as the Co-ordinator. Thube left the team at the end of June 1982, after having served as a useful member of the team. Due to pressure of work (closure of financial year) only 3 members of the team were able to participate fully in the activities of the Group.

Activities.

So far the Group has held 18 meetings/workshops or seminars with the Health personnel in the field, Ministry of Planning and Economic Development, Ministry of Finance, Central Bureau of Statistics, and so on.

A Schedule of activities is enclosed.

One of the main reasons why the Group had to make these extensive consultat was to ensure that we meet the deadlines set by the MPED especially that of submitting our Introductory Chapter by November of 1982. For that reason, (and the fact that baseline data has to be collected), the Group's main objective was to get materials from the field and to ensure that the production of the plan is done by those who will implement it. So far the Group has consulted literary all Provincial Health Teams and all District Medical teams (except North-Eastern Province where restriction of movements has been our constraint).

The team has also held at least 2 workshops with Medical Officers of Health and their teams.

In these workshops, detailed discussions on the process of preparing the health plan at the District level were held.

Improvement of Planning Capability at District Level.

Several papers have been written by the Group and circulated to the Health teams who scrutinised them and made useful suggestions to improve them.

An attempt has been made to create and improve the planning capacity and capability at District level

The feedback the Group has received indicates a beginning of a new era where the planning of Health Development will be done from the District level.

Three Meetings have been held with the Ministry of Planning and Ministry of Finance. The purpose of these meetings were to obtain guidelines on the National Development Policy before embarking on the task of writing the health plan. Health Sectoral Planning Group has been formed to co-ordinate the activities of writing the Chapter with those of the MPED.

The Group has participated in consultative workshops organised by Ministry of Economic Planning and Development.

Achievements.

The greatest achievement so far is that besides the fact that District and Provincial Health teams (at this very moment)are working hard to prepare realistic plans for their areas, we now have almost an up to date statistical information and data which heads of departments can utilize for their day to day administrative tasks

Immediate Objective.

The objective of the Group is to have the introduction Chapter ready before October 1982. Districts and Provinces will have their documents ready by the end of August 1982.

Constant consultation between District and Provincial teams has been maintained so far - despite problems here and there. Nearly all PMOs have been extremely helpful, and appear to be committed to the idea of producing a practical and realistic plan.

The main draft of the plan will start immediately the Introductory Chapter is ready. By February of 1983, tentative main draft will be complete so that discussions with the implementors (who will have produced it) may start April 1983. By May of 1983, we should be in a position to submit our draft to the MPED (complete with budget provision worked out).

Field Officers Commitment

Health Workers in the field are committed to produce realistic and practical plans. They have critically examined previous plans. They have given us a very comprehensive list of what was planned, accomplished and what was not accomplished with well conceived reasons.

The District teams know what they need. They have come up with Health problems affecting their District and it is on the basis of these Health problems that they will form their strategies and ways to overcome them.

The theme to be adopted is that of increasing accessibility of Health Care to the people (aiming at the universal goal for "Health for All by the Year 2000).

They have already evaluated the resources they have to enable them to implement programs they will propose, and most of them have even considered constraints they might face during implementation.

8. Team Work

The Working Group has noted with approval the consistent team work at the Provin-cial and District levels. With this kind of enthusiasm and team spirit, we can achieve our objectives.

9. Major Constrain in Limiting Curative Services.

One major difficulty that has come up is that of reconcilling theory and practice. Although all teams are committed to the need for preventive and promotive care, the programmes being submitted to the Working Group show that curative care continues to receive greater attention and to dictate our thinking. At the second meeting for Nyanza and Western District Teams this issue was discussed, and it was resolved that all teams in the two provinces would try to come up with criteria or a workable methodology with which preventive/promotive care can be quantified and qualified.

The idea here is to increase preventive programmes practically rather than continuing with the present philosophy where all are committed to the idea of prevention/promotion of health, without coming up with implementable programs which can be quantified or qualified. Dr. Kayo and Dr. Okombo are organising these criteria. Dr. Migue of Coast is also keen that we come up with better preventive criteria.

10. North Eastern Province.

We have not been able to contact North Eastern Province because of restrict of movement in these parts. Nevertheless, we are determined that we get th as soon as possible so that we may be able to complete the programme. Also a workshop for Nairobi area is yet to be held. We need funds for that so that we can have the Health Plan for the City Council of Nairobi as well as Nairobi Hospitals.

11. The Working Group.

We have yet to get Secretarial Services, personnel or even transport. Throu Charles Drew Assistance, we were able to make the field Trips for consultations and collect these data. These resources have more or less come to an end. We therefore, need transport, Secretarial/Clerical Services and Office accommodation. For example, we were stranded at Kisumu (on the w to Kakamega) until MOH Kisumu helped us because the vehicle we were offered for this journey from here was so old that it could not get to the distinati planned. It seems that even at the Ministry HQ, there is a need for better co-ordination and resource planning - if we have to reach the provinces.

12. Meeting for Heads of Departments.

Can we have your approval to call for 1 day's heads of Department meeting in August 1982? We need their assistance in evaluating information we have obtained from the field.

L.K. Ndungu
Administrative Secretary
Group Co-ordinator.

c.c.

Senior Deputy Director of Medical Services

Deputy Secretary

Chief Nursing Officer.

9th July, 1982

HEALTH PLANNING AND INFORMATION PROJECT
CHRONOLOGY OF ACTIVITIES RELATED TO THE NATIONAL PLANNING PROCESS

DATE	VENUE	SUBJECT
2nd & 23rd April, 1982	Safari Park Hotel	National Workshop on the Planning Process - The Fifth National Development Plan.
h - 6th May, 1982	A.M.R.E.F.	Intra-Ministerial Seminar on the Planning Process for the Fifth National Development Plan. Opened by P.S.
th & 27th May, 1982	Karen College	Provincial Level Workshop on the Planning Process for the Fifth National Development Plan. Opened by D.M.S.
1 June, 1982	Chulaimbo, Kisumu	Provincial and District Workshop on the Planning Process for the Fifth National Development Plan. This Workshop covered Nyanza and Western Provinces - Kisumu, Siaya, Kisii, S. Nyanza, Kakamega, Bungoma and Busia.
June, 1982	M.T.C. Nakuru	Provincial and District Level Workshop on the Planning Process. Teams: Nakuru, Trans Nzoia, Kericho, Baringo, Nandi, Kajiado, Narok, Elgeyo Marakwet, Turkana, Kapenguria Uasin Gishu.
June, 1982	Nyeri Inn	Provincial and District teams, Planning Process Teams: Kirinyaga, Kiambu, Nyeri, Muranga, Nyandarua.
June, 1982	Embu	Provincial and District Teams. Embu, Meru, Marsabit, Kitui, Machakos.

DATE	VENUE	SUBJECT
16th June, 1982	M.T.C. Mombasa	Provincial and District Lev on the Planning Process for Fifth National Developme Mombasa, Kilifi, Kwale, Tana Taita/taveta, Lamu.
10th May, 1982	M.E.P.D. Treasury Building	Meeting with Senior Planner Health Policy Guidelines.
7th - 11th June, 1982	Community Building, Nairobi	Monitoring and Evaluation of Development Projects Workshop Organized by K.I.A., M.E.P.D.
22nd June, 1982	M.E.P.D., Treasury	Sectoral Group Meeting - Mr. Mr. Adagala, Miss Emokor, Dr. Mr. Thube, Mr. Ong'ayo, Mr. K Mr. Kungu, Mrs. V. Brown, Mr.
23rd June, 1982	M.E.P.D. Mr. Ngugi's Office	Population Studies and Planni Mr. Ngugi, Mr. Kariuki, Prof. etc.
24th June, 1982	C.B.S. Building	Demograph Trends Meeting.
25th June, 1982	M.T.C., Nyeri	Follow up District Teams Planning and data collection.
30th June, 1982	M.T.C., Mombasa	Follow up District Teams as well as collection of data.
5th July, 1982	Mbale R.H.T.C.	Follow up on Nyanza and Western Provincial & District Teams.
7th July, 1982	Nakuru, M.T.C.	Follow up on Rift Valley District Teams.

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Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 27381
When replying please quote
Ref. No. A/I/I/14 Vol. XV- 261
and date

Group Composition

The Health Working Group consists of:

Dr. R. Gipson	Resource person
Mr. S. Ong'ayo	Member
Mr. F. Ouka	Member
Mr. L. K. Ndungu	Co-ordinator
Dr. J. Maneno	Asstisting Coordination & Logistics

Mr. C. Thube left the Group in July for further studies. No replacement will be made - shortly - from the Ministr of Planning and Economic Development due to shortage of Economists/Planners

Terms of reference:

The Group was established to help the Ministry in the preparation and production of the Health Chapter for inclusion in the 5th National Development Plan - which will be launched on 12th December 1983, on the 20th Anniversary of Kenya's Independence.

The Introductory Chapter was expected to be ready for submission to the MPED by December, 1982.

The final draft of the MOH was expected to be ready before May 1983.

The development plan must reflect the Health Development that has taken place for the last 20 years. Districts and provinces will write their plans with the help and guidance of the Planning Group. Heads of Departments will consider these plans and amend where necessary.

The Planning Group will compile and produce

The Planning Group was to work in close collaboration with the Ministry of Planning and Economic Development, Ministry of Finance and other agencies involved in the production of the Health Plan.

3. Activities of the Planning Group:

A detailed Schedule of the Groups activities are attached. (Appendix A). As can be seen from this schedule, the group has been able to hold 2 meetings workshops, with the District and Provincial Planning teams. In some Provinces, three workshops have been held.

The first field visit was aimed at 'sentitizing' District Health Groups orienting District officers to the planning process. Basic techniques of preparing health plans were discussed in details. Information documents and questionaires were issued. Field officers seemed excited by the new approach the Ministry had take (of involving them in the writing of the Development Plan). Problems of writing development plans were discussed and questions raised by the District Planning Groups were answered. PMOs proved most helpful in supporting our submissions and were instrumental to the success of these workshops.

The second workshops were aimed at collecting information already distributed to the districts (during the 1st meeting) and in answering problems that teams might have encountered when completing the questionaires. During this period, detailed discussion centred around demographic and epidemilogic sections of the questionaire Most teams expressed inability (due to lack of experience) to calculate demographic portions of the questionaires. The Planning Group therefore prepared and issued guidelines to the District teams. With these papers and workshop discussions, teams expressed satisfaction. (See example I).

Information received from the District teams which alread completed their information documents were collected by the Planning Group. Deadlines of completing the Introductory Chapter were set as 30th August, 1982.

The third meeting is a follow-up aimed at collecting the final Introductory Chapters and also for getting information of the Integrated Rural Health/Family Planning Project. This session has been used to get District teams to complete and update their District maps - an exercise aimed at improving our information system. (See example 2 and 3).

These District Introductory Chapters will now be compiled for consideration by heads of Departments for amendments and comments. After that, the Ministry Introductory Chapter will be produced - possibly before November 1982. From the information received so far, it would appear that the Objectives and Strategies of the Ministry will not change much from previous development plans.

4. Liaison with other related Health Agencies:

The Planning Group has also held discussions with various heads of Units and Departments. Communication with guidelines have been sent to the Church Health Authorities the Dean, Faculty of Medicine, the Medical Officer of Health, Nairobi City Council, the Director, Kenyatta National Hospital, The Chairman of the Department of Dentistry and Pharmacy.

The Provincial Medical Officers have been requested to liaise their planning processes with the Municipal Health Authorities as well as private Health providers of their areas. Provincial and District Plans will have Chapters on both Government and non-Government agencies.

The tentative figures still indicate that the Ministry has the highest number of beds in the country (over 58%) followed by the Church Health Authorities 30% and the Private hospitals with slightly over 12%..

The Planning Group has also provided link between the field officers and agencies which can provide information - such as the Central Bureau of Statistics.

The group has worked closely with the Project Manager IRHFP programme and the Rural Health Planning and Implementation Unit (Architectural group).

6. The Working Group's Contraints:

The group has yet to be provided with Secretarial and transport facilities.

The A.S.U. has tried to support the Unit with transport but problems are there as reported earlier.

7 Tentative time schedule:

August to 25th September, 1982 - Receiving the (and processing) Introductory Chapters from the

26th - 15th October, 1982	Compilation of these Chapters and production of a draft Introductory Chapter for consideration by heads of department
16th - 1st November, 1982	Making arrangement for the plan budgeting. Production of the main draft will be continuing
November, 1982	Circulation of the Introductory Chapter to heads of departments for comments.
5th - 15th December, 1982	Obtaining approval from Steering Committee to submit the draft to MPED.
21st December, 1982	Submission of the final Introductory Chapter to MPED
27th December, 1982	Completion of the tentative programme of writing the final draft of the Health Plan
February, 1983	Collection of information for the final draft from the field.
April, 1983	Discussion of the draft plan with heads of department. Circulation of the final working draft to the heads of departments for comments. The draft will be circulated to all who contributed
May, 1983	Discuss final plan with the Steering Committee
End of May, 1983	Submission of the Ministry's Plan to MPED.

APPENDIX 'A

HEALTH PLANNING WORKING GROUP

CHRONOLOGY OF ACTIVITIES RELATED TO THE NATIONAL PLANNING PROCESS

22nd & 23rd Apr.1982	Safari Park Hotel	National Workshop on the Planning Process - the Fifth National Development Plan.
5th-6th May, 1982	AMREF	Intra-Ministerial Seminar on the Planning Process for the Fifth National Development Plan. Opened by P.S.
26th & 27th May.1982	Karen College	Provincial Level Workshop Planning Process for the Fifth National Development Plan. Opened by D.M.S.
7th June, 1982	Chulaimbo,Kisumu	Provincial and District workshop on the Planning Process for the Fifth National Development Plan This workshop covered Nyanza and Western Provinces - Kisumu, Siaya, Kisii, S. Nyanza, Kakamega, Bungoma and Busia
9th June, 1982	M.T.C. Nakuru	Provincial and District level workshop on the Planning Process. Teams: Nakuru, Trans-Nzoia, Kericho Baringo, Nandi, Kajiado, Narok, Elgeoyo Marakwet, Turkana, Kapenguria and Uasin Gishu, Samburu, West Pokot

11th June, 1982	Nyeri Inn	Provincial and District Teams, Planning Process Teams; Kirinyaga Kiambu, Nyeri, Muranga, Nyandarua
14th June, 1982	Embu	Provincial and District Teams, Isiolo, Embu, Meru, Marsabit. Kitui, Machakos
16th June, 1982	M.T.C. Mombasa	Provincial and District Level Teams on the Planning Process for the Fifth National Development Plan. Mombasa, Kilifi, Kwale, Tana River, Taita/Taveta, Lamu
10th May, 1982	M.E.P.D. Treasury Building	Meeting with Senior Planner-Health Policy Guidelines.
7th-11th June, 1982	Community Building Nairobi	Monitoring and Evaluation of Development Projects Workshop :- Organised by K.I.A., M.E.P.D. UNI.
22nd June, 1982	MEPD Treasury	Sectoral Group Meeting - Mr. Ngugi Mr. Adagala, Miss Emokor, Dr. Gipson, Mr. Thube, Mr. Ong'ay Mr. Kristin, Mr. Kungu, Mrs. V. Brown, Mr. Igwe.
23rd June, 1982	MEPD Mr. Ngugi's Office	Population studies and Planning Mr. Nugui, Mr. Kariuki, Prof. Ominde etc.
24th June, 1982	CBS. Building	Demograph Trends Meeting
25th June, 1982	MTC Nveri	Follow up District Team Planning and data collection.
30th June, 1982	MTC Mombasa	Follow up District Teams as well as collection of data.
5th July, 1982	Mbale RHTC	Follow up on Nyanza and Western rovincial & District Teams.
7th July, 1982	Nakuru MTC	Follow up on Rift Valley District Teams
17th -20th July, 1982	Aga Khan Hall Kisumu	Planning of Primary Health Care Workshop for Kisumu District. Planning Group participation included preparation of the PHC Project Costing/Budget. This document is a step forward in

30th July, 1982	Dental Unit, University of Nairobi	A meeting with the Chairman of Dental Department to discuss the Dental Health Plan. Dental report receiv
31st July, 1982	Faculty of Medici University of Nairobi	Planning Group discussed Public Health problems as they affect planning.
		2nd meeting with the Eastern Province District Teams... Information documents were collected and discussions held on the planning process. Work- requested the planning Working group to request the Permanent Secretary to assist in amending Treasury Circular issued recently which requires LPO's to be endorsed by the District Accountant before purchases are made. Draft Introductory Chapte: to be ready by the end of August, 1982.
13th August, 1982	Dental Unit, Nairobi	Met the Chairman of the Dental Department to review progress on writing the Development Plan. Agreed that final draft of the Introductory Chapter will be ready before 30th August, 1982.
18th August, 1982	MTC Nairobi	Met the Central Province District Team for the third time. This time, Nyeri has finished Introductory Chapter and has done an excellent job. No problems experienced. Other teams have also finished, but remains to be done. Agreed that all teams will have sent in their bits by August 30th 1982. District maps updated and completed during the same meeting.
18th August, 1982	NBI Treasury	POPULATION STUDIES MEETING - 2nd meeting of the population series
17th August, 1982	Amani House Nairobi	Discussed Development Plan and Costing with Church Health Authorities - Catholic and P.M.C.A.
25th August, 1982	MTC Nakuru	Third meeting with the Rift Valley District teams. Collect

11th June, 1982	Nyeri Inn	Provincial and District Teams, Planning Process Teams; Kirinyag Kiambu, Nyeri, Muranga, Nyandaru
14th June, 1982	Embu	Provincial and District Teams, Isiolo, Embu, Meru, Marsabit, Kitui, Machakos
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17th -20th July, 1982	Aga Khan Hall, Kisumu	Planning of Primary Health Care Workshop for Kisumu District. Planning Group participation included preparation of the PHC Project Costing/Budget. This document is a step forward in

27th August, 1982	Treasury Nairobi	Sectoral Planning Group meeting held under the Chairmanship of Mr. Ngugi - Chief Planner. Planning Group sumitted papers which have been used as guidelines for the field staff as wel as the progress report.
16th August, 198:	Upper Group Floor MOH Hq.	Held a meeting with Consultants of the Integrated Rural Health to discuss the identification of Facilities for the 1st Phase of the IRH/FP Programme.
29th July, 1982	Upper Ground Floor MOH Ho	Met the Evaluators of the Health Planning and Implementation Project.
31st August, 1982	MEPD	Sectorial Planning Group Meeting Chairman - Mr. Ngugi
2nd Sept.1982	MTC Mombasa	Third meeting with District Teams for draft Introductory Chapters.

THE CHAIRMAN,
STEERING COMMITTEE (P.S).

THE DIRECTOR OF MEDICAL SERVICES.

PROGRESS REPORT - HEALTH PLANNING WORKING GROUP

This is the first progress report of the Planning Working Group which was appointed by you on 7th May 1982. The main task of the Group was to facilitate the process of preparation and production of the Health Chapter for inclusion in the 5th National Development Plan which is due to be launched on 12th December 1983, at the Celebration of our 20th Independence Day.

Composition.

The team is composed of five officers. Mr. F. Ouka, Dr. R. Gipson, Messrs S. Ong'ayo and C. Thube and Mr. L.K. Ndungu - as the Co-ordinator. Mr. C. Thube left the team at the end of June 1982, after having served as a useful member of the team. Due to pressure of work (closure of financial year) only 3 members of the team were able to participate fully in the activities of the Group.

Activities.

So far the Group has held 18 meetings/workshops or seminars with the Health personnel in the field, Ministry of Planning and Economic Development, Ministry of Finance, Central Bureau of Statistics, and so on.

A-Schedule of activities is enclosed.

One of the main reasons why the Group had to make these extensive consultat was to ensure that we meet the deadlines set by the MPED especially that of submitting our Introductory Chapter by November of 1982. For that reason, (and the fact that baseline data has to be collected), the Group's main objective was to get materials from the field and to ensure that the production of the plan is done by those who will implement it. So far the Group has consulted literary all Provincial Health Teams and all District Medical teams (except North-Eastern Province where restriction of movements has been our constraint).

The team has also held at least 2 workshops with Medical Officers of Health and their teams.

In these workshops, detailed discussions on the process of preparing the health plan at the District level were held.

Improvement of Planning Capability at District Level.

Several papers have been written by the Group and circulated to the Health teams who scrutinised them and made useful suggestions to improve them.

An attempt has been made to create and improve the planning capacity and capability at District level.

Design/Implement Planning Functions and Procedures _ _ _ _ _ _ _ _ _ _ _ _ _ [C]

During Project Year I, the HPIP assisted the IRHP in developing the general guidelines and procedures for a decentralized management process. This was viewed at the time as the tentative strategy for introducing the entire MOH to a formal management control system (encompassing planning, implementation and evaluation of the MOH delivery system).

Since the formation of the HPWG, an exponential leap has been taken in involving national, provincial and district levels in a systems-wide planning/evaluation process.

Materials developed and widely distributed during Project Year II are attached.

Within the context of the Project requirements, the objective of designing and implementing planning functions and procedures is considered to be about 50% complete. Remaining is the task of ensuring that the newly introduced functions and procedures become fully institutionalized through strengthening of HPWG coordinative capacities, strengthening of provincial supervisory structures to ensure that planning activities will be continuously carried out, and strengthening of district level understanding and application of planning principles.

DISTRICT LEVEL

HEALTH PLANNING

CRITERIA

FOR

THE FIFTH NATIONAL HEALTH DEVELOPMENT PLAN

MAJOR STAGES IN HEALTH PLANNING

Planning tends to explore the uncertainties of how the best use can be made of limited resources to meet priority needs. Planning includes forecasting and predicting into the future.

Experience in health planning has led to the identification of a series of systematic stages in the planning process. Being a dynamic process, planning should not be viewed as a single movement up a rigidly structured static stairways of steps. The categorization that will follow provides a general of what needs to be done to ensure a systematic approach. In real life situation many activities should be carried out concurrently in order to provide a mutually supportive flow back between various stages of the process.

From the start it should be pointed out that in any planning structure the policy making body should represent the political power structure, the general public and the health professionals. Health activities must fit general public desires. Planners should be closely associated with administrators since the success of any planning group or unit is determined by its ability to make itself useful to administrators.

Stage I: Statement of policy and broad goals:

Planning policies and goals are politically determined. The health planner should ensure that the planning goals fit the policies of the political groups responsible for implementation. Long-term goals and short term objectives should be distinguished and each should be stated with clear recognition of time and priority implication.

Stage 2.: Data gathering:

Information is very important in decision making. Information costs money and planners should insist on collecting what is truly meaningful data. As it was pointed out during the previous workshop planners should differentiate among essential, desirable and interesting categories of data. As a minimum the following essential data is needed for planning:

..../2

a) Demographic data

b) Epidemiologic (Health problems and status)

c) Human resources

d) Physical resources

e) Financial resources

f) Service statistics

g) Economic data

h) Estimation of demand for various categories of services.

The power to influence decisions is directly related to professional competence. The planner must know that informed recommendations directed at tangible objectives, backed by careful analysis and sound data is the only way politicians and other leading personalities can be convinced of decision being taken as they are not interested in rhetoric.

Stage 3: Statement of priority health problems:

This is considered as the heart of the health planning process by most planners because once priorities have been set, the subsequent steps can be considered progressive moves towards implementation. At this stage judgement and wisdom are most needed together with the ability to synthesize many relevant details.

The greatest skill is to balance variables which have very different quantitative relationships and infant lie in different dimensional scales. Too often mistakes arise from giving undue stress to one dimension e.g. the epidemiologist may tend to view priority setting as primarily a matter of defining relative mortality and morbidity from specific health problems while the sociologists, politicians and the public tend to view priority setting as chiefly a response to popular feelings about what is important. To the later group what is important is what the public wants done and what health programs will be acceptable. Economists would lay emphasis on costs while administrators may be concerned with the availability of technical methods for controlling the health problems.

The points raised above call for a balanced approach in handling the various interests.

Stage 4: Plan outline with statement of major alternative proposals:

With priority decisions in hand it is necessary to start working on alternative proposals which represent possible ways of coping with the health problems defined. Points to be raised include: a clear definition of the technical aspects of the program, the organization framework personnel and facilities needed, costs and approximate benefits to be expected.

Stage 5: Development of detailed plan with targets and standards:

Construction of a detailed plan document is usually worked out in phases. Long term goals are clearly stated along with the proposed steps necessary to carry them out. Any programs requiring several years must be stated in flexible terms.

It is at this stage that target setting and standard setting should be done. Targets set should be specified in quantitative terms and within a clearly stated time framework. Both should be realistic and based on general human responce and experience.

Stage 6: Implementation:

This is included as an integral part of the planning process. Plans produced should not be so complicated as not to be understood by implementers. They should have bearing on reality and must be acceptable. A plan which merely confirms existing conditions has the best chance for acceptance. The plan proposal should be such that it contains seeds of progressive change that the political leaders, health personnel and the public can accept. It is important to note that the probability of acceptance of plan proposals increases proportionately with the extent to which health personnel, political leaders and the public participate in the planning process. The balance between centralization and decentralization must be kept.

Stage 7: Evaluation:

This is an important part of the total dynamic process of planning which makes the whole exercise cyclic, with the evaluation step leading into the initiation of a new planning cycle. Essentially there are two types of evaluation:

(1) Continuing evaluation for administrative purposes.

(2) Periodic Evaluation: This type is more definitely related to the planning process. A centrally directed activity is set up with the primary purpose of quantifying achievement in particular planning periods e.g. every five years. This evaluation often goes beyond the mere measurement of achievements in terms of previous standards and targets. It concentrates on assessment of such basic issues as whether the original goals and objectives were in fact appropriate, whether resource development is actually moving in the direction most suited to local conditions both in terms of manpower and facilities, whether the priority setting was in fact justified and whether the data gathering system is producing useful information.

Health Indicators and Information:

Generation of health information is a complex process and the statistical support system within the ministry is very shallow. Due to shortage of resources for information system the need for adopting new approaches and the search for more practical effective and economic health measures and statistical methods should be emphasized.

Health indicators are designed to reflect the key objectives of the national health policy. It is by comparing available data with key indicators selec that we can point out the weak points in present data base and say what need to be done. Health indicators are an excellent means of promoting statis comparisons within our health facilities in the country. There has to be some consistency and standardization in the more basic tools of measurement

Definition of Health Indicators:

Health indicators may be defined as statistics selected from the larger pool because they have the power to summarize, represent a larger body of statistics or to serve as indirect or proxy measures for lacking information They are chosen because they are efficient and effective tools for planning, management and evaluation.

Indicators are usually expressed as percentages, rates and ratios so that the necessary comparison can be made. As a rule they represent or summariz class of data only e.g. mortality or morbidity and not the two together. Th indicators chosen should be simple to construct, interpret and used and also they should be less vulnerable to cross-cultural differences.

Some of the indicators useful for planning and evaluation include the follo

a) Survival/Length of Life:
   - Life expectancy at birth
   - Infant mortality rate
   - Child mortality rate
   - Maternal mortality rate

b) Diseases:
   - Incidence and prevalance of selected communicable diseases of maj health importance to the population.
   - Four major causes of death in order of frequency in age groups 0-4 5-14, 15-44, 45 and above.

c) Disability

- Persons with sick days per 1000 and the volume of sick days per 1000 during the past two weeks.
- Persons per 1000 with disabling and chronic diseases.
- Proportion of population resident in hospitals.

d) Growth and development of children:

- Proportion of low birth weight new borns (i.e. under 2500 grams).
- Proportion of children at specified ages less than 80% of index va[illegible] for weight and height.

e) Social and Economic Conditions:

- Population size, age structure, rural-urban distribution, rate of growth.
- Proportion of persons with less than the minimum food intake (calories and proteins).
- Proportion of households without adequate supply of safe water and basic sanitation.
- Literacy rates for female and male adults.
- Proportion of population with less than a specified income.

f) Health Services Coverage:

Number of health care personnel per 10,000 population by type and geographic area.

- Number of hospital beds per 10,000 population per geographic area.
- Proportion of population within a specified travel time to a health facility.
- Home care visits and number of persons visiting or visited per 1000 population per year.
- Hospital discharges and number of people discharged per 1000 population per year.

g) Health Services Financing:

- Proportion of GNP spent on health
- Ratio of expenditures for preventive/promotive services to expenditures for curative services.

h) Health Services Effectiveness:

- Infant mortality rate
- Maternal mortality rate
- Incidence and prevalence of treatable communicable diseases.
- Proportion of births attended by trained health personnel.
- Proportion of School-entry age children having completed basic immunization series.
- Incidence per 1000 births of neonatal tetanus.

PROCESS OF WRITING THE HEALTH CHAPTER FOR THE 5TH NATIONAL DEVELOPMENT PLAN

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PROCESS OF WRITING THE HEALTH CHAPTER FOR THE 5TH DEVELOPMENT PLAN

1. STEPS TO BE TAKEN

The steps outlined in this Chapter are not meant to be exclusive but a guide to the discussions in this session.

The first step should be to identify health and social institutions involved in the implementation of the health plan. These institutions include:-

(a) All health delivery facilities e.g. Hospitals, Health Centres, Dispensaries, Clinics including private clinics and the mobile clinics.

(b) Organisations (both Government and non-government) involved in implementations. Ministry of Health (MOH) departments and Units which will be involved in planning and implementation of the health chapter.

Within the MOH it is necessary to identify categorical programmes and health divisions which will be expected to participate and provide inputs for the plan. Such Units include Rural Health Services, Medical Research, Health Education, Nutrition, Health Insurance, Environmental Health etc. etc. Most of these Units are listed in details on page 8.

(c) Identify heads of Units and who will participate and provide proposals on how their Units will develop within the plan period.

2. SITUATION ANALYSIS

Situation analysis of the MOH organisation structure and its capacity and capability to effect the 5th Dev. Plan will be done: Evaluation of past achievements made in the previous health plans will be carried out as an attempt to appraise the Ministry's capability to implement plans and to evaluate its commitments to plans.

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3. DETERMINATION OF GOALS AND OBJECTIVES OF THE 5th DEVELOPMENT PLAN

3.1. The next step will be to re-define health goals and objectives and to make a clear policy statement on what is to be aimed at (long term and) during the next 5 years. The policy statement will help those involved in the writing of the health chapter to work out operational strategies. It will also help in setting up a mechanism through which most health providing agencies and the community can be involved in the planning and implementation of the health plan.

3.2. Re-examination of health measuring criteria will be made to facilitate realistic approach to the 5th national health chapter.

4. DETERMINATION OF MAJOR HEALTH PROBLEMS AND DEVELOPING ALTERNATIVE APPROACHES IN COPING WITH THESE PROBLEMS

4.1. Major health problems in the country dictates our choice of what must be done first with the little money that is available and thoose problems that can wait.

The list on page 8 (paragraph 6.11 to 6.21) will help in focussing attention to all major problems.

4.2. The exercise of identification of major health problems is most urgent now that the financial situation of the country is not very healthy. Health professionals, Administrators, Economists must join hands in identifying the health problems and in drawing priority lists of what must be done first. This is one of the most crucial exercise in planning.

4.3. Alternative Approaches

Having identified the health problems and having prioritized them, it will be necessary to work out alternative approaches or proposals in dealing with these problems. There are different ways of dealing with

health problems but some alternatives are expensive, inappropriate and difficult to implement. Consideration will be given to the shortage of both human financial and material resources when looking at the different options open to the MOH.

5. DETAILED PROCESS OF WRITING THE HEALTH CHAPTER FOR THE 5TH DEVELOPMENT PLAN

This is a brief summary of the steps required to facilitate co-ordination of the writing of the health chapter.

5.1. Setting up of the planning team

Formulation of the team responsible for the co-ordination in writing the health plan.

5.2. Data gathering mechanism

Gathering of data. A clear communication machinery must be established between the group co-ordinating the preparation of the plan and the existing vital health statistics Division. This is crucial because no planning can be done without health information.

5.2.1. Existing health information Division will provide some demographic data especially statistics on populations served by the existing health facilities as well as utilization patterns of these institutions. The Unit will also provide epidemiological data including mortality and morbidity patterns.

5.2.3. The Accounts Controller's office will provide financial dta.

5.2.4. Ministry of Finance as well as our P.F.E.O. and Deputy Secretaries responsible for development will provide budgetary figures and other figures related to expenditure patterns.

5.2.5. Economic data will be provided by the Central Bureau of Statistics and the Ministry of Planning and Economic Development. The latter will of course give MOH the parameters with which to produce the health plan.

5.2.6. Any information which is not obtained from agencies and health providers within Kenya Government or can be collected through questionaires or short surveys done by the MOH planning group.

5.3 TIME SCHEDULE

Time Schedule will be drawn covering the planning events and activities of the Ministry of Health with the time schedule already circulated by the MOPED. Without a time schedule it will be difficult for us to produce our chapter in time. For example, approval of the basic strategy for the 5th National Development Plan will be approved by cabinet in June 1982. In July 1982, a circular to all Ministries will be sent showing the summary of strategy tentative budget ceilings and district priorities. The MOPED already, has produced a paper showing quantative achievements for the last tean years. It (MOPED) has also produced a document defining basic needs sectors including the Health Sector.

These documents represent the view of the MOH and yet they have not been produced by the MOH or with proper consultation. Some of the views expressed are based on wrong assumptions which we in MOH could easily correct. But, if we do not draw up a time schedule and start working right away, MOPED will certainly plan for us and we shall be left to complain that what is planned for is not what we can implement.

5.4. CONSULTATIONS THROUGH MEETINGS

The next step will be to call a meeting - of all heads of departments, as well as in Provinces and Districts, major units and explain to them Ministry of Health's development policy as well as outlining the need to produce a realistic health plan. Heads of departments should be

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requested to contribute toward the health chapter and set a deadline for return of the proposals for the introductory chapter of their respective Units.

5.5. FOLLOW UP MACHINERY

The Planning group should set up a machinery for follow up action and provide technical help to the heads of Units who may need it.

5.7. Processing of the propposals submitted.

On receipt of suggestions or proposals from Units, the planning group should process and compile these proposals, seek guidance from the Steering Committee and compile the introductory chapter.

5.8. WRITING OF THE INTRODUCTORY CHAPTER

The introductory chapter will be circulated to all heads of departments for comments and information. After receiving comments and after amendments the introductory will be forwarded to the MOPED.

5.9. LIAISON WITH SECTOR PLANNING GROUP

Consultations will be held between the MOH and MOPED on the introductory chapters in trying to ensure that the MOH draft fits into the national goals and objectives. Consultation will Centre around MOH planning Unit and the MOPED sector planning group.

The Planning group will be collecting statistics and details of the first health chapter draft from Units and organisations while at the same time, they will be consulting MOPED to finalise the introductory chapter.

5.10. ANALYSIS OF DETAILS SUBMITTED BY UNITS

Analysis of details received from various sections will be carried out by the planning group. Continuous communication and consultations between heads of department and the planning group will be important. Several meetings will be called to discuss details

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already submitted and to seek clarifications on the details submitted by various Units. And MOPED on the introductory chapters in trying to ensure that the MOH draft fits into the national goals and objectives.

5.11. WRITING THE FIRST DRAFT OF THE HEALTH CHAPTER

The planning group will be collecting statistics and details of the first health chapter draft from Units and organisations while at the same time, they will be consulting MOPED to finalise the introductory chapter.

5.12. INTERNAL CONSULTATIONS BETWEEN PLANNING GROUP AND HEADS OF DEPARTMENTS

Analysis of details received from various sections will be carried out by the planning group. Continuous communications and consultation between heads of department and the planning group will be important. Several meetings will be called to discuss details already submitted and to seek clarifications on the details submitted by various Units.

5.13. DEADLINE FOR THE FIRST DRAFT

By December 1983, all drafts from various Ministries are supposed to have been completed and forwarded to the MOPED. That means, the health chapter will have to be completed latest by October 1982 so that it can be scrutini by heads of department and approved by the Steering Committee before submission to the MOPED. The health chapter should also be completed in time to allow the MOPED sectoral group to scrutinise it, call for amendments and approve it.

5 .14. LIAISON WITH DISTRICT

The Planning group will liaise with the Health Officers in the field where implementation will be done.

5.15. CIRCULATION OF THE FIRST DRAFT.

After the completion of the first draft, it will be circulated to all Units for comments and suggestions or amendments. Meetings will be called to make corrections and to write revise draft. There will be liaison between the MOH planning group and the sectoral planning group of the MOPED so as

to facilitate smooth flow of information during corrections of the drafts.

5.16. COMMENTS

Comments on our revised draft from the MOPED will form the basis of writing the second draft.

5.17. CIRCULATION OF COMMENTS

As in the case of first draft the second draft will be circulated and discussed widely by all departments. It will be approved by Steering Committee before it is submitted to MOPED - again for comments.

5.18. At this stage the MOH planning group and the MOPED Sectoral Group will almost work as one Unit because of the constant and continuous consultations between the two. Views of the MOH will not necessarily coincide with those of the MOPED and to fit in MOH views and opinions as well as all health programmes of the health Sector to the national plan is something that will require for compromise and "trade offs" between the

5.19. NEED FOR FULL PARTICIPATION OF MOH OFFICERS FOR REVISED DRAFT

The MOH revised draft is expected to be circulated widely as well as being forwarded to the MOPED before March 1983 - to allow sufficient time to get comments from the MOH Units in the field. Because of the dissegregation structure of the MOH, it will be necessary to consult all officers and to get realistic comments for the final draft. A lot of meetings will be held to facilitate discussions and clarifications.

5.20. MECHANISM REQUIRED FOR RECONCILIATION WITH BUDGET

The number of projects and programmes forwarded by Heads of Departments for inclusion in health chapter will probably exceed the forward budget allocated. For that reason, some reduction in expenditure will result in obvious disagreements. a

A machinery for resolving these conflicts will be required.

5.21. FINAL DRAFT

The MOH final draft is expected to be ready by June 1983. The dates shown here are tentative and will be changed depending on the situation. The number of MOH departments to be consulted are so many that one cannot provide an inflexible time schedule on them. For example some of these Units include.

6. LIST OF AGENCIES & UNITS TO BE DEALT WITH

6.1. Rural Health facilities increase: 1970-1982.

6.2. Local Government Health facilities - situation. Last 5 years.

6.3. Hospital Facilities: 1970-1982.

(i) Church Hospital and Beds. 1970-1982.

(ii) Government Hospitals and Beds. 1970-1982.

6.4. Manpower situation in 1970-1982.

i) All types of manpower

ii) Facilities for manpower Training 1970-1981.

iii) The Rural Health Project.

iv) National Family Welfare Centre Programme.

v) Research.

vi) Organisation for Commonwealth countries in Central, Eastern and Southern Africa.

vii) Itegrated Rural Health.

6.5. Health Education Unit.

6.6. Environmental Health Programme. (Status) 1981.

- Improvement of environment 1970-81.

(i) Small Scale water supplies Schemes - 1970-81.

(ii) Water quality monitoring Central Programme.

(iii) Disposal of Wastes.

(iv) Food Hygiene and food safety.

(v) Health Education.

(vi) Promotion of research and development of surveillance system.

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vii) Training Public Health Officers & Technicians.
viii) Staff requirements.
ix) Transport requirements.
x) Equipment needs.

6.7 Nutrition. Status 1970-1982

i) Nutritional Surveillance.
ii) Treatment and Rehabilitation.
iii) Nutritional education.
iv) Technical advisory service to schools and other institutions.
v) Training of Nutritionists and field workers.
vi) Construction programmes.
vii) Research.

6.8 Communicable Disease Control Programme 1970-1982. (Status)

i) Major Communicable Diseases.
- Anthrax
- Cholera
- Diptheria
- Dysenteries
- Influenza
- Leprosy
- Measles
- Meningococcal Meningitis
- Whooping Cough
- Poliomyelitis
- Rabies
- Small pox - eradicated
- Tetanus
- Trachoma
- Tuberculosis

ii) Control Methods
- Treatment of cases
- Case finding and follow up.
- Improvement of personal hygiene in homes, houses etc.
- Health information and education.

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iii) Programmes covered for 1970-82

- Health Information system. (Achievements and constraints)
- Epidemiological surveillance and control of diseases.

iv) Immunization Programmes 1978-83
KEPI - (status).

6.9 Vector-Borne Disease Control Programme - (Status)

i) Major vector-borne Disease.

- Bilharzia (Schistosomiasis)
- Coastal area, Lake Victoria, Tana River. (Status)
- Filariasis - in Coastal belt
- Hydatid Disease - Turkana and adjacent areas.
- Kala-azar - Machakos, Kitui and other lower drier ar
- Malaria - Widespread but mainly in Coast, Lake Victc Basin etc. etc.
- Trypanosomiasis - Lambwe Valley.
- Plague-report status.
- Anchocerciasis-has disappeared from Kenya.
- Arbo-virus Disease-status.

ii) Staff requirements.

6.10 Municipal or Urban Health Services.

Grants to Municipalities
Capital expenditure.

6.11 Curative Health Services (1970-82)

- District Hospitals.
- Provincial Hospital
- Amenity Annexes to Provincial and District Hospitals
- Kenyatta National Hospital
- Psychiatric Hospitals.
- Hospitals and mobile Dental Units.
- Church Hospitals.
- Other H spital and related Institutions.

6.12 SUPPLIES AND EQUIPMENT

- Medical Stores & Supplies (Regional Stores)
- Drug Inspection Unit
- New drug supply system
- Hospital maintenance Units.
- Drug quality control (Status.

6.13 Hospital Insurance Fund. Schme Status 1970-82

6.14 International Health Co-operation.

- United Nations - WHO, UNICEF, UNDP/UNFPA. Internat Atomic Agency.
- International Development Association of the Worl Bank.
- Bilateral and Multilateral Co-operation.
- European Economic Community (EEC)
- Commonwealth Medical Co-operation.
- African Development Bank (ADB).

DRAFT INTRODUCTORY HEALTH CHAPTER

FOR THE

5TH NATIONAL DEVELOPMENT PLAN

1983/88

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DRAFT INTRODUCTORY HEALTH CHAPTER

FOR THE

5TH NATIONAL DEVELOPMENT PLAN

1983/88

NYERI DISTRICT HEALTH TEAM

AUGUST, 1982

NYERI DISTRICT PROFILE

1.1 SIZE AND ADMINISTRATION:

Nyeri district is the largest of the 5 districts of Central Province. It is situated between Mt. Kenya to the east and Aberdare mountain range. The land area is about 3284 sq. km extending from 36° 37'E to 37° 15'E and lying between 0° 00's and 0 37's latitudes. It is bounded by Laikipia District to the North, Meru and Kirinyaga Districts to the East, Murang'a to the South and Nyandarua to the West (See Map. 1).

It is divided into 6 administrative divisions, which are further sub-divided into 21 locations as shown in Table 1.1.

TABLE 1:1 Administrative Sub-division of Nyeri

DIVISION	LOCATIONS	SUB-LOCATIONS
Mathira	5	36
Tetu	4	43
Mukurweini	4	23
Othaya	3	25
Kieni East	2	8
Kieni West	2	10
Municipality	1	6
	21	151

1.2 URBAN AREAS

Nyeri Municipality includes the Nyeri Town, Mathari Sattelite town, Ruring'u sattelite town, and Kiganjo sattelite town, whic has a railway station but about 8 km from the main town. Civic functions are carried on by the Municipal Council. The total population in the Municipality is 35,753. Karatina Urban area has a population of 2,980. It is situated on the Nairobi-Nanyu Road and has a railway station. This town is conducive to industrial development with agricultural orientation.

Othaya township has 2,159 people (area 2 sq. km). It has piped water, electricity, tarmac road connection, but no railwa Othaya is the township of the rich coffee-tea-dairy farming are

a high figure for use at Nyeri District and it is, therefore considered appropriate to take the followings into account for projections shown in the schedule during the plan period:-

(a) The present workload in the dental Unit at the Provincial General Hospital, Nyeri and the whole Province since the personnel attached to this Unit also is expected to cater for the other Districts in the Province.

(b) The operations and facilities at the new dental Unit when completed and becomes fully operational.

Dental Officers (interns) and dental technologists (students) are considered temporary personnel for the purpose of their training and as such they are not included in the projection schedule.

Clinical Officers:

The national projection ratio of 10.56 clinical Officers per 100,000 population as at 1980 is considered appropriate. Using this criteria, the projections shown on the schedule takes into account the followings:-

(a) Present and future workload at the Provincial General Hospital, Nyeri, Caltex Home and Mt.Kenya Hospital.

(b) Proposed improvement and subsequent upgrading of at least 12 Dispensaries to the grade of Health Centres status during the plan which will require a clinical officer at every centre.

(c) Proposed Othaya and Mukurweini Sub-District Hospitals during the plan period.

(d) Leave and sickness.

6.9 RESEARCH

The Kenya Medical Research Institute (KMRI) was responsible for co-ordination of medical research in the country and its efforts were mainly directed towards communicable and vector borne diseases control and promotive research in traditional medicine. No research activity was carried out in this district during the current development plan. This was rather unfortunate because although Nyeri has no Kala-azar, Bilhazia, sleeping sickness and, leprosy is not a major problem; Diarrhoea diseases in children , cardiavascular disease, metabolic disorders and mental health are major problems. The use of Agricultural chemicals is also widespread in the district and studies should be done to determine their harmful effect in the community.

The transfer of KMRI to the Ministry of Science and Technology may probably mean less effor spent on Medical Research.

All districts should actually participate in Medical Research. For this to be possible it may be necessary to decentralize the function of KMRI and formation of District Research co-ordinating teams.

The following should be considered as providers for Medical Research in Nyeri:-

(1) Communicable Disease - TB, Leprosy and Diarrheal diseases in children.

(2) Non Communicable diseases - Cardiovascular Diseases metabolic diseases.

(3) Mental health - Repression, Alcoholims and Drug abuse.

(4) Harmful effects of Agricultural chemicals used in spraying of crops and storage of food.

North, with the former averaging 1000mm per annum, but the latter much less 400 - 600mm per annum. This rain falls in 2 rainy seasons, which conform to the country-wide pattern, i.e. long rains March - May and short rains October - November. Kieni West and Kieni East are dry and have prolohged drought. The slopes of the two mountain ranges have much cooler and wetter climates which encourage forest fauna although at uninhabited levels of elevation.

1.5 FORESTS

The Nyeri Forestry Division has 166,252 ha under gazetted forest area comprising of Aberdare forest (Kiandongoro, Kabage and Zaina) 35,604 ha. Mt. Kenya Forest, about 89,460.8 ha (Hombe, Ragati, Kabaru) and Nyeri Hill 192.1 ha. This forest area includes areas of Meru, Laikipia and Kirinyaga districts. Other areas covered by forest are Nyeri Forest 1135.43ha, Muringato (25.10 ha), Southern Laikipia (3472.2 ha) Kiganjo (323.3 ha) Ngare Ndare in Meru District (5554.3 ha) Mukigondo (30189.5 ha) and Timau (295.4 ha). The Aberdare and Mt. Kenya Forests also include the world famous National parks of corresponding names for conservation of wild life. Apart from forests, water and land, the district has no other natural resources. Building stones are, however, widespread and quarries to exploit them are many.

1.5 LAND USE

The district has high agricultural potential with considerable cash crop development. On the basis of the rainfall, temperatures, soil types, land can be divided into 3 categories (excluding forest areas).

(a) High potential - about 175,000 ha. This is found in Tetu, Mathira, Othaya and includes forest areas.

(b) Medium potential - about 42,000 ha. These are found in parts of Kieni West, Kieni East, Northern Tetu and southern Mukurweini.

(c) Low potential - about 42,000 ha. Northern parts of Kieni West, Kieni East and the ragged mountain tops (see map 4).

Agriculture is the main productive activity in the district. The farms can be classified into 4 categories;

(a) Small holdings: (from 0.4 ha to 8 ha). They are found in Othaya, Mukurweini, Tetu and are either on food production, cash crops (tea, coffee) or mixed with dairy farming. zero grazing concept has taken root in this area and intensive farming with fertilizers, pesticides and insecticides is very popular.

(b) Large farms (20-2000 ha) mainly in Tetu and under coffee or dairy farming.

(c) Co-operative Farms - (average size 693 ha) mainly for dairy farming and ranching in both Kieni.

d) Ranching - (average size 475 ha) mainly in Kieni division

1.6 Other Activities: The co-operative movement is well established with 76 cooperatives registered. Nyeri District Union is by far the largest society with 21 cooperatives affliated. These societies assist farmers with agricultural inputs, marketing and distribution of produce.

Trading activities are spread all over the district with pockets of concentration in Nyeri, Karatina, Othaya and other divisional headquarters. The trades involve wholesale and retail of textiles, tailoring, hardware, motor vehicle accessories, hotels, farm produce, cash crops like tea, coffee and pyrethrum. Import/Export business is minimal.

Manufacturing activities are found in Nyeri, Karatina and Kiganjo. These include sawmilling, soft drink bottling, oil milling, bread production, diary products, block making and building construction. The activities of Kenya Industrial Estates are just beginning.

1.7. POPULATION

The 1969 population cnesus showed that Nyeri District had 360,845 people living on 3284 sq. km (109.9 people per sq. km). A population census in 1979 showed the population to have risen to 486,477 people (148.13 people per sq. km). The growth rate between 1969 and 1978 was 3.43%, however, the growth rate since the 1979 census has been corrected to 3.83% per annum. The population projections are summarised in Table 1.7.1.

TABLE 1.7.1

1.7.2 RURAL /URBAN POPULATION

The urban population is growing fast as a result of (a) migration from rural to urban areas and (b) population growth in the urban areas. In 1969 the rural population was 96.6% but dropped to 93.8% by 1978. The 1969 census showed 3 centres with population in excess of 2000 but 1979 census showed the number to have risen to 7 namely: Nyeri, Karatina, Othaya, Mweiga, Mukurweini, Naro moru and Kiganjo (see table).

Table 1.7.2 URBAN POPULATION

TOWNSHIP	POPULATION	AREA SQ. KM	DENSITY
Nyeri Municipality			
Karatina			
Othaya			
Mukurweini			
Mweiga			
Kiganjo			
Naromoru			
TOTAL			

(1979 Census)

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The projections of the Urban population is shown below:
Table 1.7.2B.

	URBAN POPULATION 1969	1979	PROJECTION 1985	2000
Nyeri Municipality				
Karatina				
Othaya				
Mukurweini				
Mweiga				
Kiganjo				
Naro moru				

1.7.3 Population Distribution

The most productive land is in the southern 1/3 of the district comprising of Tetu, Othaya, Mathira and Mukurweini divisions. This represents an area of 1,055 sq. km. The total population in this area is 406,173. In other words 83.5% population is living on 32.1% of the land to the south of the district. This part is overcrowded (385 people per sq. km), and is under intensive mixed farming. Practically all land in this area is under food or cash crop production. In contrast the northern 2/3 of the district (2,229 sq. km) is sparsely populated (36 per sq. km) and holds 16.5% of the people in the district. Vast areas of land are mainly for ranching. Population distribution is summarised in Table 1.7.3.

TABLE 1.7.3. POPULATION DISTRIBUTION

Division	Male	Female	Total	Area Sq. km	Density
Kieni E.	19,777	19,116	38,893	488	79
Kieni W.	20,536	20,875	41,411	546	75
Tetu	66,969	71,057	138,026	382	360
Othaya	32,454	36,046	68,500	170	401
Mathira	60,824	66,535	127,359	324	392
Mukurweini	33,845	38,443	72,288	179	402
District	234,405	252,072	486,477	3,284	148

1.7.4. POPULATION DEPENDENCY

The productive age group 15 - 59 years accounted for 42.3% of the total population in 1978 giving a dependency ratio of 1 to 1.3. This ratio may have remained the same

as the district was estimated to have 250,000 in the productive age group by 1983 (see Table 1.7.4)

Table 1.7.4 Population Projections for Nyeri by age group: These figures are from Prof. R.A. Heim, University of Nairobi.

Age	1978	1979	1980	1981	1982	1983
0 - 4	114,000	112,000	116,000	121,000	126,000	130,000
6 -12	108,000	46,000	48,000	50,000	52,000	54,000
13 - 16	44,000	216,000	225,000	234,000	243.000	250.000
15 - 59	207,000					
60 +	24,000	25,000	26,000	27,000	28.000	29.000

1.8. Social - economic situation

Nyeri is essentially an agricultural district with the majority of the people tied to farming activities. The farming is mainly of the small-holder type. (The major farming characteristic is mixed farming. About 62,229 families are engaged in farming. People in town live mainly in shanty dwellings and are poor as onntransted to people in tradition divisions of Tetu, Mathira, Othaya, Mukurweini). These people are also richer than those living in newly settled divisions of Kieni West, Kieni East, where clean water or sanitary facilities are almost non-existent. The latter group has just settled on cooperative-bought farms and is in the process of establishing themselves an economic base, notwithstanding the poor agro-ecological conditions prevailin in the area. They are not wage earners and most of them are displaced people after the Mau-Mau Emergency era of the 1950s.

1.9. Communications

The road network is well developed in the district with 1,216 km of classified roads and 776 km of unclassified roads. All major towns are united by classified roads. Trunk road from Nairobi passes through Nyeri to Nanyuki. Within the natural terrain the District roads system has been laid in an integrated manner through the Rural Access Roads Programme, which started in 1975.

Activities of this programme have been confined to Mathira, Tetu, Othaya and Mukurweini Divisions in order to open agriculturally potential areas on small holders and connecting them with the existing roads for easy transportation of their produce.

A few airfields and strips (private and public) exist in the northern drier part of the district. These are occassionally used by the flying doctor service. Electric Power is being generated in the neighbourhood of Nyeri District at the Tana River. The southern half of the district is well supplied with electric power. Other parts use local generators.

The district has 7 post offices and 10 sub-post offices. There is an automatic telephone exhhange with a capacity of 1000 connections. By 1979 Nyeri had over 1890 existing line capacity. There are also manual Telephone exchanges at Othaya, Mukurweini, Mweiga, Narumoru, Kiganjo. Karatina has automatic telephone exchange. All our health centres are connected.

1.10 WATER DEVELOPMENT

Water is available in Southern part of the district from rivers and streams, but it is far from the consumption areas. The Rural Water Projects in the district have been focused in Othaya, Mathira and Tetu, ironically the divisions which are wet where about 90% households are less 3 km from water source and about 40% households have piped water. The Kieni area has almost no water projects, the rivers are rare, and rainfall scanty. The following water projects are, however, noteworthy:-

1. Naro Moru Water Project
2. Gathaithi Water Project
3. Endarasha Water Project
4. Ruthanji-Njiruini Water project
5. Labura Water Project
6. Kiawaithanji Water Project
7. Ithekahuno Water project
8. Ihari water project
9. Gacatha water project
10. Nyeri Municipal water supply does not meet the present

demand of the growing population although working above optimum capacity.

11. Karatina water supply is too small to meet the growing demand of this industrially oriented township.

The demand for water in rural water supplies is increasing and these are therefore facing problems of water shortages. The projects have proved to be very ~~inadequate~~ inadequate to meet the requirements of the growing population.

Large scale irrigation schemes are non-existent in the district due to unfavourable terrain. However, most of the Kieni East and Kieni West are flat and most suitable for irrigation projects. This is subject to availability of water. The 3 small irrigations at Mweru (Mukurweini), Iriani-Kiangaru, and Iriaini-Ihwagi (Mathira) cover only a mere 200 acres and are under horticultural production.

In conclusion, the water supply in the towns and rural areas has been ~~xx~~ overtaken by the rapid growth of Urban centres and population in the District.

2.0 HEALTH PROBLEMS IN NYERI DISTRICT

As in other parts of this country Nyeri District has a fast growing natural increase of population, resulting from an increasing crude Birth Rate and a decreasing Crude Death Rate. The result is a young population, where 49% of the population is under 15 years (National Figures, Population Reference Bureau 1979).

The health problems are likely therefore to be associated with young population. The population at risk can breadly be considered to have 3 target groups:-

a) The 0 - 1 yr population
b) The women of the childbearing age
c) The 1 - 5 year age group

Infections and parasitic diseases, occupy large portion of the hospital morbidity figures. Diseases of the digestive system are also important. Cardiovascular diseases, (especially hypertension), endocrinal disorders, malignancies and eye diseases are also important. Malnutrition, problems of maternal child health care (high infant mortality, large families, childhood infections, morbidity associated with childbirth) are prevalent.

Shortage of running water and proper sanitation accounts for considerable morbidity (e.g. gastroenteritis) especially in the hot drier northern part of the district. Mental illnesses (schizophrenia, other psychosis, neurosis) are fast becoming a problem. There is shortage of manpower for this work.

The available hospital facilities are over used (inpatient and outpatient) resulting in overcrowding. There is need to emphasise as previously, on preventive measures through birth control, environmental hygiene (schools and other public places) nutritional hygiene, enhanced immunisation programmes, and publi health enlightment of the population. As for mental health, organisation of psychiatric services is necessary. To reduce the overcrowding in hospitals some dispensaries should be upgraded to health centres, and some health centres to hospital status.

There is a need to establish a survaillance service to monitor possible adverse effects, on human and ecological life, of pesticides, insecticides, coffee factory chemical and others, whose use is growing fast due to increased intensive farming.

3.0 HEALTH POLICY TO BE ADAPTED WHEN PLANNING

The guidelines as given by Director of Medical Services to be used while planning are:

3.1 BUDGET ON DEVELOPMENT AND RECURRENT

a) Increase the share of primary, preventive and promotive health budget.

b) Accelerate construction of more rural health facilities with bias to less served areas.

c) Strengthen and improve rural health programmes.

d) Allow only completion of hospitals already under construction and those where funds are committed, and use funds thus available to construct rural health facilities

3.2 PRIORITY PREVENTIVE PROGRAMME

a) Expand immunisation programmes

b) Introduce school health programme focus on hygiene, nutrition and family planning.

c) Expand programmes on environmental sanitation.

d) Expand and strengthen mental health programme.

e) Strengthen health information and education programme.

f) Medical Research to be geared to evolving better ways of preventing major epidemic diseases.

g) Medical Research to study traditional medicine and integrate appropriately the findings with accepted general medicine.

3.3 MANPOWER

a) Strengthen the provincial and district health teams.

b) Introduce and expand community based health care.

c) Establishing specialist training in provincial hospital

3.4 Health Planning.

a) Strengthen the rural health development unit

b) Planning unit to monitor development in District by establishing an evaluation unit within the District.

3.5 Supplies

a) To establish a ~~hmpsi~~ hospital maintenance unit, The ground work for such unit has been laid in Nyeri district

b) Explore better methods of distribution of drugs to rural areas, e.g. prepacked consignments, building of a local Central Medical Store.

c) Standardise drugs used in health institutions

3.6. Family Health and Planning

a) Strengthen information component of the programme.

b) Integrate and coordinate all interested agencies.

c) Increase facilities and manpower for Family Planning.

4.0 ACHIEVEMENTS IN THE PREVIOUS DEVELOPMENT PLAN (1979-83)

Fairly good health facilities exist in the District as most of the population benefits from medical services. The health facilities are provided by the government, church missions, private institutions and individuals. The Government provides free services through a net-work of Rural Health Units (RHU). The Integrated Rural Survey showed that by 1979 9% households were over 12 KM from the Health Facilities, whereas 18% were within 3 KM. This shows that 27% of the house-holds are within the distance ranging from 3 KM to 12 KM amd the rest travel more than 12 KM. This accessibility data is pertinent to the populous divisions of Tetu, Othaya, Mathira, and Mukuruweini only. Both Kieni Divisions are worse off. This indicates that the available health facilities are not yet within the effective reach of the rural population. This is borne out by the underutilisation of Health Centres particularly in Kieni East and West. This is also partly due to lack of information on how to utilize properly the available preventive/curative facilities and also inadequate personnel, medicines, equipment (e.g Laboratory facilities), e.t.c. The environmental health and education continue to develop and strengthen, so that the beneficiaries of these public health services are increasing.

4.1 HEALTH FACILITIES

A number of these facilities were planned for in the previous development period, some of which were accomplished. Unfortunately, many more were not completed or started. The Ministry had planned to spend £2,309,500 over a period of 5 years ending 1983.

4.1.1 HOSPITALS (Development Budget £1,897,000 over 5 years)

Before the last development plan period (1979 - 1983) there were 871 hospital beds, which were very inadequate, causing congestion in all hospital sections, but especially the maternity section. One of the objectives of the previous development plan was, therefore, to increase bed capacity by expanding Provincial General Hospital and upgrading 3 of the of the Health Centres (Karatina, Othaya, Mukuruweini) to hospital status.

1) NYERI PROVINCIAL GENERAL HOSPITAL (Planned Development Budget £1,697,000).

The number of Out-patients attending the P.G.H. in 1978 was 194,268 with 321012 revisits. This figure had enormously grown out of proportion by 1981 to 1,196,169 new cases and 980,610 revisits. The total admissions for 1978 was 14,281 but by 1981 was 16,148 (13.07% increase. See Table 4.1.1 (i)

	1978	1981	% Increase
New Outpatients	194,268	1,196,169	515.7%
Revisits	321,012	980,610	205.5%
Total Admissions	14,281	16,148	13.07%

The plan of the previous development plan had set aside K£1,697,000 spread over 5 years aimed at:-

1) Expanding the outpatient department at the Provincial General Hospital which should include (X-ray, pharmacy, and dental services)

2) Expanding the bed capacity by building a new maternity wing with 50 beds.

3) Including a ward block to increase bed capacity from 297 to 800.

4) Building an administration block.

5) New Kitchen Laundry complex
6) Building a new mortuary
7) Building New Staff quarters and increase Water Supply.

Expansion of the OPD is almost complete but not operational due to lack of funds. Premises for the other services (X-ray, pharmacy, laboratory) are needed to ease the congestion. Since the outpatient has grown 500 times, it seems that even after completion of these facilities overcrowding will not be eliminated. The construction of ward block has not started due to lack of funds. The wards, therefore, remain congested. It may be necessary to plan other hospital facilities in the district in order to ease the overcrowding.

Administration block has not been built again, due to lack of funds. The maternity wing is not also completed. The Kitchen - Laundry complex has been started but not completed due to lack of funds.

A new mortuary has been completed with facilities for refrigeration and a capacity of 24 bodies. As for Staff-quarters, 4 complexes for doctors with 12 flats have been completed and are already occupied. Housing for Doctors, other Senior and Junior Staff still remains inadequate. Water supply has been improved by commissioning early 1982 of a reservoir tank of 60,000 litre capacity at a cost of .....

ii) KARATINA HOSPITAL (£140,000)

A sub-district hospital with 70 beds and 11 cots was planned and has been completed. This hospital is now fully functional, but needs additional doctors and other staff's houses.

iii) OTHAYA HOSPITAL (K£60,000)

A similar Sub-district hospital was planned to replace the health centre. A doctor's house has been built already.

There are 6 flats for Nursing Staff. However, the construction of the hospital itself has not been started due to lack of funds and land demarcation problem. The latter problem has lately been solved. By 1979 the Othaya people had contributed over Sh. 1. million on Harambee basis for expansion of this facility.

iv) MUKURUWEINI SUB-DISTRICT HOSPITAL (Not budgeted for)

Construction has not started due to lack of funds. Planning and construction of Doctor's (two) and other Staffs' quarters is essential. This facility requires upgrading to sub-district hospital level.

4.1.2 HEALTH CENTRES (Total improvement Budget £271,500)

The previous plan intended to pursue the concept of Rural Health Unit and Rural Health Team which represents concerted government efforts to providing better facilities to rural communities with a more respohsive and cost effective service system. Each Rural Health Unit was to serve 50 - 70 thousand people. In addition to the existing 6 Health Centres, 9 more health centres or sub-centres were planned. A unit was to be eligible for sub-centres where there are 4 dispensaries. Out of the 9 planned, none has been completed, 3 are under construction, and six have never been started (see Table 4.1.2.). The reasons for failure are indentical for all of them: Lack of funds. There was no Ministerial budget for new health centres.

TABLE 4.1.2. HEALTH CENTRES PLANNED 1979 - 1983

Division	H/C	Status	Population
Mukuruweini	Njoki	Under construction	
"	Karaba	"	
"	Gumba	"	
Mathira	Gatei	Never Started	
"	Hombe	"	
Tetu	Gicira	Has had Harambee Fund raising	
"	Wandumbi	Never Started	
Kieni West	Bellevue	"	
Kieni East	Naromoru	"	

4.1.3 DISPENSARIES (Improvement Budget was £141,000)

As stated earlier 27% of the households in 1979 were within 12 Km from a health facility, which means that 73% of the households have to walk over 12Km. Therefore, all the available health facilities are not within the effective reach of the rural population. Hence, people could not make the proper use of the preventive curative facilities. 5 more dispensaries were planned at Witima, Mere, Mugunda, Ihuririo and Iohamara. All of them have been completed and are functional. However Catholic Mission Nutritional Centre at Bellevue, which was operational before, has not been re-opened as planned.

4.1.4 MOBILE CLINICS

At the beginning of the last development plan there were only 5 Mobile Clinics operational. It was intended that every Health Centre will be able to operate at least 3 mobile clinics per month. This has been accomplished so that all 6 Health Centres and P.G.H. operate at least 3 mobile clinics per month, giving an average of 240 mobile clinics per year. However, occassionally these mobile clinics are halted either due to lack of fuel or transport break down.

4.1.5 HARAMBEE CONSTRUCTED HEALTH CENTRES

The following sub-health Centres were to be built mainly on Harambee basis: Gumba, Karaba, Njoki, Thangathi, Witima, Ujiru. The work has started on all of them, but none has been finished. Currently, others have been proposed at Gatei, Gicira, Naromoru, Island Farms, Mugunda, Ihuririo. The main problem has been lack of funds.

The overall picture of Health facilities in the District is summarised in Table 4.1.5.

TABLE 4.1.5. HEALTH FACILITIES NYERI DISTRICT

INSTITUTION	GOVERNMENT	MISSION	PRIVATE	TOTAL
Hospitals	2	2	-	4
H. Centres	8	3	-	11
Dispensaries	36	7	-	43
Maternity Homes	-	-	5	5
Total	46	12	5	73

4.1.6. ENVIRONMENTAL HEALTH PROGRAMMES

The last development plan noted that hospital morbidity was mainly due to infectious diseases especially gastro-enteritis. The environmental health and health educatio was to be enhanced in order to reduce morbidity. In particular, rural water supplies, waste disposal, food sanitation and general hygiene were to be improved. Improvements and construction of slaughter houses/slabs was planned to be undertaken by the Local Authorities.

i) WATER SUPPLY

Water is available in most parts of the Southern half of the district, flowing throughout the year in permanent rivers and streams, but it is far from the main consumption areas. It has been roughly estimated that 90% of the households are under 3 Km from the source of water but the position changes in dry weather (1978). 40% of the households in the district had piped water under rural and urban water supplies in 1978. The plan was to raise this percentage to 60 by 1983. However, the figures available of the present situation seem to show that only 20% of the population has access to clean water.

The Ministry of Water Development's Programme in the District entailed operation and maintainance of the 5 urban water supplies, 4 rural water projec and many other self-help rural water projects. The Ministry of Health in conjuction with self-help groups undertook to supply water to health institutions and some schools.

a) Nyeri water supply is a full treatment water supply now serving 35,753 people. It has 2 intakes: one by gravity from Ihwa river and the other by pumping from Chania river. By 1978 the pumping capacity had increased from 288cm^3/day to 3600cm^3 with the treatment plant working above optimum capacity. Even then the water shortage was not eased and there were frequent breakdowns due to overworking of the booster pumping sets. Consequently, a long term plan was undertaken at a total cost of K£2714.5 spread over 4 years to improve the situation. This plan, although at an advanced stage has not been completed

b) <u>KARATINA WATER SUPPLY</u> (present population 2,980)

This old full treatment without filters, was unable to serve adequately its population in 1978 inspite of installation of bigger pumping set capable of delivering 18M^3/hr. By then it had 600 metered connections. The Ragati line was augmented with a 50MM. Under minor urban water supplies, Karatina was allocated K£145,000 for further development so that the capacity may serve 57,000 people. This programme is near completion. The long-term 2 million package treatment plant for Karatina is also on progress.

c) Kiganjo Water Supply was also working over capacity resulting in frequent breakdowns. It had 216 metered connections. It was to be improved under the same programme. The details of the present situation are not available

d) Othaya Urban Water Supply which had 161 metere connections by 1978 has now been merged with the Othaya Rural Water Supply so that at the present water needs seem to have been supplied

e) Mukuruweini and Mweiga Water supply plans seem to have been accomplished so that these towns now have no water problem.

f) Naromoru Water Project has now been completed and is serving the whole Naromoru settlement scheme. The gravity trunk and two 135M^3 storage tanks have been completed. The distribution lines were started in 1978 however, water rationing is still common.

g) Other important rural water projects that have been completed are Gathaithi (two reservoirs 130M^3 and 90M^3 for £2500) Endarasha Water Project, Ruthanjiiri/ Njiruini (90M^3 storage tank), Laburia, Ihari, Ithekahuno (£2500) and Gacatha. However, water rationing is common to all of them.

Water survey general and water pollution control had been allocated £115,750. National Master Water Plan studies and sub-surface water survey were also allocated £226,000 and 161,250 respectively for the whole Central Province. It is difficult to say what has been accomplished in this district.

The efforts of the Ministry of Health were directed towards small water supplies (especially to rural health facilities) as well as provision of roof catchment to schools. A total of 43 Primary Schools were supplied with rain water tanks. Total planned budget was £25,000.

ii) SEWAGE DISPOSAL

Nyeri Municipality sewage is semitreated. The sewarage system had not covered the whole Municipality. There was a plan for improvement and construction has just started. However, even now probably the sewage system when complete will be inadequate and may not cover the whole town. major area of the town utilises Septic Tanks. Karatina has also a sewarage system, together with Kiganjo. The other urban areas and market places have to use Septic Tanks.

As an incentive on proper pit latrine construction and provision in homesteads the MOH made and provided 210 Choo-tops to Kieni East, where digging of Pit Latrine is difficult due to the soil structure. This programme is to be extended to such needy areas of Gathiuru, Kahururu, Naromoru settlement Scheme and Endarasha.

Refuse collection exists in Nyeri and Karatina but is not satisfactory. No other urban/market places have adequate refuse collection system (Ministerial budget was about £30,000).

4.1.7 FOOD SAMPLING AND FOOD INSPECTION

Inspection of trade premises, hotels, for maintanance of good standards of hygiene is pursued according to the Public Health Act and implemented through the Rurral Health Unit. With the establishment of National Public Health Laboratory (NPHL) Nairobi, this field of Public Health received a lot of emphasis. Under its auspices the District Public Health Office held meetings with Health personnel in many Rural Health Units highliting the new Food, Drugs and Chemical substances Regulations 1978.

Continuos monitoring of food to establish manufacturers complaince with the Law and to ensure that the Public

..... will receive further attention. Emphasis will be on food quality control, mycotoxin and bacteriological analysis; Cheminals and additives to food and proper labelling of the commodities.

Inspection of food plants will be intensified with continuos Education of Public through barazas. Budget for running vehicles was £6,428 for the plan period.

4.1.8 COMMUNICABLE AND VECTOR CONTROL

The Government's main objectives included among others Vector disease control, immunization against disease and early detection and treatment of diseases.

There is no Vector borne disease specific for this district and hence no major activity was planned. However, whooping cough, polio myelitis, diptheria, tuberculosis are prevalent. The compaign for vaccination against these diseases has been very active. Small-pox has already been eradicated as in the rest of the country. Vaccination against tetanus had covered about 37% of all mothers attending antenatal clinics by mid 1980. By the end of 1981 this percentage had risent to about 90%. For this reason, and the fact that 95% mothers deliver in clean health institutions (Mid 1981 survey) neonatal tetanus has not been registered in Nyeri for the last 3 years.

There are about 130,490 visits to child welfare clinics per year throughout the district (Mid 1981Survey). Vaccinations recorded were BCG 28,884, DPT 25,350 and Polio 22,432. The babies born same period was 14,691 meaning that this campaign covered babies born outsid the district. Inspite of this active campaign there were 1,032 cases of whooping cough, 52 cases of acute poliomyelitis, 7,318 cases of measles, 42 cases of tuberculosis and 10 cases of a dult tetanus. The rate of measles is alarming (almost 50% children born)...

but this may have something to do with the quality, storage and adminstration of antimeasles vaccine. There were 44 cases of leprosy. Surveillance and treatment of cases of tuberculosis and leprosy is guided from the M.O.H. Headquarters through the Cotulep.

4.1.9 SPECIFIC DISEASES VECTOR CONTROL

Bilharzia, filialiasis, leishmaiasis, trypanomiasis, onehorcerciasis and arbovirus may only occassionally be encountered in Nyeri District. As such, no major vector control activities have been planned. Nevertheless, 25,926 cases of malaria were notified and treated in 1981. It is debatable whether malaria is endemic in Nyeri. The sanitary activities against the malial vector have been limited to advise on proper drainage of towns and other areas, and insecticide spraying of marshy areas. This campaign has neither been active nor successful.

4.1.10 EPIDEMIOLOGICAL SURVEILLANCE TEAMS

No such teams have had in-service training course and it is doubtful if any had been planned. However, the P.G.H. maintains a cholera survaillance team

4.1.11 ANTIMALARIAL CONTROL MEASURES

As mentioned above this campaign has not been very succesful. The Nyeri Municipality and other local authorities continued to receive advice on clearing of open drains and improving drainage in towns and other urban areas. There have been occasional spraying of stagnant waters carried out by the Health Personnel. It is hoped that drainage of Nyeri Municipality would be improved and this extended to Karatina, Othaya, Mweiga, Endarasha and Naro-moru. Gakindu and Kiahugu require proper drainage. The Southern parts of the District bordering with Kirinyaga and Muranga Districts register more malaria cases. These rural areas require speciall considerations during the next plan period as regards antimalarial measures.

4.2.0 AVAILABLE RESOURCES

Below is a summary of available resources that could be deployed during the next Development Plan.

4.2.1 FACILITIES

(i) TABLE 4.2.1. HEALTH FACILITIES

	GOVT		MISSION		PRIVATE		TOTAL	
	Hosp	Beds	Hosp	Beds	Hosp	Beds	Hosp	Beds
H Hospitals	2	402	2	379	-	-	4	781
H. Centres	8	97	-	-	-	-	8	97
Dispensaries	39	-			-	-	39	
Nursing/Mat. Homes	-	-	3	41	5	46	8	87
TOTAL	49	499	5	420	5	46	59	965

(ii) Distribution of Health Facilities

(a) Hospitals:

There are 2 hospitals in the Nyeri Municipality (Mathari Mission 206 beds and Provincial General Hospital 311 beds). Both cater for the 35,753 Municipal population, also all the surrounding population. Besides, this disadvantage, Mathari Hospital caters for selected patients as it is a paying institution. Provincial General Hospital serves as a district as well as a Provincial hospital. Therefore, over-crowding is inevitable unless its bed capacity is increased.

Karatina Sub-district Hospital (70 beds only) serves the populous Mathira Division (127,359 population). The fourth hospital (Tumutumu 173 beds and also a paying institution) is in the same division. There is a 12 bed health centre and a 6-bed maternity givin a bed population ratio of 0.0020493 in the division - compare with the District ratio of 0.0019836 excluding cots.

(b) Health Centres

There are 8 health centres and 8 maternity or Nursing Homes (total beds 184) in the district. Their distribution is uneven as shown in Table 4.2.1 (ii)b.

TABLE 4.2.1 (ii) b. Distribution of H/C, Maternity Homes by Division. (Excluding Hospitals and Cots)

DIVISION	HOMES	BEDS	POPULATION	BED/POP. RA
Mathira	2	18	127,359	0.0001413(*0.0020493)
Othaya	3	39	68,500	0.0005693
Tetu	4	35	138,026	0.0002535
Mukuruweini	4	53	72,288	0.0007331
Kieni West	2	27	41,411	0.0006520
Kieni East	1	12	38,893	0.0003085
TOTAL	16	184	486,477	*0.0019836

*These figures are corrected to include beds availab in the 4 hospitals.

Mathira has 2 hospitals and 2 maternity homes giving a corrected bed/population ratio of 0.0020493.

This is better than for the whole district. The distances from Karatina to Hombe dispensary, the farthest, is about 20 KM. However, the roads near the mountain are not all weather. For this reason, and the fact that high population increase is in Mathira, only two New Sub-H/Cs may be proposed at Hombe and Gatei upgrading the old dispensary. More hospital beds may be obtained by enlarging the existing Karatina Hospital. This is the best served

Othaya Division has 3 homes with a bed/population ratio 0.0005693 which is 3.5 times lower than the district average. The division holds 14% of the population in the district. The land terrain is not favourable for quick travel and roads are not all weather in most areas. A Sub-H/Cs may be proposed at Ihuririo and Kamoko to replace the old H/C at Othaya, while the old H/C may be upgraded as intended in the previous plan to a 100 bed hospital. At present this division is under served with bed capacity and should have priority.

Tetu Division has 4 homes and 2 hospitals but due to its urban population seems under served. However, with the expansion of bed capacity in the Provincial General Hospital, Nyeri, increasing bed capacities at Wamagana, Kinunga Health Centres, and completing the already planned for Gicira Health Centre the population would be well served.

Mukuruweini has 15% of the District population and 4 homes, giving a bed population ratio of 0.0007331 one of the best in the district. However, travel in some areas is hindered by land terrain and road conditions in wet weathers although distances are not long. A 70-bed hospital at Mukuruweini divisional headquarter with upgrading of 2 existing dispensaries to 12-bed Sub-Health Centres at Gumba and Karaba should surfice.

A different situation exists in both Kieni divisions with 16.5% of the population living on 2/3 area (2229sq. KM) of the district where population density is only 36 per sq. KM. However, the bed population ratio is 0.0003085 and distances are far and wide. This is a poorly served area, but at the moment building of new hospitals may not be justified. Upgrading old dispensaries to 12-bed Sub-health centres at Mugunda, Amboni (Kieni West) and Naromoru, Island Farms and Kiganjo in Kieni East should be adequate.

(c) DISPENSARIES

The distribution of dispensaries is shown on Table 4.2. (ii) c. Even though, there are several of them in Othaya, Tetu and Mukuruweini, the population density is high. Using the criteria 1 dispensary for 11,300 population Nyeri District will require a total of 68.48 dispensaries by 1987. This would mean about 30 new dispensaries to cater for the projected population of 773,868. However, due to the fact that many previously planned for projects were not completed, funds are hard to come by and some areas have land problems, only 15 new dispensaries may be proposed. It is hoped that the upgraded institutions will continue to offer outpatient services as before. A list of all health facilities proposed for improvement is shown on Schedule 4.2.1. All the listed institutions should be provided with housing for staff. At present many dispensaries and Health Centres have no staff houses. Workers have to travel distances in some places.

TABLE 4.2.1(ii) c. DISTRIBUTION OF DISPENSARIES

DISPENSARIES	LOCATION	POPULATION	AREA Sq. KM	DENSI
1. Gatitu) 2. Gicira) Aguthi)	Aguthi	32,622	73	442
4. Wandumbi) 5. Unjiru) 6. Kiandogoro)	Tetu	21,049	64	389
7. Zaina) 8. Ihururu) 9. Kabage)	Muhoya's	13,679	72	190
10. Unjiru	Thegenge	34,923	99	353
11. Witima) 12. Ihuririo)	Othaya	33,286	76	432
13. ~~Kamoko~~	~~Ghinga~~ ✓ ~~Mahiga~~	16,691	50	330
13. KAMOKO	~~Mahiga~~ ✓ ~~Gitimbi~~	18,523	43	438
14. Nairobi) 15. Naromoru)	Naromoru	24,313	332	73
16. Island Farms) 17. Ndathi Forest 18. Mere)	Kabaru	14,580	156	93
19. Kahurura) 20. Gathiuru)	Gakwa	-	-	-
21. Amboni	Mweiga	26,731	282	94
22. Bellevue) 23. Mugunda)	Gatarakwa	14,680	254	55
24. Njoki	Muhito	27,657	49	564
GUMBA	Lower Muhito	6,189	31	198
25. Karaba	Gikondi	16,987	38	445

26. Gumba 27. Mihuti 28. Thangathi 29. Icamara	Githi	21,481	60	353
30. Chehe	Iria	21,022	48	431
31. Ndimaini	Konyu	32,181	57	558
	KiriMukuyu	26,938	55	485
32. Hombe	Ruguru	26,408	89	295
33. Gatei 34. Ragati	Magutu	20,805	72	285
35 - 38	Nyeri Municipality	35,753	71	497

Schedule 4.2.1 HEALTH FACILITIES TO BE IMPROVED

INSTITUTION	IMPROVEMENT	YEAR REQUIRED
P.G.H., Nyeri	OPD/MATERNITY/OFF. BLOCK	1982-84
	WARD BLOCK TO 800 BEDS	1982-87
Karatina Hospital	Additional 30-40 Beds	1985
Othaya Hospital	Upgrade to 100 beds Hosp.	1983-88
Mukuruweini Hospital	Upgrade to 70 beds Hosp.	1983-84
Hombe or Ndimami	Upgrade to 12 bed SubCentre	1986
Gatei	Upgrade to 12 bed Subcentre	1989
Ihuririo	Upgrade to 12 bed Subcentre	1984
Kamoko	Upgrade to 12 bed Subcentre	1984
Wamagana H/Centre	Increase beds to 20	1984
Kinunga H/Centre	Increase beds to 20	1984
Gicira Dispensary	Upgrade to 12 bed Subcentre	1984
Gumba Dispensary	Upgrade to 12 bed Subcentre	1985
Njoki Dispensary	Upgrade to 12 bed Subcentre	1984
Karaba Dispensary	Upgrade to 12 bed Subcentre	1986
Amboni Dispensary	Upgrade to 12 bed Subcentre	1987

MINISTRY OF HEALTH

Telegrams: "MEDICAL", Nye
Telephone: Nyeri 2488/9
When replying please quote
Ref. No. .....
and date

CENTRAL PROVINCE GENERAL HOSPITAL
P.O. Box 27, NYERI

14th August, 1982

FIFTHY DEVELOPMENT PLAN

MANPOWER PROJECTIONS

Doctors/Medical Officers:

The projections for registered Medical personnel during the year 1978/80 provided 12.09 Doctors per 100,000 population. The same criteria has been used to project manpower requirements on this cadre during the 5th development plan taking into account the population projections as at 1979 and the growth rate of 3.5% for the entire district.

It is anticipated that 96.8 Doctors will be required in the whole District at the end of the 5th development plan to cover adequately 800,953 population as indicated on the projection schedule. This projection covers any anticipated expansions of the Provincial General Hospital, Nyeri whose bed compliment is expected to rise to 800 beds, proposed Othaya and Mukurweini Sub-District Hospitals and perhaps a further hospital either at Kieni East or Kieni West. This figure indicates that Medical Officers' establishment will exceed the present establishment by over 200% during the plan period.

Dentists:-

In projecting for this cadre, Senior Dental Officers and Dental Officers have been grouped together in the projection schedule. The national projection of 12.09 Dentists per 100,000 population as per 1980 projection is relatively

.../2

Mukurweini, Naromoru and Mweiga are other Urban areas with population more than 2,000 people but with good communication connections, see table 1.2.

TABLE 1:2 URBAN AREAS

URBAN AREA	AREA sq. km.	Population (1989)	Dens:
Nyeri	71	35,753	497
Karatina	1	2,980	1,[illegible]93
Othaya	2	2,159	749
Mweiga			
Naro Moru			
Mukurweini			
TOTAL			

1:3 TOPOGRAPHY

The elevation of the district varies from 1600m to 3000m above sea level. The two massifs of Mt. Kenya and the Aberdares rise respectively to 5199m and 3999m. The original lava flows from these formerly active volcanoes has been deeply weathered over the years to give the land lying between them rich red soils for food and cash crop production. This area has numerous ridges and valleys punctuated by fast-flowing rivers that predispose to soil erosion. This land terrain greatly hampers transportation and mechanised cultivation.

The northern half of the district, however, ~~xxxxx~~ bordering with Laikipia district is flat with fewer streams This part is dry. Clean water in this area is scanty and food production is inadequate. Irrigation could improve the area as it has rich cotton clay soils. Due to inadequate rainfal this is a ranching area. To the south near Kirinyaga and Murang'a boundaries the ridge - and - valley terrain is interrupted by hills, including Nyeri Hill, Karima Hill and Tumutumu Hill. There is no natural vegetation as practically all land is under cultivation and grazing.

1.4 CLIMATE

The whole district has a ~~xxxx~~ cool climate due to its elevation above sea level with temperatures averaging 24°C through the year. Rainfall, however, differs from South to

D. Pharmacists:

The national ratio of 1.95 Pharmacists per 100,000 population as at 1980 is considered more appropriate as opposed to one Pharmacist per 100 patients being used by the Ministry Headquarters for projection purposes.

The projections shown on the schedule during the plan period has provisions for anticipated expansions of pharmaceutical services at the Provincial General Hospital, Nyeri, Mt. Kenya Hospital including the proposed Othaya and Mukurweini Sub-District Hospitals.

E. tered Nurses:

National ratio of 43.66 Registered Nurses per 100,000 population as at 1980 has been used to project manpower requirement on this cadre during the plan period. The figure shown on the schedule is relatively high and broadly takes into account the on-going extensions of the Provincial General Hospital, Nyeri, Town Health Centre, Mt. Kenya Hospital including proposed Othaya and Mukurweini Sub-District Hospitals.

F. Public Health Officers:

There is no national projections for this cadre. The manpower projections during the fifth development plan aims at providing one Public Health Officer per every location (23 locations) and one at every sub-location (111 sub-locations). Two extra Health Officers and two extra Public Health Technicians are projected to cover leave and sickness.

G. Laboratory Technologists (Med.)

The Present establishment of 6 personnel (3 at the main Hospital and 3 at M.T.C.Nyeri) is anticipated to progressive grow at the rate of 2 additional personnel per year during

the plan period assuming that the new Laboratory Department will be operational. A provision for leave and sickness has been included in the projections.

H. Laboratory Technologists (EMT)

This cadre is not applicable at the present.

I. Pharmaceutical Technologists

The present establishment of 5 Pharmaceutical Technologists is anticipated to rose to 20 by the year 1988. This is phased out at the region of 2 to 4 personnel per year depending on the present and anticipated workload at the Provincial General Hospital, Mt.Kenya Hospital, Town Health Centre including the proposed Othaya and Mukurweini Sub-District Hospitals.

J. Physiotherapists

It is anticipated that the present Physiotherapy Department will be expanding on the present establishment of 6 personne is expected to double by the year 1988. This is at the growing rate of 1 physiotherapist per year.

K. Occupational Therapists

This Department will be intensified by introducing the following sections along with any other proposed expansior of the entire Department during the plan period:-
Psychiatric
Paediatric
Physical disabilities
Paediatric Unit at Caltex Children Home.

Every section would require one occupation Therapist in order to cater adequately for the proposed industries which may bring about more physical disabilities due to accidents

Due to rapid rise of population, the projected establishment of 4 personnel as at 1984 is expected to double as at 1985.

It is anticipated to start a new project to carry out domiciliary occupational therapy on or around the year 1986/87 and as such one additional occupational Therapist would be required. The projected manpower thereafter grows at the rate of two additional personnel per year.

Dental Technologists/Therapists:

It is anticipated that the present establishment of 2 Dental Technologists will rise to 14 by the year 1988. This is phased out at the rate of 2 personnel per year and takes into account the anticipated intersification of dental services at the Provincial General Hospital as well as other Districts in the Province. This also applies to dental therapists.

M. Orthopaedic Technologists

The present demand of this cadre is relatively low. The present establishment of 3 personnel is anticipated to grow at the rate of one (1) personnel per year throughou the plan period.

N. Radiographers - Diagnostic:

The present x-ray facilities at P.G.H.Nyeri will be improved and expanded during the plan period. The present establishment of one (1) Radiologist is, therefore, expected to double when the proposed extensions becomes operational.

O. Radiographers - Therapists

This cadre is expected to rise from 10 to 20 by the year 1988 which is phased out at the rate of 2 additional radiographers per year. This projection takes into account the proposed expansion of the x-ray department and the present workload including leaves and sicknesses.

P. Enrolled Nurses (All)

The national ratio of 56.91 Nurses per 100,000 population appears appropriate. Using this criteria, the present establishment of 301 Enrolled Nurses will rise to 455.8 as at 1988. This projection will adequately cover and intensify nursing services at the Provincial General Hospital, Mt.Kenya Hospital, proposed Othaya and Mukurwein Sub-District Hospitals, Health Centres and Dispensaries.

Q. Laboratory Technicians (Med.)

The present establishment of 12 personnel is projected to grow at the rate of 2 personnel per year upto 1986. This will bring the total personnel in the Department to 30 and no additional personnel would be required due to inadequate working accommodation and facilities.

R. Laboratory Technicians (Ent.)

This cadre has not been existing although most essential. It is proposed to start this project in the year 1982 with 2 personnel and subsequently the establishment progressively grows at the rate of one additional personnel every year during the plan period and onwards.

S. Radiographic Film Processors:

Taking into account the present and anticipated workload particularly when the proposed new x-ray unit becomes operation, the present establishment of 6 personnel on this cadre is expected to rise to 16 as at 1988. This is at the growth of at least 2 additional personnel per year

The projected manpower also covers leaves and sicknesses.

T. Rural Health Technicians:

The projections shown on the schedule aims at providing one Health Technician in every sub-location (111 sub-locations) during the plan period hoping that, the required personnel will be supplied at the rate of 12 personnel per year.

U. Nutrition Field Workers:

At least 12 Dispensaries are proposed for improvement and upgrading. Each of these stations will certainly require one Nutrition Field Worker during the plan period and this will bring the present establishment to 26 as at 1988.

V. Family Health Field Educators:

It is anticipated that the present establishment of 47 family Health Field Educators will rose to 61 by the year 1988 in order to adequately cover the proposed new Hospitals and Health Centres.

W. Dental Therapists:

At the moment there are two Dental Therapists. Due to the expansion of the dental unit, this establishment is anticipated to grow at the rate of 2 personnel per year throughout the plan period.

X. Medical Records Officers:

It is proposed to allow this establishment to progressively grow at the rate of 1 personnel per year during the plan period in order to cope with rapid expansion of Medical Records Services at Provincial General Hospital and other proposed new Hospitals in the District.

Y. Medical Record Technicians:

The demand of this cadre is anticipated to rose to 35 in th year 198[illegible]. This is at the growth rate of at least 5 person per year during the plan period. The volume of work at the new O.P.D. is expected to raise rapidly treamendously. Additional personnel are also provisioned to cater for leav and sicknesse

Z. Statistical Clerks:

It is proposed to have at least 13 statistical clerks for deployment at various sections handling medical records duties at this Hospital, Health Centres and proposed new Hospitals in the year upto 1986. This establishment is expected to rose to 15 personnel by the year 1988. (se Schedu

MANPOWER PROJECTIONS 1982/1990

	1982	1983	1984	1985	1986	1987	1988	1989	1990
Doctors	40	80.4	83.2	86.1	90.4	93.6	96.8	100.2	103.7
Dentists	5	7	9	11	13	15	17	19	21
Pharmacists	2	12.9	13.3	13.9	14.6	15.09	15.6	16.2	16.7
Clinical Officers	49	70.3	72.7	75.3	79	81.7	84.6	87.5	90.6
Registered Nurses	35	290.5	300.6	311.2	328.45	337.87	349.70	361.94	374.6
Public Health Officers	11	14	18	22	26	30	34	38	42
Lab. Technologists (Med)	6	8	10	12	14	16	18	20	22
Lab. Technologist (ENT.)	-	-	-	-	-	-	-	-	-
Pharm. Technologists	5	9	11	13	16	18	20	22	24
Physiotherapists	6	7	8	9	10	11	12	13	14
Occup. Therapists	3	4	4	8	9	11	13	15	17
Dental Technologist	2	4	6	8	10	12	14	16	18
Orthopaedic Technologists	3	4	5	6	7	8	9	10	11
Radiographers Diagnostic	1	-	-	2	-	-	-	-	-
Radiographers Therapists	10	-	12	14	16	18	20	22	24
Enrolled Nurses (All	301	378.8	391.8	405.6	425.5	440.4	455.8	471.8	488.3
Laboratory Tech. (Med.)	12	14	16	18	20	-	-	-	-
Laboratory Tech. (ENT.)	-	-	2	3	4	5	6	7	8

	1982	1983	1984	1985	1986	1987	1988	1989	
adiographic Film Processors	6	-	8	10	12	14	16	18	
ural Health Technicians	57	69	81	93	105	117	129	141	
utrition Field Workers	14	-	17	19	22	24	26	28	
amily Health Field Educators	47	-	50	53	56	59	62	65	
ental Therapists	2	-	4	6	8	10	12	14	
adio Physicist	-	-	-	-	-	-	-	-	
arastologists	-	-	-	-	-	-	-	-	
ochemists	-	-	-	-	-	-	-	-	
ntomologist	-	-	-	-	-	-	-	-	
ical Record Officers	1	2	3	4	5	6	7	8	
edical Record Technicians	5	10	15	20	25	30	35	40	
tatistical Clerks	-	13	13	13	13	15	15	16	
opulation Projections	642,864	665,364	688,651	712,753	747,699	773,868	800,953	828,987	85

4.3 CONSTRAINTS

As in the previous development programme severa problems are anticipated

The shortage of funds will continue to be a problem. The Harambee Spirit prevailing in the district now seems somewhat overstretched, but this still can be considered as a possible source.

ii) Shortage of manpower to meet the increasing population will continue to dilute the efforts of the government in achieving the defined health standards.

Cont:

Population growth rate seems the greatest obstacle and all medical institutions should step up the campaign for fertility rate reduction in the district.

The Private Sector in this district plays almost negligible role in providing hospital bed facilities. This should be encouraged

Inefficient Management, organisation and poor staff deployment should now pose less problem with established of RHU under the District Management Team led by the Medical Officer of Health. To this end the Team work 6-week course at Maragua Rural Health Demonstration Centre has, and should continue to contribute.

As proposed above an epidemiological surveillance team should help in information flow.

Local authorities (County Council and Municipal) should form Public Health Departments.

4.4 PREVENTIVE AND PROMOTIVE HEALTH

Immunization of children should be stepped up in child welfare clinic. Diarrheal diseases should be combated with clean water supply especially in the Kieni Divisions and surveillance teams should be deployed in these areas. On Vector Control, control measures should be undertaken especially by the local authorities.

As previously, Family Health Programmes should continue to aim at reducing maternal, perinatal, infant and child mortality. However, the main emphasis now should be laid on population control as resources and facilities are being fast depleted or over used.

4.6. ENVIRONMENTAL PROGRAMMES

Inspection of Meat and Diary products, eating places, food handlers, e.t.c. has continued in this district. These programmes should continue in the next develop ment period through the REU concept. Water Supply received good attention, especially the richer parts of the district, but rural water projects have not supplied adequately the growing population. The newly settled areas of Kieni received little attention. This development period should focus first on supplying water to these drier parts, and secondly to improving water supply to other parts to minimise rationing. Water quality has so far received little attention. Nyeri town water supply is fully treated and filtered. Karatina water supply will receive full treatment works as planned in the last period. However, other urban and rural areas have no treatment works. This should be looked into this time.

As stated before, waste/disposal is not adequately dealt with. Sewage systems in the urban areas should be improved. Refuse collection in all urban and Market places should be improved. All these programmes could be better accomplished if the local authorities are encouraged to have Public Health Departments.

There have been some activities in control of malaria vector but not a very active campaign. This also should be looked into in order to coordinate government, local authority and people's efforts. Environmental health education and information should be persued through R.H.U.

Previously, there have been no research in environmental pollution. Many sewage disposals, coffee factory by-products, multiple pesticides now widely used in this district due to intensive farming end up in rivers untreated.

This now should call for promotion of research in environmental pollution, establishment of epidemiological surveillance station and training of personell for this work. Long-term studies of the environmenta should be started now.

4.7 RURAL HEALTH SERVICES

As in the past, this plan should focus on upgrading or improving Health Centres and dispensaries as well as allocation of new facilities. Specific activities should include completion of the on-going projects, provision of new facilities in under served areas to improve the bed/population ratio. especially in the Kisii Divisions.

Promotion of community and non-government agencies (Private and Missionary) to participate in health programes. In particular, these should be encourage to offer more hospital beds and to participate in population control activities.

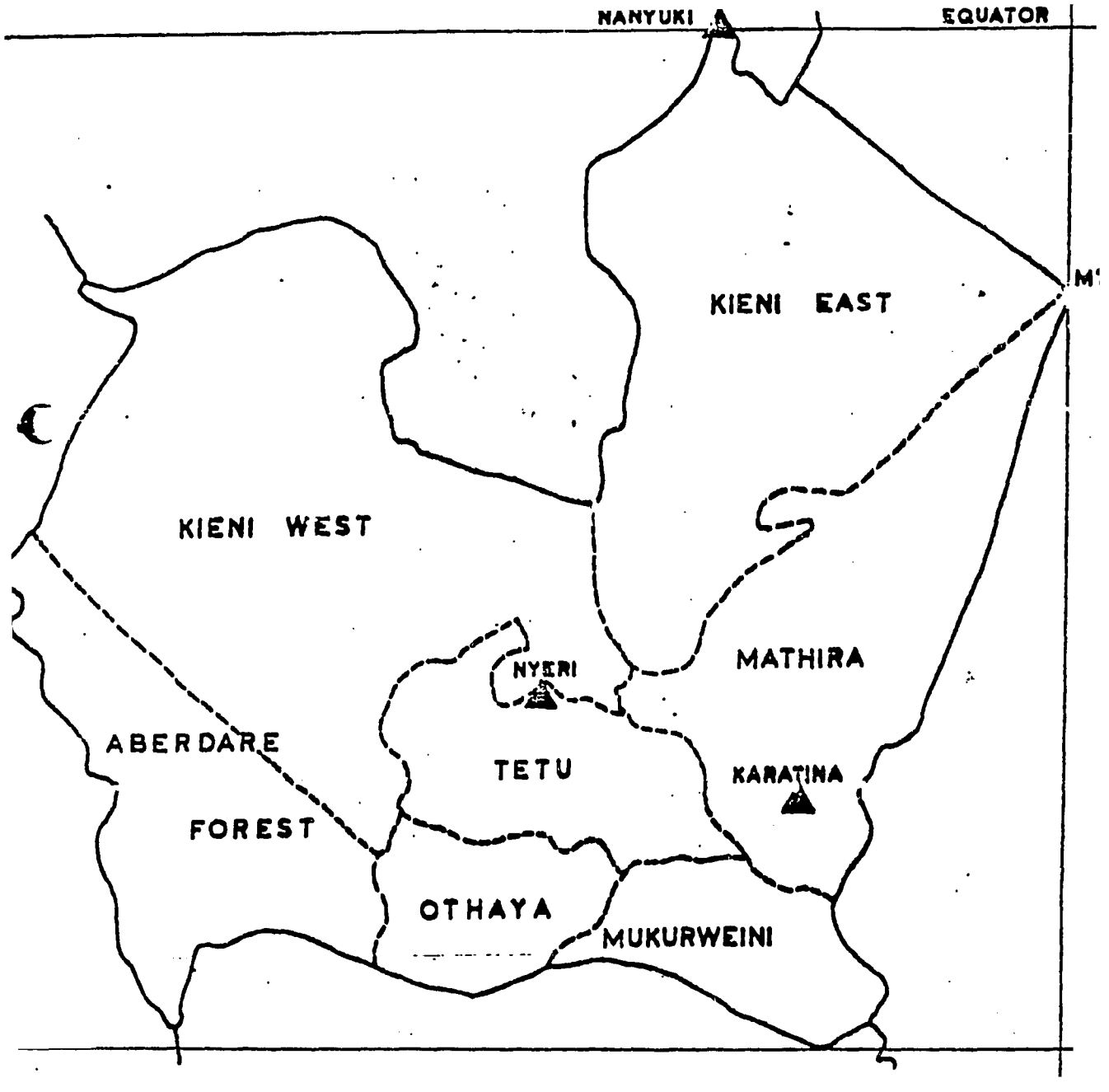
Rural Health Training Centres and utilisation of the demonstration centres is only beginning. The demonstration centres now have more in-patients and daily attendences. This should be encouraged further.

The training of community Nurses and Public Health Technicians is going on in the district at the P.G.H. This has been strengethened by participation of specialists, in their training. Training of Dental Health Personell is not carried on locally in the district.

The psychiatric services in this district require organisation and streamlining. More Nurses (Registered and Enrolled) in this field are required. Accommodation for patients is absolutely inadequate.

The Provincial General Hospital should be improved to serve as the Regional Referral Centre. Already there are Consultants in almost all major disciplines of Internal Medicine, Ophthalmology, Psychiatry, Dermatology, Paediatrics, Surgery and Obstetrics/Gynaecology Accommodation for patients is scarce. Laboratory backu is not up to date due to lack of space, equipment and pe sonell. This will perhaps be improved with completion of facilities at the O.P.D. The training role for this hospital has continued to grow. There are about 14 doctor - Interns every year. In-service training courses for doctors and Nurses from this and other districts continues. This hospital should continue in this role, while the three proposed sub-district hospitals at Karatina, Othaya and Mukuruweini should be the focal points in provision of primary health care and community based health care. In this plan, as before, the emphasis has been laid on improving services to underserved areas. Only those hospitals proposed in the previous plan have now been included. It is hoped that private and missionary institution will complemen the government efforts in providing hospital beds and family planning services.

NYERI DISTRICT
MAP Nº 1
ADMINISTRATIVE BOUNDARIES



KEY

——— DISTRICT BOUNDARY

- - - - - DIVISIONAL BOUNDARY

TETU..... DIVISIONAL NAME

Develop Scheme of Service for Planning Personnel _ _ _ _ _ _ _ _ _ _ _ [E and O]

In April 1982, HPIP undertook to clarify the possibility of responding to this requirement, given the constraints of existing GOK personnel practices. An official letter of inquiry on the matter was sent to the Personnel Office of the GOK.

Information received in response to that inquiry suggested that procedures and decision-making related to revision of schemes of service are entirely outside the scope and parameters of a project such as HPIP --- and are, indeed, outside the perogatives of the MOH.

In subsequent discussions, the MOH has concurred that this item should be deleted from the Contractor's Terms of Reference.

Train Planning Staff (off-site)

1. M.P.H. _____ [M]

Three MOH physicians enrolled at Loma Linda University in California, and four MOH physicians enrolled at the University of Massachusetts (these not under Drew supervision), have now completed their requirements for the M.P.H., and have returned to Kenya. Two additional participant trainees have been authorized to remain at Loma Linda for two quarters further study in epidemiology.

None of these returned participant trainees has been assigned to the HPIP or HPWG.

In the current view of the MOH, medical professionals who receive training in public health administration should serve in field administrative positions for at least one year following the completion of such training, in order to allow their newly acquired skills to be practiced. For this reason, the physicians who recently completed participant training at the universities in the U.S. are in the process of being posted as District Medical Officers of Health with the responsibility for planning, implementing and evaluating health programs in their districts. In due time, these individuals will be considered for posting in planning positions at the national level.

In the interim, other staff with more field experience and M.P.H. degrees will be posted in national level planning positions.

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Within the context of the Project requirements, the objectives for training of five (5) MOH officials at the master's level is considered to be approximately 88% complete.

2. Short-term _____ [M]

During June and July 1982, five MOH officials participated in a short-term training program in planning and evaluation at the Charles R. Drew Medical School in Los Angeles. Their experience did not merely provide for theoretical learning but required the participants to develop a Training Manual in Health Planning and Evaluation that could be used as a tool in the training of District Health Teams.

The outcomes of that training program are best evidenced by the attached materials which were developed by the group. A further outcome of the training program was that the Ministry subsequently designated this resource group (Writing Team) to assist in the delivery of training to an additional ten health administrators (as called for in the HPIP contract).

During 11 - 22 October, 1982, two District Management Teams (comprising the ten short-term trainees called for in the HPIP contract), along with an additional three District Management Teams, will participate in the short-term planning/evaluation training program, using the materials developed in Los Angeles. Training resources for the program will include the Writing Team, Provincial Officers, the HPWG, and the HPIP staff.

Within the context of the Project requirements, the objective of providi short-term training for fifteen (15) MOH officials in Planning/Evaluati ·is close to completion.

3. Observational Tours

During Project Year II, a total of nine (9) observational tours wei undertaken. Trip reports covering visits to Ivory Coast, Nigeria, To and Cameroon during February 1982, and to Tanzania/Zanzibar during Mar 1982, are attached.

An additional tour for one MOH official was arranged during July 198 Dr. S. Kanani, SDDMS, traveled to Los Angeles for the dual purposes assisting and supporting the short-term training program (providing a official MOH presence and policy direction for the trainees), and making tour of the comprehensive, urban, primary health system operated by th King/Drew Medical Complex.

One additional observational tour is planned during Project Year III.

DRAFT EDITION

PLANNING AND EVALUATION FOR DISTRICT HEALTH PLANNING TEAMS

A SHORT-TERM COURSE

Ministry of Health

Republic of Kenya

July, 1982

ACKNOWLEDGEMENT

Development of this manual, and the companion Trainer's Guide, was jointly facilitated and supported by the Ministry of Health, Republic of Kenya; and the Charles R. Drew Postgraduate Medical School, Office of International Health and Economic Development, with assistance from the U.S. Agency for International Development; under the terms of USAID Contract No. 615-0187, Health Planning and Information Project.

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PREFACE

Since the early 1970s, the Government of Kenya (GOK) has been committed to a policy of providing comprehensive health care (which includes primary health care), to its people. In this connection, the government issued a policy statement to move from a pattern of centralized planning, administration, and evaluation, to a decentralized pattern which emphasizes the district as the nucleus for these management functions.

In 1982, the Director of Medical Services, Ministry of Health, issued a paper entitled, "Health Strategy for Kenya", which translated this decentralization policy into operational terms. District Health Management Teams (DHMTs) were established as the unit responsible for district level planning, administration, and evaluation of health services. The provision of comprehensive and accessible health services for all was stressed. Also embodied in the paper was the expectation that most people will be motivated to regard health as their responsibility and to actively respond to their "felt needs."

In order to meet the prescribed mandate, the Ministry of Health (MOH) determined the need to equip the DHMTs with appropriate management skills which, in part, include planning and evaluation techniques. Furthermore, the need to identify approaches to incorporating greater community participation in the planning and delivery of health care services became apparent. With improved management skills and community involvement at the district level, the Ministry of Health anticipates more effective and efficient delivery of health care services throughout the country.

To facilitate development of this decentralized capability, the Ministry of Health called upon existing resources. In 1980, the Ministry of Health, with financial assistance from the U.S. Agency for International Development, initiated a Health Planning and Information Project (HPIP) in collaboration with the Charles R. Drew Postgraduate Medical School. The on-going project is concerned, in part, with various types of training for key Ministry of Health personnel in health planning, administration, and evaluation. Consistent with this charge, and to further the Ministry's interest in strengthening district

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level management capabilities, the HPIP has assisted in organizing a series of planning workshops/seminars for provincial and district administrators during 1982.

Related to these project activities, this manual and the companion Trainer's Guide have been developed: 1) to further standardize district level planning and evaluation training; and, 2) as part of an anticipated comprehensive management training programme for District Health Management Teams. The training materials were developed by a group of five Ministry of Health professionals during a six-week course in Planning and Evaluation offered by the Drew School in Los Angeles, California. It is envisaged that this manual and Trainer's Guide will greatly facilitate the strengthening of planning and evaluation skills at the district level.

Great appreciation and thanks go to the Permanent Secretary and Director of Medical Services, Ministry of Health, Kenya, for encouraging and facilitating the production of this manual, and for granting permission to the five Kenyan health professionals to participate in the planning/evaluation course, and to serve as the Writing Team.

Special thanks also go to Dr. S. Kanani, Senior Deputy Director of Medical Services, Ministry of Health, and to Dr. Reginald Gipson, the Drew School's Chief-of-Party for the HPIP in Kenya, both of whom traveled to Los Angeles and worked with the Writing Team for a short time during the course. In addition, Dr. M. Alfred Haynes, President/Dean, and Dr. James Haughton, Executive Vice President, both of the Drew School, provided wise guidance throughout the effort.

The key course instructor, Dr. Alfred K. Neumann, Professor in the School of Public Health, International Health Division at the University of California at Los Angeles, and Professor of Community Medicine at the Drew School, provided invaluable instruction, support and assistance to the Writing Team. Dr. Neumann, who has worked in Kenya at intervals for the past fourteen years, drew upon long years of teaching and writing experience, and the planning/evaluation concepts covered in his forthcoming book on the subject, to assist the Writing Team in completing its task.

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The efforts of Ms. Denise Fairchild, Acting Director of the Office of International Health and Economic Development and Executive Editor of the manuals, and those of Ms. Mildred Pollard, Kenya Project Administrator and Training Coordinator, are also deeply appreciated.

Many thanks go to Dr. Bartley McSwine and Mr. Alfonso Washington of the Drew School's Curriculum Development Division, who assisted throughout the course and writing periods. In addition, Dr. Richard Piper of the Southwest Regional Laboratory for Educational Research and Development (SWRL), provided valuable guidance and assistance in development and writing of the Trainer's Guide.

During the course, the Drew School provided a healthy atmosphere for production of the training materials. The Office of International Health placed its entire clerical, word processing, editorial, and administrative resources at the disposal of the Writing Team. The production of these manuals would not have been possible without the special efforts of Ms. Trudy Dorsey, Ms. DarLinn Lucas, Ms. Cynthia McCall, and Ms. Doris Reed. For final editing, graphics and reproduction, the Office of International Health called upon the efficient services of SWRL.

Without all of this help, the manual and Trainer's Guide would not have come to fruition in such a short period of time.

THE WRITING TEAM

- Dr. R. K. Arap Kalya, Deputy Director of Medical Services/PMO, Rift Valley
- F. A. Mworia, Senior Hospital Secretary in the Planning and Implementation of Integrated Rural Health and Family Planning Programmes, Ministry of Health
- N. A. Keyonzo, Head, Evaluation and Research Division, National Family Welfare Centre, Ministry of Health
- T. A. Oduori (Mrs.), Senior Nursing Officer, Ministry of Health
- Dr. A. O. Oyoo, Deputy Director of Medical Services/PMO, Eastern Province

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ABBREVIATIONS

AMREF	— African Medical and Research Foundation
ASU	— Administrative Support Unit
CBHC	— Community Based Health Care
CHC	— Community Health Committees
CHW	— Community Health Worker
DDC	— District Development Committee
DHMT	— District Health Management Team
DHPT	— District Health Planning Team
DMOH	— District Medical Officer of Health
DMS	— Director of Medical Services
FPAK	— Family Planning Association of Kenya
FP	— Family Planning
GNP	— Gross National Product
GOK	— Government of Kenya
IMR	— Infant Mortality Rate
KSh	— Kenyan Shilling
MCH/FP	— Maternal Child Health/Family Planning
MCH	— Maternal/Child Health
MOEPD	— Ministry of Economic Planning and Development
MOF	— Ministry of Finance
MOH	— Ministry of Health
MOW	— Ministry of Works
NPV	— Net Present Value
PAC	— Planning Activities Checklist
PS	— Permanent Secretary
PDC	— Provincial Development Committee
PERT	— Program, Evaluation, and Review Technique
PHC	— Primary Health Care
PHPT	— Provincial Health Planning Team
PMO	— Provincial Medical Officer
PSS	— Project Submission Sheet
RHF	— Rural Health Facilities
SDP	— Service Delivery Point
TBA	— Traditional Birth Attendant
USAID	— United States Agency for International Development
WHO	— World Health Organization

BACKGROUND

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B - BACKGROUND

B1. RATIONALE FOR THE TRAINING COURSE

During the past ten years, the desire of the Government of Kenya (GOK) has been to establish formal planning activities within each Ministry, and to decentralize planning processes to the district level.

As stressed in the last two development plans, 1974-78 and 1978-82, this policy direction has resulted in the establishment of Provincial and District Development Committees. The Committees, composed of ministerial, non-government organizations and community representatives, deal with the planning of sectoral and inter-sectoral programmes and projects. However, in many instances, these Committees have not functioned well because represented groups do not have adequate knowledge of planning principles.

The Ministry of Health's concerns with building decentralized planning cababilities are consistent with, and even predate by some years, the general government direction.

Prior to 1970, the management of Rural Health Facililties (RHF) was the responsibility of the local government. However, in 1970 the Ministry of Health was given the responsibility for the development and management of rural health services.

The immediate problems with which the Ministry of Health was faced were: poor and inadequate physical facilities, understaffing, and unsatisfactory standards of service. In response to these problems, a major collaborative effort was undertaken in June and July, 1972, between the Kenya government and the World Health Organization (WHO) which resulted in the formulation of a document entitled "Proposals for the Improvement of Rural Health Services and Development of Rural Health Training Centres in Kenya." This document sets forth a basic plan for the development of rural health services for the period 1972-82.

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This new emphasis on rural health services was an obvious landmark change in MOH policy. In order to implement this policy, Rural Health Units were established, thereby creating an infrastructure for organized health planning and management. The Ministry of Health's direction was further strengthened in the mid-seventies when the government established its general policy of decentralization of planning processes in all sectors.

A further development within the Ministry of Health was the establishment of an "Administrative Support Unit" (ASU), which was created with a view toward strengthening planning and managerial capabilities throughout the Ministry. Up until recently, however, emphasis within the ASU and the Ministry overall, has been placed on broad managerial concerns. Although planning is a critical function of management, very little attention has been directed toward that aspect of management which specifically focuses on planning and evaluation.

Because of the need to strengthen and decentralize planning capabilities at the district level, in 1979 the GOK signed an Agreement with the U.S. Agency for International Development (USAID) to assist in developing health planning infrastructures and to train health planners. To facilitate this cooperation, in October, 1980, the MOH entered into a contractual agreement with the Charles R. Drew Postgraduate Medical School. Since then, a variety of short and long term training activities in health planning have been undertaken, involving national, provincial and district health administrators.

In this connection, there is a critical need to design and develop standardized training materials and to train District Health Management Teams in planning and evaluation. Development of this training manual, and the related district level training activities that are planned for the next year are among the first concrete steps undertaken to build a decentralized planning staff capability within the Ministry of Health. Ultimately, it is anticipated that such training will play a key role in developing standardized planning capabilities, and will also serve as a prerequisite for the building of future planning foundations in the health sector in the Republic of Kenya.

B2. ORGANIZATION OF HEALTH SERVICES IN KENYA

The Ministry of Health (MOH) is organized on a centralized basis with strong support from provincial and district levels. At the national (central) level, the MOH is headed by a Minister who is a political head and responsible to the Cabinet. The Minister and Assistant Ministers are assisted in running the Ministry by the Permanent Secretary who is the civil head of the Ministry. The Permanent Secretary is assisted by two Deputy Secretaries. One is in charge of administration and the other of planning and development. The Director of Medical Services (DMS) is the chief advisor to the Ministry on professional matters.

At the provincial level, the MOH is represented by the Provincial Medical Officer (PMO) who is responsible for overall health services. The PMO leads a team of functional heads who are responsible for various health services components. These officers include the Senior Hospital Secretary, Senior Public Health Officer, Senior Nursing Officer, Senior Health Education Officer, and Senior Nutritionist.

At the district level, the District Medical Officer of Health (DMOH) is responsible for overall health services. The DMOH leads a team of health officers, including the Public Health Officer, Hospital Secretary, and Nursing Officer. For planning and general management, emphasis is currently being shifted to the district, where the DMOH is in charge of the District Health Management Team (DHMT). Consequently, the Ministry of Health intends to reorganize the district headquarters into a Hospital Management Team and a Rural Health Management Team. The Hospital Management Team will be composed of the Medical Officer in charge (or Medical Superintendent), the Hospital Secretary and Nursing Officer in charge. The Rural Health Management Team will be composed of the District Public Health Officer, the District Nutrition Officer, and the Distict Health Education Officer. The creation of the new post of Medical Officer-in-Charge is expected to free the DMOH from the

day-to-day administration of the district hospital thus, enabling him to provide guidance to the Rural Health Management Team which will, in the future, give its help to Rural Health Facilities (RHF) staff.

The present health care delivery system is a pyramid-shaped network of health services. The base of the pyramid is composed of rural health centers and dispensaries. District and provincial hospitals make up the intermediary (secondary) level. At the top of the pyramid, at the national level, is Kenyatta National Hospital.

Although local government health services were handed over to the Ministry of Health in 1970, some municipal councils, including the City Council of Nairobi, were left free to organize their own health care, with strong support and guidance from the central government.

Nongovernment health services are provided by three main groups: church, private, and industrial organizations. The church health services account for 30 percent of total hospital beds, and are predominantly distributed in rural areas. The African Medical and Research Foundation (AMREF) provides health services primarily in poorly served areas through flying doctor services. The Family Planning Association of Kenya (FPAK) also provides health services primarily in family planning. These services are, however, subsidized by the government in the form of grants.

Private organizations provide health services on a "fee for service" basis through hospitals and solo private clinics. About 62 percent of the registered medical practitioners are engaged in private practice and are mainly located in urban areas. Industrial (company) health services are provided soley for the workforce of the respective companies, and may or may not include the employees' families. Industrial health services are not available to outsiders even when they live in the neighbourhood or can afford to pay the full cost of consultation and drugs.

B3. THE NATIONAL HEALTH PLANNING PROCESS

3.1 Health Management Cycle

Figure B-1 depicts the three key steps in the planning and administration of health services. The diagram emphasizes that planning is a function of management. The planning function identifies the changes needed to provide for the health and welfare of the people. Administration handles the task of translating approved plans into viable service programmes. Evaluation is a mechanism for "feedback" on how efficiently the planned objectives and targets have been, or are being achieved, and provides guidance for replanning.

3.2 Health Planning/Implementation Cycle

Figure B-2 concentrates on the processes which occur in planning and implementation (steps 1 and 2 of the Management Cycle). The process begins at the district level, moves through the MOH, brings interministerial coordination into play, and involves Parliament in the approval and allocation of resources. Finally, authorizations are transmitted from Parliament back to the MOH for implementation by applicable Provincial and District Health Planning Teams (PHPTs and DHPTs). The complex steps involved in this process emphasize the need for clear policy guidelines, and the ability to clearly identify problems, to formulate definitive plans, and to justify plans in relationship to competing priorities.

3.3 Organization of Health Planning Functions

Figure B-3 further elaborates on how the processes of planning and budgeting are undertaken by the Ministry of Health (MOH), the Ministry of Economic Planning and Development (MOEPD), and the Ministry of Finance (MOF). Within the MOH, the Health Working Group reviews plan proposals, analyses feasibility, sets priorities based on policy guidelines, and facilitates the approval of plans by the Accounting Officer. Upon completion of these steps, the Estimates Working Group, composed of representatives from the three key government departments responsible in matters of planning and budget approval (MOH,

MOF, and MOEPD), further re-examines priorities for budget allocation. Finally, the MOF considers available resources (money, manpower, material), and recommends the appropriate allocation to the Parliament for approval. Once Parliament has approved the budget allocations, programme implementation is based on approved resources.

B4. FACTORS AFFECTING HEALTH CARE PLANNING

Just as in other aspects of health care, health planning is affected by various factors:

4.1 Social/cultural
4.2 Economic
4.3 Political
4.4 Geographic Features
4.5 Demographic Features

In addition, the above factors may differ from place to place. Consequently, when planning programmes and projects, due consideration should be given to the specific features of a locality in order to make the planning process relevant. The main principles related to analysing these various factors are discussed below.

4.1 Social/Cultural

Health planners should be sensitive to, and attempt to understand, the social values, habits/practices, beliefs and language of the community in which they serve, (e.g., eating habits, taboos, the concept and cause of disease, etc.).

4.2 Economic Factors

Living conditions, employment opportunities, literacy rate, means of communication (roads, telephones), agricultural products, all have great influence on the health status of the people.

Figure B-1 The Health Management Cycle

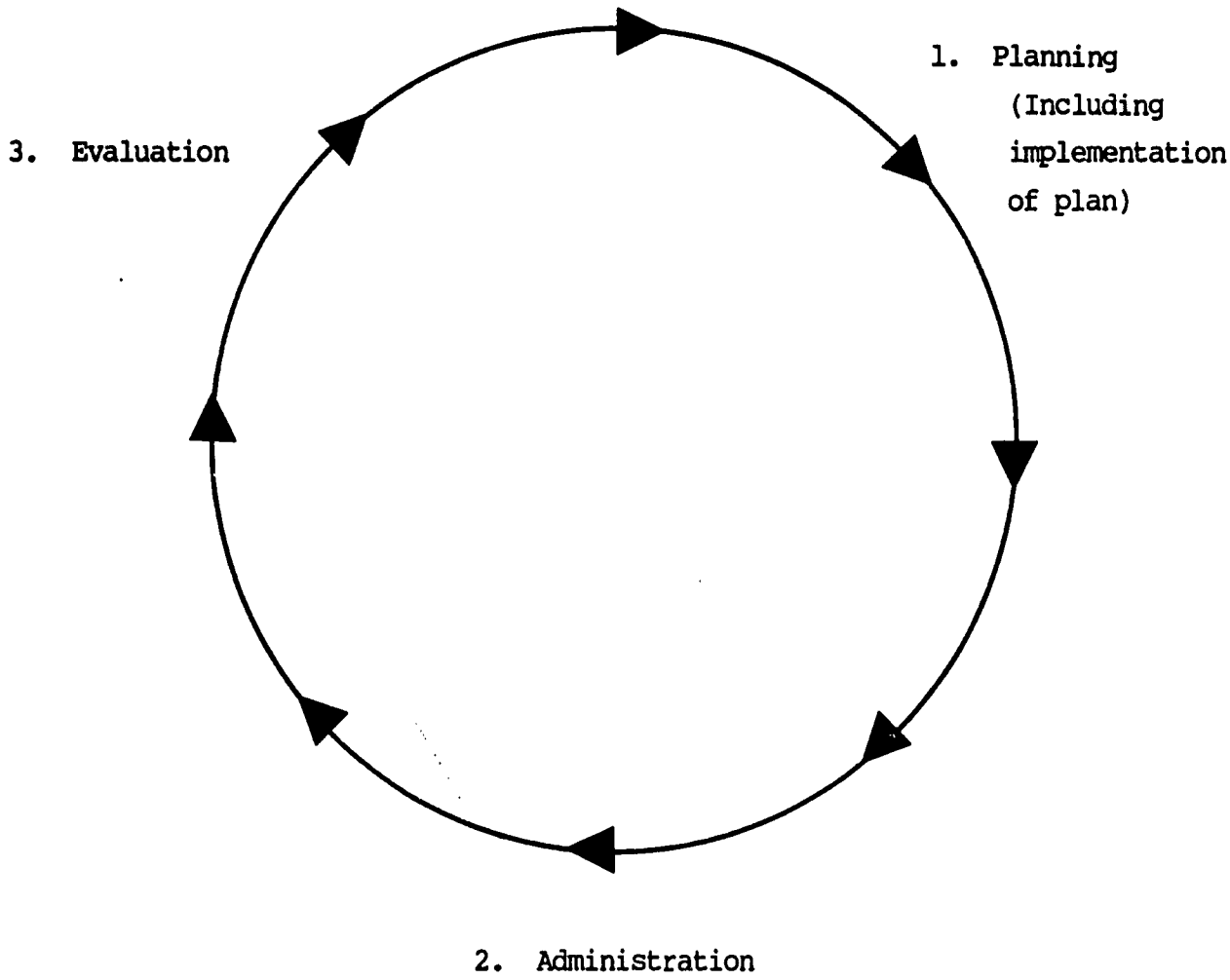

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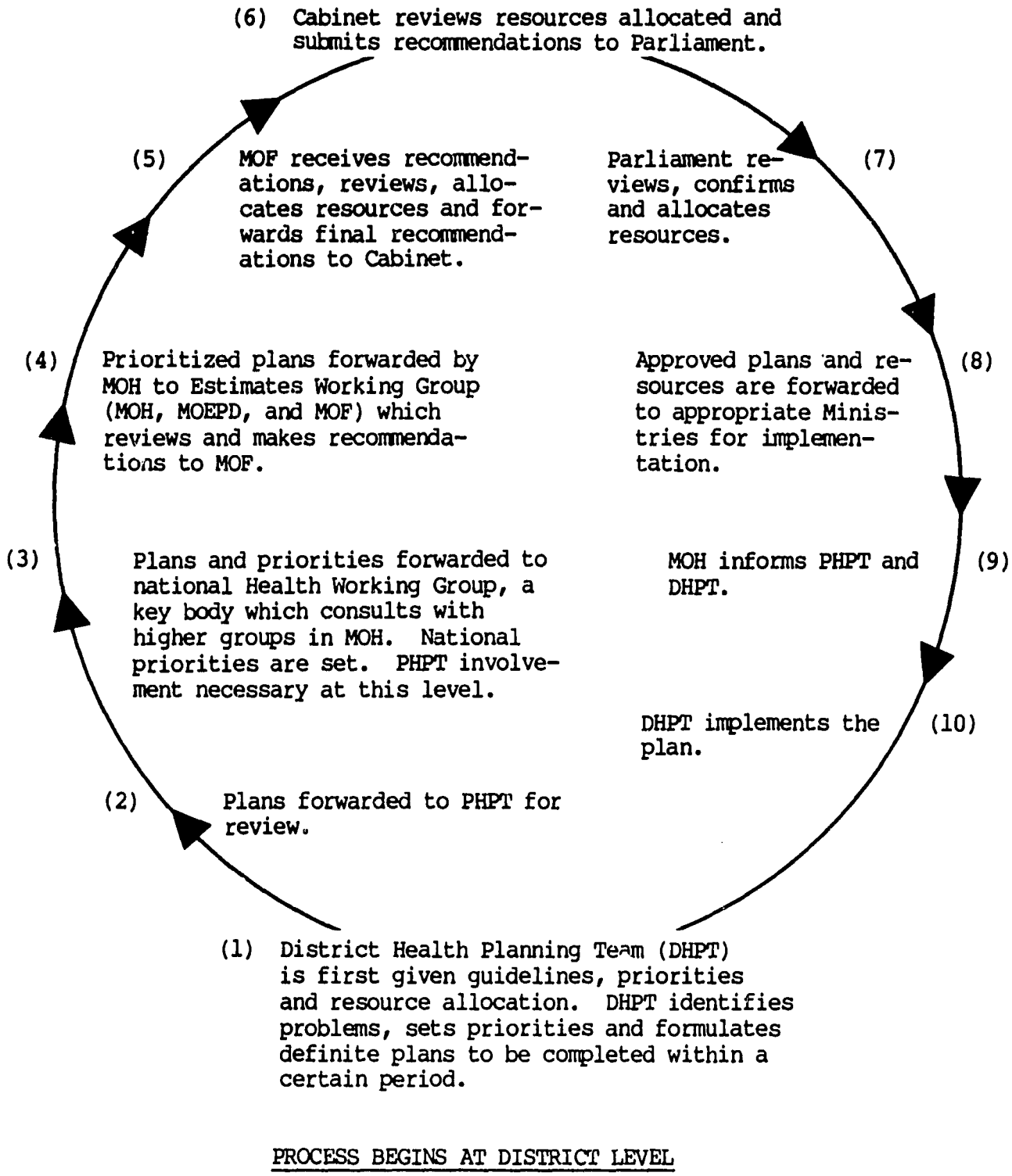
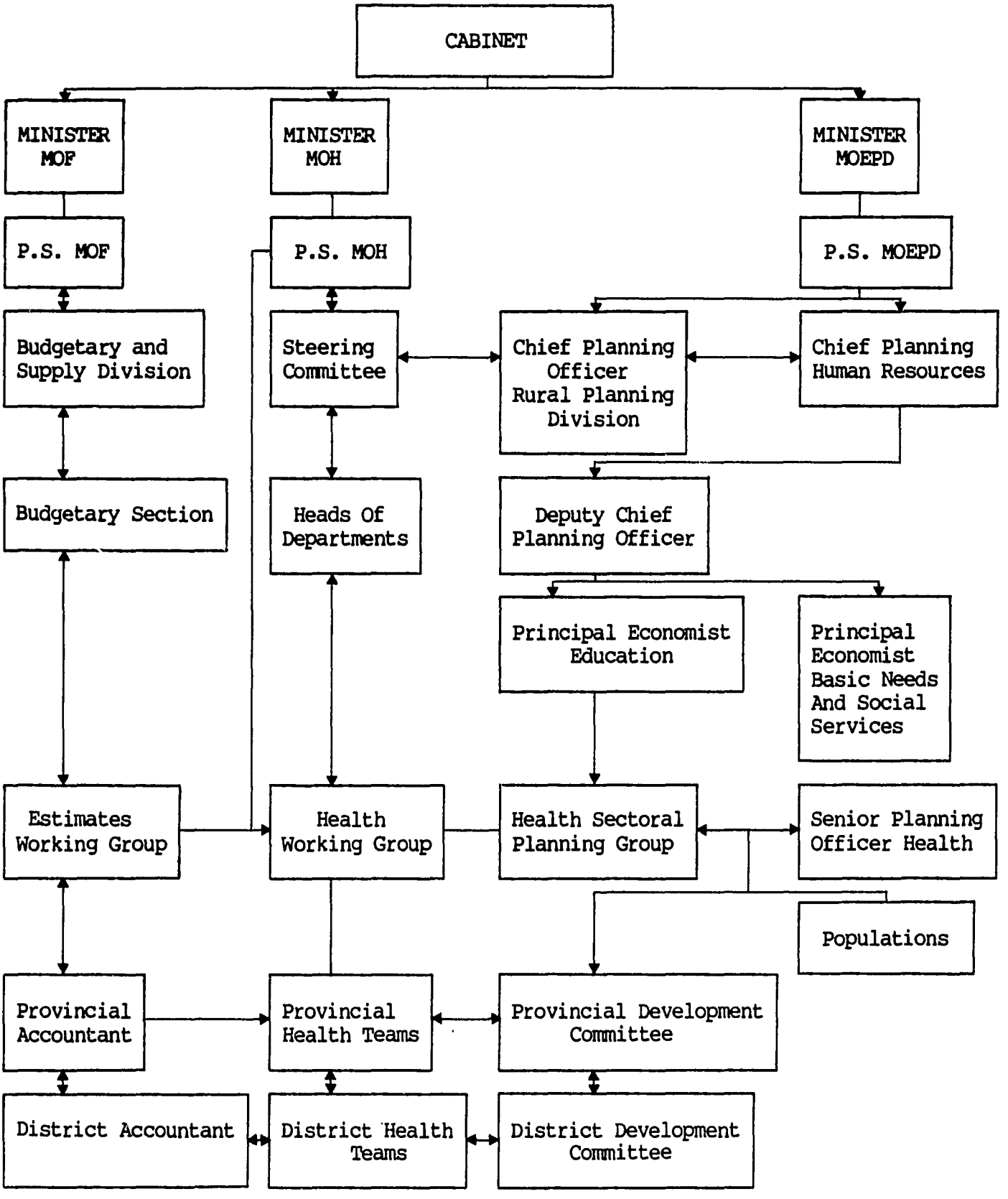
Figure B-2 The Health Planning/Implementation Cycle



PROCESS BEGINS AT DISTRICT LEVEL

Figure B-3 Organization of Health Planning Functions



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4.3 Political Factors

Political will and ideology play a vital part in facilitating effective health care planning. Therefore, due consideration and involvement of the political opinion leaders are essential.

4.4 Geographic Features

When planning health care facilities, geographical features (e.g. rivers, mountains and climatic conditions, etc.), should be taken into account to ensure accessibility and optimum use.

4.5 Demographic Features

In health planning, demographic factors are crucial, as they help the planner to determine the type of programs, target population and areas to be covered. Consideration should be given to population size, density (concentration), distribution, migration patterns, fertility, mortality and morbidity rates, etc.

TRAINING COURSE OVERVIEW

Section		Page No.
TC1	COURSE DESCRIPTION	(TC-1)
TC2	COURSE GOALS	(TC-1)
TC3	SPECIFIC COURSE OBJECTIVES	(TC-1)
TC4	COURSE DESIGN AND SCHEDULES	(TC-2)
TC5	PLANNING ACTIVITIES CHECKLIST	(TC-6)
TC6	TEACHING/LEARNING METHODS	(TC-7)

TC - TRAINING COURSE OVERVIEW

TC1. COURSE DESCRIPTION

This is a basic health planning and evaluation training course, oriented to comprehensive health care. By means of lectures, readings, discussions, and development of a practical plan, participants will be helped to acquire the skills needed to formulate, implement and evaluate comprehensive district health care programmes.

TC2. COURSE GOALS

2.1 To improve the health status of the people by improving the planning and implementation of health care programmes and projects.

2.2 To strengthen the health services infrastructure by means of providing training in health planning to District Health Planning Teams.

TC3. SPECIFIC COURSE OBJECTIVES

At the completion of the course, participants will be able to:

3.1 Identify, describe, list and differentiate the social, cultural, economic and political factors inherent in health care planning.

3.2 Identify, list, critically analyse, and evaluate:

a. Health related problems and needs
b. Actual and potential resources
c. Planning constraints
d. Planning priorities
e. Goals
f. Measurable objectives and targets

3.3 Develop and write:

a. A work plan
b. A job description
c. An activity time chart

d. An intersectoral approach
e. A resource requirements list
f. A budget
g. A budget justification
h. A comparative cost analysis scheme
i. A supervisory structure
j. An evaluation plan

3.4 Identify, differentiate, and describe key elements of:
a. A health information system
b. A community-based health care system

3.5 Describe and justify a new project or programme sufficiently well to win its acceptance at national, provincial, district and community levels.

3.6 Organize, implement and evaluate a quality assurance program to:
a. Define a problem
b. Appoint a quality of care committee
c. Develop criteriac
d. Set standards
e. Set performance levels
f. Monitor performance
g. Implement steps to correct any deficiencies found
h. Report to District Health Management Committee

3.7 Identify, list, and evaluate critical elements of an implementation plan.

TC4. COURSE DESIGN AND SCHEDULES

The Administrative Support Unit (ASU) has established a two-week course in Health Administration for District Health Management Teams (DHMTs). For practical purposes, members of the DHMTs and the District Health Planning Teams (DHPTs), are the same. It was reasonable therefore, when designing a Planning and Evaluation Training Course for DHPTs, that ways would be sought to consolidate

this course with that being conducted by the ASU. Figure TC-1 shows a recommended schedule for a programme which covers both Planning and Evaluation, and Administration. The Planning and Evaluation Training Course, however, can be provided separately or jointly with Administration training.

Materials contained in this Manual relate only to the Planning and Evaluation portion of the District Health Management Training Course. Figure TC-2 describes in more detail the agenda for the first week (Phase I), the Planning and Evaluation Training Course.

As shown in Figure TC-2, prior to arrival at the training site, DHPTs are required to come with a practical health planning problem which will be assigned by the Provincial Medical Officer (PMO). Developing a plan to solve the problem and a plan for evaluating the planned programme is the focal point and main exercise of the training course. At the end of the second week of the Phase I training, the DHPTs return to their respective districts to continue working on the health planning and evaluation assignment for three to four weeks. During that period, it is expected that the DHPT will spend 40 percent of the time on the assignment and the rest of the time on routine work. At the end of the field exercise, the teams return to the training centre for one week. They will spend two-and-a-half days presenting their completed health plans. The presentations are critically and constructively analysed by other participating DHPTs and the course teachers. The remaining two-and-a-half days are spent on the administration portion of the Health Management Training Course.

Figure TC-1 Overview of Health Management Course

PHASE	I		II	III	
VENUE	Training Center		Working District	Training Center	
DURATION	One Week 2/	One Week	Three to Four Weeks	2.5 days	2.5 days
ACTIVITIES	Planning and Evaluation 1. Lecture 2. Reading 3. Discussion 4. Critical Analysis 5. Problem Solving 6. Initial development of a new plan. (To be completed during Phase II. This is the group planning exercise.) At end of week a progress report and field work proposal for Phase II are submitted and presented orally.	Administration	1. Normal Duties 60%/Time 2. "Homework" 40%/Time a. Complete development of new plan, i.e. Item 6 b. Administration assignment	Planning and Evaluation 1. Each district team presents the plan it has formulated. 2. Each person submits a written anonymous critical analysis of each team presentation.	Administration

1/ The title, "Health Management Course," refers to the joint Planning/Evaluation and Administration Course, as shown in this figure. By design, the Planning and Evaluation Course can also be provided separately.

Figure TC-2 Kenya Health Planning and Evaluation Course Schedule—First Week

DAY TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30 a.m. to 10:30	- Welcome and Introduction of Teams - Overview Review of Course Goals, Objectives and Schedule	- Value of Planning Theory and Definitions - Problems, Needs, Wants, & Demand - Demographic Data - Morbidity Data - Constraints - Resources - Community-Based Health Care - Review Case Study	- Activity/Time Charts - Systems Analysis	- Performance Standards - Health Information System	- Implementation and Summary of Plan
10:30 a.m. to 11:00	T E A B R E A K				
11:00 a.m. to 12:45	- Statement of Problem by Each Team	- Cost Analysis - Priority Setting - Goal(s), Objectives and Targets Review of Subject and Discussion	- Evaluation	- (Work Groups Continued)	- Each team gives progress report and proposal for work during phase II (see TC4)
1:00 p.m. to 2:00	L U N C H B R E A K				
2:00 p.m. to 3:15	- Teaching philosophy and learning methods for this course.	- (Continued from Above) - Possible Goals, Objectives and Targets for each Planning Team's problem.	- (Evaluation Continued)	- Budget formulation and fiscal control.	- (Report Continued)
3:15 p.m. to 3:30	T E A B R E A K				
3:30 p.m. to 4:30	- Theory of Planning: definitions and concepts - Importance of specific planning mandate - Use of Planning Activities Checklist	- Work Groups District teams meet individually to plan, assisted by trainers.	- Work Groups	- Work Groups	- Review and Course Evaluation

TC5. PLANNING ACTIVITIES AND CHECKLIST

The following checklist describes the steps the District Health Planning Team (DHPTs) will be expected to follow in preparation for (Phase I), and completion of (Phase II), the Plan which will solve the problem assigned by the PMO.

5.1 Review planning assignment, indicate further clarification needed.

5.2 Review existing health services in the area.

5.3 Ascertain what demographic or vital data is needed (i.e., population, death rate, birth rate, morbidity and mortality rates, disease and accident incidence and prevalence rates.)

a. Existing data - ascertain reliability for planning purposes.

b. Additional data - ascertain what is needed and how to obtain.

5.4 Estimate time required and resources needed to complete the planning assignment.

5.5 Arrange to meet with a DHPT Trainer in order to receive feedback, obtain needed clarification and request additional resources needed to complete planning task (i.e., number and type of staff required, etc.).

5.6 Reconvene at the district level and assign detailed responsibility to individual team members for obtaining detailed information needed and to clarify the planning assignment (include in this process a meeting with the community).

5.7 Review constraints.

5.8 Identify needs for intersectoral cooperation and present the problem and background information obtained thus far to the

District Development Committee (DDC) for information and guidance.

5.9 Systematically analyse resources available and consider various possible solutions to the problem(s).

5.10 Work out a cost benefit analysis.

5.11 Prioritize solutions according to resources available.

5.12 Define goal(s) and formulate specific objectives and targets.

5.13 Identify and review relevant performance standards.

5.14 Develop activity time (GANTT) chart.

5.15 Develop work plan.

5.16 Plan the evaluation.

5.17 Develop an information system indicating specifically, method(s) of recording, retrieving and disseminating data.

5.18 Prepare budget.

5.19 Justify the budget.

5.20 Plan the implementation.

5.21 Prepare a summary of the plan, not to exceed two typed pages.

C6. TEACHING/LEARNING METHODS

The organization of this course and the teaching and learning inherent in the method utilized has been in use many years and has included students from all over the world. The training partic-

ipants will, in a few weeks, join the ranks of those for whom the methods of planning and evaluation have been "demystfied" (to quote an alumnus of the course).

The course will be absorbing and everyone will work very hard, but each participant will be launched on the road to scientific planning and evaluation.

The key to success lies in active learning; in learning by doing. The course is practical-applications oriented. Participants come to the training programme with a real problem to address, and the course is designed to help solve it.

Please reread all of the short parts of the "TC" section of the manual and the Table of Contents. Now focus on Figure TC-2, the Kenya Health Planning and Evaluation Course Schedule.

During the first session on Monday morning, material in the "B" section of the manual will be reviewed and all will clearly understand the importance of the District Health Management Teams in the new decentralization scheme and will better appreciate the need for effective planning and evaluation at the district level.

In the second session, the participants will formally meet each other and learn about the problem assigned to each team to solve during the course.

In the third session, the class will review and discuss in detail the "TC" section and compare "active" task-oriented learning as contrasted to teaching by lecturing and "passive" learning.

By the fourth session, everyone should have read the MAKUTANO CASE STUDY which is a model for what will be produced within less than two months. During this session the case study will be analysed. Probably the single most useful item in this manual is section TC-5, the Planning Activities Checklist, (PAC). It is the guide followed in developing the Makutano Case Study. It is a helpful

guide to program and project development. The PAC also serves as the guide to the development of the "P" section units, each of which is the distilled essence of many books and papers which were reviewed by the planners of this course to extract those elements most useful to the District Health Planning Teams.

In summary, the focus throughout the course is on practical problem solving. The Makutano Case Study serves as an example of how others dealt with a problem comparable to the one assigned to each team. A tested guide to solving the problem is provided, the Planning Activities Checklist. The component steps of planning and evaluation will be learned in connection with solving the assigned problems. The group is learning by doing. This is an example of "active" learning. Each team's "reward" is the satisfaction of seeing its plan unfold. Finally, each team will have the experience of presenting its proposal and "selling" the plan to its colleagues. Participants will also have practice in reviewing and critiquing other plans with the instructors assisting and commenting. This final presentation will also be a kind of final exam. Altogether, the process will be stimulating, exciting and very worthwhile.

CASE STUDY

Section — Page No.

CS1 SUMMARY—MAKUTANO HEALTH PLANNING CASE STUDY ... (CS-1)

CS2 CASE STUDY OUTLINE ... (CS-1)

CS3 THE MAKUTANO HEALTH PLAN

3.1 Planning Assignment ... (CS-3)

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3.4 Available Resources ... (CS-8)

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CS - CASE STUDY

CS1. SUMMARY - MAKUTANO HEALTH PLANNING CASE STUDY

A case study focusing on the hypothetical, medically underserved area of Makutano has been prepared. The population size is 15,000, which is not large enough to justify a health centre and greater than that typically served by a rural dispensary. Health problems are many and resources few, a typical situation. The solution presented is the provision of a dispensary Type II with a community-based outreach program involving organization of Community Health Committees (CHC), training of Community Health Workers (CHW), and Traditional Birth Attendants (TBA). All of these features are in line with the most recent Republic of Kenya health policy.

Altogether, the Case Study reviews virtually all aspects of the planning/evaluation process. The Case Study, together with the Planning Checklist, provide a guide to planning, and an example for District Health Planning Teams.

CS2. CASE STUDY OUTLINE

The following provides an outline of the materials presented in the Case Study.

2.1 Planning Assignment

Communication from the PMO - the Makutano DMOH

2.2 Health Sector Analysis of Makutano Area

a. Geographic Features
   - Size
   - Physical Characteristics
   - Roads
   - Rainfall

b. Demographics
- Number of people
- Age
- Distribution
- Children/workers

c. Social/Economic Description
- Where wage earners are employe
- Nature of economy
- Sources of income

d. Health Problems
- Mortality by age and sex
- Morbidity by age and sex
- Immunization status

e. Health Services
- MOH physical facilities
- Mobile health services
- Traditional services

2.3 Constraints to Development

2.4 Available Resources

2.5 Intersectoral Implications

2.6 Goals, Objectives, and Targets

2.7 Performance Standards

2.8 Activity/Time Chart

2.9 Work Plan

2.10 Evaluation Plan

2.11 Information System

2.12 Budget, Justification, and Cost Analysis

2.13 Implementation Strategies

CS3. THE MAKUTANO HEALTH PLAN

3.1 Planning Assignment

File No. XX 1/3/79

TO: District Medical Officer of Health

RE: Makutano Area

From the information available to this office it would appear that Makutano area, with a population of approximately 15,000, has no adequate health services. You are kindly requested to develop a plan for improvement of health services in the area.

Due to the prevailing economic situation, we are not in a position to undertake major development. For instance, it is not possible to fund a hospital or health centre project. Annual recurrent budget will be limited to KSh210,000.

Some capital construction funds may be made available if an innovative plan for providing community health services to a maximum number of people in Makutano can be derived.

Please submit your proposal within 90 days. You are further requested to meet with the Provincial Health Planning Team in 30 days from the date of this letter to report on progress and for any necessary consultation.

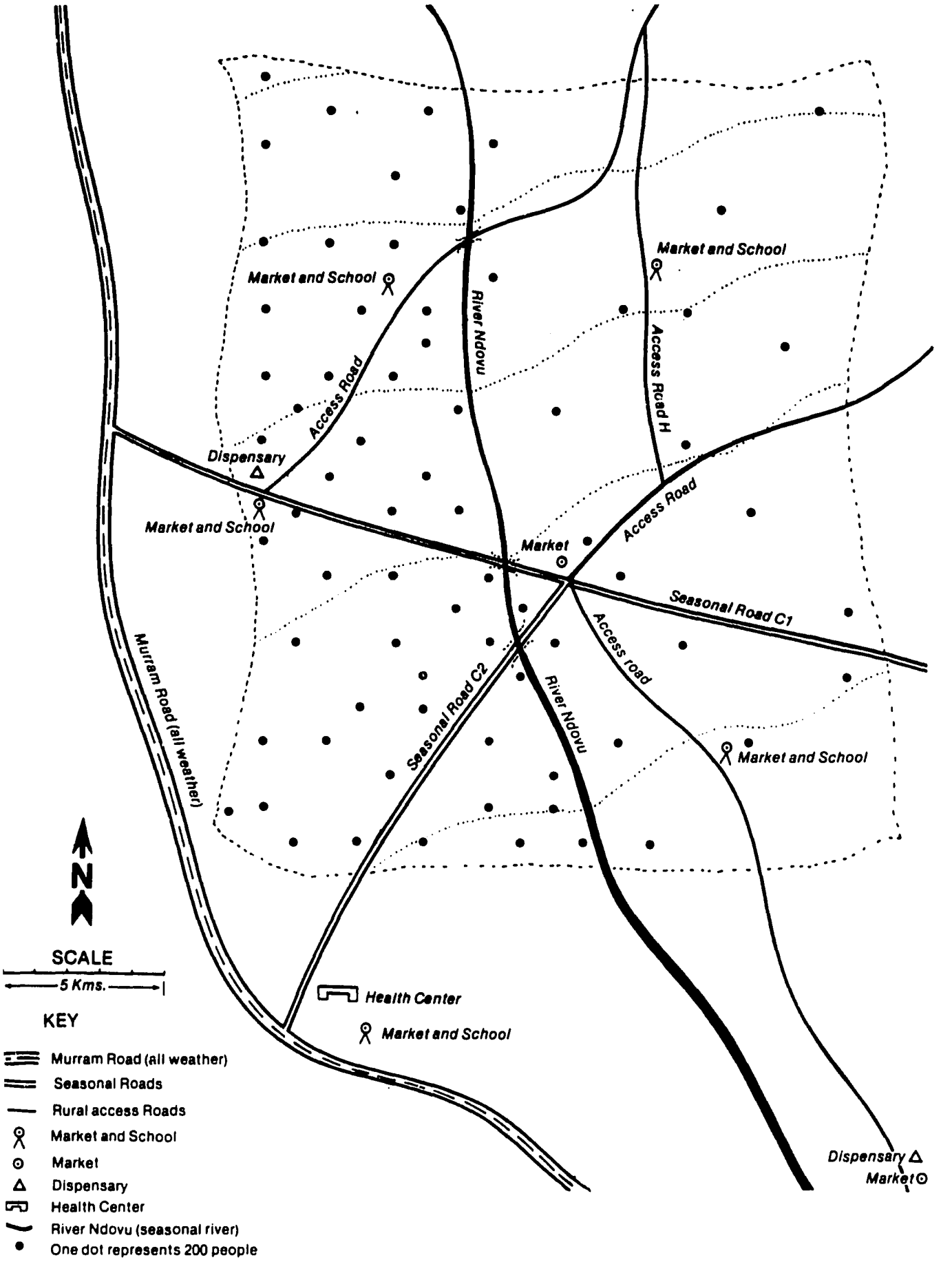
3.2 Health Sector Analysis of Makutano Area

(See map on following page)

a. Geographic Features

1. This is a rural area of approximately 400 sq. km. in Sabatia location, Magongo district. It is 50km.

A MAP OF MAKUTANO AREA



south east of the district headquarters.

2. Altitude - between 1000-1500 metres (3000-5000 ft.) sloping from north/northwest to east/southeast.

3. Rainfall in the area averages 510mm. (20.5 inches) per year in the east and 750mm. (30 inches) per year in the west. There are two rainy seasons; long rains between March and May and short rain between September and November.

4. Vegetation - Bushed grassland.

5. Communication - There is a murram road (all weather) running from the north to the southeast of the western part of the area. In addition, there are two seasonal roads occasionally maintained by the Ministry of Transport and Communications. There are a few rural access roads which are not well maintained by the local authority. River Ndovu, which is seasonal, runs from north to south through the area.

b. Demographics

The following characterizes the population of the area.

1. Approximately 15,000, people of which about 70 percent live on the fertile western part, while the rest (approximately 5,000) live on the drier eastern part of Makutano.

2. Forty-eight percent of the people are dependent children under the age of 15 (7,000).

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3. Twenty-two percent of the people are women between the ages of 15 and 49.

4. Twenty percent of the people are children under five years of age.

5. Four percent of the people are over the age of 60 years.

c. Social/Economic

The majority of the people live in family homesteads and are engaged in subsistence farming. About two percent (2%) of the people are employed in formal sectors. An average of 20 percent adult males are away from the area at any given time. Surveys carried out in the past have indicated that on the average, incomes are low and that poverty is both pervasive and extensive. However, there is good potential for agricultural development. Presently, it is noted that there exists a timber industry and a coffee factory in the district west of the area, and there are limited opportunities for employment in public service. Because of a shortage of qualified, experienced teachers, the quality of education is poor and the literacy rate is low.

d. Health Problems

This area is characterized by a high infant mortality rate (estimated at over 120 per 1,000) and high maternal mortality. The crude death, and the crude birth rates are estimated to be 17 and 57 per 1,000 respectively, giving a natural growth rate of four percent. The life expectancy is currently 44 years.

The common causes of ill-health include: pulmonary tuberculosis, malaria, malnutrition, diarrhoeal diseases, intestinal worms, measles, and acute respiratory

infections. However, immunization coverage of the six common diseases (poliomyelitis, measles, T.B., tetanus, whooping cough and diptheria) is about 15 percent.

There are very few latrines, refuse pits or protected water sources.

e. Health Services

There exists one government dispensary located on the western boarder of the area adjacent to a main all-weather road. Additionally, a health centre is located about five kilometers from the border (of the area) on the main road. A community located about 10kms. southeast of Makutano's southern border has constructed, on a self-help basis, a dispensary which the District Medical Officer of Health (DMOH) has opened as a service delivery point (SDP). These are the only accessible health delivery services for the community.

The local population use and benefit from traditional healers, who include herbalists, bone-setters and sorcerers, just to mention a few. It is estimated that traditional birth attendants conduct most of the deliveries. Nevertheless, there has been no attempt to identify and assess the extent of their contribution to the health care delivery system.

3.3 Constraints to Development

The district health planners are faced with several major, but common constraints:

a. Finance

In view of the existing economic difficulties, the government is generally in short supply of both capital and recurrent funds. Equally, on account of low incomes, the majority of people are not able to raise adequate funds to provide health care on a self-help basis.

b. Manpower

There is a shortage of skilled health workers required to staff health services above the health centre level. For instance, there are inadequate numbers of doctors, nurses and clinical officers. In addition, the workload in the Ministry of Works has grown to the extent that the available building experts cannot be deployed to undertake major health development projects.

c. Drugs, Equipment, etc.

The scarcity of finances and manpower has generated other problems. Presently, there is an acute shortage of drugs, dressings, and equipment in health service institutions. Equally, the available drugs and equipment are not equitably distributed in the district.

d. Environment

The environmental conditions of the area pose a number of problems. The roads are poorly maintained and there is no bridge across River Ndovu. During the dry seasons the river dries up.

e. Cultural

Some cultural beliefs hinder acceptance of conventional health services. Causes of ill-health are more often than not attributed to witchcraft.

4 Available Resources

The following summarizes the extent of basic resources now available to the DHPT:

a. Finance

-	Capital Expenditure:	KSh 1,000,000
-	Recurrent Expenditure:	KSh 200,000
-	Community-based Health Care	KSh 10,000
	TOTAL:	KSh 1,210,000

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b. Manpower

- Skilled - Three Enrolled Community Nurses
  - One Public Health Technician
- Semi-Skilled - Two Patient Attendants
- Unskilled - Three subordinate staff

c. Materials

Any expansion of health services in the Makutano area will require substantial new inputs of drugs, supplies, furnishings and equipment.

d. Community Participation

A self-help committee has been established in the area.

3.5 Intersectoral Implications

To improve health and welfare of the people there is need to collaborate with various government agencies and non-government organizations. The area has a high potential for agricultural development but, roads are poorly maintained and there is no bridge across River Ndovu making it difficult to move agricultural products to the market. In addition, the illiteracy rate is high. These factors emphasize the need to involve Ministries of Agriculture, Transport and Communications, and Education in a comprehensive community development effort. In order to strengthen the existing self-help groups, inputs from the Ministry of Culture and Social Services and non-governmental organizations will be vital.

3.6 Goals, Objectives, and Targets

Based on all of the information collected thus far (and described on pages CS4-7), a plan to improve and expand health services in Makutano has been developed.

a. Goal

"To improve preventive and curative health services east of River Ndovu in Makutano."

The objectives of the plan are listed below.

b. Objectives

1. To provide MCH-oriented preventive and curative health services, including immunization, health education, environmental sanitation, and water supply, family planning, pre- and post-natal services, improved delivery practices, simple curative services, and patient referral, when appropriate.

   Targets

   - To attain 30 percent coverage of target population within 36 months of plan approval.

   - To attain 60 percent coverage within 48 months of plan approval.

2. To construct a rural dispensary Type II, on rural access road H in Makutano about five kilometres east of River Ndovu.

   Targets

   - Construction, furnishing and equipping to be completed within 30 months of plan approval.

   - Staffing with three enrolled community nurses, one public health technician, two patient attendants and three subordinate staff to be completed within 34 months of plan approval.

   - Medical supplies and instruments to be fully available within 34 months of plan approval.

3. To organize a community-based Harambee (self-help) outreach programme. (This is to be carried out by the dispensary staff with the help of the health centre staff.)

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Targets

- To identify five community clusters for satellite health services, each about four kilometers from the dispensary and surrounding the dispensary.

- To organize community health committees in each of the five community clusters targeted for satellite services.

- To identify felt health needs as well as local resources.

- To identify one potential Community Health Worker (CHW) in each cluster.

The first four targets to be completed within 38 months of plan approval.

- To train CHWs at the nearest health centre within 36 months of plan approval.

- To give CHWs basic diagnostic tools and approved medications within 36 months of plan approval.

4. To provide outreach services by the dispensary staff in each of the five satellite areas once in two weeks, within 36 months of plan approval.

5. To provide supervision and appropriate in-service training for the local CHW on the day of the visit of the Dispensary Team. To initiate the same within 36 months of plan approval.

6. To organize and supervise community health oriented self-help activities, such as latrine construction, environmental clean-up and water supply improvement.

Targets

- Fifty percent of households to have latrines within 48 months of plan approval.

- Sixty percent of households to use pits for refuse disposal and sweep area around house daily within 48 months of plan approval.

- Twenty percent of households to have access to protected water sources within 48 months of plan approval.

7. To plan, organize and implement a family planning programme integrated with the health care services and intersectoral cooperative efforts, such as with school teachers and agricultural extension workers.

Targets

- Integrated Family Planning programme to be fully operational within 36 months of plan approval.

- Family Planning Services to be available to 75 percent of the population within 40 months of plan approval.

- Twenty percent of eligible couples in child bearing years to be actively practicing family planning within five years of plan approval.

8. To organize and carry out a Traditional Birth Attendant (TBA) training scheme and at the same time, inform the community of the key elements of the TBA training.

Targets

The following targets to be operational within 40 months of plan approval.

- Working through community health committees, identify all TBAs in the area.

- Advise TBAs on training programme and invite their participation.

- Provide training at the health centre.

- Training to include antenatal delivery and postnatal practices, nutrition education and family planning motivation.

- To arrange for resupply, supervision and needed in-service training (to be carried out by dispensary staff with a visit to each TBA at least once in two months).

3.7 Performance Standards

Performance standards are useful tools for evaluating quality of health services being provided by health workers. This should be objective, appropriate, reproducible and designed for all activities to be executed. The standards must be reviewed from time to time.

For the proposed new dispensary in the Makutano area, steps for managing a patient with diarrhoea have been developed. They form the basis for Figure CS-1: PATIENT CARE EVALUATION FORM, which focuses on pediatric diarrhoea. Evaluators are to use this form to measure actual performance of the dispensary staff against stated expected performance level. This will provide the basis for measuring staff performance.

Figure CS-1 also provides an example and model for evaluation of other conditions or procedures.

Figure CS-1 Patient Care Evaluation Form

Quality care plan of a child presenting with diarrhoea to a dispensary.
Below are a set of questions and/or expected examination procedures which should be carried out on every patient presenting with diarrhoea at a dispensary. A score is awarded for every point as indicated.

Information Needed/Activity (Criteria)		Expected Performance Level (Minimum % of cases where question should be asked or activity carried out.)	Observed, Actual Performance Level (For each case check if question was asked or procedure carried out.)*
Name of Patient _____			
Patients O.P. Number _____			
Date _____			
Time of Arrival _____			
Address _____			
Mother Occupation _____			
Age of Child _____			
Weight of Child _____			
Who looks after child:		90	
Mother	☐		
Baby Sitter	☐		
Method of Feeding		90	
Bottle	☐		
Cup & Spoon	☐		
Breast	☐		
Illness			
a) Diarrhoea - if yes			
(i) Duration - 1 day	☐	90	
(ii) Characteristics of Stool	☐	90	
- Watery	☐	80	
- Blood Stained	☐	95	
- Any Other	☐	80	
(iii) Frequency - 3 times in 12 hrs.	☐	90	
- more than 3 times in 12 hrs.	☐	90	
b) Vomiting			
(i) Duration - 1 day	☐	95	
- more than 1 day	☐	95	
(ii) Frequency - After feed	☐	90	
- Between feeds	☐	90	
c) Fever			
(i) Temperature - Normal	☐	90	
(ii) - Sub-normal	☐	75	
- High	☐	95	
(iii) Other Symptom	☐	80	
d) Micturation (Last Time)			
(i) More than last 6 hours	☐	90	
(ii) More than last 12 hours	☐	90	
e) Physical Signs			
(i) Fontanelle - Sunken	☐	80	
- Not sunken	☐	90	
(ii) Mucous Membrane - Dry	☐	80	
- Not dry	☐	80	
(iii) Skin - Elastic	☐	75	
- Inelastic	☐	75	

* Total all the checks for each category and compare with total cases seen to obtain a percentage figure of "Actual Performance Level." This is then compared with "Expected."

3.8 Activity/Time Chart

All of the major activities that will be involved in developing the programme have been analysed. The activities are first presented in narrative form and then in the form of a chart. The first major steps are:

a. Planning assignment received from the Provincial Medical Officer (PMO).

b. Planning proposal formulated and submitted to PMO.

c. Consultation between District and Provincial Health Planning Teams to discuss proposals.

d. Plan proposal submitted to DDC for approval.

e. Plan proposal submitted to PDC.

f. Approved plan submitted to MOH headquarters for approval.

g. Plan submitted to the Ministries of Economic Planning and Finance for prioritizing and resource allocation.

h. Plan approved by Parliament and funds allocated.

i. Approved plan, including a MOH Brief received by the PMO and DHPT, indicating that the programme may proceed.

Furthermore, it should be noted that the activities to be undertaken in the next five (5) years once funds are available have been formulated. The next step in this process is the development of an Activity/Time Chart, using the GANTT* method as shown in Figure CS-2.

The GANTT format for organizing and describing planned activities was orginally developed by a planner named Gantt. The method is now widely used by all types of programme/project planners.

Figure CS-2 Activity/Time Chart—Makutano Health Project

	ACTIVITY	DURATION				
		Year 1	Year 2	Year 3	Year 4	Year 5
1.	Project Approved					
2.	Project Programme/Brief Submitted to MOW.					
3.	Sketch Design (MOW)					
4.	Project Design Approved by MOH.					
5.	Detailed Sketch Works, Drawings (MOW)					
6.	Preparation of Bills of Quantities (MOW)					
7.	Project Tendering and Evaluation (MOW)					
8.	Project Acceptance (MOH)					
9.	Construction Work					
10.	Project Commissioning (equipment, staff, finance and drugs)					
11.	Dispensary Operates					
12.	Evaluation					
12.1.	Design and Construction					
12.2.	Health Service Operation					
13.	Community Based Health care					
13.1.	Formation of Community Health Committees					
13.2.	Identification and Training of:					
	a. CHWs					
	b. TBAs					
13.3.	Identification of Community Health Station by Communmity					
	Implementation Operation of:					
13.4.	a. Community Based Health Services					
	b. CH/FP					
14.	Service, Evaluation (supervision), on the job training, and re-supply.					

Key △ - Site meetings
△ - PMOs safari visits

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The Activity/Time Chart is constructed to show the administrative and technical processes to be undertaken to implement capital building works and opening of a dispensary facility. The process encompasses facility planning, administration and evaluation that will be initiated immediately upon approval of the programme.

Project execution commences with receipt of a brief on functional content and operational procedures prepared by the Ministry of Health, following fund allocation.

A Project Planning Team composed of representatives from the Ministry of Works and Ministry of Health is to be formed to coordinate the implementation plan. The Team will meet regularly to monitor construction works and other preparations. This includes regular site meetings by MOH, PHPT, DHPT and MOW. At the same time, the PHPT and DHPT will be arranging the commissioning of the facility. It should be noted that some of the activities depicted on the chart may have to run concurrently.

The DHPT will introduce the concept of community-based health care to the Makutano community through public meetings, with an aim of winning community participation in the improvement of its own health. The MOH and other related sectoral agencies will also play a facilitating role.

The Activity/Time Chart conveys the entire process in a glance.

3.9 Work Plan

a. Project Approval

This stage is reached when the health planning process has been completed (i.e., starting from the planning assignment by the PMO to approval by the Parliament and subsequently handed over to the Ministry of Health). The project is approved by the MOH for implementation by the District Health Planning Team.

b. Project Programme and Brief Submitted to MOW

A Project Submission Sheet (PSS) which stipulates the nature of the construction project, is submitted to the MOW. The MOH also provides a detailed brief indicating specific components (location, project's physical layout) which enables the project architect to prepare a sketch design.

c. Project Sketch Design by MOW

Project architects prepare a sketch design based on brief submitted by MOH.

d. Project Sketch Design Approved (MOH)

The sketch design is submitted to the MOH's Project Development Committee which studies the design and makes appropriate recommendations, if any, on operational layout. The Project Development Committee represents the views of the ultimate users of the project.

e. Detailed Work Drawings (MOW)

This is a detailed operational architectural design specifying actual physical components of the project (drainage, electrical, mechanical, landscaping, measurements, etc.).

f. Preparation of Bills of Quantity

This is a purely project costing activity by Quantity Surveyors providing an estimate of capital expenditures.

g. Project Tendering and Evaluation (MOW)

Tenders are invited from qualified and registered building contractors to be submitted within a specified period. In some cases, and depending on the cost involved, a project may be negotiated with selected contractors without the normal procedure of open tenders. Tenders are awarded to a competent building contractor.

h. Project Acceptance (MOH)

The Permanent Secretary, MOH, enters into legal contractual agreement with the selected contractor.

i. Construction Work

Construction of dispensary Type II is started and completed within a legally stipulated time period.

j. Project Commissioning

This process starts from the briefing stage through actual construction work to the time the dispensary is operational. It involves procurement of furniture, equipment and drugs, recruitment and deployment of needed personnel and appropriation of recurrent funds.

k. Dispensary Operates

Health services are provided at the dispensary.

l. Evaluation

1. Design and Construction

To ensure that project design and construction is accomplished to the satisfaction of the MOH, PHPT, DHPT and health workers at the Rural Health Unit Headquarters. It involves, interalia, site meetings and liability period.

2. Health Services Operation

To ensure that all operating procedures in health care delivery as spelled in objectives and targets are

accomplished. This includes development of performance standards, and a cost benefit analysis.

m. Formation of Community Health Committees

The Assistant Chief of the area is contacted and the concept of community-based health care is discussed with him. He arranges a series of meetings with the people of the area to discuss and agree on the format for establishing Community Health Committees. The Committees are charged with the following functions:

1. Identification of health problems and suggesting appropriate solutions.

2. Organizing self-help activities.

   Example: Problem

   Bad water source.

   Solution

   Organize self-help fund raising to protect water source with technical guidance by the public health technician at the dispensary.

3. Identifying Community Health Worker (CHW) candidates.

4. Providing administrative supervision to CHWs.

5. Responsible for generating funds for CHWs.

n. Identification and Training of Staff

1. Community Health Workers (CHWs)

   Community Health Committees are responsible for identifying and selecting CHWs. Guidelines for selection of CHWs are discussed with the committees, taking into consideration such factors as marital status, involvement in community activities, social status, education level, occupation, etc.

Selected CHWs are trained at the nearest health centre. Topics to be covered in the course include environmental sanitation (housing, construction and use of latrines, refuse disposal, protection of water sources, etc.), nutrition (importance of balanced diet, what foods to grow in gardens), identification and treatment of simple health problems such as fever, diarrhoea, cut wounds, information on family planning and its importance, and simple methods of communication techniques (health education). The training programme will be conducted yearly.

2. Traditional Birth Attendants (TBAs)

The Community Health Committees also identify and select TBAs. TBAs are trained at the health centre. The training is geared towards improving their performance. Areas to be covered include: recognizing antenatal cases at risk, observation of cleanliness and care of the cord while conducting a delivery, proper feeding during pregnancy and postnatally, information on family planning and its importance, etc. Before and during training, the TBAs' communities are informed of the purpose for the training and the need for them to accord necessary recognition to the trained TBAs.

o. Identification of Community Health Stations

Five sites are to be identified at which dispensary staff will conduct mobile clinics every two weeks. Community Health Committees are expected to identify buildings for such services.

p. Implementation of Services

1. Community-Based Health Services

Once CHWs and TBAs have been trained, the role of Community Health Committees spelled out, communities have been made aware of the community-based health

care, and CHWs and TBAs have been supplied with all necessary equipment/drugs, the programme will be launched and work commences. Health needs are to be identified and appropriate remedial measures instituted by the Committees on a continuous basis. Dispensary staff will visit the communities every two weeks to supervise, provide on-the-job training, bring supplies to CHWs and TBAs, and conduct mobile health services. Where funds are required to solve identified health problem(s), community health committees may raise funds through self-help (Harambee). Technical guidance will be provided by the dispensary staff as and when required.

2. MCH/FP

Equipment and drugs for Maternal Child Health/Family Planning (MCH/FP) services will be made available at the dispensary. During mobile health clinics dispensary staff will provide MCH/FP services. CHWs and TBAs will provide appropriate information about MCH/FP to clients. They will also treat minor ailments among mothers and children. TBAs will conduct deliveries.

a. Service Evaluation

Dispensary staff will conduct regular supervisory visits. During these visits they will ensure that objectives and goals as pre-oriented are being accomplished. The health centre staff and DHPT will conduct regular visits to Makutano to evaluate the programme and provide necessary assistance to dispensary staff and the communities.

3.10 Evaluation Plan

The DHPT recognized that, at the time of developing a health plan, it was also important to think of an evaluation plan.

This foresight enables the DHPT to visualize in a better way what the project intends to achieve and how those achievements can be measured. Below, is an outline of the Evaluation Plan developed by the DHPT.

a. Existing Baseline Data

This data will help the health staff to determine health status before the start of the project. The data might already exist. Some of the already existing baseline data are:

1.	Demographic	- High infant mortality, estimated at over 120 per 1000 - High maternal mortality - Crude birth and death rates estimated to be 57 and 17 per 1,000 respectively - Growth rate of 4 percent.
2.	Morbidity data	- (See Health Sector Analysis, Section CS3.2)
3.	Health Problems	- Health units not easily accessible to the population. (See Section CS 3.2d)
4.	TBA Services	- Conduct most of the deliveries.
5.	Social/Economic Factors	- Low incomes and poverty are both pervasive and extensive.

b. New Data Required

Some baseline data which will be needed to evaluate some targets, are not included in the existing data. There will probably be a need to carry out a simple Makutano community diagnosis to determine additional data

required. These data will enable the staff to reflect on the progress being made on their specific objectives and targets. However, it should be stressed that a community diagnosis should be followed immediately by provision of health services. Once the community is asked about its problems and needs, expectations regarding a response to those needs will be raised. A community diagnosis should, therefore, be carefully planned to coincide with the commencement of services.

The following information will probably be useful:

1. The community's knowledge and attitudes towards the practice of family planning.

2. Environmental sanitation - estimates on how many households own latrines, number of protected water sources within the community, proportion of households having kitchens, gardens, etc.

3. Community Resources
   - Are there any organized groups within the area? If so, types of groups, their roles and estimated effectiveness.

   - Indication on how many TBAs there are, their role, quality of their services, their support system, etc.

4. Nutrition information - Proportion of the population that is currently covered by the existing health services, nutrition programme, etc.

<u>Continuous Project Evaluation</u>

1. Statistical Monitoring

   Information generated by service statistics should be

compiled, analysed and utilized to assess performance of some activities (e.g., family planning acceptors, immunizations, etc.)

2. Monthly Meetings

   Monthly meetings should be held with health centre staff to review project progress and plan for the next month. Each staff member involved in the project should give a progress report on specific activities for which he/she is responsible. The report, where possible, should include intersectoral cooperation. Where problems are mentioned, individuals should be encouraged to state how they should deal with (or request assistance to solve) the problem. A clear, task-oriented plan for the next month should be worked out, specifying the duties to be carried out by the team members.

3. Progress Reports

   Quarterly progress reports that reflect on the activities and objectives/targets of the projects should be prepared. Guidelines on activity reporting should be developed.

   At the end of each year, a report along the same lines of the quarterly reports should be prepared.

d. Periodic Project Evaluations: Supervisory Visits

1. Dispensary staff responsible for TBAs and CHWs should periodically check on the work of these cadres and prepare reports. (Each TBA should be visited once every month.) These reports might be used for organizing ongoing training for these cadres.

2. The health centre team should periodically make

quality check visits. It should examine samples of the health information forms and dispensary/clinical procedures that have been established, and determine how well they are being followed.

If there are problems, there should be a meeting to look into ways of solving them immediately. (See also the Health Information System, and Performance Standards.)

3. If possible, the provincial team should make an on site visit once a year. This visit might be considered as a periodic external evaluation. Feedback should be given to DHPT, health centre and dispensary staff.

e. Documentation of Community-Based Activities

Information on key activities within the community should be periodically gathered, for example:

1. Identification and formation of Health Village Committees, their frequency of meeting and effectiveness of functioning.

2. TBAs - their characteristics, experience, content covered during training, etc.

3. CHWs - their characteristics, recruitment process, activities performed, performance, etc.

f. Managing the Ongoing Evaluation

The evaluation plan should be reviewed before the implemtation of the project. A health centre staff member will be identified to make sure that the various planned evaluations are being executed. Procedures set will continuously be reviewed after six months to make sure that they are appropriate and acceptable.

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g. Planning the Final Evaluation

In consultation with the provincial team, the district team will plan the final evaluation six months before the end of the project. The DHPT will carry out the final evaluation.

Evaluation results will be made available to relevant authorities - PHPT, MOH Headquarters, DDC, community leaders, politicians, opinion leaders, etc.

A one day, multi-sectoral seminar at the district level will be organized by the DHPT to discuss evaluation results.

Plans will be made for future directions of the project.

3.11 Information System

In order for the Makutano DHPT and staff to determine the progress being made or to improve the services and effectively serve the community, there is a need to have a built-in information system. Information can be obtained from the already existing Ministry of Health service statistics (information that is collected routinely), or new ways developed/designed to gather data before and during the project.

a. Existing Data

Some of the information needed for supervision, administration, planning and evaluation, will be obtained from the already existing service statistics within the Ministry of Health. Data on MCH and Family Planning attendances/acceptors, general disease diagnosis, treatment and characteristics of the patients are already being collected. However, there will be a need to check on how well the data are being recorded and kept.

Various forms for collecting this information have already been designed. However, a review of the forms might be necessary.

b. New Data

Information collected during the community diagnosis will facilitate organization and orientation of the village health committees, recruitment and training of CHWs and TBAs and planning of environmental programmes. Information might include:

1. Common diseases within the community.

2. Environmental health sanitation activities.
   - Number of latrines built
   - Number of protected water sources
   - Number of Kitchen gardens started, etc.
   - Number of deliveries conducted by TBAs
     - Number of normal deliveries
     - Number of referred cases

3. Family planning motivation.

4. Felt health needs, including medical problems.

5. Number of other cases referred to health centre.

6. Identification of TBAs, health leaders who might become members of the village health committee and potential CHWs.

The health staff will then endeavor to effectively use all of the information collected in order to facilitate planning, effective training, good service delivery and evaluation.

3.12 Budget, Justification, and Cost Analysis

The plan includes a carefully thought out budget plus a justification, including cost analysis of the funds requested. Table CS-1 shows the budget statement.

The budget request is divided as follows:

a. Development Budget

A sum of KSh1,000,000 under Development expenditure, is required for land acquisition, construction and procurement of furniture and equipment of the proposed dispensary facility. MOW will design and supervise the standard of construction right up to the operation stage. A sum of KSh130,000 (or 13% of the project cost) will be paid as professional fees to the MOW. The actual construction of the facility building is estimated to cost KSh750,000. Further, KSh120,000 (or 12%) of the funds will be utilized to procure furniture and equipment essential for the operation of health services. The contract agreement has an additional 75 percent added to allow for price escalation on building materials during the course of the contract period.

b. Recurrent Budget

It is planned that construction work will last for a period not exceeding one calender year. This implies that the facility will be opened to provide health services at the commencement of the next financial year. It is estimated that a sum of KSh200,000 will be required for operating expenses, that is to meet recurrent costs on staff salaries and allowances, training, drugs, transportation and miscellaneous expenses.

c. Community-Based Health Care (CBHC)

The Ministry of Health recognizes that good health is first and foremost the responsibility of the individual, and

Table CS-1 Budget—Makutano Health Project

A. Development

(i)	Professional fees	KSh	130,000
(ii)	Construction works of dispensary	KSh	750,000
(iii)	Furniture & Equipment	KSh	120,000
	TOTAL	KSh	1,000,000

B. Recurrent

1.	Personal Emoluments	KSh	100,000
2.	Allowances	KSh	3,000
3.	Uniforms	KSh	3,500
4.	Training (inservice)	KSh	1,500
5.	Supplies	KSh	20,000
6.	Miscellaneous/Other	KSh	12,000
7.	Drugs	KSh	20,000
8.	Fuel	KSh	10,000
9.	Transportation	KSh	10,000
	TOTAL	KSh	200,000

C. Community-Based Health Care

(i)	TBAs - Training, Equipment Supplies	KSh	2,000
(ii)	CHWs - Training, Equipment and Supplies	KSh	2,000
(iii)	Self-help Grants (Miscellaneous)	KSh	4,000
(iv)	Family Planning	KSh	1,000
(v)	Health Education	KSh	1,000
	TOTAL	KSh	10,000
	TOTAL ALLOCATION	KSh	1,210,000

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secondly, that traditional healers have a contribution to make both to cure diseases and improve health. In this regard, some limited funds not exceeding KSh10,000 will be allocated during the first financial year to carry out a pilot programme on community-based health care, in the area of health education, family planning, training of CHWs and TBAs, and miscellaneous grants to supplement self-help programmes. It is emphasized that voted funds are supplementary to local resources and that by and large CBHC will be generated from local sources.

3.13 Implementation Strategies

In early December, 1982, the DMOH for Magongo District received communication from the MOH that the Makutano Health Project had been approved. Figure CS-3 is a copy of the authorization letter.

Word of the good news began to spread very quickly, but many people - particularly those in the community - were not sure how this new activity would affect them personally (e.g., what they could expect from the new health facilities, and what, in turn, would be expected of them). Clearly, much organizing and preparatory work needed to be done before the project could become fully implemented.

For instance, the PMO will need to make sure that the DHPT is taking the necessary steps to assemble the staff for the dispensary. A careful selection process is important to facilitate the work (especially the community outreach aspects), and to minimize frequent transfers out of the area.

At the community level, the first step is to form the community health committees and to orient them. Next, the district health team together with the dispensary staff will need to plan how they can involve the community in

identifying the TBAs and CHWs who will be trained. The DHPT will also need to guide the health centre and dispensary staff on how best to carry out the training of the CHWs and TBAs. Procedures for procurement of drugs and equipment for the dispensary will need to be made clear to the DHPT, health centre and dispensary staffs. The district team should also clearly indicate the criteria and procedures for supervision and evaluation. And finally, it will be necessary to orient/train the dispensary staff in community work as called for in the plan, prior to their posting.

Figure CS-3 Authorization Letter—Makutano Health Project

File No. XX/1/3/79

TO: District Medical Officer of Health

Authorization for Makutano Health Project:

Your proposal for funding of a Health Project in Makutano has been approved by Parliament. Total funds available for capital development (construction of buildings) plus the purchase of equipment is KShl,210,000. It is further estimated that the recurrent expenses during the first year including some specifically identified community health services will account for another KSh230,000.

A friendly external donor agent has agreed in principle to meet 80 percent of the capital development cost from its microproject funds, leaving the Government of Kenya to meet the balance of 20 percent.

It is further agreed that the future recurrent costs will be met by the Government of Kenya.

You are requested to identify a suitable site for the project, and proceed with your implementation plans.

PMO
Any Province

December 3, 1982

PLANNING, IMPLEMENTATION, AND EVALUATION PRINCIPLES AND GUIDELINES

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P - PLANNING, IMPLEMENTATION, AND EVALUATION PRINCIPLES AND GUIDELINES

P1. PLANNING—THE VALUE OF THEORY AND DEFINITIONS

1.1 Introduction

Politicians, finance officials, and health managers faced with mounting pressure from growing numbers of people to provide modern health services in the twin jaws of inflation and recession are increasingly demanding rational planning. Increased numbers of effective, rational health planners are needed. In order to meet the demand for health planners, educators of these planners see the need for development of rational planning theory. This is needed so that health planners can have their own scientific basis and body of knowledge to assist them in what they do, and to help sell their plans to the public, politicians, and finance officials.

Planning theory is necessary in order to develop the type of rigor and scientific discipline demanded of planners today.

Though entire books and many articles have been written about planning theory, a number of practical, useful summary statements can be made. First of all, it is important for the planner to appreciate that there are a number of theories of planning and that no one theoretical approach may be totally applicable to a specific health planning environment. However, a knowledge of the various theories can assist the health planner in identifying an approach which suits the requirements of a particular planning task.

1.2 Theories of Planning

Planning theories are mostly concerned with planners understanding themselves and the environments in which they operate. For example, when a District Health Planning Team has a clear understanding of how the Provincial Health Planning Team functions, as well as how central planners function, it is in a better position to develop plans which will be well received.

Leading theories of planning can be categorized into three groups, each having two extremes.

a. Conceptually-Based Planning

1. Rational/Comprehensive (Also sometimes called "Administration Defined") - In this model, central programme planners usually feel they have considered every alternative and that the solution put forth is the most workable. The entire "available action space" has been considered and the solution derived from an exhaustive definition of the problem to be solved.

2. Disjointed/Incrementalist Planning (Also called "empirical" or "practical/experience-based") - All possibilities are not explored and defined. The total "action-space" is not known. Each planning group functions quite independently. There is no rigid master plan. The "action space" is ill-defined and not exhausted.

b. Policy-Based Planning

1. Blueprint - The planning agency for a given project feels every detail has been planned for with certainty. The classic model is that of a carefully designed bridge construction project where the designers feel every possibility has been considered and will permit no local deviation from their plans. They are not concerned with the total "action space," but for their project, feel they have considered everything and have the ideal plan. Implementing workers only follow orders.

2. Process - Implementation of plans is flexible and can be adapted during implementation if new and encouraging information indicates that such a change is desirable.

c. Management-Based Planning

1. Normative - This is a style or mode whereby the limits of action for a given planning group are defined, usually by a central planning body. The subsidiary planning teams, such as District Health Planning Teams in Kenya, are given goals or objectives, setting limits to the freedom of the DHPT. These limits of action or "limiting the action space" are made in a decision process and can be changed as the need may arise.

2. Functional - A style or mode of planning whereby the limits of action are not defined.

All organizations present some combination of the above described characteristics. However, there is no hard-fast rule as to which pattern or mode should be used in a given situation. Some highly centralized, rigid, doctrinaire regimes can be characterized as highly "rational/ comprehensive," "blueprint," and extremely "normative." In other words, central planners seek to plan in all areas and in every detail. In this example, there is no local initiative or local change allowed in procedures as prescribed. At the other extreme would be a totally laissez-faire economy where there is no central planning; where no one looks at the whole (total action space not defined); and, where each planning group has a narrow perspective ("disjointed/incrementalist" or "empirical") and feels free to change plans as conditions may warrant, without referring to any higher authority.

An understanding of these concepts presented very briefly will help Kenyan planners work out the "golden middle ground." Most will agree that some centralized review of all health related problems and "definitions of the action space" is desirable.

Since, Kenya is firmly committed to developing local initiative and encouraging a measure of "empirical approaches," the question is now to find an optimal balance.

1.3 Definitions of Planning

As there are different theories of planning, there are various definitions of planning. This is also consistent with the social science background of planning.

One definition characterizes planning as the rational art and technique by which a planner analyses problems and needs, resources and constraints; sets goals and objectives; considers alternative courses of action; and selects a course of action for the attainment of the goals and objectives selected which maximizes the likelihood of their attainment.

Alternatively, the term planning may be used to refer to the process of deciding in what way the future may become better than the present, what changes are necessary to help bring about the desired improvements, and how these changes can be implemented and executed.

P2. PROBLEMS, NEEDS, WANTS, AND DEMAND

2.1 Definitions

The terms, "problems," "needs," "wants," and "demand," are constantly being used by many people, including planners. Unfortunately, these terms are used in different ways by different people to the confusion of all. For our purposes, in health planning the following standard definitions are suggested:

Problem: a. A perplexing question or situation.
b. A question proposed for solution.

Need: The lack of anything requisite, desired, or useful. This may be objective or subjective. Needs may be determined by individuals external

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to a community or by families or individuals in the community and are then called "felt needs."

Want: What people would like, a desire. This is highly subjective.

Demand: A want plus the money to pay for the want.(i.e., what people say they 'want' and are willing to pay for). This is the economist's definition of demand.

2.2 Needs and Wants

"Needs" and "wants" are terms often used interchangeably but strictly speaking are different. Considering the former, the first question which should be asked when the issue of "needs" is brought up is, "Needs according to whom?"

To aid understanding of the concept of "needs," visualize a rural community of 500 people. Also, for purposes of the present discussion, only health needs are considered. At any given time in any community there is a certain amount of acute and chronic illness. There are uncorrected eye problems which could be helped by proper eyeglasses. There are hearing problems which could be corrected by middle ear surgery and/or a hearing aid. There may be dental problems which could be corrected by a dentist. There are immunized or partially immunized individuals. There will be anaemia and perhaps a mild degree of malnutrition. There may be those who are not feeling well due to intestinal parasites. There may be a child with a paralyzed limb due to paralytic polio who could be helped by a prosthesis and special training. There may be young women unable to get pregnant because of a low grade pelvic infection. There may be families with chronic diarrhoea due to a contaminated water supply, etc. The point is, there are more needs than are documented and even if they were all known, not all could be

dealt with. This is all backgound for a hierarchical scheme for analyzing and understanding needs.

The following describes ways in which needs might be conceptualized:

a. The universe of all health needs of a population. This is never really known.

b. Health needs of a community as documented by a sophisticated expert survey which includes environmental studies including such items as water testing, parasite vector studies, etc.; and also includes careful medical examination of the citizens, both physical examinations and laboratory studies, and such tests as electro-cardiograms. It is appreciated that it would be a rare situation where all of this can be done. The point to be made is that the more one employs the sophisticated techniques to search for needs the more one finds will be uncovered. These will be fewer than in a.

c. Health needs according to local health experts based on day-to-day experience, but not with the benefit of the costly studies mentioned in b., will reveal few needs.

d. Health needs according to an intelligent village headman. This will represent one version of "felt needs."

e. A not very intelligent villager who takes for granted his chronic diarrhoea and moderate malnutrition in children, may only express a "need" for the treatment of such maladies like frequent cuts and something for his arthritis.

f. Finally, there may be those who are only interested, for example, in better tasting water.

Each individual or group will be speaking of "needs" of the same village, each will be correct from their perspective, and each will have a different statement of needs. Therefore, the health planner must carefully distinguish who is the source of information about health needs, how was this information collected, and finally, how reliable is the information.

2.3 Wants and Demand

In the same village as in the example above, the people may state certain needs but when asked what they "want," will present a slightly different list.

When asked what they are willing to pay for, something quite different may emerge. It is a want backed-up with money which translates into effective demand. What people are able and willing to pay for is the real want which the economists call "demand." (We ignore the lay definition of "demand" as anything requested by the people).

There is a famous case study of a community which was promised a sum of money by a private foundation for a health project provided the community, with the help of the local health authorities, would conduct a health survey, identify needs, discuss alternatives, set priorities, and formulate a plan which included a strong community self-help component. The community wisely decided that the single most important measure to improve the health of the community was to improve the water supply, and worked out a plan whereby village labour would be used to protect the spring and pond on a hill above the village which could become the chief water supply. Community volunteer workers would dig a trench in which pipes would bring the water to a series of strategically located distribution points to replace open ditches currently in use. Outside money would be needed for pipes, taps, and some cement. The foundation gave the requested sum to the village

council on the basis of the very fine, detailed, realistic plan.

Six months later when the foundation representative returned with a photographer, he found the water situation unchanged but a wonderful soccer field and a smiling team in distinctive new uniforms. Though the community "wanted" an improved water supply, the effective demand or demand (where they spent their money) was for a soccer field and an impressive team.

In summary, the health planner must be clear about sources and accuracy of information, analyse the information, and advise/guide the community in implementing the needs.

P3. DEMOGRAPHIC DATA

3.1 Introduction

Demography refers to the study of population including such factors as size, structure, and distribution. Population is defined as the number of people living in a given area at a given time.

Population is dynamic. It is always changing. The growth (or decline) of population is a function of fertility, mortality, and migration.

The population growth rate in Kenya is high because of high fertility and declining mortality. As a result, Kenya has a young population, i.e. most of the population (48.4%) are under age 15 whereby only 4% are above age 60.

a. Fertility Trends - The main features of Kenyan fertility are that it is high, appears to be increasing, and shows considerable variation by region, ethnic group, and socioeconomic status.

Fertility rates in all age groups are high, but are higher in the younger age groups (20-29).

b. Mortality Trends - Adult mortality in Kenya is relatively lower than infant mortality. Mortality in infants accounts for about a third of total deaths. The infant mortality rate is estimated at 87/1000. The distribution of deaths by age groups indicates that more than half the deaths occur among children under five years of age.

3.2 Sources of Demographic Data

The central Bureau of Statistics, within the Ministry of Economic Planning and Development, has the main responsibility of carrying out major demographic surveys, population census, and population estimates. It has statistical officers at the provincial and district levels. Civil registration is under the Attorney General's Office. There are also other data collecting units in various ministries that gather information relevant to their own needs (for example, the health information system within the Ministry of Health).

It should be noted that the exercise of collecting data is expensive and time consuming. There are various means of obtaining demographic data.

a. Demographic Survey - Sample surveys are carried out periodically and are fairly good indicators of changes in fertility and mortality.

b. Population Census - A census is done every ten years in Kenya. This is a physical count of everybody within the country at a given time and includes many questions such as age, sex, and marital status.

c. Population Estimation - Because the census is done every ten years, estimation of the population and sample

surveys are done periodically in order to obtain updated information.

d. Civil Registration - Births and deaths are registered as they occur and this provides very useful information for various purposes such as estimating population growth rate.

e. Community Diagnosis - For health planning, specific information is needed which is not obtained by the census. Therefore, specific health surveys of the community are useful community diagnostic tools and also help in updating some demographic data.

3.3 Data Utilization

Mere data gathering without knowledge of how to use the data does not serve a useful purpose. Demographic information can be used in many ways. Examples of relating demographic data to targets are discussed below.

a. When developing an immunization project, there is a need to know the target population which the project intends to serve. The largest population should be children below the age of five years. This will help in determining or setting specific coverage targets and facilitating evaluation.

b. When designing a family planning programme, there is a need to know the percentage of female population within the reproductive ages (15-49), and fertility and mortality patterns. This information is needed in setting objectives/targets for eligible couples in child-bearing years that should be actively practicing family planning.

P4. MORBIDITY DATA

4.1 Overview

Information on health status in Kenya is limited. A survey on primary health problems in Kenya, using 1969 as a base year, indicated that vast segments of rural populations suffer from some major categories of illnesses. The categories were described as maternal and child health problems, malnutrition, diarrhoeal diseases, and communicable diseases. The preceding health conditions accounted for 50 percent of all out-patient consultations in public health institutions. Table 4-1 below summarizes data available for 1978.

Table P-1 Distribution of Out-Patient Cases at District Hospitals and Below, 1978

TYPE OF DISEASE	NUMBER OF CASES (1,000s)	% OF TOTAL CASES
Acute Respiratory Infections	5,881	31.2
Malaria	4,417	23.4
Disease of the Skin	3,262	17.3
Diarrhoeal Diseases	1,664	8.8
Intestinal Worms	1,126	6.0
Accidents	1,120	5.9
Gonorrhea	507	2.7
Measles	292	1.5
Pneumonia	288	1.5
Other	358	1.7
TOTALS	18,915	100.0

SOURCE: "Integrated Rural Health and Family Planning Project," Government Printer 1982

The prevalence of infection and infestation to some extent reflects poverty and lack of education. Malaria, though relatively uncommon at higher altitudes, continues to be an important cause of morbidity and mortality. Other major causes of morbidity among infants and young children are respiratory infections, diarrhoea and worm infestation. The incidence rate of severe protein-energy malnutrition may

appear to be low. However, in a nutrition survey carried out in 1977/78,* mild and moderate protein-energy malnutrition was found to be fairly widespread with one-third of all children surveyed to be below 80% of the standard weight index.

Most of the diseases and illnesses could be prevented or treated very inexpensively if detected and treated in early stages.

4.2 Sources of Morbidity Data

Most of the morbidity data is collected through hospital out-patient departments and in rural health facilities in Kenya. Morbidity data is collected routinely by completing various forms in the out-patient departments which are sent to the Health Information System of the Ministry of Health, where it is analyzed. Morbidity data can also be collected by carrying out special surveys, population census and estimations.

4.3 How to Use the Data

In order to plan for health services within the districts, it is important for the DHPT to know the morbidity trends or patterns within their districts. This will be of great use in objectives and target setting and in determining how to use the available resources.

P5. CONSTRAINTS IDENTIFICATION ANALYSIS

Constraints are deterrants to achieving set goals, objectives, and targets. In health planning, it is important to identify and analyse factors that constitute constraints. These may include: resources (i.e., manpower, materials, money), resource distribution, political influences, language barriers, professional

*A Nutrition Survey - Central Bureau of Statistics, Ministry of Economic Planning and Development, 1977/78.

bias, value of health as perceived by other persons/agencies, environmental factors, etc.

Economies that are mainly dependent on agricultural production are unstable because natural calamities like floods, droughts etc., may adversely affect them. On the other hand, countries whose economies depend on oil and industrial products are likely to have a steady and predictable Gross National Product (GNP). Limited resources may act as a constraint in health planning.

Physicians and other senior health personnel have a tendency to concentrate or work in urban and better developed areas of the country. This leads to mismatching of demand against supply of personnel. This phenomenon calls for close intersectoral planning in order to improve facilities in the underserved areas.

Socio-cultural values, beliefs, etc., may act as constraints. Posting of staff to areas where they cannot communicate in the local language(s) that are clearly understood by the community could be a constraint. It would also be desirable for such staff to attempt to understand social values, beliefs, and languages, as much as possible.

And, finally, political decisions frequently influence health planning and may facilitate or act as a constraint to achieving health goals. For instance, the siting of a health facility may be influenced by political considerations which may ignore health priorities. This might lead to making some adjustments in resource allocation or the need to change/adopt alternative strategies of delivering health care when most needed.

P6. RESOURCE IDENTIFICATION AND ANALYSIS

Resource identification should be guided by overall health goals. Some of the key resources required for adequate health care delivery are discussed below.

6.1 Finances

Financial resources can come from internal sources (government) or external sources (various donor agencies).

In order to draw up a meaningful health budget, it is essential to have some estimate of the available financial resources. This will act as a guide in determining priorities which are consistent with the available resources.

It also helps to determine what resources can be contributed by the community, and what contribution the government can make, e.g., putting up a dispensary or health centre in an underserved area or protecting water springs.

6.2 Facilities

This includes hospitals, health centres, dispensaries and community-based health care programmes.

Before putting up new health facilities, it is important to identify all the existing health facilities, both government and non-government, static and mobile, their distribution and utilization.

The foregoing information will assist in determining whether there is a justifiable need for a new health facility and if so, where and of what type.

Community input or involvement is of paramount importance. It is therefore important to identify community opinion leaders who are respected by the community, are able to win community confidence, and can mobilize community participation. It is also important to gain the involvement of local politicians to ensure that pressure groups and local antagonisms do not develop since this may be counter- productive.

6.3 Communication Means

Communication includes vehicles, roads, telephones, etc. These have an important bearing in health care planning and must be taken into consideration because they determine the degree of accessibility to health facilities for patients, drugs, and supplies. If these factors are not taken into account, there are possibilities of putting up health facilities which are only accessible to a small fraction of the community at certain times of the year due to some geographical considerations such as flooded rivers or inaccessible roads, etc.

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Personnel as a resource in health planning are important. Therefore, in health planning one has to make a careful selection of the personnel, taking into account tribal background, level of education, and how staff will be utilized after training. For example, admitting into training programmes candidates who come mainly from one area may create problems in future deployment as they may be unwilling to serve in remote areas like Turkana.

The number of candidates put into training should also take into account the service needs. Likewise, deployment and distribution of personnel should be consistent with the demand. Furthermore, those with experience should mix with the newly trained and less experienced. This will ensure that the staff with good know-how will assist the less experienced. It is equally important to know individual levels of qualification and capability in order to deploy staff in areas where they can be most productive. For instance, a newly trained nurse may also have had some earlier training or experience as a teacher. This combination of skills and background may suggest a future teaching role for this individual.

P7. SHORT SUMMARY OF COST ANALYSIS

7.1 Introduction

For analytic purposes, costs are categorized in two (2) ways:

a. Direct vs. Indirect Cost

1. Direct costs are those which are clearly and immediately linked to the particular activity or organization under consideration. For example, the salaries of staff and the cost of drugs are direct costs in the operation of a health care facility.

2. Indirect costs are those which are not immediately linked to the activity or organization under consideration, but which could be traced to it through cost incurred by the parent organization.

   An example of indirect costs would be the cost of training staff for a health care facility at a special training centre. When the trained staff member comes to work in the health care facility, his/her salary is charged as a direct cost to the facility. However, the cost of his/her training would constitute an indirect cost to the facility, e.g., a cost incurred elsewhere in the organization from which the health care facility benefits. With a little imagination, one can see that the trail of indirect costs for a cost item could become quite long and pass through a number of activities/organizations. The cut-off point where an analyst stops including indirect costs is somewhat subjective and two different analysts may not always agree where the line should logically be drawn. A systems model or flowchart is often helpful in determining this cut-off point.

b. Recurrent (Operating) vs. Capital Costs

1. Recurrent costs are those which recur in every costing cycle, usually a year in most accounting methods, though this is not an absolute requirement.

2. Captial costs are those which occur infrequently (possibly even only once) and which are amortized (spread or divided) over more than one costing cycle. Staff salaries are a good example of recurring costs, while capital construction costs are the most common example of nonrecurrent costs. There is no fixed rule as to whether recurrent and nonrecurrent (amortized) costs should be mingled in a single cost figure for a given activity or organization. If the purpose of costing is equity (e.g., each person who receives the service pays his fair share), then a single all-inclusive cost figure would be useful. If, on the other hand, the cost data are to be used for planning purposes, then it may be more useful to show recurrent costs and nonrecurrent costs separately. This is especially true if the nonrecurrent costs already incurred would be very different from the cost of that same item in the future. Capital construction costs in an area of rapid inflation would fall into this category.

7.2 Cost Analysis

There are three types of cost analyses:

a. Cost-control (monitoring)

Cost-control (monitoring) is simply following the cost of a particular activity or organization, usually for the purpose of assuring that it is staying within some stipulated limit. The implication is that if costs move beyond the limit, rectifying measures will be considered.

b. Cost-effectiveness

Cost-effectiveness is an analysis of input/output ratio in which input is expressed in money terms (cost), and output is expressed in some non-money unit of benefit. For example, if input is expressed as "immunized child," the output might be "polio case averted"; if input is expressed as "contraceptive continuation," the output might be "birth averted."

Cost-effectiveness analysis is a measurement of efficiency; e.g., how many units of input are required for each unit of output. It is a useful tool for evaluating different approaches, presumably with different costs, to achieving the same objective. For example, if the objective is to immunize children against polio, one could conceive an approach which requires the children to be brought to an immunizing centre, while another approach would take the immunization team to the children. Each approach would have a different cost and might even result in different numbers of children immunized. The two approaches could be compared in advance, using input and output values derived either from a feasibility study or a theoretical analysis drawn on previous experience.

c. Cost-benefit

Cost-benefit is an analysis of input/output ratio in which both input and output are expressed in money terms.

The conversion of output benefit to monetary values is often very difficult and may not be very precise.

Nevertheless, money may be one of the few common denominators available to us so as to permit the comparison of two drastically different uses of resources and resultant benefits. For example, a legitimate question for a developing nation to ask is, "Should we spend a certain amount of money on improvement of our health care system, or should we spend that money on economic development?" How could one answer such a question if one could not find a common measure for the benefits of both programmes?

While cost-effectiveness analysis is fairly straightforward and can be employed rather readily by many programme planners in the health field, cost-benefit analysis demands very sophisticated econometric techniques and concepts and is usually employed by specialists in the field. However, health-oriented people should be aware of what value judgments are being made in the analysis. Moreover, health people should also be aware that any argument concerning human value and economic benefits will always discriminate against the very old and the very young, i.e., "nonproducers," in economic terms.

7.3 Net Present Value

This econometric concept is so ubiquitous in cost analysis that the student should have some familiarity with it. As is well known to all, the value today of a given amount of money is not the same as its value some time in the future. In a period of financial inflation, money today is worth more than in the future. Net Present Value (NPV) is a tool for converting the value of future money (or cost) to a value today. This permits us to compare costs of programmes which might yield the same benefit, but in different time scales.

Essentially, the conversion of "stream" of money to NPV is the inverse operation of calculating interest, except that the rate at which the accumulation of money changes is called the discount rate instead of the interest rate, for reasons which will become obvious. The equation used is:

$$NPV = \frac{t\,M}{(1 + r)^t}$$

where $\underline{t}$ = no. of time units under consideration

M = average amount of money over time t

r = constant discount rate over time t (in our example, the inflation rate)

Example: Suppose a programme to eradicate malaria in a country would cost KShl,000,000/yr. on the average for five years. Let the constant rate of inflation be 7%.

$$NPV = \frac{5(1{,}000{,}000)}{(1 + .07)^5} = \frac{5{,}000{,}000}{1.61} = \text{KSh}3{,}571{,}429$$

But suppose that a different programme could do the job in seven years at an average rate of expenditure of KSh800,000 per year (total = KSh5,600,000)

$$NPV = \frac{7(800{,}000)}{(1 + .07)^5} = \frac{5{,}600{,}000}{1.61} = \text{KSh}3{,}478{,}264$$

It may be seen that, if all else were equal, the second programme would be the better buy, even though it appeared to cost more.

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P8. PRIORITY DETERMINATION

In determining health priorities, it is essential to identify and list important health problems. The DHPT is concerned with identifying these problems and arranging them in order of priority.

After important health problems have been identified and listed, the next step is to gather information or ascertain health data that is required to solve/plan for these problems. Data might help to review already identified and prioritized health problems.

The third step is the examination of available resources and potential constraints related to various health problems. Here the DHPT identifies the available resources and lists possible sources.

When problems have been identified, data gathered and analysed, and resources/constraints reviewed, then an examination of alternative programme strategies can be done. Those alternatives which are most efficient and effective in terms of dealing with priority problems identified earlier, are chosen.

The following factors should be considered in determining priorities.

a. The magnitude of health and disease problems identified.

b. The seriousness of the problems in terms of morbidity and mortality.

c. What problems are feasible, given the available resources, cost/demand (wants and money), etc.

d. Community health "felt" needs. When does the community state what its felt needs are?

e. Related social, economic, political, geographic and demographic implications.

Some of the above factors might carry more weight than others in priority determination. Alternatively, consideration could be limited to one or two of the above factors. However, two main factors seem to be of paramount importance in priority determination: (1) the extent to which the reduction in disease can be achieved, and (2) the availability of resources that can be used in achieving reduction.

P9. GOALS, OBJECTIVES, AND TARGETS FORMULATION

9.1 Importance

Goals, objectives, and targets are important concepts in health planning. These concepts serve to:

a. Give a sense of direction by clarifying activities to be performed in a systematic manner within a given period, subject to existing resources and constraints.

b. Enable a health planner to analyze problems accurately so as to avoid any ambivalences.

c. Provide a means of working out alternative ways of solving identified problems.

d. Enable a health planner to set priorities and formulate appropriate work plans.

e. Assist in formulating realistic budgets.

f. Provide a means of establishing prerequisites for effective evaluation.

g. Help an organization to convince the government and/or donor agency to provide needed resources, such as funds.

9.2 Definitions

a. Goal. A goal is a broad statement of what is to be accomplished. It normally deals with broad economic, social

and/or political aims. It may be measurable in quantitative terms or it may be identified only through quantitative and behavioral criteria.

EXAMPLE:

To improve preventive and curative health services east of River Ndovu in Makutano.

b. Objective. An objective is a specific measurable result or effect which a programme or project is to accomplish.

EXAMPLE:

To construct a rural dispensary Type II on rural access road H in Makutano about five kilometres east of River Ndovu.

c. Target. A target is a specific end-product expected at any level of the objectives of a programme or project. Targets are frequently time and quantity specific.

EXAMPLES:

1. Construction, furnishing, and equipping of a rural dispensary Type II to be completed within 30 months of plan approval.

2. Staffing with three enrolled community nurses, one public health technician, two patient attendants, and three subordinate staff to be completed within 34 months of plan approval.

d. Programme. A programme is a broadly-based activity, such as development of a network of dispensaries and satellite clinics or a traditional birth attendant and supervision scheme, which aims to solve a broad range of family health related problems.

e. Project. A project usually focuses on a specific problem and is limited in time. The World Health Organization's smallpox eradication project is a classic example.

P10. ACTIVITY/TIME CHARTS

Activity/Time Charts are simple to construct and highly useful aids to the planner and administrator to simplify the planning, administration and evaluation of a programme or project.

The simplest activity/time chart is often called a GANTT (or GANT) chart after the man who popularized its use. The simplest Activity/Time Chart is a bar graph with activities down the left side and time running across the horizontal axis. See the illustrative chart attached.

The next phase of evaluation can be to add simple milestones. For example, for a rural health programme which includes training of 30 Community Health Workers (CHW) in three lots over a two year period, the bar reflecting CHW training might have three small boxes indicating when the training of each group is to be completed.

Finally, by indicating, using arrows, critical relationships between the boxes or milestones on various lines, one creates a network activity time chart. Such a chart is sometimes called a PERT because it is sometimes used by the Programme, Evaluation and Review Technique people.

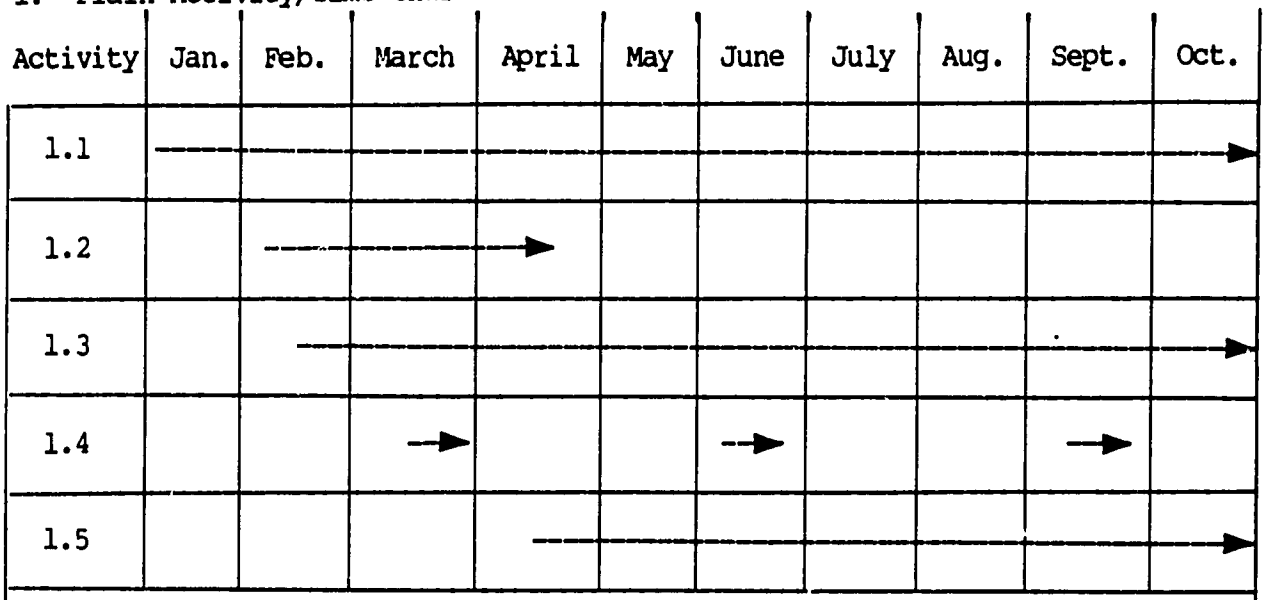
The first two are useful and easy to construct. The network chart is more difficult because interrelationships, in practice, frequently change and one may have to spend excessive amounts of time modifying the charts with little gain.

Use of plain Activity/Time Chart with milestones as a routine aid to planning is practically mandatory. At a glance they help planners and reviewers see a proposal laid out and see many interrelationships.

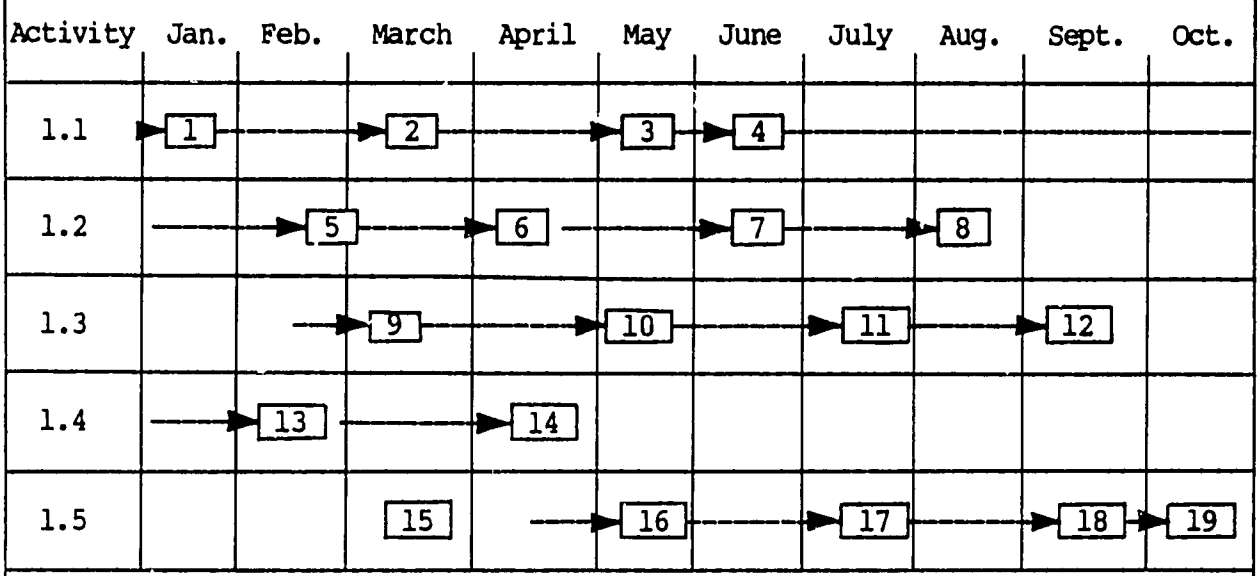
Figure P-1 shows various examples of how Activity/Time Charts can be constructed.

Figure P-1 Activity/Time Chart (GANTT)

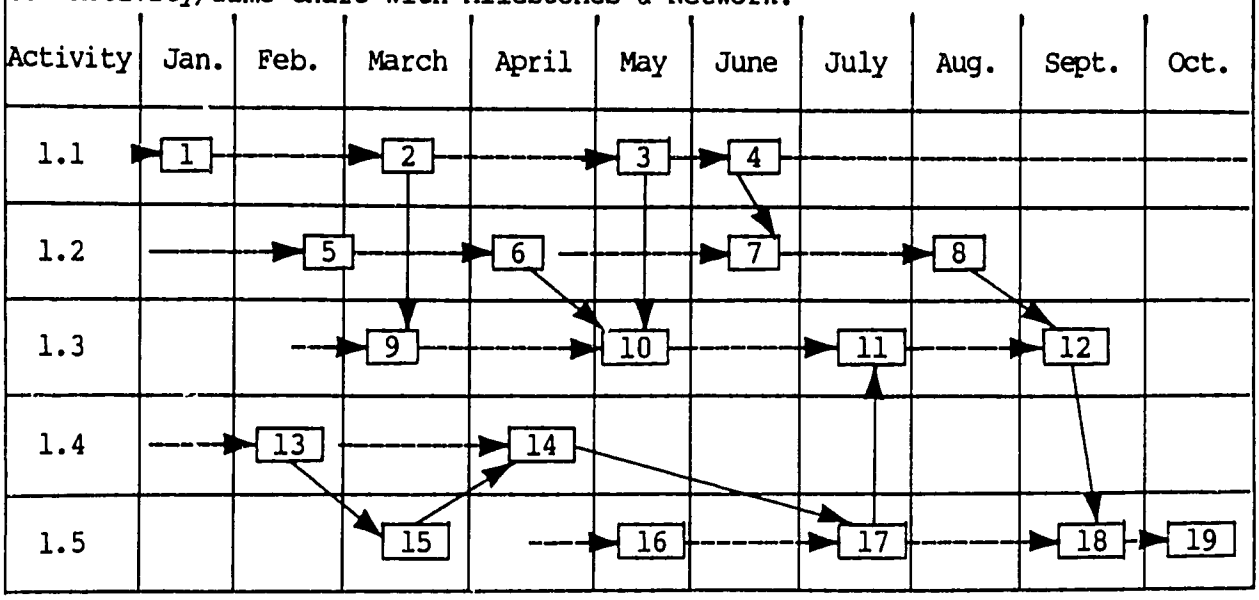
1. Plain Activity/Time Chart.



2. Activity/Time Chart with Milestones.



3. Activity/Time Chart with Milestones & Network.



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P11. EVALUATION

In addition to this section, important elements of evaluation are viewed in sections, P7. - Short Summary of Cost Analysis, P12. - Systems Analysis, and P13. - Performance Standards.

In this section, a comprehensive outline of what must be considered in planning and carrying out an evaluation is presented. Altogether, this section and sections P7., P11., and P13., constitute a comprehensive introduction to the health evaluation field. In addition, the Makutano Case Study will be helpful in mastering concepts and approaches to evaluation.

11.1 Definition of Evaluation

Evaluation is defined as the analysis of a programme or project and measurement of what progress has been made toward accomplishment of stated goal(s), objectives, and targets since the baseline period (or since the last evaluation). The purpose of evaluation is to improve future performance. Evaluation addresses itself to answering the question, "How well is the programme or project doing?"

Evaluation is both an art and a science and is becoming increasingly precise because of the availability of better methods and tools for measurement and analysis. Essential prerequisites to useful evaluation are a cooperative, facilitating environment, clearly predetermined goal(s), objectives and service standards, accurate measurements and baseline data.

11.2 Prerequisites to Evaluation

a. <u>Goal(s), Objectives, Targets and Quality Measures</u>

These terms answer the questions:

1. Where?
2. What?
3. When?
4. By whom?
5. How? (Includes criteria and standards.)

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b. Facilitating Environment

1. Cooperation and support.
2. Consider the reasons for evaluation.

c. Reliable Information

1. Baseline (i.e., demographic, morbidity, mortality, community problems, environmental circumstances, etc., which existed at the start of the planning cycle).

2. Ongoing (i.e., collected continuously, including community problems, health centre or dispensary statistics).

11.3 Concepts

The following describes the major concepts used in evaluation.

a. Internal and External Evaluation

"Internal" refers to evaluations done by staff within the programme. "External" refers to evaluations done by an outside group.

b. Continuous and Episodic (Or Periodic) Evaluation

c. Quantitative and Qualitative Evaluation

(See section P13 PERFORMANCE STANDARDS)

d. Evaluation by Stage in the Programme or Project Cycle

1. Input Analysis.

(Number and kind of personnel, drugs, immunizations, health education efforts, etc.)

2. Process Analysis.

This has to do with how the inputs are used (i.e., are staff doing their jobs, are vaccines being used, etc.).

3. Intermediate Indicator Analysis.

An example of an intermediate indicator would be to use "oral contraceptive continuation rates" as a means of predicting a drop in birth rates. (Because the pill is so effective, a woman using them continuously will not get pregnant, and for a group of continuous users, one can accurately predict a drop in birth rate. Another example of an intermediate indicator, is a properly carried out smallpox immunization programme for the majority of the population. The vaccine is so good that the statistics regarding the population immunized (intermediate indicator) are a good predictor of the end result.

4. End Result Analysis.

(That is, decrease in morbidity, mortality and birth rates.)

e. Measurement Tools (e.g., service statistics describing what and how much was done, how it was done, and how well it was done.)

f. Analysis of Information

g. Interpretation of Data

h. Formulation of Recommendations

i. Decision-making

j. Implementation

11.4 Evaluation Procedure Checklist

a. Review the Planning Assignment

Determine the following:

1. Purpose (e.g., who or what is to be evaluated?)

2. Who or what agency requested the evaluation?
3. How is the evaluation being funded?
4. How will the results of the evaluation be used?
5. Time available for evaluation.
6. Resources (e.g., expert personnel, transport, data processing equipment, etc.).
7. Constraints (e.g., time, money, poor data, etc.).

b. Plan the Evaluation

1. Time and resources allocated to review the plans, baseline data and reports (i.e., existing information). Include in this area interview with senior officials.
2. Time and resources allocated to field activities.
3. Estimate time needed to review and analyse old existing data.

d. Interpretation.

e. Recommendation writing.

c. Data Assessment

Review plans, baseline data, and notes of senior official interviews, especially look for the following:

1. Existence of planning document, and if so, does it contain:
   - Demographic information
   - Geographic information
   - Economic data
   - Relevant social/political data
   - Health status characterization, i.e., morbidity, general mortality, infant mortality rate, etc.
   - Health resources analysis
   - Relevant intersectoral resources listing
   - Constraints analysis
   - Community resource analysis, i.e., self-help efforts, money, indigeuous medicine practitioners, TBAs, etc.

2. Existence of clear goals, objectives, and targets.
3. Existence of quality assurance guidelines and measures (criteria and standards).

d. Estimate Reliability of Information Available

e. Conduct

Field level evaluation including the following:

1. Analyse data routinely collected and how it is collected.
2. Ascertain whether those gathering the data understand the purpose of the exercise, and to what extent the district level personnel intend to use the data for ongoing planning and evaluation.
3. Are the staff meeting the quantitative targets?
4. Are the staff following prescribed procedures qualitatively?
   - Physical diagnostic protocols
   - Laboratory procedures
   - Records properly maintained
5. Are staff apparently cooperative, friendly, and truthful?
6. Are patients served satisfactorily?
7. Patient complaints and suggestions.
8. Are objectives and targets being met?
   - Quantitatively?
   - Within stipulated time frame?
   - Qualitatively?

   NOTE: Explain any shortfalls or significant accomplishments of the targets at an earlier period and also in quantity..
9. Community self-help programme evaluation where indicated.
10. Intersectoral efforts -- evaluate where applicable.
    a. Do they add or detract from programme? Explain.
    b. How might intersectoral efforts be improved.

f. Review, Analyze, Interpret and Summarize Data

P12. SYSTEM ANALYSIS

12.1 Introduction

A basic overview of systems analysis concepts is presented because the systems approach is useful in health management, and it is quite possible for District Health Planning Teams to use systems analysis techniques in their work.

We are all systems analysts. Everyday, consciously or unconsciously, we apply a "systems approach" and use tools of systems analysis in managing our daily affairs. We establish overall goals such as the goal to acquire material goods, esteem, and satisfaction. We also establish objectives which, when accomplished, facilitate reaching our goals. Examples of objectives are to sell more goods or to practice our profession with a high degree of excellence. We recognize that we are subunits of a large system and somewhat dependent on other persons and events. We think we have some effect on the large system (we vote, we are pleasant). We sketch out our relationships with other elements of the system (at least mentally) to try to understand who or what they are, how they affect us, and how we can affect them.

We modify our own actions on the basis of perceived reactions from other parts of the system. The procedure (technically labeled "flowcharting") is basic to the systems analytic process. It is also one of the most common methods we employ to organize our daily living, whether organizing a sequence of tasks to do or places to go. In the latter case, especially, we try to arrange the sequence to meet some personal criterion of efficiency, e.g., least time used or least distance traveled. And finally, we employ cost analysis (see P7 - Short Summary of Cost Analysis), to monitor household expenditures, to compare costs of two or more types of items manufactured for the same basic purpose such as Mercedes Benz and Volkswagen automobiles.

A systems analyst would consider these as cost-effectiveness analyses. A more complicated cost-effectiveness analysis could consider the relative cost and benefits of two more available courses of action, such as whether to take an expensive long vacation or purchase a new car. Viewed in this light, the fundamental concept of systems analysis is the application of common sense in a somewhat formalized way to problem-solving and decision making.

The purpose of this section is to acquaint the reader with the generalized approach to problem-solving and action-planning called the "systems approach." Some basic and useful analytical tools will be introduced. By understanding and applying rudimentary systems analysis to his own problems, the reader can gain the confidence needed to move on to more sophisticated applications. This section will enable the motivated reader: (1) to personally apply the techniques described in appropriate situations, and (2) to recognize the potential usefulness of systems analysis in planning, management, and evaluation of more complex solutions to problems.

2.2 Systems

a. Definition of a System

In simplest terms, a system is a collection of interacting parts. For practical purposes, it is usually limited to the set of parts (or components) which play some meaningful role in the context of interest. Ideally, all the components of the system are supposed to drive towards a common goal. This is quite rational, but unfortunately not often so, especially in human social systems. For example, in health care systems of many countries where health care revolves around a private enterprise economic format, one of the goals of health providers (e.g., doctors) is to make a profit at the same time that recipients (patients) are trying to minimize their costs.

b. Characteristics of Systems

1. Boundaries

By definition, then, and for obvious practical reasons, systems are considered to be bounded. Elements that have little, if any, impact on the functions of the system are excluded. There are two approaches to describing the boundaries of a system. In the first approach, all the components which have an effect on the functioning of a system (even those over which the system operators have no control), are included within the boundaries of the system. The second approach sets the boundaries of the system to include only those components which can be manipulated by the system operators while still recognizing the impact of those components which have been excluded. In this second format, the components included are labeled endogenous, while the excluded ones are labeled exogenous. An example of an exogenous component in the health care system would be national policy on the minimum wage, which would effect health care costs but which the national health care system probably could not influence in return.

In applying systems analysis, it does not make much pragmatic difference which format is used to describe the system.

2. Nested System

Nearly all systems, especially social systems, exist as subsystems of larger systems and in turn are divisible into a series of interconnecting subsystems. Each subsystem could also be viewed in its own right as a system. For example, an individual hospital can be viewed as a subsystem of a larger health care delivery system comprising a number of other components such as other hospitals and clinics. These are in turn part of an even

larger delivery system encompassing in addition to hospitals and clinics, private providers, a financing scheme, manpower training, organization, drug and equipment manufacturers, etc. A national system for provision of health services may be seen as only one component of an even larger national system of social welfare which also provides for public education, public safety, public finance, and external relations. Returning to the example of a hospital, it can be seen that the hospital is composed of a number of subsystems.

3. Rationality/Irrationality

Systems may be characterized as rational or irrational. In a perfectly rational system, all elements of the system operate in harmony, each tending to enhance the effect of the others. In an irrational system, one or more components operate to negate part of the effect of the other as the system moves to accomplish its purpose. As mentioned earlier, some degree of irrationality seems inevitable in large social systems because its human components may have different and conflicting goals. The degree of irrationality in a given system has a strong influence on both its efficiency and its effectiveness. Effectiveness is the measure of how well the system actually accomplishes its goals. Efficiency is the measure of the level of some activity in the system relative to expenditure of resources. Both of these concepts will be expanded upon in the context of health care in a later section.

4. Inputs/Outputs

The principle of input/output is very important in systems analysis. Input refers to resources made available to, or expended by, the system. As a rule,

inputs come into the system from outside its boundary. Output is a product of the system. For example, in a training system, untrained persons are one of the inputs to the system and trained persons are the outputs. With regard to the therapeutic subsystem of a larger health care system, sick people are an input and, theoretically at least, cured people are the output. Note that the output of one system may be the input to another system at a different level or to another subsystem at the same level.

5. Deterministic/Stochastic

Finally, a particular system can be characterized as deterministic or stochastic. (Stochastic may also be called "probablistic.") A deterministic system is one which when repeatedly given identical inputs will yield the same output every time. That is, without considering possible malfunction, it is 100 percent predictable. Many physical systems such as electrical or mechanical systems are deterministic. By contrast, it is hard to imagine a social system of any degree of complexity being fully deterministic. Even very simple systems in which human beings play key roles are stochastic systems. (There is unpredictable variation.)

12.3 The Systems Approach to Project Management

a. Value of the Systems Approach

The systems approach to project management centres on the view of the programme as a system whose goals (i.e., desired result or output) are well-defined, whose component parts are known, and whose linkages are understood as fully as possible. In short, it stresses an understanding of how the system operates. Definition of goals, components, and linkages does not come automatically, however, at least not to the extent that an application of the systems approach requires. The

manager must see a real and pressing need for definitions and set about with determination to do this task. Once this comprehension is realized, effective management is much more likely to follow. For example, knowing that social systems often are irrational (in the systems sense) may lead the thoughtful manager to conclude that his system needs some redefinition of objectives and targets.

A rural clinic is a good example of this. The most obvious objective of the clinic is to provide care. A less obvious objective, but just as real and important in determining how the clinic functions, is that of providing jobs for the people who staff it.

Knowing the system components and how they interact offers an opportunity for rational planning for change. If one knows the system, one can know in advance what the likely result will be if inputs or linkages are altered.

The value of formulating objectives explicitly can hardly be overstated. A clear statement of objectives encourages the process of evaluation, i.e., of measurement of progress toward those objectives. Without a commitment to evaluation, a system may function for a long time at a lower level of efficiency, and/or waste precious resources, and fail to accomplish what it ostensibly was established to do. Eventually, such failure would probably be detected, but a built-in evaluative component will detect the problem much earlier and moreover, if properly designed, will point out the way toward a workable solution.

12.4 Implementing the Systems Approach

a. Establishing Goals, Objectives, and Targets

It is worth stating again that a precise, written statement of the goals, objectives, and targets of a pro-

gramme is an invaluable aid to successful management. This is where implementation of the systems approach begins.

Within each objective is a set of targets which, if attained, are defined as accomplishing that goal. Whereas goals may be stated in generalized terms which are very difficult to quantify directly (i.e., "improve health status," "reduce birth rate," "improve environmental sanitation," etc.), objectives with targets are specified in quantifiable terms which enable the manager and his staff to evaluate the progress of the programme towards its objectives.

b. Defining the System

The next step after defining goals and objectives is a definition of the system itself. For the manager, this is a process of stock-taking: What resources are available to do the tasks, how are they organized (or how should they be organized), what are the constraints of the system? Put in the formal language of systems analysis, we are asking for a statement of the system elements (and by a process of exclusion, thereby its boundaries) and their linkage, or how they interact with one another. Constraints represent certain conditions which are stipulated in the sense of maximum resources which may be input and minimum performance standards, or output, which must be met.

c. Evaluation of the System (See also the Evaluation and Performance Standards sections)

A built-in evaluative subsystem serves as the manager's monitor of how well the main system is functioning, that is to say, whether or not progress is actually being made toward achievement of the system's objectives. It is possible to construct and operate a system without an integral evaluative subunit, but this almost inevitably

means that the manager is doing evaluation in his head and in a somewhat haphazard manner. Much more certain results can be obtained if the evaluation process is carried out in a more formal manner.

The basic evaluative measurement is that of effectiveness, in which quantitative indices are compared to target values. One of the mistakes most frequently made in the name of evaluation is measuring process or activity, and not outcome. This is why it is so important to frame objectives in quantitative terms.

Having emphasized the value of genuine outcome evaluation versus mere process-counting, it is useful to back away from this hard-and-fast position and recognize some of the realities faced by the manager in a true-life position. Sometimes, the real outcome or objective desired is one which occurs quite gradually and thus, may not show measurable change over short periods of time. In fact, the variability inherent in many outcome measurement devices might even allow for apparent change in the wrong direction when in fact the trend is in the right direction. Therefore, process data may be the only quantifiable material available to evaluate a programme as it moves along. This is quite acceptable as long as the ultimate measurement flows rationally from the interim measurement of choice.

For example, in a programme where the goal is to improve the health of children and, within which one objective is to reduce the incidence of polio by X%, a very useful interim measurement may be the number of children immunized against polio. On the other hand, if another objective under the same goal is to improve nutrition status, counting the number of mothers who sit through health education lectures on child-feeding may not be a very good proxy for level of improvement in nutrition

status because a good many factors intervene between the two variables, i.e., cause and effect are somewhat uncertain.

Although effectiveness is the basic concept in evaluation, there is a second evaluative concept which is important to the programme manager - efficiency. Where effectiveness shows the progress of the system toward its objectives and goals, that is to say, whether levels of outputs were meeting established targets, efficiency deals with the relationship between output levels and input levels, or consumed resources. In testing the efficiency of his system, the manager is comparing outputs to inputs in an effort to determine if the output/input ratio is the best obtainable within the constraints imposed on the system by exogeneous forces. In an immunization programme, for example, there may be several possible modes of allocation of staff and transport from the time the vaccine is received from the manufacturer to the time when the vaccine is injected. Two possibilities might be adopted: (1) have the field staff start out for the field each day from a central place, carrying the day's supplies with them; or (2) keep part of the staff and part of the transport fleet in the field from the beginning of the programme to its end and use the remaining staff and transport to resupply the field group. In facing such a problem, the manager's objective is to maximize the output/input ratio by obtaining the largest number of immunizations per unit time (in this case a fixed level of resources is present and the objective is to make maximum use of it).

When inputs are converted to monetary terms, it is a special case of efficiency evaluation which has come to be called cost-effectiveness. As with effectiveness, it is perfectly legitimate to employ interim process measurements in evaluating efficiency when an assumption

of high correlation between interim process and outcome have already been validated. In a polio immunization programme, the objective is not the process of immunization as such, but to bring about circulating antibody at a protective level in a very large proportion of those receiving the antigen. Since it has been demonstrated that injecting the antigen reliably leads to formation of protective antibody, we may use the process measure as our immediate yardstick. (This is an example of a good "intermediate indicator.") Nevertheless, the evaluation of the programme in the long run should be based, first, on a demonstration of high antibody titres in the recipient population, and second, in the longer run, a reduction in the incidence of polio in that population.

d. Feedback/Modification Loops

A feedback loop is a mechanism for monitoring output at one or more points in the system and then using this information to modify the inputs to the system. Hence the loop (or circular) concept: inputs generate outputs which lead to new inputs which in turn generate new outputs. The "looping" is carried out (also called "cybernetics") either on a continuous or a recurring basis. In a sense, feedback loops are actually part of the total scheme of evaluation, with an action component which aims to "adjust" the system as it operates so that outputs are more effective and/or efficient, or that cost-effectiveness is enhanced.

The most logical places to insert feedback loops are at points in the system where significant interim measurements can be obtained. In the immunization programme, used as an example in the previous section, the manager might ask for daily or weekly reports on the number of immunizations given and for sample survey results on pre- and post-immunization antibody levels.

From these daily or weekly reports of immunization, the manager could try to determine (perhaps by means of actual field experimentation, or perhaps by means of deductive logic) if there might be some other way of employing his available resources so as to yield a higher rate of immunizations. With the information on the antibody levels, the manager could, hopefully, show that the ultimate objective - decrease in specific morbidity rates - is actually likely to ensue, or, were he to find that titre changes were unsatisfactory, examine his system for flaws which might yield this result, for example a flaw in the cold chain which is required for some live vaccines.

12.5 Summary

Principles and practical examples of systems analysis have been presented which can be of great value to the DHPT and must be very carefully studied and considered in order to derive the full benefit of this section.

P13. PERFORMANCE STANDARDS

13.1 Rationale

There are QUANTITATIVE and QUALITATIVE aspects to the delivery of effective health services. To provide a service which is not properly carried out does a disservice to the country. This subsection, therefore, is an introduction to quality of care review. The purpose of quality of care review is to help ensure health services of acceptable quality.

13.2 Definitions

a. Quality of Care

This has a scientific element, that is, one follows certain scientifically determined procedures such as blood typing and cross matching. It is also influenced by what is called "contemporary norms," i.e., what is taught and practiced by the recognized leaders in the medical profession.

b. Criteria

The statements that define elements of care which have been developed for use as quality of care indicators or measures. Note, the terms criteria and guidelines are used interchangeably.

c. Standards

Are the expected performance levels for given criteria. For example, in the establishment of criteria for an antenatal examination, there are usually accepted methods of taking a history, carrying out a physical examination which includes, taking blood pressure, reflex testing, weighing, and urine analysis. Many will add heart and gynecologic examinations, haemoglobin testing, blood typing, etc. These are criteria. Standards for each criterion will determine whether each item should be carried out or done each time the patient is seen and how or under what circumstances.

d. Quality Assessment

Is the measurement phase of quality review during which the presence of a problem is determined, e.g., antenatal visit criteria and standards, which are only rarely followed.

e. Quality Assurance

Is the phase during which something is done about problems identified. Measures are taken to ensure the practice of prescribed criteria and standards.

13.3 Levels of Quality Assessment

a. Problem recognition

b. Problem clarification and definition

(Then something, hopefully, is done to rectify the problem, i.e. quality assurance)

c. Problem reassessment - i.e., further evaluation to find out if the problem has been solved. If not, the cycle repeats itself.

13.4 Assessment Approaches

Every country has health care "norms" which students observe and learn in the course of their studies. In addition, virtually all countries are establishing quality review committees which are systematically doing assessment, and then assisting with the task of improving the quality of health care. One example is given for the development of criteria and standards for the diagnosis of diarrhoea in the Makutano Case Study. The concept and process of quality assessment and assurance are straightforward and can be carried out at the district level.

There are three different ways of approaching quality assessment and quality assurance. Questions might be asked about one or more of the following:

a. Structural Analysis

What are the health system resources and how are they organized?

b. Process

Events and activities which do or do not occur when patients and the health care system interact. This has to do with administration, quantitative factors and criteria and standards, that is, qualitative factors.

c. Outcome

End result, that is, is morbidity and mortality reduced?

13.5 Summary of Tasks for Quality Review

The following are steps that should be undertaken in establishing a quality review:

a. Make the decision to establish a quality assurance programme. This will be done jointly by the District Health Planning Team (DHPT) and the Provincial Health Planning Team (PHPT). Responsibility for quality assurance must be pinpointed. This is best accomplished by appointing a committee.

b. The committee must plan a course of action. It will have to decide which topics will be studied first. For example, among the following listed topics, it will have to choose which topics will come first:
   - antenatal procedures
   - diarrhoeal disease
   - sterilization procedures (equipment and supplies)
   - fever case diagnosis
   - management

   The committee will have to establish goals, objectives and targets for its work. It will also need a working definition of quality of care.

c. Develop criteria and standards for topics which will be studied.

d. Assessment. Obtain data.

e. Analyze and summarize the data and report.

f. Identify the source of problems.

g. Develop solutions and gain approval for their implementation.

h. Implement solutions.

i. Reassess.

With a little practice this process will work easily and very well. One quality of care assessment approach for diarrhoeal disease diagnosis is included in the Makutano case study.

P14. COMMUNITY-BASED HEALTH CARE: SOME PRINCIPLES AND THOUGHTS

14.1 Introduction

Even prior to the landmark WHO/UNICEF-sponsored Primary Health Care Conference in Alma Ata in 1978, Kenya had embarked on a policy of providing health care for all. One component of this objective was community-based health care. A number of excellent community-based health care pilot demonstration projects have been successfully implemented in Kenya, and some very useful lessons have been and are being learned.

Similarly, most countries of the world now have community-based primary health care programmes. The Chinese "Barefoot Doctor" is one of the most famous of the world's community health workers. Many countries have developed traditional birth attendant (TBA) training schemes. In India, for instance, indigenous medicine practitioners (IMP) such as Vaids and Hakims have received special attention, and valiant efforts have been made to integrate traditional and modern or allopathic medicine. And, in China, the traditional herbalist works side by side with the western oriented health worker in many health facilities. Similarly, in China, most allopathic or modern medicine trained health professionals are oriented to many traditional practices including acupuncture.

When one looks at the ways various countries remunerate their CHWs, four different patterns emerge:

a. Those who are traditionally paid by the villagers they serve, such as TBAs and herbalists.

b. Those recruited and trained by the government and paid a modest stipend by the government (e.g., India and Liberia).

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c. Those trained by government staff and are sold medicines at a substantial discount by the government but sell them at the regular price and are allowed to keep the difference as a fee for their services (e.g., Thailand).

d. Those recruited and trained by the government but are supposed to "volunteer" their services and somehow to be rewarded by the community. This is found in many countries with highly variable degrees of success.

14.2 Health Worker Development

Conceptually, there are a number of generally recognized, accepted, and practiced steps inherent in the recruitment, training, and functioning of almost all health workers. It would be helpful to keep in mind as examples the enrolled cadre of nurse/midwives, registered nurse/midwives, dentists, doctors, etc. The conceptual steps are:

a. Identification of a need and education of the community on the need for and role of health workers.

b. Establishment of job descriptions, and recruitment standards or entry qualifications.

c. Recruitment

d. Training

e. Registration and licensing

f. Placement on job

g. Remuneration

h. Supervision
   1. Administrative
   2. Professional

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i. In-service (or refresher) training as needed.

j. Provision of certain supplies and equipment as needed.

k. Possible re-registration and re-licensing.

l. Possible loss of registration/license and with it the ability to practice.

It is stressed that the above process, with only minor variations, are accepted by every country in the world with respect to government staff and modern (allopathic) practitioners who are in private practice. A case review of the Chinese Barefoot Doctor best illustrates these processes in practice.

14.3 The Chinese Barefoot Doctor

a. The need for community-based health care was established at the commune level. Commune health committees were organized.

b. Job descriptions and qualifications were established.

c. The commune selected from among the farmers of the commune, those who had the interest, intelligence, and motivation to become its "Barefoot Doctor(s)."

d. The government trains them.

e. The government certifies them.

f. The new "Barefoot Doctor" then begins work in a modest dispensary, locally constructed according to government standards, and is equipped and supplied with medicines and consumable supplies by the commune, but along government guidelines.

g. Remuneration is provided by the commune. All members of the commune share the income of the commune according to the quality and quantity of their labours. The determination of how much a member receives is made by an appropriate commune committee. The "Barefoot Doctor's" (the local community health worker) labours are included in the overall evaluation and distribution process. In other words, there is a culturally built-in mechanism for paying the "Barefoot Doctor" at the local level out of locally generated income (cash-in-kind). A comparable local payment mechanism exists in few societies.

h. Administrative supervision to ensure that the "Barefoot Doctor" is regularly attending his duties (e.g., improving environmental sanitation, responding to requests for help, performing in a polite, friendly manner, etc.) is done by the commune health committee. Professional supervision is provided by government staff who share their evaluation of the "Barefoot Doctor" with the commune health committee. If work is unsatisfactory, pay may be reduced. Public criticism may lead to possible removal from office.

i. Refresher training is provided by the central government.

j. Replacement of equipment, supplies and drugs are usually paid for locally, but obtained from the government, though some may be paid for by the government.

k. The government by means of periodic evaluation, determines who may continue to practice as "Barefoot Doctors" and who, on professional grounds, should not.

l. In practice there is quite a high turnover among "Barefoot Doctors." After two to four years quite a high percentage return to farming or previous activities voluntarily, but remain knowledgeable about health matters.

New workers are then recruited and the cycle repeats itself.

Some of the community health workers remain "Barefoot Doctors," receive in-service training and become quite proficient. Some go onto become doctors, nurses, or other levels of health professionals.

The Chinese "Barefoot Doctor" analysis reveals a smooth functioning, comprehensive system whose elements parallel all the elements of the 14.2 - Health Worker Development section.

14.4 Analysis of Failures

a. Many TBA training schemes concentrate on recruitment, training, and provision of a delivery kit stocked with a starter supply of consumables and with the assumption that someone will provide supervision, that the community will "come to know" of the improved service and pay accordingly, and that new consumable supplies will be purchased in the market by the TBA or somehow made available by the Ministry of Health. However, unless specific provision is made in advance and effective mechanisms are developed to provide follow-up supervision, refresher training, and new supplies on a regular basis, the TBA will revert to traditional patterns within months and the value of the training effort will be lost. These sad facts have been borne out by unpublished evaluations in a number of countries.

b. Other CHW schemes where follow-up supervision, retraining, medications resupply, and remuneration were not forthcoming, resulted in the CHW loosing interest and becoming inactive.

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14.5 Analysis of Successes

When one reviews community-based health care pilot programme success stories, a number of key factors emerge:

a. There must be an organization such as the MOH which is committed to promoting community-based health care. Such an organization should have motivated staff who are suitably trained and properly deployed for community work, as well as adequate recognition and encouragement for the work they render to the community. This means provision of such items as transport (maybe a bicycle), supplies, educational materials, technical back-up (e.g., sanitarians and water specialists), functioning inter-sectoral linkages, etc.

b. An effective community organization, which understands the value of community-based health care, wants it and is willing to help support a suitable programme by means of money and self-help projects, establishes a community health committee.

c. Identification and training of respected, capable, motivated individuals who are willing to function as CHWs.

d. CHWs must have remuneration commensurate with their efforts or the majority will fall by the wayside. The form of remuneration is not specified. It is best if it comes from the people served; either in the form of cash, food, labour or usable gifts. It may also be derived from the sale of medicines. The least desirable remuneration mechanism is by payment from the government. This is costly and difficult to administer.

   In some countries, such as Indonesia, where voluntary service for several hours a week has become a national norm, CHWs will regularly give a certain accepted number of hours a week. Therefore, it may be necessary to train

and supervise many CHWs each of whom will serve for a few hours a week or find supplemental funding for a few who will devote significant amounts of time to community health work.

In practice, the training and upgrading of TBAs, especially if they are also herbalists, such as in some parts of Ghana, pose the least problems. This is especially true if their training is paralleled by a community education programme which stresses elements of the training and the resultant increase in value of the TBA. Because it is culturally established that the TBA is remunerated, the level of payment can be increased following the training because the skills and value of the TBA have been upgraded.

5 Specific Application in Kenya

The guidelines hold true in Kenya, but details will differ depending on the district. More trial-and-error experimentation is needed and DHPTs must become familiar with the results of pilot CHW training schemes nearest to them.

The Makutano Case Study provides one approach to community-based health care. Because of the five satellites, experience has shown that demand for service at the dispensary will decline. This will free up time of the dispensary staff for community work. The effort of dispensary staff members in each community health station in emphasizing prevention and including environmental services, MCH/FP, and supervision and resupply of CHWs and TBAs, will encourage the community based health workers. The main unsolved problem is reward of the CHWs. TBAs already culturally receive something for their services. CHWs are a new group and will give some time because of the "Harambee" tradition, especially if they receive proper recognition and

support. How additional compensation can be provided has not been worked out. In some countries, CHWs are beginning to be remunerated in the manner of TBAs.

14.7 Summary

Community-based health care is feasible in Kenya but requires a series of interrelated activities on a regular basis and must be systematically and officially linked to the Ministry of Health system and there must be intersectoral cooperation. Important components of this are training, supervision, supply, and out-patient referral to government facilities.

P15. HEALTH INFORMATION SYSTEM

It is a very well documented fact that information is a powerful asset for planning and evaluation. An information system is defined as a systematic process of collecting, compiling, analysing, and utilizing data or information. The process of gathering data involves the following considerations:

- What type of data should be collected ?
- What data are important ?
- How should it be collected ?
- When should the data be collected ?
- For what specific need or purpose should data be collected ?

15.1 Types of Data

a. <u>Manpower (Human Resources)</u>

1. Type of cadres
2. Qualifications
3. Deployment
4. Experience

b. Facilities

1. Number
2. Location (Site)
3. Size and type
4. Administration
5. When established
6. Type of services offered and when

c. Logistics Support

1. Transport
   - Number of vehicles
   - Type and when purchased
   - Operating condition
   - Distribution

2. Drugs
   - List of commonly used drugs
   - Availability
   - Storage
   - Control (monitoring)

3. Supplies
   - Availability
   - Storage
   - Distribution

4. Equipment
   - Type and when purchased/received
   - Operating condition
   - Availability
   - Distribution

d. Demographic Data

1. Population size of area
2. Fertility
3. Mortality: Adult, Infant, Maternal, etc.

4. Age and sex distribution
5. Population density
6. Migration pattern

e. Morbidity
1. Disease pattern of the area
2. Incidence of disease
3. Disease rates/prevalence
4. Population groups at risk by disease type
5. Environmental sanitation

f. Social/Economic Data
1. Income/Income Per Capita
2. Communication Means
3. Employment Opportunities
4. Literacy Levels
5. Agriculture/Industry, etc.
6. Social Values and Beliefs
7. Habits/Practices
8. Language

It should be noted that the type of information given above is not exhaustive.

15.2 Collection of Health Information

Information can be collected by various methods. These include routine forms which are especially designed for specific information (e.g., service statistics), observing and recording, and sample survey/surveys by the use of questionnaires.

a. Type of Data Collecting Tools Used in the Ministry of Health
1. Hospital Admission Forms and Discharge Sheets
2. Registers - (Admission & Discharge)
3. Immunization Sheets
4. Family Planning Forms (Register)

5. Coupon System Forms
6. Tally Sheets
7. Drug Register
8. Monthly Summary Sheets

The above forms have different coding. For example, 'S' form which is used to collect drugs.

5.3 Data Utilization

Lack of data might not be the problem in Kenya, but rather its timely collection and organization into usable form and subsequent analysis. Data exist or are collected but are not efficiently utilized. Part of the problem may be that staff do not know how to use the data collected and may require in-service training.

Health data can be used by health staff for programme management/administration, supervision, monitoring and evaluation, planning, and research/studies. Examples of how data can be utilized are given below.

a. <u>Project Planning</u>

1. When planning for a maternal child welfare and family planning for an area, in order to set targets and to evaluate the programme, the following information is needed.

   - Percentage of children under 5 years
   - Percentage of women between ages 15-49
   - Fertility rate
   - Infant mortality rate
   - Accessibility of the population to health facilities
   - Maternal mortality rate
   - General morbidity data and social/economic Data

The above information will help when making decisions on coverage of targets, location of health facility, and the mix of programmes.

2. Periodic analysis of the morbidity data collected through service statistics can help in determining the amount and type of drugs that should be ordered. This helps to avoid ordering/keeping drugs that are not necessary.

b. Supervision

Systematic analysis of data collected from various health centres can assist health personnel to determine the workload in each health unit, number of staff required - as per given staffing norms, their mix and experience.

Data information can also be used to review the staffing pattern and make the necessary changes regarding staffing, supplies, drugs, etc., to either reduce or increase the quantity and quality of each.

c. Evaluation

In any given programme there is the need to know whether the stated objectives and targets are being achieved. For example, a project on environmental sanitation might set a target of getting 50% of households in the project area to construct latrines. If no data are collected, it will be difficult to determine to what extent that objective has been accomplished.

Another project objective/target might be to have a particular staffing pattern for a given health facility within a given period, in order to ensure that certain services are offered. There will be need to have data on

the type of staff, qualification, experience and deployment, in order to evaluate that objective and to make decisions on specific measures to be taken.

d. Research

At times, data collected might not be detailed enough to address specific problem areas but will indicate that there is some problem that requires detailed/special study in order to determine its cause.

P16. BUDGET FORMULATION AND FISCAL CONTROL

16.1 The goals and objectives of decentralized planning are to improve district plans, facilitate formulation of realistic budgets, and ensure effective use of resources (money, materials, and manpower). The plans formulated by the DHPT should form a single "master plan" prepared in detail, to show development and recurrent expenditures expected to be available during the respective financial year (annual) and in subsequent years (forward budget). Table P-2 on the following page provides an example of a District Health Budget.

In Kenya the budgeting procedure covers six main programmes. These programmes are administrative services, curative services, promotive and preventive health, rural health services, health training, and medical supplies and equipment. (Note that in the example shown, supplies and equipment are not broken out separately, which would likely be done in a real budget since supplies/equipment are treated as a specific cost category by the MOH Accounting Officer.)

Within each programme area are itemized expenses by major subcategories. For instance, under Preventive Services, MCH/FP and Health Education Services, specific items of expenditure like buildings, vehicles, and equipment are listed separately.

Table P-2 Example of a District Health Budget

DISTRICT	TOTAL BUDGET			EXTERNAL SOURCES		
	Annual	Forecast		Annual	Forecast	
DEVELOPMENT BUDGET	1982/83	1983/84	1984/85	1982/83	1983/84	1984/85
1. Administrative Services						
1.1 Capital Building Works/ Renovations/Extensions	-	-	-	-	-	-
1.2 Vehicles	7,000	7,000	-	-	-	-
1.3 Office Equipment	5,000	5,000	7,000	-	-	-
1.4 Salaries	50,000	55,000	70,000	-	-	-
1.5 Allowances	5,000	6,000	10,000	-	-	-
1.6 Transport Expenses	15,000	16,000	17,000	-	-	-
1.7 Other Costs (Specify) ..	18,000	9,000	10,000	-	-	-
Sub-Total K£	90,000	104,000	114,000	-	-	-
2. Curative Services						
2.1 District Hospital/Rural Hospital						
- Buildings/Extensions/ Renovations	-	10	50,000	-	-	-
- Vehicles	10	7,000	-	-	-	-
- Furniture & Equipment	-	-	10	-	-	-
- Housing	-	10	25,000	-	-	-
Sub-Total K£	10	7,020	75,010	-	-	-
3. Preventive Services						
3.1 MCH/FP Services	10,000	15,000	18,000	8,000	12,500	14,000
3.2 Vector Borne Diseases Control	5,000	5,000	6,000	-	-	-
3.3 Communicable Diseases Control	5,000	5,000	6,000	-	-	-
3.4 Expanded Programme of Immunization	10,000	10,000	7,000	8,000	8,000	5,000
3.5 Community Based Health Care	3,000	3,000	3,000	-	-	-
3.6 Health Education	1,000	1,000	1,000	1,000	1,000	1,000
3.7 Equipment	4,000	4,000	4,000	4,000	4,000	4,000
3.8 Vehicles	10,000	10,000	10,000	-	-	-
Sub-Total K£	48,000	53,000	91,000	21,000	25,500	24,000
4. Rural Health Services						
4.1 Health Centers	-	-	-	-	-	-
4.2 Dispensaries Type II ...	10	25,000	25,000	-	-	-
4.3 Dispensaries Type I	-	-	-	-	-	-
4.4 Mobile Health Services .	1,000	1,000	1,000	-	-	-
4.5 Vehicles	10,000	10	10	-	-	-
4.6 Equipment	10	10	5,000	-	-	-
4.7 Drug Supplies	30,000	35,000	50,000	30,000	45,000	50,000
Sub-Total K£	41,020	61,020	81,010	30,000	45,000	50,000
5. Health Training						
5.1 Nurse Training School(s)	-	-	10	-	-	10
5.2 CO/Env.Tech/Lab Tech Courses	-	-	-	-	-	-
5.3 In-service Training Courses	1,000	1,000	1,000	-	-	-
5.4 Multi-Disciplinary Courses	500	500	500	-	-	-
5.5 Maintenance Schools	10	5,000	7,000	-	-	-
5.6 Equipments	10	7,000	7,000	10	7,000	7,000
5.7 Vehicles	10	10,000	10,000	10	10,000	10,000
Sub-Total K£	1,530	22,500	25,510	20	17,000	17,000
The Total Dist. Development Budget Est. K£	180,560	247,540	386,530	51,020	87,500	91,000

The percentage of the total national expenditure appropriated for health services is a reflection of how much planners in the Ministry of Economic Planning and Development (MOEPD) value health services compared with growth in other spheres of the economy. For example, the 1979-83 development plan allocated 7.2% of the national budget for health care services. Approved budgets are presented in the form of printed estimates of expenditure, but are subject to revision during the course of the year. Planning and budgeting, however, can only be meaningful if it is conducted with prior knowledge of the resources to be provided.

In practice, the Treasury issues a circular with predetermined financial ceilings based on past year(s) forward budget. This acts as a guideline for the finanical resources which may be made available. The task of the district working group should be to focus attention on the approved plans in regard to each individual service/ programme, and to identify resources required to achieve the specified target. The exercise should address itself to physical development, availability of various cadres of staff, hotel services, and supplies of drugs and equipment. The required resources are subsequently expressed in terms of money as a common measure (medium of exchange).

To illustrate this point, let us take an example of a programme intended to construct a dispensary as the foundation for extending community-based health care to an underserved community. The district health planning team would first prepare a brief on the requirements for the programme clearly spelling out the operational procedures. This brief would be submitted to the professionals in the Ministry of Public Works (architect, engineer, and quantity surveyor) who would draw up a definite work plan, facility design and prepare cost estimates for building works and equipment. The details would be discussed with all parties

concerned to agree on the plan of implementation. The finance officer(s) would prepare budgets, service, and other operation targets based on "intervention programmes" to achieve objectives. Needless to say, coordination of district plans to ensure that adequate budgets are developed and that the team works within the financial provisions is a vital function of the DHPTs.

Once the plans and budgets proposed have been agreed upon, appropriate officers have authority to spend financial allocations. Nevertheless, it is equally important that performance is monitored and budgets controlled to ensure that money is spent for the purpose for which it was voted. The DHPT is expected to be "finance conscious" and is accountable for the economic and efficient use of money, both as individuals and as a team. The hospital administrator by virtue of his administrative role and as a member of the DHPT, will be held responsible for coordinating preparation of budgets and for providing up-to-date information on expenditure trends and commitments, including control procedures.

The PHPT will coordinate preparation and control of budgets in their provinces. At the "Headquarters" level, the Principal Finance and Establishment Officer, on behalf of the Accounting Officer will exercise control to ensure that the total expenditure matches revenue resources available and that subvotes are used efficiently in relation to the results achieved. Since funds are voted for specific targets within agreed plans, any proposals to switch expenditure between programme heads/sub-heads, or to carry over unspent balances from one year to the next, or to incur over-expenditure, must strictly be approved by the Accounting Officer. Certainly there will be need to institute interval audit, as necessary, to ensure that there is no waste, extravagance or misappropriation of public money.

P17. IMPLEMENTATION

Planning, per se, is not an end to itself, unless it is accompanied by a clearly defined implementation strategy.

It is therefore pertinent that the following implementation stages should be taken into account.

17.1 Develop a clear, understood and accepted plan (e.g., the implementation team, which may be comprised of intersectoral agencies and members of the community, should be conversant with the plan to be implemented).

17.2 Ensure adequate availability of resources:

a. Human

b. Money

c. Materials

17.3 Develop clearly defined duties, responsibilities and accountability for all parties involved in the implementation of the plan.

17.4 Develop clearly defined channels of communication and consultation vertically and horizontally.

17.5 Review Activity Chart (work plan) to ensure that you are still on the same track.

17.6 Obtain formal approval to start implementation from concerned authority.

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DRAFT EDITION

A TRAINER'S GUIDE

HEALTH PLANNING AND EVALUATION FOR DISTRICT HEALTH PLANNING TEAM

Ministry of Health

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PREFACE

Once the Writing Team had thoroughly analysed the task of developing a planning and evaluation training course for District Health Planning Teams (DHPTs), it became clear that no effort of this type would be complete without also providing specific guidance to instructors on how to effectively use the course materials.

The Writing Team has recommended that implementation of this training programme be coordinated by a designated senior MOH official. Those involved in the development of these training materials (i.e., the Writing Team), will then be available to assist as the activity moves from the development stage to the implementation stage.

Although the Writing Team assumes that officials selected to conduct the training course will have had some prior preparation to function as trainers (either through experience or as a result of having received some special course in training), it is however, recommended that the trainers actually undergo the experience of the course as trainees. In this manner, familiarity with the course materials will be guaranteed. A second step in preparation would then be to become thoroughly familiar with the contents of this guide. Finally, as with the implementation of any "project," the trainers should each develop a work plan which identifies all of the logistical and management requirements that should be attended to before, during, and after the course is conducted.

However, even with such preparation, the Writing Team is also firmly commited to the concept of "active learning" and the notion that experience is the best teacher. It is expected therefore, that the trainer's effectiveness in using the materials and in delivering the training programme, will improve as experience is gained.

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The course administrators will look forward to reviewing the trainers' experiences through the mechanism of the course evaluation. The trainers' insights will be vital to the process of refining of the course and making it progressively more effective and useful to the DHPTs.

THE WRITING TEAM

- Dr. R. K. Arap Kalya, Deputy Director of Medical Services/PMO, Rift Valley
- F. A. Mworia, Senior Hospital Secretary in the Planning and Implementation of Integrated Rural Health and Family Planning Programme, Ministry of Health
- N. A. Keyonzo, Head, Evaluation and Research Division, National Family Welfare Centre, Ministry of Health
- T. M. Oduori (Mrs.), Senior Nursing Officer, Ministry of Health, HQ, Nairobi
- Dr. A. O. Oyoo, Deputy Director of Medical Services/PMO, Eastern Province

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1.0 PRINCIPLES OF TRAINING - AN OVERVIEW*

1.1 Introduction.

The concepts discussed in this section of the Trainer's Gui describe the key philosophical and psychological foundatic underlying the instructional approaches used in designing th course. This overview is provided as an introduction (for t individual who has not previously been "trained as a trainer or as a review for the previously "trained trainer," and shou be used as a supplement to other types of technical preparati as may be available.

In addition, at the back of this document can be found select reprints of articles on the subject of learning/instruction theory. The trainer is encouraged to review these, and refer to the original sources and other publications, f additional information on the subject.

1.2 The Trainer as Facilitator of Learning

When a trainer begins the development of an instruction activity, one of the first things that should be done is identify and write learning objectives for the activity. addition, the trainer must also identify and write t underlying learning tasks that the trainees must perform accomplish the objectives. In effect, a good instructor c analyze any given objective and list the most appropria learning tasks that a trainee must perform to successful accomplish the objective.

This section of the Trainer's Guide provides a conceptu framework that will assist the Trainer in selecting the mo appropriate learning tasks and instructional methods for given learning objective of the course.

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* Throughout this section, terms such as, "trainer," "teacher," "instructor;" "participant," "trainee," "student," "learner;" "educational," "instructional;" are used interchangeably. The principles discussed apply equally to formal education (in-school), and job-related (training) situations.

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1.3 The Philosophy of Learning

Learning is generally considered to be relatively permanent, observable, and/or recognizable change in the relationship between a stimulus (i.e., instructional content) that a trainee perceives and the trainee's response to the stimulus, whether overt (i.e., observable, detectable, and public) or covert, (i.e., occurs within the trainee and is therefore not readily observable or detectable) relative to the cultural experiences (or socioeconomic background) of the trainee.

A well known educational theorist, Gagne, has classified learning behaviours into eight categories, or skills, that progress from simple to complex. These are:

a. Signal Learning - the acquisition of a conditioned response to a given signal (or stimulus).

b. Stimulus/Response Learning - the connection of a specific response to a given stimulus.

c. Chaining - The establishment of an interrelated series, or set, or responses (also known as skill learning).

d. Verbal Association - a type of chaining in which verbal units are linked to a concept, object or skill, (e.g., associating the name of an object with the object itself).

e. Multiple Discrimination - the ability to distinguish between acquired verbal and skill chains.

f. Concept Learning - the ability to respond to a stimulus in terms of abstract characteristics, such as colour, shape, position, and number, as opposed to concrete or physical characteristics such as length weight texture, etc.

g. Principle Learning - the ability to associate and relate two or more concepts, (e.g., recognizing the relationship between "atomic fusion" and "radiation."

h. Problem Solving - the ability to combine two or more previously learned rules or concepts into a higher order rule or concept (e.g., applying the "laws of biology" to solve a medical problem).

Learning can be characterized in the following ways:

- it is a dynamic perceptual activity that results from direct contact through the senses;
- it progresses from the progressive acquisition of simple skills to more complex skills;
- it is either abstract, (i.e., symbolic or conceptual) or concrete, (i.e., based upon direct sensory experiences);
- and, it is influenced by the socioeconomic environment within which it occurs.

1.4 Learning And Objectives

The importance of defining learning objectives as an initial step in planning learning or instructional systems has been emphasized by educators and instructional designers for more than 40 years. Learning objectives are generally considered to be an integral part of a systems approach that involves three stages: 1) input; 2) process or practice; and 3) output or feedback.

1.4.1 At the input stage the instructor identifies his goals and objectives and determines whether or not they can be accomplished given the available resources and the weakness or limitations of the socioeconomic environment in which the learning system must function.

1.4.2 At the process or practice stage the instructor analyses and selects the quality and quantity of information that

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will be needed to support the instructional activities.

1.4.3 The final output stage is an implementation/evaluation activity in which a small experimental learning system is put into operation and evaluated based upon the objectives that were identified in stage one. At this point the system is either ready to become fully operational or is re-examined and altered where necessary.

1.5 Writing Learning Objectives

Because learning objectives are such an important part of the overall systems approach to instruction they must be clear, explicit, measurable, and obtainable via instruction. Learning objectives which have these characteristics are called behavioural objectives.

A good behavioural objective describes three things:

a. the terminal behaviour the learner will be able to perform to demonstrate that the objective has been reached;
b. the conditions under which the learner will be expected to demonstrate his or her competencies; and
c. the criteria that will be used to evaluate the learner.

The example provided below illustrates how a good behavioural objective should be written. The terminal behaviour is underlined with a broken line (_ _ _ _); the conditions are underlined with a single line (_____), and the criterion is underlined with a double line (____).

EXAMPLE:

Given a list of permanent secretaries, the trainee will be able to list the permanent secretaries who have worked in the Ministry of Health, Republic of Kenya since 1962, with at least 90% accuracy.

1.6 Classifying Objectives

A good instructor must analyse learning objectives to determine the most appropriate learning tasks a trainee must perform to successfully accomplish them. To facilitate this process, behavioural objectives have been classified into three domains: cognitive, affective and psychomotor. Each domain has also been further subdivided into "hierarchical variables" that progress from simple to complex based upon their respective order of complexity.

1.6.1 Cognitive Objectives are related to knowledge and the ability to think and understand. This, means that cognitive objectives specify the mental reasoning tasks the student will employ and/or use to learn a given amount of cognitive information. These mental reasoning tasks or "hierarchical variables" commonly associated with cognitive objectives are:

a. Memorization - the ability to recognize and recall objects, symbols, ideas and facts on a specified matter. For example the terminal behaviour for a typical memorization task, would require a student to write the steps required to perform a patient care procedure; write the name of a specific drug; or; recall the time and place of an important historical event.

b. Comprehension - the ability to demonstrate an understanding of the significance or meaning of objects, symbols, facts or ideas. The terminal behaviours for a comprehension task would require a student to explain the importance of a patient care procedure; identify the function or effects of a specific drug, or; discuss the significance of an important historical event.

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c. Application - the ability to apply learned principles (facts or ideas), objects or symbols to new situations or problems. The terminal behaviour for an application task might require a student to employ a mathematical procedure to solve or develop an equation; use a diagnostic technique to identify an illness, or; demonstrate the relationship between a historical trend and a current event.

d. Analysis - the ability to separate an object, idea or fact into its component parts; and name and define each component part and the relationships between them. The terminal behaviour for an analysis task could include the ability to examine the functions and vital processes of the parts of a living organism; calculate the chemical composition of a specific drug, or; formulate the sequence of events that lead to a clinical illness.

e. Synthesis - the ability to combine parts or elements to form a whole or formulate principles or rules from previously learned facts, ideas or learning events. The terminal behaviour for a synthesis task could include the ability to identify or demonstrate the operation of a medical theory in a clinical case study, or; create a new technique for treating an illness based on previously acquired information.

f. Evaluation - a problem solving behaviour involving the ability to make accurate judgments based on available evidence or criteria. The terminal behaviour for an evaluation task could include the ability to assess the physiological or psychological effects of a given illness; compare and rate two or more research studies, or; measure effects of a specified treatment procedure.

1.6.2 Affective Objectives specify the attitudes or values the student will acquire as a result of the learning that will occur. Affective objectives, therefore, specify learning tasks which require students to make judgements regarding the degree to which their learning experiences have either positively or negatively influenced their feelings and values.

The hierarchical variables, or learning tasks, associated with affective objectives include:

a. Attending/Receiving - behaviours which demonstrate the student's willingness to accept and pay attention to a given instructional mode or learning stimulus. An example of a terminal behaviour for an attending task could include the ability to listen and take good notes during a lecture or while viewing a film that illustrates an important topic.

b. Responding - behaviours that demonstrate the student's willingness to participate in scheduled learning activities. Typical terminal behaviours for responding tasks could include attending a required field trip; designing a chart or graph that illustrates a previously discussed concept, or; asking relevant questions on an ongoing basis during a lecture or group discussion.

c. Valuing - behaviours that demonstrate a student's preference for a given idea, attitude, instructional mode or learning stimulus. Examples of terminal bahaviours for valuing tasks include choosing to read a book rather than view a film on a given topic, or; expressing a positive opinion about a given learning activity.

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d. Organizing - behaviours which indicate that a student has acquired or developed a specific value or set of values that will influence future behaviour. Examples of terminal behaviours for organization tasks include suggesting or developing a method for solving a problem based upon previously acquired information, or; writing a brief essay on the importance of a treatment procedure or the significance of a social issue.

e. Characterization - behaviours which demonstrate that the student has organized a set of values and attitudes into a consistent philosophy or belief system. Terminal behaviours for characterization tasks could include practicing good personal hygiene; respecting the opinions of others in a small group discussion, or; developing good study habits.

1.6.3 Psychomotor Objectives specify the physical and manipulative skills students will develop as a result of instruction. Thus psychomotor objectives should require a student to learn to use specific skills during actual or simulated work experiences. The hierarchical variables, or learning tasks, for psychomotor objectives include:

a. Perception - an awareness of a situation which may result in or require a given skill. The terminal behaviour for a perception task could include the ability to identify and name the equipment and/or materials needed to perform a skill; recall the specific sequence in which the skill should be performed, or; recognize and describe the circumstances in which a skill will be used.

b. Set-adjustment or Readiness (to perform a required skill) - this implies that the student is mentally and emotionally prepared to learn the skill. Terminal behaviours for this affective task could include the ability to gather and arrange the equipment and/or materials needed to perform a skill, or; to express his or her desire or readiness to perform the skill that must be learned.

c. Guided Response - imitating the instructor's performance of a skill and/or trying various responses in a trial-and-error fashion. A terminal behaviour for this affective task would be the ability to accurately imitate the instructor's performance of the steps required to perform a given skill.

d. Mechanism - developing an habitually correct response. A terminal behaviour for this affective task could be the ability to perform the entire sequence of steps associated with a given skill with a minimum amount of assistance from the instructor.

e. Complex Overt Response - performing a given skill with ease and without hesitation or prompting by the instructor. A terminal behaviour for this affective task would be the ability to perform a skill smoothly and efficiently with an acceptable degree of coordination and confidence without being assisted by the instructor.

Thus each of the behavioural objectives written for any instructional system should include the terminal behaviour the learner will be able to perform, the conditions under which the learner must demonstrate his or her compentencies, and the criteria that will be used to

evaluate the learner performance. In addition, the objectives should be classified as either cognitive, affective or psychomotor. Finally, the most appropriate learning tasks that the student must perform should be developed, and then ordered from the most simple to the most complex, based upon the hierarchical variables commonly associated with each objective.

1.7 Insuring Active Learning

The emphasis that is placed on writing behavioural objectives and utilizing a systems approach when developing an instructional activity illustrates the need to develop and implement learning experiences in which a student is actively involved in the learning process. Active learning implies active teaching. In other words, the instructor must be prepared to perform certain instructor- related tasks to ensure that the students are involved in active learning experiences. These tasks include:

1.7.1 Assuming Leadership - Analyse the learning, (i.e., classroom) environment to ensure that the learning activities focus on learning tasks, student feelings and control. Develop and use leadership techniques that increase student morale and production.

1.7.2 Developing good communication skills - Learn to interpret the real feelings behind a student's expressions of dissatisfaction or uneasiness with the learning tasks that must be performed. Avoid actions that shut off the student's real feelings and/or discourage open communication.

1.7.3 Applying sound student management techniques - Provide reasonable opportunities for student self-management in the classroom. Select and use instructional materials that encourage student participation in the learning

process whether individually or as part of small group skill practice exercises. Develop an activity schedule that will enable you to cover all the material you must present, and provide students with adequate time to accomplish their learning tasks.

1.7.4 Arranging classroom space - Select and use classrooms that are appropriate for the number of students present. Make sure that the space is clean and that classroom furnishings and instructional media are conveniently arranged to allow for the most optimum use by the students.

1.8 Methods of Instruction

The following represents a compendium of instructional methods that might be employed by the Trainer. These methods can be used flexibly according both to the individual teaching style and preferences of the Trainer, and as appropriate to a particular learning task. The Trainer is invited to explore various methods for appropriateness and effectiveness, and to go beyond this Trainer's Guide to learn more about particular methods.

The principal methods by which instruction may be provided are:

Case Study - An activity in which learners are provided with a written description of a hypothetical situation in which others are attempting to solve a particular problem. Through analysis of the hypothetical situation, learners gain insight into the principles and approaches that might work for them when faced with a similar task.

Comparative Analysis - A thought process, structured by the teacher, which employ as the description, classification, and analysis of more than one system, group so as to ascertain and evaluate similarities and differences.

Conference - A one-to-one interaction between teacher and learner where the individual's needs and problems can be addressed. Diagnosis, evaluation, and prescription may all be involved.

Demonstration - An activity in which the teacher or another person uses examples, experiments, and/or other actual situations to illustrate a principle or show others how to do something.

Directed Observation - Guided observation provided for the purpose of improving the study, understanding, and evaluation of that which is observed.

Discussion - An activity in which learners, under teacher and/or student direction, exchange points of view concerning a topic, question, or problem to arrive at a decision or conclusion.

Drill - An orderly, repetitive learning activity intended to help develop or fix a specific skill or aspect of knowledge.

Experimentation - An activity involving a planned procedure accompanied by control of conditions or controlled variation of conditions together with observation of results for the purpose of discovering relationships and evaluating the reasonableness of a specific hypothesis.

Field Experience - Educational work experience, sometimes fully paid, acquired by pupils in a practical service situation.

Field Trip - An educational trip to places where learners can study the content of instruction directly in its functional setting, (e.g., dispensary, data center, or community meeting).

Group Work - A process in which members of the class, working cooperatively rather than individually, formulate and work toward common objectives under the guidance of one or more leaders.

Laboratory Experience - Learning activities carried on by learners in a laboratory designed for individual or group study of a particular subject matter area, involving the practical application of theory through observation, experimentation and research, or, in the case of foreign language, instruction, involing learning through demonstration, drill, and practice. This applies also to the study of art and music, although such activity in this instance may be referred to as a studio experience.

Learning Assessment - The continuous determination of the nature of learning difficulties and deficiencies, used in teaching as a basis for the selection of day-to-day or moment-by-moment content and methods of instruction.

Lecture - An activity in which the teacher gives an oral presentation of facts or principles, with the class frequently being responsible for note-taking. This activity usually involves little or no pupil participation in the form of questioning or discussion.

Manipulative and Tactile Activity - Activity by which learners utilize the movement of various muscles and the sense of touch to develop manipulative and/or perceptual skills.

Modeling and Imitation - An activity frequently used for instruction in speech, in which the learners listen to and observe a model as a basis upon which to practice and improve their performance.

Programmed Instruction - Instruction utilizing a workbook or mechanical and/or electronic device which has been "programmed"

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to help pupils attain a specific level of performance by, 1) providing instruction in small steps, 2) asking one or more questions about each step in the instruction, and providing instant knowledge of whether each answer is right, and 3) enabling learners to progress at their own pace.

Project - A significant, practical unit of activity having educational value, aimed at one or more definite goals of understanding and involving the investigation and solution of problems.

Reading - Gathering information from books, periodicals, encyclopedias, and other printed sources of information, including oral reading and silent reading by individuals.

Recitation - Activities devoted to reporting to a class or other group about information acquired through individual study or group work.

Research - An activity in which learners are engaged in investigation or experimentation aimed at discovering and/or interpreting facts, revising accepted theories or laws in light of new facts, or the practical application of new or revised theories or laws.

Role-Play - An activity in which learners and/or teacher take on the behaviour of a hypothetical or real personality in order to solve a problem and gain insight into a situation.

Seminar - An activity in which a group of learners, engaged in research or advanced study, meet under the general direction of one or more staff members for a discussion of problems of mutual interest.

Sensitivity Training - An activity in which a group and a trainer meet to self-consciously examine their immediate

feelings and preceptions about themselves and each other in order to gain skill in authentic communication, leadership, behavioural flexibility, or social sensitivity.

Skill Practice Session - All activity in which learners have opportunity to put into practice those skills and understandings previously learned through other instructional activities.

KENYA HEALTH PLANNING AND EVALUATION COURSE SCHEDULE - FIRST WEEK

The Schedule shown on the following page essentially describes the structure of the course. The order in which sections appear in the trainee's manual, as well as the listing of activities in the Instructional Guide (see pages 22 to 30), generally adhere to the sequences shown in the Course Schedule.

The Schedule has been designed to present the subject matter in a sequence and time frame which will appear logical and manageable to all. The Trainer may, however, observe some instances where adjustments to the schedule might facilitate learning. The schedule should not be modified during the course, but suggestions should be documented as part of the Trainer's evaluation of the course.

KENYA HEALTH PLANNING AND EVALUATION COURSE SCHEDULE - FIRST WEEK

DAY TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30 a.m. to 10:30	- Welcome and Introduction of Teams - Overview Review of Course Goals, Objectives and Schedule	- Value of Planning Theory and Definitions - Problems, Needs, Wants, & Demand - Demographic Data - Morbidity Data - Constraints - Resources - Community-Based Health Care - Review Case Study	- Activity/Time Charts - Systems Analysis	- Performance Standards - Health Information System	- Implementation and Summary of Plan
10:30 a.m. to 11:00	T E A B R E A K				
11:00 a.m. to 12:45	- Statement of Problem by Each Team	- Cost Analysis - Priority Setting - Goal(s), Objectives and Targets Review of Subject and Discussion	- Evaluation	- (Work Groups Continued)	- Each team gives progress report and proposal for work during phase II (see TC4)
1:00 p.m. to 2:00	L U N C H B R E A K				
2:00 p.m. to 3:15	- Teaching philosophy and learning methods for this course.	- (Continued from Above) - Possible Goals, Objectives and Targets for each Planning Team's problem.	- (Evaluation Continued)	- Budget formulation and fiscal control.	- (Report Continued)
3:15 p.m. to 3:30	T E A B R E A K				
3:30 p.m. to 4:30	- Theory of Planning: definitions and concepts - Importance of specific planning mandate - Use of Planning Activities Checklist	- Work Groups District teams meet individually to plan, assisted by trainers.	- Work Groups	- Work Groups	- Review and Course Evaluation

3.0 PREPARING FOR THE COURSE

3.1 Logistics

The trainer will be expected to do several things prior to the beginning of the course. First, he/she must identify and reserve the venue, and ensure that all personal amenities of trainees will be provided for. The venue should provide a classroom of sufficient size to accomodate up to 25 persons. In addition, there should be five small conference rooms adjacent to the classroom. These should accomodate teams of five persons. Each room should be furnished with tables and chairs.

The venue should also provide living accomodations for the participants, (including meals and other support services).

Second, the trainer must contact participants and provide all necessary pre-training orientation. This will be done in cooperation with the PMO and the various DMOs. The participants will consist of three to five District Health Planning Teams, each made up of a medical doctor, a public health nurse, a hospital secretary, a public health officer, and a health education officer.

Third, the trainer must arrange for the instructional materials to arrive at the venue prior to the beginning of the course. You will need to order one Trainer's Guide for yourself, one trainee's manual for yourself and for each participant, and one Appendix for yourself and for each participant.

Finally, the trainer must identify and provide appropriate orientation for all resource persons.

3.2 Instructional Resources

The trainer should ensure that the following resources are available at the training site:

a. The Trainer's Guide
b. Trainee's manuals entitled "Planning and Evaluation for District Health Planning Teams"

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c. The Appendix to the trainee's manual (handout materials). These should be reproduced in sufficient supply to distribute one set to each participant.

d. A sufficient supply of paper, pencils, pens, chalkboard and chalk and/or chart paper, tape, felt-tipped pens, etc.

3.3 Using the Resources

This Trainer's Guide is intended to assist the trainer in preparing for conducting and evaluating the course. The Trainer should have this document handy in the classroom and use it as a guide to conduct classroom activities.

The trainee's manual is to be given to the participants for their use. Each participant should be given a copy prior to his/her arrival or upon his/her arrival at the venue. Each participant should study the "B" section (i.e., B1, B2, B3, B4), and Sections P1, P2 and P14 before the first class on Monday, since these selections are central to the content of the first day's instructional activities. Thereafter, participants will need to be given specific direction on a daily basis in terms of additional reading assignments (handouts, etc.) that should be completed prior to the next day's events.

3.4 Using the Instructional Guide

On the pages immediately following, you will find a guide for conducting the course. Each page of the guide is divided into four columns as follows:

3.4.1 Objectives: In this column the course objectives are referenced in terms of the code numbers found in the trainee's manual, TC3.

3.4.2 Instructional Activities: This column provides instructions for conducting the training activities. Each activity was designed to help the participants accomplish a specific objective. The trainee should,

therefore, conduct all the activities that are suggested, omitting none. The trainer should also conduct the activities in the order given. If any suggestions for changing or improving the course arise during the week, these should be included in the trainer's evaluation.

3.4.3 Estimated Time

This column provides suggestions about the amount of time to be spent on each activity. These suggestions should be treated flexibly. Some groups will need to spend more time on a given activity, others less. As the instructional leader, the trainer must decide this. Nevertheless, it is important that the trainer guide the participants at such a rate that the suggested activities will all be completed in the course of the week. On the Trainer's Assessment evaluation form provided in the Evaluation section of this guide, a place is provided for the trainer to account for actual time, as was found necessary to complete activities. This information will assist course administrators in making appropirate modifications to the guidelines in the future.

3.5 Conducting the Work Group Sessions

Some session on Tuesday, Wednesday, and Thursday are dedicated to work groups.

By the end of the week, each District Health Planning Team is required to produce a draft of a plan for improving health services in its own district. The plan must address each of the points found in the Planning Checklist (pages TC6 and TC7) of the trainee's manual.

Since the Planning Checklist provides the basic organizational framework for the plan, the course has be designed to address

the points on the Checklist systematically, comprehensively, and sequentially. Material relevant to points 5.1 - 5.12 is presented on Monday and Tuesday. Material relevant to points 5.13 - 5.16 is presented on Wednesday. Material relevant to points 5.17 - 5.19 is presented on Thursday. Material relevant to the remaining points is presented on Friday.

In order to facilitate the elaboration of the plan, time has been allotted for the Teams to work in small groups. Those sessions that take place during the last work period of the days may, at the trainer's discretion, continue into the evening hours. It is expected that the teams will take great pride in their work and that they will want to continue working until their work satisfies their own criteria for quality.

The trainer is responsible for making these work sessions as fruitful as possible. It is therefore, suggested that the Trainer do the following:

1. Provide an orientation prior to beginning each work session. Such an orientation might take the following form, "Today you were introduced to the following topics.... Each of these topics was elaborated using background essays, the Makutano Case Study, and related discussion. During the work session today, you should begin (or continue) the elaboration of your plan, taking care to address each of the points we have covered so far. Use the Case Study as a model. I will move among the teams to provide whatever assistance I can. Are there any questions?"

2. Once the questions have been answered, assign each of the teams to its own small conference room to begin work on its plan.

3. The trainer should circulate among the teams to provide assistance. At the technical level, the trainer should be prepared to answer any questions about the topics presented in the preceding sessions. At the procedural level, the trainer should help the teams to keep moving toward their goals when they get bogged down in disputes over which of two or more alternatives to adopt. In this case, encourage the team to make a decision, recognizing that this is a draft, and that if they are to complete it, they will have to keep moving.

3.6 The Course Evaluation

A detailed description of the evaluation procedures is presented in section 5.0 EVALUATION GUIDELINES. This paragraph is therefore designed only to call attention to the fact that the heart of the evaluation is each team's presentation of its plan to the whole group on Friday afternoon. The participants should therefore be informed prior to the first work session on Tuesday afternoon, that their presentation will be subject to a critique by the trainers and the other participants. Each team should therefore work as carefully and conscientiously as possible in order to make the most effective presentation possible.

4.0 THE INSTRUCTIONAL GUIDE

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
	Welcome the participants to the course.	Monday 1 hour (8:30 a.m. - 9:30 a.m.)	
	Present an overview of the course. Be sure to cover the following points: 1. Description (TC1) 2. Rationale (B1) 3. Goals (TC2) 4. Objectives (TC3) 5. Design and schedules (TC4) 6. Underlying philosophy of teaching and learning (TC6 plus Introduction in this Guide) 7. Instructional resources available and their uses 8. Approach to course evaluation	1 hour (9:30 a.m. - 10:30 a.m.	TC1 TC2 TC3 TC4 TC6 B1
	Invite the members of each District Health Planning Team (DHPT) to present the health services problem on which they will be working over the course of the week. Give each team 15 minutes to make their presentation, followed by 10 minutes for open discussion.	105 minutes (11:00 a.m. - 12:45 p.m.)	Each group will bring a written description of its problem, one copy to be presented to the Trainer.

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.1 To identify, describe, list, and differentiate social, cultural, economic, and political factors inherent in health planning.	Present a global view of health planning in Kenya. Begin with a general examination of planning theory (P1), then show the relation of that theory to health services and health planning in Kenya (B2, B3, B4).	1 hour 15 minutes (2:00 p.m. - 3:15 p.m.)	P1 B2 B3 B4
	Show how this course fits into Kenya's approach to health planning. Indicate that the the course is organized in terms of a Planning Checklist consisting of 21 steps. Emphasize that at each step, there is a three-fold movement. 1. Study of relevant background papers 2. Application of the background material to the development of a health services plan for Makutano. 3. Extension of what is being learned to each Team's own problem Take this opportunity to review the Planning Checklist (TC5), the "P" and "CS" sections of the trainee's manual. Ask the participants to study the Case Study plus P2, P3, P4, P5, P6, P7, P8, and P9 in preparation for Tuesday's sessions.	1 hour (3:30 p.m. - 4:30 p.m.	TC5 "P" documents Case Study (CS) Appendix

OBJECTIVE	INSTRUCTIONAL ACTVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.2 To help participants learn to identify, list, critically analyse, and evaluate: a. Health related problems and needs b. Actual and potential resources c. Planning constraints d. Planning priorities e. Goals f. Measurable objecttives and targets g. Community-based Health Care	Lead the participants to distinguish among problems, needs, wants, and demand: the art of establishing priorities (let participants establish a prioritized list of problems, etc.)	Tuesday 20 minutes (8:30 a.m. - 8:50 a.m.)	P2
	Present the content of P3 and P4. Ask the participants to justify their list of priorities in terms of eack district's demographic and morbidity data.	40 minutes (8:50 a.m. - 9:30 a.m.)	P3 P4
	Present the content of P5 and P6. Ask each Team to critically analyse and reformulate their list of priorities in terms of constraints and limitations on resources in their own district.	40 minutes (9:30 a.m - 10:10 a.m.)	P5 P6
	Present the concept of Community-based Health Care and its relation to the policy of decentralization. Refer to P14 as well as to a successful CBHC pilot program that already operates in Kenya.	20 minutes (10:10 a.m. - 10:30 a.m.)	P14

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.3 To help participants learn how to develop and write: 3.1 A work plan 3.2 " 3.3 " 3.4 " 3.5 " 3.6 " 3.7 " 3.8 " 3.9 " 3.10 "	Show the participants how to conduct a cost analysis of the first item on the list of priorities.	30 minutes (11:00 a.m. - 11:30 a.m.)	P7 Costing data for Health Services
	Discuss the content of P8 and determine whether or not any priorities need to be re-ordered.	15 minutes (11:30 a.m. - 11:45 a.m.)	P8
	Lead the participants to distinguish between goals, objectives, and targets; note application to Makutano; apply to practice examples.	135 minutes (11:45 a.m. - 3:15 p.m.)	P9 In Appendix or Trainer's Guide: 1. Verb list 2. Practice Examples
	Ask the participants to finalize problem statement. Then, using Planning Activities Checklist, systematically respond to items 2 through 12 (but no further).	60 minutes (3:30 p.m. - 4:30 p.m.)	
	Help the participants to distinguish between activity/time charts which use milestones (events), and activity/time charts which use networks; study use of time chart in Makutano example; establish time sequenced activity list for Team problem; translate list into activity/time chart.	Wednesday 60 minutues (8:30 a.m. - 9:30 a.m.)	P10 (There is a need to develop an example that makes milestone numbers meaningful.)

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.5 Identify, differentiate and describe key elements of: a. A health information system b. A community-based health care system	On Systems Analysis read P11. Discuss key terms. Study application to Makutano.	60 minutes (9:30 a.m. - 10:30 a.m.)	P11 (Work out a Systems Chart of Makutano)
3.6 Organize, implement and evaluate a quality assurance program: a. Define a problem b. Appoint a quality of care committee c. Develop criteria d. Set standards e. Set performance levels f. Monitor performance g. Implement steps to correct any deficiencies found h. Report to District Health Management	Present a lecture on the theory of evaluation based on the first two pages of P12. Provide clear health related examples of each concept. Go on to show that evaluation must occur at every stage of planning and implementation as discussed in P12, focus on the following steps: 1. Review the project with special emphasis on goals and objectives. 2. Plan the evaluation 3. Review the evaluation plan 4. Estimate the reliability of the information obtained. 5. Conduct a field-level evaluation. 6. Review, analyze, summarize, and interpret data.	180 minutes (11:00 a.m. - 3:15 p.m.)	P12 CS10 Evaluation Planning Sheet

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.6 (Continued)	Lead the group in a review of the evaluation plan associated with the Makutano case study. Note that this plan is consistent with the criteria specified in P12. Tell the group that each team will be asked to elaborate an evaluation plan and that they should be guided in doing this through the use of P12, CS10, and the Evaluation Planning Sheet. Ask them to suggest a goal, some related objectives, a procedure that could be used for evaluating the degree to which each objective was accomplished, a suggestion of the person who should be responsible for conducting this evaluation, and the deadline for completing the evaluation. (Ignore the subject of "Performance Standards," for the moment.)		
3.7 Identify, list, and evaluate critical elements of an implementation plan.	In work groups, continue the elaboration of project plans. Begin where left off on the previous day. Continue through Step 16 of the Planning Checklist. (Ignore subject of "Performance Standards until Thursday.)	60 minutes (3:30 p.m. - 4:30 p.m., plus evening, if necessary)	P1 through P12 Case Study Planning Checklist Evaluation Planning Sheet

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.7 (Continued)	Lead participants in a discussion of performance standards with emphasis on the content of P13. Note the application of the principles of performance standards in the Makutano Case Study (CS7, 11, 12).	Thursday 60 minutes (8:30 a.m. - 9:30 a.m.)	P13 CS7 CS11 CS12
	Use P15 to illustrate the types of information that can be collected. Emphasize that the purposes for collecting health data are: 1. To describe the existing conditions 2. To identify areas in need of improvement. 3. To justify plans for health related projects. 4. To demonstrate the benefits that flow from a given health project Examine the data in the Case Study and identify the purposes for which the data are presented there. Encourage the participants to use P15 in determining the data they will collect for their project and the reasons for collecting it.	165 minutes (9:30 a.m. - 12:45 p.m.)	P15 Case Study

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
	Present a lecture using P16 to help participants to understand budgeting procedures in Kenya. Also use the figures in the "B" section. Emphasize the difference between a <u>development</u> budget and a <u>recurrent</u> budget. Similarly, differentiate between an <u>annual</u> budget and a <u>forward</u> budget.	1 hour 15 min. (2:00 p.m. - 3:15 p.m.)	P16 B3 B3.2
	Study the budgeting example in the Case Study. Emphasize that this is the format they must use in tabulating the budget for their project.		CS12
	In work groups, apply this procedure to the elaboration of each group's budget. Please justify each line item.	60 minutes (3:30 p.m. - 4:30 p.m.)	
3.7 Identify, list, and evaluate critical elements of an implementation plan	Reinforce the relationship between planning and implementation. Participants should be instructed to read P17 for homework the night before the class. Each team writes a summary of their work plan.	<u>Friday</u> 60 minutues (8:30 a.m. - 9:30 a.m.)	P17
3.8 Describe and justify a new project or programme sufficiently well to win its acceptance at national, provincial, district, and community levels.	Review the overall planning and evaluation process with emphasis on refining district team health care plans.	120 minutes (9:30 a.m. - 12:00 noon)	District Team Workplans

OBJECTIVE	INSTRUCTIONAL ACTIVITIES	DAY/TIME	INSTRUCTIONAL RESOURCES
3.8 (Continued)	Each team gives a progress report and summary proposal for work during phase II (See TC4 Health Management Course Overview)	120 minutes (12:00 noon - 3:15 p.m.)	
	Distribute forms and instruct participants in completing their evaluation of the course.	60 minutes (3:30 p.m. - 4:30 p.m.)	Participant's Assessment form (See Trainer's Guide)

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5.0 EVALUATION GUIDELINES

The major purposes for evaluating the course are, 1) to obtain information regarding how the trainees viewed the instructional activities; and, 2) to assess the administrative methods used to conduct the course. Three evaluation instruments, entitled "DHPT Performance Checklist," "Trainers Assessment," and "Trainee's Assessment," are provided on pages 33 - 42 of this section.

The data collected by use of these forms should be summarized in writing. This summary, along with copies of the completed forms will constitute an evaluation package which may be used by those who will be responsible for monitoring the training and making revisions in the course. This evaluative input will be extremely important for those purposes.

Many of the questions shown on these forms may also need to be revised once judgements have been made regarding the various respondent's ability to understand the intent of questions and to answer in a manner that will assist the trainer and course administrators. Unclear or inappropriate questions should be eliminated or restructured after the evaluation instruments have been used once or twice.

The complete evaluation process should take no more than three hours, and should be supervised by an evaluator or other educational coordinator for the course.

The "Performance Checklist" should be used to monitor trainee progress and identify problem areas as the course proceeds. The Checklist should then be used again at the end of the course as part of the final evaluation activities.

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*Do not write on "master copies." Duplicate forms in the quantities needed for distribution.

The "Trainee Assessment" form should be administered on the last day of training to obtain trainees' views about the administrative and instructional methods used to conduct the course.

When the evaluation forms have been completed, collected and summarized, submit them to the appropriate office as designated by the MOH for review.

DISTRICT HEALTH PLANNING TEAM
PERFORMANCE CHECKLIST

District Health Planning Team: _____

Date of Evaluation: ___/___/_____ Evaluator: _____

Instructions to the Trainer:

The following checklist describes the tasks the District Health Planning Teams (DHPT) has been expected to follow in preparation (during Phase I) for, and completion (during Phase II) of the Plan which will solve the problem assigned by the PMO.

Please rate the team's ability to perform each task by placing an (X) in the space that represents the degree to which you have observed the described tasks. The basis for making judgment are given below:

1. The team has not performed this task.
2. The team is often reminded to perform this task.
3. The team is occasionally reminded to perform this task.
4. The team performs this task adequately with few reminders.
5. The team always performs this task accurately.

Planning and Implementation Tasks

1. Reviews planning assignment and indicates further clarification needed.

   ____ 1 ____ 2 ____ 3 ____ 4 ____ 5

2. Reviews existing health services in the area.

   ____ 1 ____ 2 ____ 3 ____ 4 ____ 5

3. Ascertains needed demographic or vital data.
   - 3.1 Population ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
   - 3.2 Death Rate ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
   - 3.3 Birth Rate ____ 1 ____ 2 ____ 3 ____ 4 ____ 5

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3.4 Morbidity & Mortality Rates

1 2 3 4 5

3.5 Disease & Accident Incidence

1 2 3 4 5

3.6 Ascertains reliability of existing data for planning purposes

1 2 3 4 5

3.7 Ascertains additional data needed and how it can be obtained

1 2 3 4 5

4. Estimates time required and resources needed to complete the planning assignment

1 2 3 4 5

5. Arranges to meet with PHPT to:

5.1 Receive feedback

1 2 3 4 5

5.2 Obtain needed clarification

1 2 3 4 5

5.3 Request additional resources needed to complete planning task

1 2 3 4 5

6. Reconvenes at the district level and assigns detailed responsibilities to individual team members to obtain detailed information needed to complete the planning task (i.e., demographic and vital data; equipment and supply needs; number and type of staff needed, etc.)

1 2 3 4 5

7. Reviews Constraints

1 2 3 4 5

8. Identifies needs for intersectoral cooperation and presents the problem and background information obtained to the DDC for information and guidance.

1 2 3 4 5

9. Systematically analyzes available resources and outlines various possible solutions to the problem(s)

1 2 3 4 5

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10. Works out a cost benefit analysis

1 2 3 4 5

11. Prioritizes solutions according to resources available

1 2 3 4 5

12. Defines goal(s) and formulates specific objectives and targets

1 2 3 4 5

13. Identifies and reviews relevant performance standards

1 2 3 4 5

14. Develops Activity/time chart (GANTT Method)

1 2 3 4 5

15. Develops a work plan

1 2 3 4 5

16. Plans the evaluation

1 2 3 4 5

17. Develops an information system indicating specifically, method(s) of recording, retrieving and disseminating data

1 2 3 4 5

18. Prepares a budget

1 2 3 4 5

19. Justifies the budget

1 2 3 4 5

20. Plans the implementation

1 2 3 4 5

21. Prepares a summary of the plan, not to exceed two typed pages

1 2 3 4 5

TRAINER'S ASSESSMENT

The activities as listed below, respond to the sequence of course "Instructional Activities," as shown in the Instructional Guide. In the third column, please indicate the actual time required for completion of each segment. The fourth column has been provided for you to make necessary and appropriate comments. Those items on which you feel you would like to make comment should be noted in the column. Your detailed comments regarding those items should then be provided on a separate page if need be. Include your observations and findings regarding the adequacy/inadequacy of the materials, your own presentation/discussion, the trainee's response to the session, etc.

Activity	Estimated Completion Time	Actual Completion Time	Trainer's Comments
- Welcome	1 hour		
- Overview	1 hour		
- Statement of Problem	1 hour 45 minutes		
- Discussion - Health Planning Process	1 hour 15 minutes		
- Theory and Reading Assignment - Case Study	60 minutes		
- Checklist	60 minutes		
- Discussion - Problems and Priorities	20 minutes		
- Justifying priorities	40 minutes		
- Reformulate priorities	40 minutes		
- Community-based Health Care	20 minutes		
- Cost analysis	30 minutes		
- Discussion - P8	15 minutes		

Activity	Estimated Completion Time	Actual Completion Time	Trainer's Comments
- Goals, objectives, and targets	2 hours 15 minutes		
- Work Groups (Wednesday)	60 minutes		
- Activity Time Charts	60 minutes		
- Systems Analysis	60 minutes		
- Evaluation	3 hours		
- Performance Standards	60 minutes		
- Information and data collection	2 hours 45 minutes		
- Budgeting	1 hour 15 minutes		
- Implementation	60 minutes		
- Plan justification	4 hours		
- Course Evaluation	60 minutes		

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PARTICIPANTS' ASSESSMENT OF THE COURSE

Instructions:

Please respond to the following assessment questions by selectir responses and writing comments that best represent your experience during this training program.

1. Do you feel that you were adequately informed about this healt planning course before you came?

   Yes _____ No _____

   If not, what information would you have liked to have received?

   _____

   _____

   _____

   _____

   _____

   _____

2. Place a check in the space provided that represents your reaction to the following program activities:

Activity	Valuable		Amount of time scheduled		
	Yes	No	Adequate	Too Much	Too Little
a. Welcome and Introduction of Team Members	___	___	_____	_____	_____
b. Overview	___	___	_____	_____	_____
c. Statement of Problem by each team	___	___	_____	_____	_____
d. Teaching Philosophy and Learning Methods	___	___	_____	_____	_____
e. The Value of Planning	___	___	_____	_____	_____
f. Case Study Review	___	___	_____	_____	_____
g. Cost Analysis	___	___	_____	_____	_____

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Activity	Valuable Yes	Valuable No	Amount of time scheduled Adequate	Too Much	Too Little
h. Priority Setting	___	___	_____	_____	_____
i. Goals, Objectives and Targets	___	___	_____	_____	_____
j. Activity/Time Chart (Work Plan)	___	___	_____	_____	_____
k. Systems Analysis	___	___	_____	_____	_____
l. Evaluation	___	___	_____	_____	_____
m. Performance Standards	___	___	_____	_____	_____
n. Health Information Systems	___	___	_____	_____	_____
o. Budget Formulation	___	___	_____	_____	_____
p. Budget Justification	___	___	_____	_____	_____
q. Developing Work Plan Summaries	___	___	_____	_____	_____
r. District Health Planning Team Presentations	___	___	_____	_____	_____
s. Work Group Sessions	___	___	_____	_____	_____

3. Which two topics/aspects of the health planning course do you feel were the most valuable?

_____

_____

_____

_____

_____

_____

4. Which two topics/aspects of the health planning course could be improved?

_____

_____

_____

_____

_____

_____

5. Which two aspects of the overall administrative arrangements and support in this programme were most valuable?

_____

_____

_____

_____

_____

_____

6. Which two aspects of administrative support could be improved?

_____

_____

_____

_____

_____

_____

7. Do you feel that the instructor(s) were adequately prepared to present the information they provided?

Yes _____ No ____

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8. Were the instructional materials you received appropriate and adequate for the instruction you received?

Yes _____ No _____

9. Were the instructors available when needed or as scheduled?

Yes _____ No _____

10. Was the information provided by the instructors presented in a clear, concise and understandable manner?

Yes _____ No _____

11. Were the goals and objectives for this health planning course clearly explained to you?

Yes _____ No _____

12. Did the course content adequately cover the course objectives?

Yes _____ No _____

13. Were the facilities and equipment provided for the course adequate?

Yes _____ No _____

14. I will be able to plan my health care activities better because of this course.

Yes _____ No _____

15. Although a certain amount of pressure and stressful activity is expected during any training course, in this course stress could be reduced by:

_____

_____

_____

_____

_____

_____

16. I would give the following overall rating for this health planning course:

_____ A waste of time

_____ A good course that needs improvement

_____ Appropriate and useful

17. I would recommend this health planning course to my fellow workers.

Yes _____ No _____

18. The following specific activities (or changes in activities) and recommendations would strengthen this health planning course:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Supplement

SELECTED READINGS ON LEARNING/INSTRUCTIONAL THEORY

VERB LIST FOR WRITING EDUCATIONAL OBJECTIVES

Knowledge

cite
count
define
draw
identify
indicate
list
name
poi
q
r

recite
recognize
record
relate
repeat
select
state
tabulate
tell
trace
write

Comprehension

associate
classify
compare
compute
contrast
describe
differentiate
discuss
distinguish
explain
estimate
express
extrapolate
interpret
interpolate
locate
predict
report
restate
review
translate

Application

apply
calculate
complete
demonstrate
dramatize
employ
examine
illustrate
interpret
interpolate
locate
operate
order
predict
practice
relate
report
restate
review
schedule
sketch
solve
translate
use
utilize

Analysis

analyze
appraise
contract
criticize
debate
detect
diagram
differentiate
distinguish
experiment
infer
inspect
inventory
question
separate
summarize

Synthesis

arrange
assemble
collect
compose
construct
create
design
detect
formulate
generalize
integrate
manage
organize
plan
prepare
prescribe
produce
propose
specify

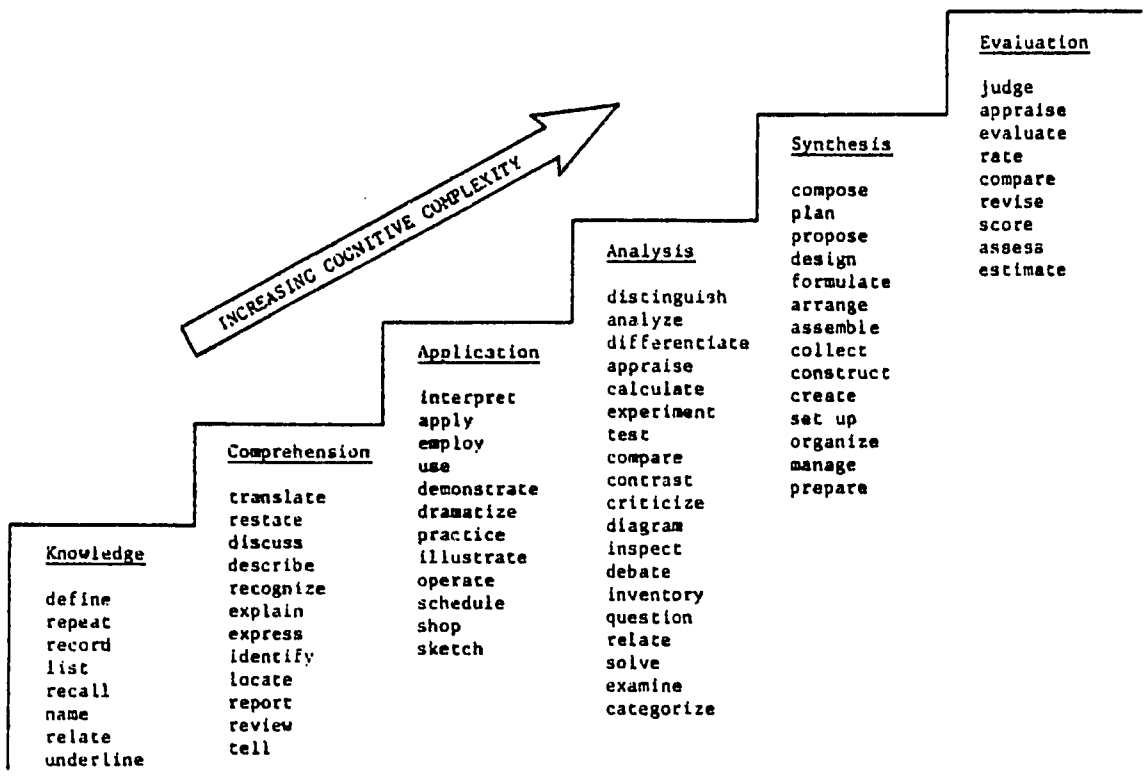
Evaluation

appraise
assess
choose
critique
determine
estimate
evaluate
grade
judge
measure
rank
rate
recommend
revise
score
select
test

4. Analysis (to *examine* a complex communication and break it down into its parts)
   - Learner will compare and contrast the political viewpoints of two newspaper columnists.
   - Learner will decide the steps needed to solve an arithmetic problem.
5. Synthesis (to *put together* information in a *unique* or novel way to solve a problem)
   - Student will construct a physical geography map.
   - Student will produce a plan for political action.
6. Evaluation (to make a *judgment* about something in light of some criteria)
   - Learner will evaluate the paintings and select the one most appropriate for display
   - Student will decide if the poem meets standards for Haiku poetry.

The following chart may be helpful to show verbs for different higher orders of objectives. Using these verbs does *not* guarantee a higher-order objective—but it may help.

Some Possible Verbs for Use in Stating Cognitive Outcomes*



*Compliments of Marybelle Savage.

TABLE 1
An Annotated Cognitive Domain Taxonomy*

This classification describes, from simplest to most complex, six degrees to which information that is taught can be learned.

1. Knowledge. *Recalling information pretty much as it was learned.*
   In its simplest manifestation, this includes knowledge of the terminology and specific facts—dates, people, etc.—associated with an area of subject matter. At a more complex level it means knowing the major sub-areas, methods of inquiry, classifications and ways of thinking characteristic of the subject area, as well as its central theories and principles.

2. Comprehension. *Reporting information in a way other than how it was learned in order to show that it has been understood.*
   Most basically this means reporting something learned through an alternative medium. More complex evidence of comprehension involves interpreting information in "one's own words" or in some other original way, or extrapolating from it to new but related ideas and implications.

3. Application. *Use of learned information to solve a problem.*
   This means carrying over knowledge of facts or methods learned in one specific context to completely new ones.

4. Analysis. *Taking learned information apart.*
   Analysis means figuring out a subject matter's most elemental ideas and their interrelationships.

5. Synthesis. *Creating something new—and good, based on some criterion.*
   This creation can be something that communicates to an audience, that plans a successful goal-directed endeavor, or that subsumes a collection of ideas within a new theory.

6. Evaluation. *Judging the value of something for a particular purpose.*
   This means making a statement of something's worth based either on one's own well-developed criteria or on the well-understood criteria of another.

*Adapted from *TAXONOMY OF EDUCATIONAL OBJECTIVES: The Classification of Educational Goals: HANDBOOK 1: Cognitive Domain*, by Benjamin S. Bloom, et al. Copyright ©1956 by Longman Inc. Previously published by David McKay Company, Inc. By permission of Longman Inc.

In those cases where you as evaluator are asked to offer an opinion of the quality of the program's aims themselves, you might use the taxonomies as a guide in formulating your response. Ask yourself:

- Does the program contain a sufficient number of high-level objectives, given its time frame and the group of students for whom it is intended?

TABLE 2
An Annotated Affective Domain Taxonomy*

This classification describes the various ways in which a person might display an attitude about something. A good way to think of this list is as a progression in the person's willingness to have some phenomenon (an event, a body of subject matter, a person, etc.) affect him. The list describes levels of behavior from barest exposure to deep involvement.

1. Receiving. *Paying attention.*
   Most basically, this means just knowing that something exists or is going on. It also includes alert watching and listening.

2. Responding. *Active exploration or participation.*
   At base, responding means not-necessarily-enthusiastic willingness to take part in something. A more developed manifestation includes satisfaction, pleasure, or even pursuit of a certain activity, person or thing.

3. Valuing. *Consistent behavior showing positive regard for something.*
   This might mean behavior in keeping with advice from others about the right—but not necessary pleasurable—route to a desired goal. At a deeper level, it involves commitment, expression of a particular point-of-view, and assuming responsibilities.

4. Organization. *Building and behaving according to a single set of life principles.*
   Organization includes holding consistent points-of-view about many aspects of life, without contradictions or conflict.

5. Characterization by a value or value complex. *Being predictable.*
   This means showing a strongly detectable—and effective—pattern of growth or adjustment to life in general.

*Adapted from *TAXONOMY OF EDUCATIONAL OBJECTIVES: The Classification of Educational Goals: Handbook 2: Affective Domain*, by David R. Krathwohl, et al. Copyright ©1964 by Longman Inc. Previously published by David McKay Company, Inc. By permission of Longman Inc.

Principle No. 3: Objectives may be written for a whole program as well as for individuals

You have probably noticed that sometimes objectives refer to goals for a whole program. For instance:

> Eighty percent of the students shall score above the 50th percentile on the Iowa Test of Educational Development.

This objective does refer to observable student behavior—test-taking—which is specified in detail in the manual for the administration of the test chosen for the program.

TRIP REPORT

ON

OBSERVATIONAL TOUR TRAINING

TO

IVORY COAST, NIGERIA, TOGO AND CAMEROON

FEBRUARY, 1982

DR. R. GIPSON

HEALTH PLANNING AND INFORMATION PROJECT

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TRIP REPORT ON AFRICAN OBSERVATIONAL TOUR TO IVORY COAST, NIGERIA, TOGO AND CAMEROON

I - INTRODUCTION

(a) Brief Background: One of the components of the Health Planning and Information Project is to organize and make arrangements for observation tour training for Kenyan Health officials in African countries.

(b) To these ends arrangements were made for 4 Ministry of Health officials to participate in an observation tour training experience by visiting the Ivory Coast, Nigeria, Togo and the Cameroon over the period of February 12th to 24th, 1982. The list of the Kenyan delegation is included in Annex A. The Itinerary of the delegation and names of persons interviewed are included in Annex B.

II - PURPOSE OF AFRICAN OBSERVATIONAL TOUR TRAINING

The primary purpose of the Tour Training were as follows:

(a) To provide participants with an opportunity to briefly study the organization and management of Rural Health Services Delivery in African countries.

(b) To observe different approaches of solving Rural Health Delivery problems, with a view towards learning ways in which the solutions might be adopted and applied to solving similar problems in Kenya.

(c) To observe the major regional and country training programmes in planning and management.

(d) To observe regional programmes for strengthening Health Delivery Systems in other African countries.

III - BRIEF REPORT ON COUNTRIES, REGIONAL TRAINING PROGRAMMES OR REGIONAL PROJECTS VISITED

a) Project for strengthening Health Delivery Systems in Central and West Africa, SHDS.

(b) Project for strengthening Health Delivery Systems in Central/West Africa, SHTH, is a regional project which aims to strengthen Health Delivery Systems in 20 countries of Central and West Africa.

The participating countries are as follows:

Benin, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo and Upper Volta.

The project functions under the auspecies of the World Health Organization regional office for Africa and is funded by the United States Agency for International Development.

SHDS was developed when the countries of the region involved in the WHO smallpox - measles eradication campaign requested a comprehensive follow-up program to assist them in improving other aspects of health services.

SHDS collaborates directly with Ministries of Health, WHO regional training centres, academic institutions and regional endemic disease control organizations in Central and West Africa.

SHDS is governed by two committees composed of representatives of Ministries of Health of the 20 countries, WHO/AFRO and AID. One committee meets every two years to review program objectives; the other meets annualy to review program activities.

SHDS has its principal project office in Abidjan, Ivory Coast. Boston University, the project contractor, together with the Centre for Disease Control (CDC) in Atlanta, provides professional and administrative program support in collaboration with WHO/AFRO. SHDS staff and consultants come primarily from Africa and the U.S.

SHDS programs are being carried out in association with:

- the WHO Regional Training Centres in Togo and Nigeria,

- the WHO Centre for Health Planning, Programming and Management in Senegal,

- the post-basic nursing education programs in Senegal, Cameroon and Liberia,

- the two endemic disease control organizations (OCEAC in Cameroon and OCCGE in Upper Volta), and

- the Ministries of Health in Ivory Coast, Cameroon and the Gambia.

The SHDS program goal is to develop the capability to plan, implement and manage effective and economically feasible health delivery systems in the West and Central Africa region. This goas is to be achieved by the following four objectives:

I. To improve national and regional health planning and management;

II. To increase skills and to improve utilization of health personnel providing generalized health services at the supervisory and local levels;

III. To improve regional and national disease surveillance and health demographic data systems and to integrate these systems into national health planning delivery systems;

IV. To develop low-cost (affordable) health delivery systems.

In collaboration with WHO, CDC and the participating countries, the projec has thus far:

- Conducted the first top level regional inter-sectoral management workshop for senior level officials from 8 countries and ministers from 4 countries.

- Developed instructional materials for training village health workers and initiated new courses for training trainers of village health workers at the WHO Regional Training Centres in Togo and Nigeria.

- Initiated a follow-up program in the regional training centres to help students design and implement village health worker training programs in their own countries.

- Held workshops for over 140 participants on curriculum development, training of village health workers, epidemiology and primary health care.

- Evaluated current programs in nursing education and planned new curriculum for post-basic nursing education emphasizing primary health care.

- Provided support to over 200 participants receiving training in health planning and management, public health and health education.

- Developed EPI demonstration and training areas in 3 countries with the goal of reducing morbidity and mortality due to immunizable contagious childhood diseases by 50% in 36 months.

- Held courses for national managers of EPI, training 82 people from 44 countries.

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- Initiated in-country training programs for mid-level managers of EPI.

- Conducted 5 regional workshops on primary health care. These workshops resulted in a soon-to-be published manual on primary health care program development.

- Initiated a program to train people from the region to carry out applied research in primary health care

VISIT TO W.H.O. TRAINING CENTRE FOR HEALTH SERVICES PERSONNEL, YABA, LAGOS, NIGERIA.

As stated earlier a component of the SHDS Project is to assist in strengthening the management training capacity of the WHO Training Centre for Health Services Personnel which is a regional training centre for Africa located in Yaba, Lagos. The group was given an over view of the training program by the Training Director, Dr. E. L. Neil. Dr. Neil stated that the following process were offered as a component of their training program:

1. Course in systematic cost design in community mobilization for trainers of Primary Health Care workers which is a 12 week course.

2. A course in Health Services Management for middle level health personnel which is an 8 week course.

3. A course in environmental health in malaria control techniques for mid level health personnel which is a 10 week course. These courses are given twice a year and participating countries select candidates who attend the course in Yaba, Lagos. The objectives for the course in Health Services Management for middle level health personnel will review in great detail. The following information was gained by the review. This course is designed for health centre administrators,

Nurses, Midwives, Health Centre Superintendents and others who have been in the health care delivery service of their country for a minimum of five years.

Candidates to this course must have or will have direct responsibility for planning, organising, directing and controlling in one or more areas of the following health care components: health education, food supply and nutrition, safe water and basic sanitation, maternal and child health care, immunization against major infectious diseases,prevention, control and treatment of locally endemic diseases and the management of injuries and the supply of essential drugs.

The course aims at preparing the participants in mobilization of communities and the management of the health delivery systems in the context of Health For All By The Year 2000 A.D.

DURATION OF THE COURSE: 8 weeks.

BROAD OBJECTIVES: At the end of the course, the participants will be able to:

1. Examine the implementation of Primary Health Care in Africa.
2. Examine the foundations of African Management Processes.
3. Isolate relevant characteristics of African ways of life for effective health services management.
4. Use African case studies in health care delivery services to practise management decision-making.
5. Mobilise the community to actively participate in health care delivery services.
6. Provide effective leadership for co-workers.
7. Design, implement and evaluate health education activities.
8. Plan, implement and evaluate in-service health training programmes.
9. Evaluate the impact of health care delivery services.
10. Maintain adequate statistical health records.
11. Promote adequate food supply to the community.
12. Promote proper nutrition among communities.
13. Use appropriate technology to produce safe drinking water and solve other basic local sanitation problems.
14. Organise Maternal and Child health activities.
15. Coordinate immunization activities against major infectious diseases.

Nurses, Midwives, Health Centre Superintendents and others who have been in the health care delivery service of their country for a minimum of five years.

Candidates to this course must have or will have direct responsibility for planning, organising, directing and controlling in one or more areas of the following health care components: health education, food supply and nutrition, safe water and basic sanitation, maternal and child health care, immunization against major infections diseases,prevention, control and treatment of locally endemic diseases and the management of injuries and the supply of essential drugs.

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4. Use African case studies in health care delivery services to practise management decision-making.
5. Mobilise the community to actively participate in health care delivery services.
6. Provide effective leadership for co-workers.
7. Design, implement and evaluate health education activities.
8. Plan, implement and evaluate in-service health training programmes.
9. Evaluate the impact of health care delivery services.
10. Maintain adequate statistical health records.
11. Promote adequate food supply to the community.
12. Promote proper nutrition among communities.
13. Use appropriate technology to produce safe drinking water and solve other basic local sanitation problems.
14. Organise Maternal and Child health activities.
15. Coordinate immunization activities against major infectious diseases.

2. Use such developed course to train primary health care workers.
3. Collaborate with and work in rural communities for the improvement of community and individual health in their villages.
4. Collaborate with other workers in community development to improve community and individual health in the rural areas.
5. Evaluate the performance of primary health care workers during their training and periodically afterwards.
6. Supervise the work of trained primary health care workers.
7. Plan and give all the necessary support to primary health care workers to facilitate the delivery of health care to the rural areas.
8. Organize retraining programmes for practising primary health care workers as and when needed.
9. Evaluate periodically the impact of the trained primary health care workers on the health of communities in the rural areas within the context of health for all by the year 2000 A.D.
10. Communicate the results of such evaluation to other levels of the health care delivery system in a manner which will help in the development of aocoherent national health plan.

A site visit was completed to the field training area where a community mobilization programme for primary health care workers was initiated by the training participants.

OBSERVATIONAL TRAINING TOUR VISIT TO OCEA AND CESSI

The group visited the W.H.O. host country headquarters in Yaounde. An over-view was given of W.H.O. and SHDS collaboration in assisting the OCEA and CESSI programmes in Yaounde. A visit was made to the OCEA office and the Senior Director of OCEA reviewed the programme and gave the group a tour of the Training Centre. The Director stated that OCEA was a regional programme with member countries to provide training for laboratory mid level personnel and to conduct research into specific areas identified by the participating countries. A visit was also made to CESSI and the Programme Director reviewed the project and the following was noted.

CESSI was started in 1972 with the training of post graduate nurses from 15 countries in the areas of community health. Upon completion of the

course the nurses were awarded certificates just below the Bachelor of Nursing Degree. Regional approach to strengthening training in management was a viable approach towards assisting countries in increasing their capacity to manage health services. Therefore, observational tours were planned to visit East and Southern Africa Management Institute in Arusha to take a look at the Regional Training Centre for East Africa in management.

A N N E X A

LIST OF AFRICAN OBSERVATIONAL TOUR TRAINING PARTICIPANTS

1.	Mr. P. Kariuki	-	Deputy Secretary
2.	Dr. J. Maneno	-	Assistant Director of Medical Services
3.	Dr. R. Kalya	-	Provincial Medical Officer Rift Valley
4.	Mr. D. Omolo	-	Senior Nursing Officer
5.	Dr. R. Gipson	-	Senior Health Planner (HPIP)

A N N E X B

ITINERARY FOR OBSERVATIONAL TRAINING TOUR IN IVORY COAST

Friday 12.2.82	18.30 hrs.	-	Arrival at Abidjan, Ivory Coast.
Monday 15.2.82	08.30 - 12.00 hrs.	-	Visit Strengthening Health Delivery Systems in Central and West Africa.
		-	Meet with Dr. David French.
	12.00 - 14.00 hrs.	-	L u n c h
	14.00 - 16.00 hrs.	-	Meet with Strengthening Health Delivery Systems, Training Coordinator.
Tuesday 16.2.82	19.00 - 12.00 hrs.	-	Meet with Strengthening Health Delivery Systems, Epidemiological and Research Officer.
	12.00 - 14.00 hrs.	-	Lunch with Dr. French.
Wednesday 17.2.82	10.00 hrs.	-	Leave for Lagos, Nigeria by plain.

ITINERARY FOR OBSERVATIONAL TRAINING TOUR IN LAGOS, NIGERIA.

Thursday 18.2.82	19.00 - 12.00 hrs.	-	Visit the World Health Organizati Training Centre for Health Servic Personnel,
		-	Meet with Training Staff Director Dr. E. L. Neil.
	12.00 - 14.00 hrs.	-	L u n c h
	14.00 - 16.00 hrs.	-	Tour Training Facility.
Friday 19.2.82	08.00 - 14.00 hrs.	-	Visit Field Training Sight for Trainers of Primary Health Care workers.

ITINERARY FOR OBSERVATIONAL TRAINING TOUR IN YAOUNDE, CAMEROON

Monday 22.2.82	14.00 - 16.30 hrs.	-	Visit the World Health Organization Headquarters,
		-	Meet with Mr. Assomba.
Tuesday 23.2.82	08.30 hrs.	-	Visit OCEA,
		-	Meet with Senior Director
		-	Review Program and visit Training Centres.
	13.00 - 14.00 hrs.	-	L u n c h
	14.00 - 16.30 hrs.	-	Visit CESSI,
		-	Meet with Training Director.
	18.00 hrs.	-	Departure from Yaounde by plain for Douala and Douala to Nairobi.

RIP REPORT

ON

AFRICAN OBSERVATIONAL TOUR TRAINING

TO

TANZANIA / ZANZIBA

MARCH, 1982

DR. R. GIPSON

HEALTH PLANNING AND INFORMATION PROJECT

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TRIP REPORT ON AFRICAN OBSERVATIONAL TOUR TO TANZANIA AND ZANZIBAR

I - INTRODUCTION

(a) Brief Background: A component of the Health Planning and Information Project is to organize and make arrangements for Observational Tour Training for Kenyan Health Officials in African countries.

(b) To these ends arrangements were made for three Ministry of Health officials to participate in Observational Tour Training experienced by visiting Tanzania and Zanzibar over the period of the 3rd to 10th March, 1982. The list of the Kenyan delegation is included in Annex A. The Itinerary of the delegation is included in Annex B.

II - PURPOSE OF AFRICAN OBSERVATIONAL TOUR TRAINING

The primary purpose of the Tour Training were as follows:

(a) To provide participants with an opportunity to briefly study the organization and management of Rural Health Services Delivery in African countries.

(b) To observe different approaches of solving Rural Health Delivery problems, with a view towards learning ways in which the solutions might be adopted and applied to solving similar problems in Kenya.

(c) To observe the major regional and country training programmes in planning and management.

(d) To observe regional programmes for strengthening Health Delivery Systems in other African countries.

III - BRIEF REPORT ON COUNTRIES, REGIONAL TRAINING PROGRAMMES OR REGIONAL PROJECTS VISITED

Visit to the Tanzanian Ministry of Health with specific focus on the planning unit within the Ministry. On the 4th of March, 1982 the Tanzanian Ministry of Health was visited by the Observational Tour Training group. The major Ministry of Health officials were met and reviewed their specific functions within the Ministry. Specific focus was given to the planning unit within

the Ministry. The overall organization of the Ministry was given as represented by the diagram below. The following information was gained in reference to the task and organization of the planning unit. The overall functions of the planning unit were identified as follows:

1. Production and dissemination of health and other related information for managing health services.

2. Formulation of short, medium and long term health sector development plans in collaboration with the Divisions of the Ministry, Regions and other relevant and related sectoral Ministries.

3. Monitoring implementation of the development plans.

4. Designing and Follow up of construction of health sector construction projects and advise on maintenance of health buildings.

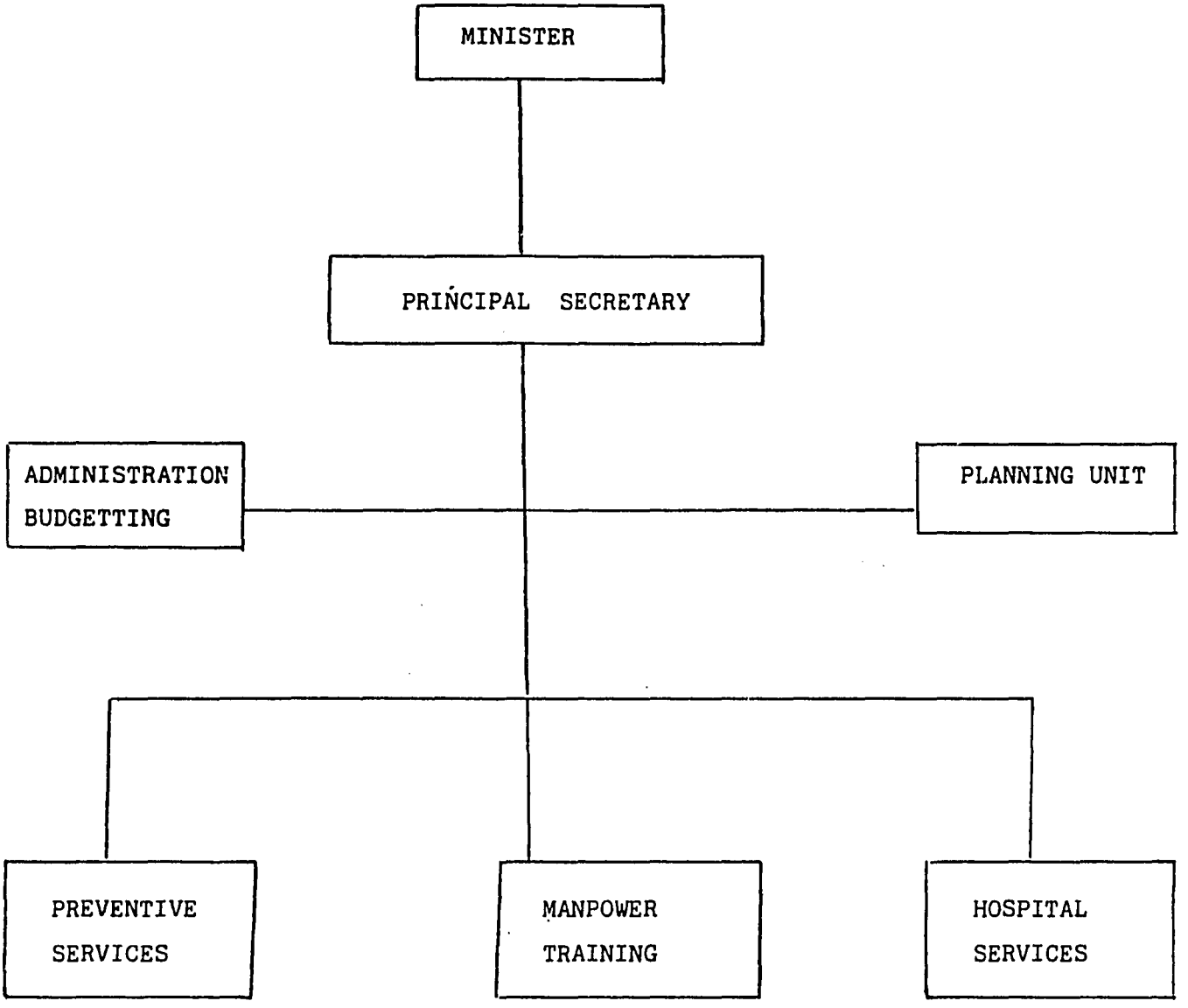
5. Coordination of all donor inputs into the Health Sector.

Organization

The Planning Unit should be divided into FOUR Sections each dealing with a major task which will entail several functions. The proposed sections are:-

1. Information and Evaluation:
1. This section will perform the following major functions:
1. Production of health information which will include:

- Health service statistics: MCH, Manpower (attendances, immunization), inpatient, outpatients attendances, health facilities (distribution: updation of the inventory of health facilities),
- Health economic statistics: unit costs, expenditure and trends in expenditure, regional health expenditure,
- Health /vital/demographic statistics: population projection, fertility and mortality rates and morbidity statistics: incidence and prevalance of priority diseases and patern of morbidity, nutrition status etc.,


MINISTER
PRINCIPAL SECRETARY
ADMINISTRATION
BUDGETTING
PLANNING UNIT
PREVENTIVE
SERVICES
MANPOWER
TRAINING
HOSPITAL
SERVICES

- Enviromental health statistics: accessibility to safe water, latrines, food etc.

This could be effently done in close collaboration of various agencies: BRALUP, Bureau of Statistics, Maji, University, Faculty of Medicine, TFNC, Institute of Medical Research, Regions, Prime Ministers Office, Epidemological Unit, Health Education and Building Research Units.

2. Evaluation of Programmes/Health Services:

- Creat awareness of the need for continuous evaluation of health programmes/services,
- Fully participate and provide technical inputs into the planning, designing of evaluation studies and advise on the analysis of the data.

3. Sociological Aspects of Health Care Delivery:

- Undertake in collaboration with other agencies population based sociological studies related to health care delivery.

4. Develop a Data Bank for health information and other related information.

5. Desseminate health and related information:

- Preparation of quarterly and annual health information bulletins/reports,
- Training of health workers and teachers of health workers.

6. Improve in collaboration with relevant authorities/agencies the sources of health and related information

Health Planning:

This section will perform the following major functions:

1. Prepare short, medium and long term development plans for the Health Sector in collaboration with all the Divisions of the Ministry, related sectoral Ministries, Regions, Prime Ministers Office, the Ministry of Planning and Economic Affairs and other relevant agencies.

2. Provide guidelines for the preparation of Regional Health Sector Plans and ensure that the plans fall within the overall national health sector plans.

3. Health Economic Research into the utilization of health resources and advise on economic utilization of scarce resources.

4. Development of new Health Programmes especially the economi aspects.

5. Periodic Review of the Health Sector Plans.

6. Advise on Health Manpower Planning and utilization.

III Implementation/Monitoring:

This Section will perform the following functions:

1. Preparation of the Annual Development Budget within the contract of the short, medium and long term plans for the development of the Health Sector.

2. Follow up the implementation of all health projects/programm (national and regional).

3. Preparation of Quarterly Implementation Report and applicati for the release of development funds.

4. Mid-Year review of the Annual Plan.

5. Annual Performance report in respect of the Annual Plan.

6. Advise on management aspects of health care delivery system at various levels.

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IV Building

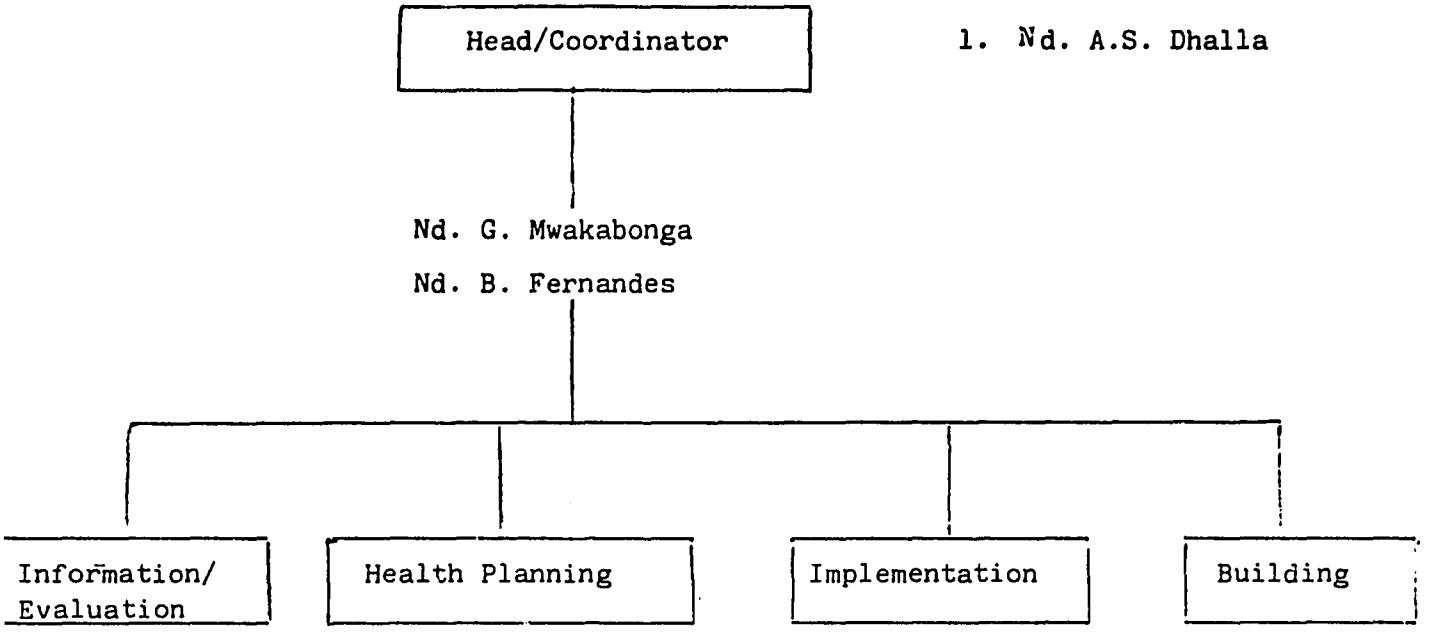
This is a technical construction section which in collaboration with the Ministry of Works, Regional/District Engineers and the Building Research Unit perform the following functions:

1. Design of any new health construction projects
2. Follow up the construction of health projects
   - national and regional.
3. Preparation of Quarterly Implementation Report in respect of health construction projects.
4. Prepare a programme of upgrading/improving of existing health facilities: Hospitals, Health Centres, Dispensaries and Training institutions.
5. Follow up of the implementation of the upgrading programme.
6. Advise on the maintenance of health buildings and train 'funds' to do the ordinary maintenance work and prepare a simple mannual of maintenance of buildings for distribution to RMOs, DMOs, Principals of Schools.
7. Advise the Ministry on all matters pertaining to design and construction.

Coordination of the Planning Unit and Donor Inputs

As the Health Sector receives substantial development support from several donor agencies - bilateral and multilateral. There is a great need to have this function performed by the Head/Coordinator of the Planning Unit in addition to coordination of all activities within the Planning Unit. He should also coordinate and initiate operational research into the health care delivery system. The proposed organ for the Planning Unit is as shown below:

PLANNING UNIT



Information/ Evaluation	Health Planning	Implementation	Building
1. Nd. J. Ruta-banzibwa	1. Nd. E. Manumbu	1. Nd.S.Ngatunga	Nd. T. Gfertsen
2. Nd. F.Macha	2. Nd.G. Berleen		Nd. P. Breum
3. Nd.Sangalala			Nd. C. Nordin

DEVELOPMENT OF HEALTH SECTION TANZANIA (Mainland)

The following information was gained in reference to the Health Section in Tanzania. The Kenyan delegation felt that some aspects of the planning unit that were observed could be applicable to the need for a planning unit within the Ministry in Kenya. But there was also a feeling that a lot of the basic functions might be similar with slight modifications for the difference in the Kenyan system. The Kenyan delegation was taken on a tour to visit three dispensaries, two health centres and Bagamoyo Regional Hospital.

Area: 937,062 sq.km. (including 53,483 sq.km. of water area).

Demographic Characteristics:	1967	1976	1978
- Total Population	11.0m	16.3m	175.0m
- Crude Birth Rate /1000	47	46	46
- Crude Death Rate /1000	22	17	15
- Rate of Growth (%)	2.5	2.9	3.1
- Life Expectancy at Birth	35	47	50
- Total Fertility	6.2	6.2	6.2
- Infant Mortality Rate /1000	161	152	135(estimate)
- Maternal Mortality Rate /1000 (institutional)	3.6	2.0	1.5 - 2.0
- % of population below 15 years			46%

National Income:

Per Capita GDP:

- At current prices (1979) .....T.Shs. 1,895 (US $ 230)
- At 1966 prices (1979) .....T.Shs. 678 (US $ 82)

Health Expenditure:

Per Capita Expenditure on Health T.Shs. 55 (US $ 6.5)

Disease Pattern:

Infective and Parasitic Diseases cause 35-40% of all hospital attendances and admissions.

Health Facilities:			Target	Actual
	1961	1972	1980	1980
Hospitals	98	146	149	149
Health Centres	22	99	300	235
Dispensaries	975	1501	2300	2600

Health Manpower:

	1961	1972	Target 1980	Actual 1980
- Doctors (University Trained) Total	425	494	830	889
- Nationals	12	195	700	566
- Assistant Medical Officer	32	140	300	258
- Medical Assistants	200	335	1200	1400
- Rural Medical Aids	380	578	2800	2310
- Nurse/Midwives	1372	3259	6800	7275
- M.C.H.As	400	700	2500	2070
- Health Assistants	150	290	1800	681

Coverage/Accessibility of Health Facilities - Some Regions

% of population living within 10 km of any health facility

Region	1973	1978
Dodoma	78	92
Kilimanjaro	99	99
Coast	67	93
Ruvuma	69	88
Kigoma	89	91
Mwanza	73	98

Future:

Four major goals for Health Development Plan to the year 2000 are as follows:-

1. To increase average life expectancy at birth from 50 years at present to 60 by reducing the current Infant Mortality Rate of 135 per 1000 live births to 50.

2. Health for all by the year 2000 through Primary Health Care.

3. To continue to be more self reliant in health personnel; and

4. To improve management of health care delivery system at all levels.

IB:

Health Centre: Key Staff: Medical Assistant or Assistant Medical Officer
Nurse Midwives
Rural Medical Aid

	Beds 30 - 40 Has kitchen and laundry drug store One vehicle usually Landrover.
Dispensary: Key Staff:	Rural Medical Aid Maternal and Child Health Aid two helpers
Assistant Medical Officer:	Secondary School graduate who is Medical Assistant and has received extra training in surgery Medicine and Obstetrics/Gynaec (licenced doctor).
Health Assistant:	Secondary School graduate with 3 years training in General Medicine Surgery and Midwifery.
Rural Medical Aid:	Primary School graduate with 3 years train in general medicine and osme elements of surgery, and midwifery (can recognise dangerous signs and make relevant referal after first aid).
Nurse Midwife:	Register A - Secondary School graduate tra for 3 years general Nursing and one year i Midwifery.

OBSERVATIONAL TRAINING VISIT TO MINISTRY OF HEALTH, ZANZIBAR

A meeting was held with the Permanent Secretary, Director of Medical Services, Director of Preventive Services and Director of Curitive Services for Zanzibar. It was stated that Zanzibar and Pemba had a population of 500,000 with three hospitals, approximately 50 physicians. Each director gave a brief review of their department's organization and responsibilities. The delegation toured Linen Hospital and the Psychiatrist Mental Hospital for the Island.

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OBSERVATIONAL TRAINING TOUR VISIT TO EAST AND SOUTHERN AFRICAN MANAGEMENT INSTITUTE, ARUSHA

The group met with Mr. Joshi who is the Director for the Management Programme and also met with the Director of the Institute, Mr. Okumu. ESAMI has 17 member countries who send participants to participate in the three main types of programmes as follows:

1. Postgraduate Management Diploma.
2. Masters in Business Administration, a one year programme.
3. Two ten weeks courses in health, small industries, finance, management of human resources, project planning, management of human services, transport and communication.

The Institute has a total of 120 participants at a time which are housed within the institution. The institution is 85% self supporting with 15% coming from the member states. The institute has 22 professionals and 100 administrators and supportive staff, 6 training rooms. The course in Health Management was developed as a result of a meeting with the Ministries from the member countries who requested that the institute should organize a course on Health Management. The institute offers the following courses:

1. Course in Systematic Course Design and Community Mobilization for Trainers of Primary Health Care workers (12 weeks).

2. Course in Health Services Management for Middle-Level Health Personnel (8 weeks).

3. Course in Enviromental Health and Malaria Control Techniques for Middle-Level Health Personnel (10 weeks).

A N N E X A

LIST OF AFRICAN OBSERVATIONAL TOUR TRAINING PARTICIPANTS

1.	Dr. J. Maneno	-	Assistant Director of Medical Services
2.	Dr. R. Kalya	-	Provincial Medical Officer Rift Valley
3.	Mr. D. Omolo	-	Senior Nursing Officer
4.	Dr. R. Gipson	-	Senior Health Planner (HPIP,

HEALTH PLANNING AND INFORMATION PROJECT

PROJECT NO. 615-0187

TECHNICAL SERVICES TO THE MINISTRY OF HEALTH

GOVERNMENT OF KENYA

Annual Report

(for period October, 1981 - September, 1982)

V O L U M E II

Contractor

Charles R. Drew Postgraduate Medical School

Office of International Health and Economic Development

1621 E. 120 Street

Los Angeles, CA 90059

Contractor's Director (Chief-of-Party)

Reginald F. Gipson, M.D., M.P.H.

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- A Trainer's Guide - Health Planning and Evaluation for District Health Teams, Draft Edition, July 1982
- Trip Report on Observational Tour Training to Ivory Coast, Nigeria, Togo and Cameroon, February 1982
- Trip Report on Observational Tour Training to Tanzania/ Zanzibar, March 1982

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- News Article Referencing "Districts Made Lab of Progress"
- Exemplary Workshop Package - Ministry of Health Workshop on Planning Process for the Fifth National Development Plan (sponsored by HPIP) at Amref, 5-6 May, 1982

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Attachments

- Minutes of the Meeting Held on Information Required for Producing Annual Reports for the Ministry of Health, September 11, 1981
- Workshop Product - Inventory of Health Information System at District Level
- Guidelines for Data Needed for District Level Planning -- Review of District Health Plan
- Consultative Report (on assessment of Health Information System), April 1982
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Assistance to Planning Staff (on-job)

1. Appraise Health Sector Policies and Programs _____ [F]

During Project Year II, the HPIP assisted the HPWG in developing a strategy paper on "Redefining Health Policy". That paper, which was circulated within the MOH, is attached.

Additionally, the HPIP assisted the HPWG in the major undertaking of reviewing the "Report and Recommendations of the Working Party on Government Expenditures" (also known as Sessional Paper No. 4). This review was prepared on behalf of the MOH and provided the Ministry's views on health policies and development programs. The attached review document was presented at an interministerial Symposium on Preparation of the Fifth National Development Plan.

These activities represented the first official efforts of the HPWG to function in its capacity to appraise health sector policies and programs. A considerable amount of support and guidance was required in these efforts. It is anticipated that during Project Year III, HPIP will concentrate with the HPWG on identifying still other opportunities in which its responsibilities in this area can be exercised.

Within the context of the Project requirements, the objective of assisting planning staff in appraising health sector policies and programs, is considered to be approximately 30% complete (in terms of the need to expand and institutionalize this capability).

2. Organize Operations Research _____ [H and J]

During Project Year I some preliminary steps were taken to assist the MOH in identifying the types of research agendas that might be undertaken in connection with the HPIP. At that time, a questionnaire regarding research priorities was prepared and distributed to health management teams as part of the data gathering and planning of the Integrated Rural Health/Family Planning Programme.

During Project Year II, HPIP continued to assist the MOH in further defining and focusing its research priorities. Particular attention was given to building coordinative relationships between the MOH and other entities within the GOK whose concerns relate to health research. For instance, the National Council on Science and Technology (NCST) is the ministry within the GOK charged with establishing guidelines and coordinating all research within the government. NCST has the capacity to fund research projects and receives a specific portion of the national budget for this purpose. Secondly, the Kenya Medical Research Institute (KEMRI) is specifically charged with undertaking a broad range of medical and health-related research, including the types of research that would be appropriate in connection with HPIP. KEMRI can be seen as a technical resource that might support or expand upon HPIP-sponsored research. Further, the Ministry of Economic Planning and Development has established a research committee which supports overall rural development. Health is one of the sectoral issues which falls into the scope of this research committee's concerns.

In the interest of assisting the MOH in developing health research priorities, HPIP staff represented the MOH throughout Project Year II at meetings called by the MOEPD's research committee. In addition, in December 1982, HPIP will participate with MOH, NCST and KEMRI in sponsorship of the First National Conference on Health Research Priorities.

In spite of HPIP's general assistance to the MOH in creating the associations that will eventually facilitate strengthening the MOH's capacity to mount research activities, little progress was made during Project Year II in actually establishing the mechanisms by which research would be undertaken. Major constraints have related to:

a. difficulty in obtaining information from USAID/K regarding its balance of project funds that will be specifically earmarked and obligated for the contracting of research activities; and

b. delays within the MOH in establishing a sub-vote for its contribution to support of research contracting (as provided for in the HPIP bilateral agreements).

By way of responding to these concerns, HPIP has alerted MOH officials to both issues. As a result, in May 1982, the MOH requested clarification from USAID regarding the status of bilateral funds available for research. No response has been received to-date. Secondly, the HPIP assisted the MOH in preparing its application to the Ministry of Finance for the necessary sub-vote to authorize expenditures in applied research. The outcome of that application will not be known until March 1983.

Regardless of the eventual outcome of the financing matter related to organizing research under the terms of the HPIP contract, it is expected,

at a minimum, that the Project will be able to assist the MOH and relate entities in identifying health research priorities in the country.

If and when specific funds become available, HPIP will be in the positio to further assist the MOH in organizing contract administration monitoring of the research activities, and ensuring appropriat dissemination of research findings.

Within the context of the Project requirements, it is considered that n more than 10% of this objective has been completed.

3. Develop Programs/Projects _____ [K and L

As in Project Year I, the HPIP continued during Project Year II, to play a key role in development of the Integrated Rural Health/Family Plannin Programme detailed implementation planning. Because the detailed plannin phase of the IRHP incidentally coincided with the national, provincial an district level planning of the Fifth Development Plan, the genera planning concerns of the MOH and those specific to the IRHP could b addressed simultaneously. HPIP's support to the IRHP has therefore tende to be a natural consequence which was complementary to HPIP objectives.

However, as the IRHP moves from its program planning phase int implementation, care will need to be taken to clearly define the areas o direct staff support that would be appropriate to provide to the IRH under the specific terms of the HPIP contract.

Other opportunities for program/project development have been significantly inhibited by delays in the areas of operations research* (which was originally assumed to be the mechanism by which new program/project opportunities would be identified and developed).

Within the context of the Project requirements, the objective of developing programs/projects is considered to be essentially incomplete, accounting for no more than 30% of original expectation.

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*See discussion pages F-2.

STRATEGIES FOR - REDEFINING HEALTH POLIC

BY

THE HEALTH PLANNING WORKING GROUP

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THE PLANNING WORKING GROUP. (ITS COMPOSITION AND OPERATIONAL STRATEGY)

1. PURPOSE

The purpose of this communication is to outline strategic operations of the Health Planning Working Group' in its efforts to produce the health chapter for inlclusion in the 5th National Development Plan.

This paper is addressed to the Steering Committee and is aimed at seeking policy guidelines or mandate to ascertain health policy so that the working group can be able to clarify these goals and policy when discussing it with the heads of departments, heads of Units, government and non-government health related agencies.

2. ORGANISATION STRUCTURE AND RESPONSIBILITIES FOR THE HEALTH PLANNING WORKING GROUP

i) The idea of formulating a health planning working group came out of an inter-Ministerial health planning workshop held at Safari Park Hotel in April, 1982 and a subsequent similar intra-ministerial workshop held at AMREF on 5th and 6th May, 1982.

ii) The main responsibility of the working group is to produce the health chapter for inclusion in the 5th National Development Plan. Tasks of this For this group include:- identification of the health problems, determination of priorities, analysis of the health situation, determination of strategies, presentation of the plan for approval to heads of departments, Consultation with Ministry of Finance (MOF) and Ministry of Planning and

health plans.

iii) In his circular IB/11/1/74 dated 6th May 1982, the Permanent Secretary identified members of the Steering Committee to be the Permanent Secretary, Director of Medical Services, one Senior Deputy Director of Medical Services, one Deputy Secretary and the Chief Nursing Officer. The Secretary of the Committee will depend on the issue being discussed e.g. if the issue is on Integrated Rural Health Programme the Director will be the Secretary.

In the same circular, the P.S. appointed the following officers as members of the Working Group.

Mr. Fred Ouka	-	Under Secretary (P)
Mr. L.K. Ndungu	-	Administrative Secretary.
Dr. R. Gipson	-	Resource person.
Mr. C.K. Thube	-	Health Planner/Economist.
Mr. S. Ong'ayo	-	Health Planner/Economist.

iv) Any group formulated to produce or help in formulation and evaluation of a health plan should remember that implementation of the plan remains the responsibility of the health operational branches. This came out clearly during the deliberations of the planning workshop.

v) The working group requires support on secretarial and transport needs. There is a need for budget provision for the operations of the group. This can be a sub-vote or an item under the Headquarters provisions.

There is also a need for secretarial services. The groups requires at least 2 Typists (one Shorthand Typist) and office accommodation including Library/data Section. At least one can should be made available to facilitate collection of information and consultations.

3. RE-DEFINITION OF HEALTH POLICY

i) It is necessary to determine or re-ascertain the present health goals and general objectives before embarking on the exercise of writing up the health chapter. To be able to do so, we need to identify health problems, available resources, and then make analysis of the existing health situation.

DISCUSSION WITH THE MOPED

The Working Group visited the Ministry of Planning and Economic Development on 7th May 1982, with view of finding out:

i) (a) What information the MOPED expects MOH to provide towards the production of the health chapter.

(b) Ascertain the deadlines set for various Ministries for submitting papers which would be required for consideration by cabinet before determining the National health policy guidelines which will help MOH to formulate its health policy.

(c) Ascertain membership of the health Planning Sector Group with whom the working group will liaise its activities.

(d) Obtain information on how MOH collaborated with MOF and MOPED in preparation and production of the past Health Chapters.

ii) The team was informed that the proposals for the Development have been finalised and submitted to the cabinet already, and that what we are expected to do is to wait for the policy guidelines from the MOPED which will be sent to us after June 1982. This means that MOH will be expected to tailor its health policy and produce a health chapter in accordance with policy guidelines set nationally despite the fact that we were not (we as implementors of policy) requested to provide advise, data and information on health status which would (hopefully) have assisted the cabinet in its determination of health goals of the nation.

iii) The MOPED however outlined briefly what MOH can expect as the policy guidelines for the 5th National Development Plan. This will include;

(a) Policy which will give emphasis on rural development and people's participation on health programmes which are geared towards the improvement of their own health.

(b) The health policy should also emphasize on the grobal objective of "Health for all by the year 2000". This calls for a health policy which takes into account the social economic development, co-ordination with other sectors and which will promote health development of the people.

It should include provision of essential health for all people and emphasize:-

- Preventive and promotive health.
- Health Education - all types of education.
- Incorporation of traditional health providers with the health sector.
- Research on what people feel their health needs to be besides the conventional Medical Research and establishment of the most effective means of fulfilling people's needs and wants.

(c) The MOH should also find out the best means of quantifying these activities (because there is a quantification problem) - so as to be able to justify the budget. For example, it is difficult to quantify and measure community participation and to evaluate achievements of primary health care programmes.

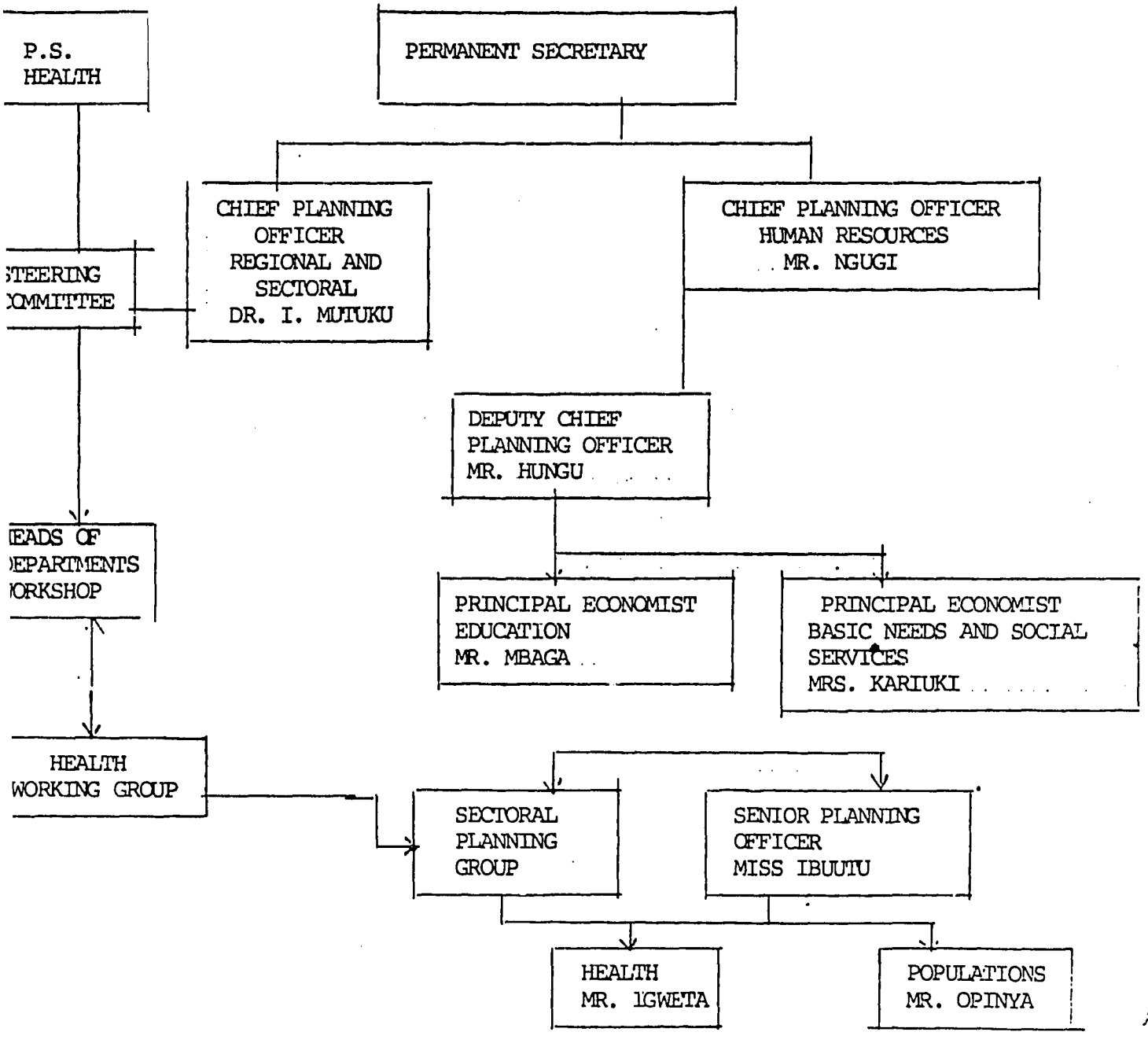
(d) The Senior Planning Officer MOPED will try to get a draft copy (from the Chief Planning Officer) of what has been submitted to cabinet so that we (MOH) can see and compare the recommendations forwarded to the cabinet.

...../5

As for the membership of the health Planning Sector Group, it was agreed that all members of the planning working group will be member of the health Sector Planning Group.

There will be one representative from Ministry of Finance and two officers from MOPED. Miss Esther Ibuutu and Mr. Igweta).

The organisation structure of the Ministry of Economic Planning and Development as far as it affects working group is as here under:-



A 5. WRITING OF A COMPARATIVE HEALTH POLICY PROPOSAL

Despite the fact that our recommendations have not been forwarded to cabinet, we can still write a health policy as we see it for comparison with the plan submitted to cabinet by the MOPED. The advantage of this exercise is that the Steering Committee can compare the two plans and if there are discrepancies or obvious contradictions between our policy recommendations and that of the MOPED then the Committee can consider taking some sort of intervention.

PURPOSE OF PLANNING

As Petterson says, Planning can be described as a means of providing decision makers (the Permanent Secretary, Director of Medical Services and even the Minister for Health) with some capability to anticipate future problems and to make appropriate policy decisions to cope with the future; in spite of the fact that such decisions are too large, complicated to handle, and in spite of the fact that such health decisions can not be divided into smaller sub-sets. Planning enables policy makers to look and interpret the future so as to exploit it.

Planning can also be used by Policy makers as an aid to political decision making and can be used (as is usually used) as a substitute to political decision making. If MOH could be given a chance to submit its case to cabinet then it will prove helpful to the cabinet because of the facts and statistical information it will use to support its case.

The above discussions on the role MOH plays in production of the health policy and in particular MOH inputs to cabinet for approval leads us to some important issues to be considered by the Steering Committee. These issues include questions such as the need for a health planning Unit in MOH to define the purpose and the seriousness with which we approach this issue.

...../7

A 6. STRATEGY FOR THE FORMULATION OF HEALTH POLICY (TO BE FOLLOWED BY WORKING GROUP

1. Formulation of National policies is the prerogative of the cabinet which may use data supplied before-hand by technical Ministry. As a technical Ministry, MOH is confronted by one of the two situations which are:-

(a) A situation where Government has clearly defined health policy it intends to pursue in which case MOH has to take full account of this policy in formulating the health plan.

(b) The second situation is where government has not defined the policy until it has received necessary technical information and data from the technical Ministry. In that case, the (MOH), (after the preparatory stage of planning) must provide the cabinet with the information needed to determine health goals, which will enable the MOH to determine priorities and propose targets. But, whichever option we are faced with, there is a need to set out our health policy realistically and practically, bearing in mind the Ministry's capacity to implement the plan.

7. IDENTIFICATION OF HEALTH PROBLEMS

Data required for the purpose of identification of health problems include data that help us to determine:-

i) Environmental factors influencing health and population such as housing and town planning, water supply, level of education, agriculture & food production, presence of vectors, social economic factors etc.

ii) Main features of the morbidity(over all morbidity, by cause of illness, morbidity by age group and sex for the country as a whole, and for every district).

iii) Main features of mortality (over all mortality, by cause of death, mortality by age and sex, for district and country as a whole).

iv) Demographic situation, size and density of population, distribution by age, by sex, by ethnic and religious groups, by social occupational group, by urban and town communities, family size, movements etc).

A 8. IDENTIFICATION OF AVAILABLE RESOURCES. We should establish the situation on:-

i) Human Resources: issues such as composition of Health teams and personnel.

ii) Material Resources: It is necessary to work out costs involved in construction and rationalise types of health facilities and the supplies requirements.

iii) Financial Resources: The MOH budget for recurrent and Development constitutes about 7.2% of the over all Government expenditure. We know that the MOH is not the only provider of health services in the country. When undertaking the planning exercise these factors should be taken into account as they influence the over all health policy.

9. IDENTIFICATION OF ACTIVITIES: Activity refers to action being taken to eliminate or modify the health problems. We should get information on:

i) Public Health control and promotion measures; e.g. vaccinations, home visits, faecal disposal, other means of environmental sanitation, and sanitary inspection.

ii) Hospitalization.

iii) Distribution of food supply.

10. SITUATION ANALYSIS

Analysis of existing health situation calls for diagnosis and projection of the future and necessitate examining our situation regarding:-

i) Demographic factors. See A 7(iv) above.

ii) Mortality: over all by cause by age group and sex.

iii) Morbidity over all, by cause by age group and sex.

iv) Factors influencing level of health.

- classify problem in order of importance for each age group and by sex regionally and by administrative district as well as on economic zones.
- make projections after that exercise.
- show the trend from the past experience (study records).
- project activities necessary to maintain the projected population at the present level of health in the light of economic development, education etc.

l. ACTUAL FORMULATION OF THE PLAN

After we have established Health Problems we shall now formulate the health plan aimed at affecting changes that would influence reduction or elimination of these problems.

.) Priorities will be drawn - as to which problems will be tackled first.

.) Realistic targets will be set (this will include) specifying the extent to which over all mortality is to be reduced and the time to be taken, the extent morbidity is to be reduced and time - and in specifying programmes required.

.i) Programmes projects and activities which must be carried out with view to achieving the targets already set will be designed. The target setting will be based on the criteria of logic, relevancy, precision,

attainability, and will be target that are observable and possibly measurable.

iv) Resources will be allocated according to the priorities and programmes set.

v) The priorities are aimed at classifying health problems by order of important using indexes and indicators which have been weighed in a complex system. For example: on the basis of available data, we in MOH may use the following indicators.

- The magnitude of the health problem.
- Vulnerability: (possibility of reducing the mortality and morbidity using the best available techniques).
- The perceived social importance of the health problem identified.
- Economic aspects of the problem i.e. impact on activities in other sectors of production such as agriculture, stock raising, tourism etc.
- Cost of the different methods to be used in reducing mortality and morbidity.

A 12. PRESENTATION OF THE PLAN

We should be able to present the plan to the Steering Committee and thereafter to the MOPED.

Detailed plan for implementation protocols will be worked out to include, priority of programmes, mobilization of material and human resources, training of staff for new tasks if any and the definition of individual heads of departments in the implementation of the plan.

Once working protocols have been drawn up, details of actual implementation will depend on administrative set up of the Ministry of Health. Guideline to all heads of department will be set and meetings will follow thereafter.

A 12 EVALUATION OF THE PLAN

Evaluation of the health plan is a process which measure the degree to which health policy objectives have been fulfilled and assess the quality of the results attained. It allows for measurement of productivity, of the resources allocated for the attainment of the target and the revision of the priorities in accordance with changing health needs.

For the current health plan, the evaluation operations will comprise of:-

(a) continuous operational evaluation. This process regards supervision as an important part of evaluation. Control procedures will include regular assessment of the work done when compared with the budget expended and its correspondence with the plan implementation. This calls for data processing mechanism, and use of information system, audit of financial technical and medical systems, period reports etc.

(b) Periodic evaluation is the evaluation done at the end of a program or at the end of the plan period.

For the MOH purpose, period evaluation will be related to the:-

(i) the social impact of the achievements.

(ii) economic value of these health achievements.

(iii) modification of the epidemiological factors.

(iv) re-appraisal of strategy adopted, techniques applied and resources used.

By using the information assembled for evaluation the current plan could be linked with the next plans.

The same indicators used when re-defining health problems and resources

should be used during evaluation exercise.

Planning should be a continuous exercise so as to lead into a realistic policy.

IMMEDIATE

File No.DMV/19/2/217 Vol.IV/(a).

1. Dr. Kanani
2. D S (a)
3. D S (b)
4. P S & L C
5. Dr. Monekio
6. Mr. Gakuu
7. Mr. L. M. Mburugu

SYMPOSIUM ON THE EXAMINATION OF
5TH NATIONAL DEVELOPMENT PLAN

Please refer to Folio 3.

The above symposium will take place at the Kenyatta Conference Centre, Committee Room 2 on September,22, 1982 at 10.00 a.m. and is being sponsored by the Ministry of Economic Planning and Development.

You should ensure that you have studied Sessional Paper No.4 of 1982 on Development Prospects and Policies, copies of which were distributed recently. In case you do not have a copy, you should arrange to have one before the meeting.

The Sessional Paper should be the basis for reviewing Ministry of Health policies and Development Programmes which review should be submitted to the Sectoral Planning Groups that have already been established for the preparation of the Fifth National Development Plan. It is therefore important that the Working Group for the preparation of the Health Chapter for the Fifth National Development Plan should be afforded the opportunity of studying Sessional Paper No.4 of 1982 and be allowed to participate in the forthcoming symposium.

Please treat this matter with the urgency and significance it deserves, and keep the PS and MMS briefed.

Best Available Document

A. S. Amisi
D S (A)

14th September 1982

c.c. P S

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File No.DEV/15/2/217 Vol.IV/(4)

TO: Mr. A.S. Amisa

SYMPOSIUM ON THE PREPARATION OF
5TH NATIONAL DEVELOPMENT PLAN

In response to your memo of 14th September, 1982, in reference to the above Symposium and review of Sessional Paper No. 4 of 1982. The Health Planning Working Group with the assistance of Dr. Waiono has reviewed Sessional Paper No. 4 of 1982 on Development Prospects and Policies.

The following is a summary of the major Development Prospects and Policies contained in Sessional Paper No. 4 as they relate to the Ministry of Health.

Under the Structural Adjustment Programme, it is stated that freedom from disease and ignorance is one of the long term objectives of the Government in its attempts to provide basic needs and strategic economic activities through wide spread participation of all Kenyans in the Development Process.

In view of the serious financial situation which has been caused by oil crisis that has resulted in limited access to export markets and deteriorating terms of trade. Economic growth has been retarded and Government revenues have become harder to raise. Foreign aid is more difficult to obtain resulting in external commercial financing of programmes at high interest rates, thus curtailing the ability to finance growing expenditures by ministries. Therefore, both immediate and longer term measures are outlined to cope with this problem.

The following is a summary of these measures in relation to the Ministry of Health.

Under Physical Policy Item 97 (page 33) it is stated that new projects that can be introduced must demonstrate improvements in service to the rural areas and to the target groups identified in the plan as the focus of the strategy to alleviate poverty. In relation to this Item the Ministry of Health is currently implementing over a six-year period, the Intergrated Rural Health and Family Planning Programme (IRH/FP); see attached IRH/FP Summary).

Item 98 (page 33) under Fiscal Policy states that the provision of basic needs is essential to the alleviation of poverty and it states that preventive and rural medicine must be given a higher priority relative to curative facilities in the urban centres. In the Director of Medical Services' Paper entitled Health Strategy for Kenya 1982 it is recommended that preventive and promotive programmes should receive priority: (see attached copy recommendations).

In Item 98 (page 33) under Improving Implementation it is stated that the improvement in the management and implementation of Government activities are essential and that measures are being introduced that focus on the planning and budgeting of development projects. In relation to this, the Ministry of Health has established the Health Planning Working Group and

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Best Available Document

charge them with the responsibilities for cordination, preparation and production of the Health Chapter for inclusion in the Fifth National Development Plan; (see attached Progress Report of the Health Planning Working Group). The Health Planning working Group is working in close colaboration with the Ministry of Economic Planning and Development as a member of the Health Sectoral Working Group and with the Ministry of Finance as a part of the Estimates Working Group.

Under Realistic Budgeting (page 34) Item 100 it is stated that it is essential that Ministry's plan their expenditures with even more care than usual. To these ends the Ministry of Health has convened the following Workshops to review and develop the Planning Process for the Fifth National Development Plan, National Interministerial Workshop with the Ministry of Economic Planning and Development and the Ministry of Finance, National Intraministerial Workshop with all Ministry of Health Heads of Departments, a Provincial Level Workshop and approximately 18 District Level Workshops.

The main objective of the above Workshops were to develop guidelines and procedures for the Planning Process for writing the Health Chapter for the Fifth National Development Plan. This process will continue in cordination with the Ministry of Economic Planning and Development and Treasury and the Budgeting Process will be a main focus to ensure that planned expenditures are carefully thought out and are consistent with overall policy.

Item 101 (page 34) states that budgetary decision making will have as its first priority operation maintenance, rehabilitation and full utilization of existing facilities and the second priority will be given to the completion of ongoing projects. The District Teams are currently following this policy in planning for facilities over the next five year Development Period.

Item 104 (page 35) states that the management and implementation capacity of operating Ministries is being reviewed and improvements in organisation management methods and staff productivity should be achieved as quickly as possible. In relation to this item, the Ministry of Health has just concluded a Management/Organisation Study which is currently being reviewed and plans developed for strengthening areas of weakness. The Ministry of Health has also conducted short-term Training Courses for improvement of Management of Health Services. District Level Management Training for District Level Management Teams is currently planned from October 1982 until December 1984; (see attached Training schedule).

Item 105 (page 35) under Expenditure Control states that a monthly flash expenditure reporting system has been introduced which sets out revenue, recurrent expenditure and development expenditure figures by Ministry. The Ministry of Health is currently piloting this system and plans to expand it to cover all departments.

Under Claiming Foreign Aid (page 36) Items 107, 108 and 109 relate to procedures which have been introduced requiring Ministries to keep claims fully up to date for donors financing individual projects. The Ministry of Health has developed a list of all donor funded projects which contains the following information. Total amount of Donor Aid for each project, the amount claimed and the amount left to be claimed.

3d

Identifying Bottlenecks and Taking Remedial Action, Item 110 and 111 (pages 36 and 37) states that implementation reports will be prepared for each Ministry, noting progress and problems. The determination and introduction of remedial measures will normally be the responsibility of the Ministry. The Ministry of Health has identified some of the bottlenecks which delay implementation of projects and has noted that some lie outside of the Ministry, like in the case of construction which lies with the Ministry of Works. Remedial steps are being taken with the Ministry of Works to decrease the amount of delays. A Steering Committee has been formed to ensure that the unforseen implementation problems and bottlenecks are looked into as soon as they arise.

Item 112 (page 37) uder District Participation emphasises the need for planning and implementation. This includes the creation of District Development Committees and the formulation of District Development Plans and expansion of local Project Planning through the Rural Development Fund. In the Health Planning Workshops the District Health Planning Teams have been notified on the importance of the points raised above, i.e. the Development of the Health Sector must have full support from the District Development Committees.

The intention of tightening administration and management of Government Programmes is outlined under article 114. (page 38) i.e.

1. to ensure that resource allocations are to activities which have been thoroughly evaluated and realistically scheduled.

2. to strengthen capacity to identify and correct implementation problems.

3. to identify and correct organisational and staffing weaknesses.

4. to tighten financial management and ensure that resource and borrowing constraints are not exceeded.

5. to ensure rapid foreign aid claim and reimbursement.

6. to strengthen the role of decentralized personnel in improving programme management and implementation.

It is expected that these measures will improve the efficiency of resource use and the pace of economic development.

As stated earlier, the Ministry of Health is currently taking action on each of the areas noted above.

In summary the paper discusses policies for coping with chronic financial and balance of payment problems. Structural adjustments are necessary in order to provide the basis for renewed and redirected growth. Monetary and fiscal problems need to be reduced to more easily manageable proportions during the years 1982 - 1984. During the writing of the 1983/84 to 1987/88 Development plan intensive reviews of all policies, economic sectors and district development priorities will be undertaken.

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It is expected that Kenya's terms of trade will begin improving this year, with both coffee and tea prices expected to rise. Crude oil prices are expected to be lower and with some revival in world markets the demand for Kenya's exports is expected to continue growing. Fiscal years 1982/83 and 1983/84 are said to be the most critical in terms of budgetary, monetary and balance of payment management.

The Government's role in overcoming these problems is emphasized and Civil Servants who provide services in public interest have a vital role in implementing corrective measures so that a greater well being for all families and renewed development vigour for the nation can be achieved.

DR. MANENO
ADMS

HEALTH PLANNING WORKING GROUP

c.c P.S.

D.M.S.

Mr. Kahari

D.S. (D)

U.S. (D)

C.P. & E.C.

Mr. Gakuo

22nd September, 1982

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Create National Health Sector Dialogue (conduct conferences) on Planning/Information Systems _____ [P]

Develop a Strategy to Decentralize Planning/Management Functions _____ [D]

Conduct Assessment/Planning Workshops at the Provincial/District Levels [C & G]

Ensure Coordination Between National Planning Staff and Provincial/District Administrators related to Implementation of National Planning Unit Activities _____ [G]

During Project Year II, all of the above objectives were consolidated into a single strategy which involved an extensive sequence of provincial/district level workshops related to the planning process. As a result of these workshops,

- awareness of health sector issues was heightened;
- knowledge of the overall planning/information system was increased;
- not only was the strategy developed, but the process of implementing a decentralized planning/management function within the MOH was substantially facilitated;
- provincial/district management teams were provided with guidance and meaningful opportunities to assess their own operational needs and give input to national health sector planning;
- the HPWG was introduced to a developmental process which established its role as a technical resource to provincial/district administrators.

Reports and documents related to selected of these workshops are attached.

Within the context of the Project requirements, the level of effort as originally conceived has been more than completed. However, the objective outcomes which relate to institutionalization of skills and a process for decentralized health planning, implementation and evaluation have only begun.

The achievements of Project Year II in this area have merely served to redefine the magnitude of the task. During Project Year III, once the Fifth Development Plan is completed, the Project will need to concentrate on,

- the next level of planning detail which relates to implementation;
- data needed to support implementation and evaluation of programs;
- strengthening the capacity of the HPWG to organize, administer the logistics and conduct provincial/district workshops and other structured interactions.

HEALTH PLANNING AND INFORMATION PROJEC

CHRONOLOGY OF ACTIVITIES RELATED TO TH

NATIONAL PLANNING PROCESS

DATE	VENUE	SUBJECT
22nd & 23rd April, 1982	Safari Park Hotel	National Workshop on the Planning Process - The Fifth National Development Plan.
5th - 6th May, 1982	A.M.R.E.F.	Intra-Ministerial Seminar on the Planning Process for the Fifth National Development Plan. Opened by P.S.
26th & 27th May, 1982	Karen College	Provincial Level Workshop on the Planning Process for the Fifth National Development Plan. Opened by D.M.S.
7th June, 1982	Chulaimbo, Kisumu	Provincial and District Workshop on the Planning Process for the Fifth National Development Plan. This Workshop covered Nyanza and Western Provinces - Kisumu, Siaya, Kisii, S. Nyanza, Kakamega, Bungoma and Busia.
9th June, 1982	M.T.C. Nakuru	Provincial and District Level Workshop on the Planning Process. Teams: Nakuru, Trans Nzoia, Kericho, Baringo, Nandi, Kajiado, Narok, Elgeyo Marakwet, Turkana, Kapenguria Uasin Gishu.
11th June, 1982	Nyeri Inn	Provincial and District teams. Planning Process Teams: Kirinyaga, Kiambu, Nyeri, Muranga, Nyandarua.
11th June, 1982	Embu	Provincial and District Teams. Embu, Meru, Marsabit, Kitui, Machakos.

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DATE	VENUE	SUBJECT
16th June, 1982	M.T.C. Mombasa	Provincial and District Level on the Planning Process for the Fifth National Development: Mombasa, Kilifi, Kwale, Tana Taita/taveta, Lamu.
10th May, 1982	M.E.P.D. Treasury Building	Meeting with Senior Planner - Health Policy Guidelines.
7th - 11th June, 1982	Community Building, Nairobi	Monitoring and Evaluation of Development Projects Workshop - Organized by K.I.A., M.E.P.D.,
22nd June, 1982	M.E.P.D., Treasury	Sectoral Group Meeting - Mr. [illegible] Mr. Adagala, Miss Emokor, Dr. [illegible] Mr. Thube, Mr. Ong'ayo, Mr. Kri[illegible] Mr. Kungu, Mrs. V. Brown, Mr. [illegible]
23rd June, 1982	M.E.P.D. Mr. Ngugi's Office	Population Studies and Planning Mr. Ngugi, Mr. Kariuki, Pr[illegible] etc.
24th June, 1982	C.B.S. Building	Demograph Trends Meeting.
25th June, 1982	M.T.C., Nyeri	Follow up District Teams Planning and data collection.
30th June, 1982	M.T.C., Mombasa	Follow up District Teams as well as collection of data.
5th July, 1982	Mbale R.H.T.C.	Follow up on Nyanza and Western Provincial & District Teams.
7th July, 1982	Nakuru, M.T.C.	Follow up on Rift Valley District Teams.

NATION – JUNE 21 – 04

Districts made hub of progress

PRESIDENT Moi yesterday directed that from next month all districts will be the base of operations in transacting Government development matters in the rural areas.

The President said that the move was designed to accelerate rural development which was of top priority in Government policy.

Making districts the hub of Government operations would, among other things, minimise necessary correspondence between headquarters and the districts, he said.

The districts, he said, were more conviniently situated to provide vital services to wananchi than from any other places of operations.

President Moi was addressing a mammoth crowd at Lodwar township at the end of his two-day official tour of West Pokot and Turkana districts.

On security along the Kenya borders, the President stressed that the country's security would never be compromised, saying that after July 2 this year, the Government would start recruiting more Turkana and Pokot youth into the administration police training college at Embakasi.

And on completion of training, the youth would be deployed to Pokot and Turkana areas as border guards to eliminate the few remaining stock thieves.

President Moi, however, commended the local Members of Parliament and other leaders for responding positively to his call made in 1979 when he toured Kapendo) to end the Ngoroko menace and retrieve illegal weapons from the culprits.

He told Turkana and Pokot MPs to maintain the same spirit in a bid to crush the remaining stock thieves and bring about rapid delopment in the area.

On health, he said that despite financial constraints, the Government would try to establish a unit to train nurses at the new Sh. 24 million Lodwar District Hospital. And the Government would undertake a massive water project to alleviate water problems in the area.

On behalf of the Government, President Moi thanked the Government of Norway for giving Kenya Sh. 20 million in aid of fish exploitation project in the area. As a result of the aid, the President added that fish business was now earning the local people half a million shillings a month.

The President instructed that enough tractor and motor spare parts be stored at Lodwar to stop farmers from making unnecessary and expensive journeys to buy spares in Kitale.

And he said a co-operative society would be formed to enable farmers in the area to market their produce and that water for irrigation would be tapped from Tukwel River in the area.

Earlier, President Moi addressed a rally at Sigor in West Pokot District after inspecting development activities in the Kerio Valley Development Authority (KVDA).

During the inspection, the President toured 880 acres on which the KVDA is carrying out experiments with 320 acres under maize.

The President noted that true Nyayo followers should avoid stealing and rumour mongering. The Government cannot continue developing the area effectively if there is insecurity, he said.

He advised the residents of West Pokot, Turkana and Elgeyo Marakwet to live in peace.

On the development of health services in West Pokot the President instructed the Ministry of Health to withdraw the present contractor if he was unable to complete the Kapenguria District Hospital on schedule.

He said it was the policy of the Government to give efficient health service to wananchi.

President Moi revealed that a cement factory would be built in the valley to serve wananchi in the area and western Kenya.

Stressing the importance of conserving soil and trees, President Moi appealed to wananchi in the district to intensify anti-soil erosion campaigns.

The President also praised farmers for heeding the Nyayo call of planting enough to feed ourselves instead of going out to look for food.

He called on Kenyans to love their country and care for her the way a mother cares for her child.

Speaking at the Uasin Gishu/Trans Nzoia boundary where he stopped on his way to Sigor and Lodwar and addressed wananchi briefly, he said he had noted with appreciation the efforts of farmers in planting maize on both sides of the road.

He noted with satisfaction that the farmers had planted maize, wheat and were keeping cattle.

— KNA

AT a Kanu meeting at Bahati, in Nairobi, yesterday, are (left to right) Kamukunji MP Nicholas Gor; Mr. Krishna Gautama, MP for Parklands; the Kanu Nairobi Branch chairman, Dr. Njoroge Mungai, the Nairobi Deputy Mayor Chadwick Adongo and Bahati MP Fred Omido. (Picture by Joseph Thuo).

City MPs warned

By VINCENT MWANGI

THE Kenya African National Union, Nairobi branch, yesterday warned it would report to President Moi, MPs, councillors and party officials who fail to attend party meetings.

Branch chairman Njoroge Mungai issued the warning when he addressed a Kanu rally at Bahati, Nairobi. Kanu had called the meeting to explain to wananchi what the one party state meant and also to allow wananchi to air their views on the issue which would be conveyed to President Moi.

The meeting, which was addressed by the five Nairobi MPs, councillors and party officials, condemned disgruntled elements who wanted to form another party. The leaders said wananchi were satisfied with Kanu and expressed their confidence in the leadership of President Moi and his Government.

They also slated those who held night meetings aimed at ousting the present constituency and ward leadership during the next elections. Speaker after speaker advised them to wait until their tenure of office was over.

Dr. Mungai announced that the branch would convene similar rallies at Parklands on June 27; Mathare, July 4; Dagoretti July 11; Embakasi, July 18; Starehe July 25 and Langata on August 2.

Works and Housing Minister Charles Rubia, Agriculture Minister Munyua Waiyaki and Environment and Natural Resources Assistant Minister Philip Leakey did not attend yesterday's meeting.

Dr. Waiyaki and Mr. Leakey were said to be out of the country while Mr. Rubia was reported to have gone to Lamu.

Dr. Mungai said the meetings were aimed at promoting peace, love and unity in Nairobi, co-operation among leaders, and the one party system which he said would promote democracy.

[NISTRY OF HEALTH WORKSHOP

ON

THE PLANNING PROCESS

FOR

THE FIFTH NATIONAL HEALTH DEVELOPMENT PLAN

AMREF

5TH - 6TH MAY, 1982

28TH APRIL 1982

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MINISTRY OF HEALTH

Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 27381
When replying please quote
Ref. No. IB/11/1/74
and date

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

28th April, 19 82

RE: WORKSHOP ON THE PLANNING PROCESS FOR THE FIFTH NATIONAL HEALTH DEVELOPMENT PLAN AMREF ; 5TH - 6TH MAY, 1982

The Ministry of Health is in the process of preparing the 5th National Health Development Plan. For this plan to be appropriate, it is important that each department be involved in the current planning activity.

In this connection, the Ministry is organizing a workshop to bring together the various departments to participate in this planning process. You are, therefore, invited to attend this workshop to be held at AMREF from 5th to 6th May, 1982.

The main objectives of this workshop are as follows:

- Review the planning process in the Ministry for writing the past four National Health Development Plans. Special focus will be given to each Department's role and interrelationships with each other.
- Review and analyse current planning process for writing the next Health Development Plan.
- Formulation of procedures for strengthening coordination of intraministerial health sector planning.

Your contribution to this workshop will be very much appreciated.

(G. R. M'MWIRICHIA)
PERMANENT SECRETARY

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I. INTRODUCTION

This workshop is planned in response to the need for intra-ministerial coordination of the planning process for writing the Health sector of the 5th National Development Plan. The main goal of this workshop is to design ways of strengthening coordination between the Ministry Departments in the Health Planning Process.

II. THE OBJECTIVES OF THE WORKSHOP

The major objectives of the workshop are as follows:

(a) Review the planning process in the Ministry for writing the past four National Health Development Plans. Special focus will be given to each Department's role and interrelationships with each other.

(b) Review and analyse current planning process for writing the next Health Development Plan.

(c) Formulation of procedures for strengthening coordination of intraministerial health sector planning.

III.

Workshop participants will be from each major Headquarters Department. (See attached list for workshop participants).

INTRA MINISTERIAL WORKSHOP ON THE PLANNING PROCESS FOR WRITING THE FIFTH NATIONAL HEALTH DEVELOPMENT PLAN

AMREF : 5TH - 6TH MAY, 1982

A G E N D A

DATE	TIME	SESSION			RESOURCE PERSONS
Wednesday 5.5.82	9.00 - 10.00 hrs.	1.0	-	Opening Session	Mr. M'Mwirichia
	10.00 - 10.30 hrs.		-	C o f f e e	
	10.30 - 11.00 hrs.	2.0	-	Objectives of Workshop	Dr. Kanani
	11.00 - 12.00 hrs.	3.0	-	Review of proceedings on National Interministerial Workshop on the Planning Process for Writing the Fifth National Development Plan, Safari Park Hotel, 22nd - 23rd April, 1982.	Dr. Maneno
	12.00 - 13.00 hrs.		-	L u n c h	
	13.00 - 14.00 hrs.	4.0	-	Review and analyse the Planning Process for Writing the past four National Development Plans	Mr. Ndungu
	14.00 - 15.00 hrs.	5.0	-	Discussion to review Intraministerial Relationships in the Planning Process	Mr. Kariuki
	15.00 - 15.30 hrs.		-	C o f f e e	
	15.30 - 16.30 hrs.	6.0	-	Review of Current Planning Process for the Writing of the Fifth National Health Development Plan.	Dr. Maneno

.../2

DATE	TIME	SESSION		RESOURCE PERSONS
Thursday 6.5.82	9.00 - 10.00 hrs.	7.0	- Identify Intraministerial Planning Activities and Outline Schedule for Coordination of activities	Mr. Amisi
	10.00 - 10.30 hrs.		- C o f f e e	
	10.30 - 12.00 hrs.	8.0	- Continuation of identification of Intraministerial Planning Activities and Scheduling of Coordination.	Dr. Kanani
	12.00 - 13.00 hrs.		- L u n c h	
	13.00 - 14.00 hrs.	9.0	- Setting out Schedule and Agenda for subsequent meetings.	Dr. Maneno
	14.00 - 15.00 hrs.	10.0	- Workshop Evaluation	
	15.00 - 15.30 hrs.		- C o f f e e	
	15.30 - 16.30 hrs.		- C l o s i n g	

LIST OF PARTICIPANTS

MINISTRY OF HEALTH

DR. S. KANANI	-	SENIOR DEPUTY DIRECTOR OF MEDICAL SERVICES
DR. J. M. GEKONYO	-	SENIOR DEPUTY DIRECTOR OF MEDICAL SERVICES
DR. J. J. THUKU	-	SENIOR DEPUTY DIRECTOR OF MEDICAL SERVICES
MRS. E. M. KIEREINI	-	CHIEF NURSING OFFICER
DR. FERNANDES	-	PRINCIPAL - MEDICAL TRAINING CENTRE
DR. SIONGOK	-	DIRECTOR - D.D.C. & R.
DR. ODUORI	-	DIRECTOR, KENYATTA NATIONAL HOSPITAL
MR. AMISI	-	SENIOR DEPUTY SECRETARY
MR. P. KARIUKI	-	DEPUTY SECRETARY
MR. G. W. CHEGE	-	UNDER SECRETARY
MR. F. O. OUKA	-	UNDER SECRETARY
MR. MBUVI	-	DIRECTOR, NATIONAL HOSPITAL INSURANCE FUND
MR. A. KIRIRO	-	HEAD, CENTRAL MEDICAL STORES
DR. J. MANENO	-	ASSISTANT DIRECTOR OF MEDICAL SERVICES
DR. A. K. GIKONYO	-	DEPUTY DIRECTOR OF MEDICAL SERVICES
DR. OTETE	-	DEPUTY DIRECTOR OF MEDICAL SERVICES
DR. F. M. MUEKE	-	DEPUTY DIRECTOR OF MEDICAL SERVICES
DR. GATHINJI	-	DEPUTY DIRECTOR, N.F.W.C.
DR. C. LUUSAH	-	ASSISTANT DIRECTOR OF MEDICAL SERVICES
MR. Z. A. GAKUU	-	CHIEF HOSPITAL SECRETARY
MR. L. K. NDUNGU	-	ADMINISTRATIVE SECRETARY
MR. MATHENGE	-	CHIEF PHARMACIST
MR. N. MASAI	-	CHIEF PUBLIC HEALTH OFFICER
MR. MBAI	-	HEAD, HEALTH EDUCATION DEPARTMENT
MR. F. A. MWORIA	-	SENIOR HOSPITAL SECRETARY
MRS. M. A. EMOKOR	-	SENIOR ASSISTANT SECRETARY

UNIVERSITY OF NAIROBI

PROF. MATI	-	DEAN, FACULTY OF MEDICINE
PROF. KAGIA	-	HEAD OF DEPARTMENT OF COMMUNITY HEALTH

REVIEW OF THE PLANNING PROCESS

MINISTRY OF HEALTH

by.

L.K. Ndungu. - Administrative Secretary

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REVIEW OF THE PLANNING PROCESS FOR THE MINISTRY OF HEALTH

1. Introduction

The preparation and production of the National Development Plans is the responsibility of Ministry of Planning and Economic Development (MOPED). We in the health sector have the duty to prepare or help in the preparation of the health section which is usually within the social services delivery chapter. In other words, MOPED set out broad the objectives at a national level and operating Ministries health included, are assigned specific tasks accordingly.

The Ministry of Health (MOH) is supposed to work out its health policy within the parameters set by the Ministry of Finance (MOF) and the MOPED. This is what should be done. What has happened in the past is that the Ministry of Health provides the MOPED with detailed lists of programmes and activities to be implemented within the plan period and the MOPED writes up the section. What finally comes out as the health chapter can only be seen as a compromise between these Ministries. In most cases, the Ministry of Health feels that the health chapter as it comes out is, strictly speaking, is not fully supported by the materials submitted by MOH. However, looking at the final product of the Health Sections as produced by the MOPED, one cannot dispute the fact that the health chapters, are well written and that they do represent the objectives of the Ministry of Health. Besides, these chapters do conform with the goals and objectives of the country.

The MOPED provides assistance to the Ministry of Health by assigning technical personnel (Planning Officers/Economists) which are needed by the Ministry. Assigning planning officers to various operating Ministries is viewed by some Ministries as a good way to achieve co-operation and to co-ordinate planning activities which is necessary if national planning objectives have to be achieved. We (in operating Ministries) also realize

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That by seconding officers to Ministries, the MOPED is in a good position to assist and control planning efforts. We also realize that through the sector planning groups, estimate groups in the MOF the planning capabilities in operating Ministries is co-ordinated and strengthened.

paper will discuss briefly, the planning process (or lack of i in the Ministry of Health. It will highlight the main constraints both from MOH's internal organisational problems and external ones. Examples will be given from the planning process that took place during the preparation of the health section of the current 4th Development Plan and the problems encountered.

MINISTRY OF HEALTH PLANNING STRATEGY

2.1. As stated in the introduction section, MOH usually submits to the MOPED detailed information of health programmes to be carried out in the plan period to the MOPED so that the latter can produce health chapter.

2.2. The MOH's planning strategy is (supposed to be) based on the need strategy such as that of bed/population ratios, doctor population ratios and so on. In other words, our plans are based on needs strategy as provided for in World Health Organisation (WHO) publications. The MOH; (and indeed MOF and MOPED) also tend to follow the Planning Strategy supported or which is required by various international or bilateral donor agencies. i.e. to focus planning efforts on quantifiable targets such physical facilities, manpower targets etc. These are targets that are easily quantifiable and measurable.

2.3. But even when these targets have been achieved, that is; when we can finally produce one health centre for 20,000 people and achieve the target of 0.8 beds per one thousand population, we still cannot say that the health of the community has improved. This is because we simply count the inputs instead of the counting what those inputs produced as outcome. The health sector should, ideally, plan on the basis the outcome such as reduction of infant and maternal mortality, reduction in morbility, reduction of disability etc. etc. The main problem in using some of these health status indicators is that one cannot attribute the improvement of health to the activities of the health sector alone. Lowering crude birth rate may be attributable to other factors such as improved conditions of living due to higher incomes, better education, better housing etc. etc.

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Measuring improved health is also complicated by the definition of health which is controversial. WHO defines health as a state of complete physical and mental wellbeing and not merely absence of disease. It is difficult to provide appropriate measurement t... for complete physical and mental health, leave alone to measure absence of disease.

2.4. Setting planning criteria on the basis of manpower targets and physical facilities as we do is inappropriate because we have probl of equitable distribution of these resources. For example, What is is the rationale of setting a criterion say of producing one doctor for 600 people when we know that 80% of all doctors are in Nairobi and Mombasa and we have no means of resolving this inequitable distribution?

These are some of the weakness of our approach to planning strategy which we are now addressing ourselves to.

3. HEALTH PLANNING FUNCTIONS

3.1. As most people know, MOH does not have a planning Unit which should handle the responsibility of producing the health chapter. Planning functions are distributed amongst various officers who perform functions that have relevance to planning. For example, The Chief Hospital Secretary's office handles planning matters related with hospital facilities construction, expansion or improvements. The planning activities of rural Health facilities including construction and improving of Health Centres and Dispensaries are handled by the Rural Health Planning and Implementation Unit which again comes under the same officer (CHS) and the Under Secretary i/c. of development ... is not quite clear as to who co-ordinates

manpower planning because there has been frequent changes of officers co-ordinate materials for manpower planning and the new schedule of duties is not yet out. Other planning activities fall under various specific functional heads of Units.

3.2. Co-ordination of these planning activities has in the past been the responsibility of a Deputy Director of Medical Services, Planning (DDMS(P). But since July 1978, planning functions come under Senior Deputy Director of Medical Services Rural Health (SDDMS(R). In the MOH planning becomes an annual event especially when MOH has been requested to produce the health chapter by the MOPED.

3.3. Mrs. Janovsky quite rightly summarised the idea of planning at the MOH as that of producing the plan to fulful the requirements of the MOFEP, MOF and the donor agencies.

3.4. Most people in MOH see the production of development plan as something which has to be done to satisfy MOPED obligations.

MOH has not, in the past, considered writing of the plan document as a useful exercise which would help the Ministry in clarifying its own policy objectives or which can be useful in evaluating the health delivery system.

There is a need to reconsider this position.

PREPARATION OF HEALTH CHAPTER - 4TH DEV. PLAN

I have stated that MOH does not have specific Unit which responds to planning requirements and that planning, and especially the production of the health section is usually regarded as the job of the PMS, Planning. This point is well highlighted by Dr. Katarina Janovsky in her PHD Thesis, when she points out that planning in health is one person exercise.

It would be useful to give an account of the planning process that took place during the preparation of the health Chapter for the 4th Development Plan in 1977/78 so as to bring home some of the difficulties and constraints faced by MOH. I append here-below a calender of planning process activities for the period March 1977 to November 1977 when the chapter was finally produced by MOPED.

On March 3 1977, the then Ministry of Finance and Economic Planning MOFP issued a circular requesting all Ministries to start preparations of the 4th National Development Plan covering the period 1978/83. All chapters were expected to be ready by December 1977 and revisions to be ready by March of 1978. The health chapter was to be included in Chapter V covering the Basic needs. This chapter covered Nutrition and Health, education and training, housing and social services and part of water development.

The MOH was informed about the production of the plan in June 1977. The MOFEP. had clearly spelt out what MOH should concern itself with. The theme of the plan was alleviation of poverty with resulting strategy for creating incomes and meeting other basic needs. MOFEP requested that all officials had to accord high priority to all tasks

4.4. He (PS) delegated the task to two people. The Deputy Secretary i/c. of Development (DS) was to produce the budgetary part of the plan and the Deputy Director of Medical Services (Planning) was to co-ordinate the actual production of the health section. The DDMS then found that he did not have either the health information data and the personnel with which to do the job. He sent out a questionaire in July, 1977 to obtain base line data. He knew of course that the existing information cannot be retrieved because it is kept in various sections of the Ministry and its retrieval was a problem. In any case the validity and relevance of the available data to development planning was questionable. Response from the field was of course poor and the DDMS (P) requested permission to spend 6 weeks in the field collecting data. This was not allowed.

4.5. The DDMS (P) asked MOH Senior officers and heads of departments to co-operate in producing proposals and materials for the Health Chapter.

4.6. DDMS (P) was assisted by a planning officer seconded to MOH by MOFP and a planning consultant employed for the purpose.

4.7. A meeting of Senior Officers (chaired by the Permanent Secretary) was held in August 1977. Sub-Committees were created to prepare and co-ordinate different sections of the plan. A budgetary Committee was formed mainly to produce a counter-proposal to the recurrent estimates which MOFP had worked out without guidance from MOH. The Committee included the Principal Finance & Establishment Officer (PFEO), DDMS (P), Chief Hospital Secretary (CHS) and Deputy Secretary, (Development

4.8. A number of meetings were held to follow up this exercise. In August, 1977 a meeting with Provincial Medical Officer (PMO's) was held. PMO's were asked to bring answers to the questionaires sent out earlier by DDMS (P). Strategies and constraints of producing the plan were discussed.

4.9. By the third week of August 1977, DDMS (P) sent a draft of policy statement outlining major programmes and discussed constraints and strategies to all Senior officers of the MOH including PMOs. He DDMS (P) received no response on this.

4.10. The draft of Policy Statement was discussed by the sector planning group consisting of MOH and MOFP representatives and approved. - in September 1977.

4.11. The P.S. called another meeting in October, 1977 to review the progress so far. Baseline data had now been collected. The MOF had undertaken to review the budget which MOH had produced.

4.12 By December, 1977 no response from MOH officers on DDMS(P's) letter. Discussion on budget proposals were under way. MOH requested MOF to increase estimates which were 20% lower.

4.13. By January 1978, DDMS (P) received response from the Rural Health Planning and Implementation Unit. An expatriate employed by DANIDA as well as the Deputy Director of Medical Services i/c. of Rura Health started attending planning meetings to help in the physical facilities planning.

This exercise attracted attention to senior officers because it involved determining the number and location of Health Centres and Dispensaries, Schools of Nursing and other health facilities to be constructed or improved during the plan period.

Information collected by Rural Health Unit for 1974-75 were not used. Information and priority lists sent to the Ministry by Medical Officers if health at District level were overruled. MOH officials wanted to use information produced during these meetings. After this allocation of health facilities exercise the tempo for planning died off.

4.14. By the end of January 1978, the first draft for several sections were readv.

4.15 The draft was reviewed by United States Department of International Development and a critique was produced.

4.16. In April 1978, World Bank mission which had come to review progress on Maternal & Child Health and Family Planning (MCH/FP) projects looked at the prepared draft of health chapter. They commented that it was unco-ordinated,not integrated and lacked perspective.

4.17. By April, 1978 brief summaries of all Public Health sub-sections as well as the cost estimates were forwarded to the MOFP. DDMS(P) requested the World Bank Mission to use the draft plan as basis for their negotiations. This was not acceptable to the Bank.

4.18. In May 1978, Sector Planning group meeting was held to negotiate budget cuts from over K£100m. down to K£65m. which was actually in the budget. As one can anticipate MOH Senior officers were working on their programmes and costing them without having regard to budget provisions.

4.19. Integrated Rural Health Services under DDMS(R) seminar took place toward the end of May 1978. One of its objectives was to;

"to co-ordinate and integrate the major fields providing rural health services with

limited resources particularly in respe
of on-going five year development plan
exercise."

This is significant in view of the fact that production of the health plan was clearly under DDMS(P).

4.20. By the end of May 1978, the second draft was submitted to the MOFP health chapter task force and also to senior officers of the MOH for comment.

4.21. In June 1978, the DDMS(P) was busy correcting original draft for the plan as well as producing a volume of detailed information for the activities to be carried out during the plan period. He was also busy refining the 2nd draft.

4.22. All this time DDMS(P) and his staff of 2 had borrowed an office to hide themselves so that they can concentrate on this task. DDMS had other functions and production of health plan was just one of many of his duties. He had to hide to get the plan produced.

4.23. The health planning consultant seconded to DDMS(P) had to leave by July because her contract expired. The other member of staff (the planning officer seconded by MOFP also left so the DDMS(P) was left alone.

4.24. The Permanent Secretary MOH called a meeting to discuss and approve the second draft plan. The draft was acceptable to the senior officials. Reconciliation between activities and the approved budget had to be done.

4.25. By July 1978, comments of the plan were received by MOH from MOFP. MOFP expressed satisfaction on the health chapter but they

the national policies and priorities specifically the alleviation of poverty and meeting basic needs.

Suggested that manpower, financial administrative allocations in the health sector should reflect priorities stated at the outset of the draft chapter such as providing emphasis on preventive measures.

The budgetary provisions were not consistent with the stated priorities because curative health was allocated substantially with more resources than the preventive health programmes.

Within curative health the proposed investments in Nairobi and Mombasa would worsen the differential in health facilities between rural and urban areas.

Within the rural areas themselves harambee package was likely to w between better provided areas and the under served areas. This was seen as the crux of the planning exercise.

4.26. On July 3 1978, the functions of planning and management were delegated to DDMS (Rural Health). Series of meetings were held, some being chaired by P/S but the issues raised by the MOFP regarding health plan were not discussed.

4.27. By July 1978, the Chairman of the task force of health planning in the MOFP requested MOH to submit a final draft.

By this time Dr. Onyango former DDMS(P) was away.

4.28 A further request for the final health plan was made to P.S. Health. No response from MOH.

4.29. By September 1978, the Chairman of task force group MOFP requested the Chief Director of Medical Services to appoint another officer

A Deputy Secretary was appointed to do the job.

4.30. Having failed to receive the final draft or further contribution from MOH, MOFP produced the final draft on behalf of MOH.

The document produced was different in style (and to some extent in substance) from that expected by MOH staff. But the rationale in making the fundamental change was to get the chapter organised around the network of health institutions in the rural areas which had the advantage of:

(a) presenting in an integrated fashion, the impact of the health sector on the target groups.

(b) help to blur the distinction between the preventive and curative medicine which had opened the health section's draft and budgetary allocations to criticisms because of their inconsistent.

4.32. When the MOH received the finalversion of the health draft, there were major objections. The final draft had been prepared and organised as MOFP had suggested in the memorandum submitted to the MOH in September 1978, based on Institutional network.
One of these objections was that - District Hospitals should not have been changed from being in their traditional category under curative division. The MOFP had shifted District Hospital from curative division to Rural Health with view to increasing rural health budgetary allocation and on grounds that in fact, District Hospitals are the Headquarters of the rural Health Services delivery system.

4.33. By September 1978, the A.I.D. produced a critique of the already produced health plan. The criticism of the Health Chapter was as

4.34. (i) The plan lacked expression of objectives as these relate to national economic and social development.

(ii) There was lack of consistency between priorities among alternative health programmes and policies that are consistent with stated objectives.

(iii) The plan did not reflect efforts to consider ways to use resources already Committed to the Health Sector much more effectively.

(iv) Plan lacks clear statement of programme strategy, linking goals, coverage, targets means and cost.

(v) The plan does not appear to adequately consider the private sector activities and trends which bear on MOH activities and the probably success of achieving r ıtional Health goals.

(vi) The plan appears to reflect inadequate attention to matters of finance.

(vii) The plan does not deal with evaluation in satisfactory manner.

<u>September 27 to October 30th 1978</u>

Committee formed to discuss the critique.

- Information was seen as vital unit to planning and management.
- Planning was to be strengthened.
- Rural Health and Manpower.

4.35 MOFinance was divided into Ministry of Finance and Ministry of Economic Planning and Community Affairs.

The sector Planning group continued to work toward a mutually acceptable health chapter - although mainly without the benefit of MOH representative.

4.37. October 13 1978

Deputy Secretary requested MOH officers to guide MOPF on what MOH can do, In view of the misunderstanding that had arisen.

4.38. October 30 1978

A letter from MOH to MOF expressed dismay over the final version of the health section.

The letter stated that rural Health included Health Centres, dispensaries, sub-centres and mobile clinics and this is what MOH had told all donors. How could MOH now include District Hospitals as part of Rural Health? This would be embarrassing and confusing.

4.39. November, 1978

Cabinet approved basic needs chapter including Health. Minister for Health was absent from Cabinet.

4.40. November 20, 1978

A meeting of MOH and MOF was held to discuss the differences.

P/S. MOP told MOH to feel free and re-write the chapter with the controversial District Hospitals back in the Hospital Category; but on condition that the text and the budget would remain consistent with one another. Should the Ministry agree to the then version of the health plan, MOH was assured that the MOP did understand the fact that the organisation of the plan was not necessarily congruent with the MOH organisation budgetary system.

preparation of the plan. For example, it was difficult to get suggestion or proposals and materials for the preparation of the plan. A lot of meetings had to be held some having to be chaired by Permanent Secretary to stress the significance of the planning exercise and to affect co-ordination. But since each head of department or Unit operates on his/her own with little regard to other units, this co-ordination was never fully achieved. The organisational structure of the MOH can be described from four approaches. It is organised according to the professional and administrative functions of the Ministry. The professional head being Director of Medical Services (DMS) and the administrative head (overall head) being the Permanent Secretary. It is also organised according to the functions of the Ministry and the allocation of funds i.e. Preventive & Curatives functions.
It is also organised according to the geographical regions. Finally, the Ministry is also organised according to ad hoc health programmes - e.g. MCH/FP, Integrated Rural Health projects, Kenya Expanded Immunisation programmes although all these programmes are co-ordinated by DDMS who does other duties.
The six major divisions include:

5.3.1. Curative Health - Hospitals at National, Provincial and District level. Yet some curative activities are provided by Health Centres and Dispensaries. The specialisation in medicine makes this Division Complex and difficult to co-ordinate.

5.3.2. Preventive Medicine and Promotive Health.

Divisions under this heading would include the entire spectrum of Public Health including

Environmental Sanitation, Communicable Diseases Control, Health Education, Nutrition, etc. etc. Each of these Units have respective head. Environmental Sanitation Unit works on its own, so does the Communicable Diseases Control and so on. Integration of all these Units into the heading of Preventive medicine and promotive Health is difficult.

5.3.3. Rural Health Services.

Under this heading we have the Rural Health Project - which has been or is being phased out. The Administrative Support Unit, the Maternal and Child Health/Family Planning, Health Planning and Implementation Unit, other Health Planning Sections, Integrated Rural Health Project etc. etc. Actual delivery of services is carried out at the Provincial and District Hospitals and in Health Centres and Dispensaries. Co-ordination of all these Units is difficult

5.3.4. Health Training.

Under this heading we have the Training of paramedical personnel at Medical Training Centre and other Schools in Provinces. (Nurses, Public Health Officers, Radiographers, Laboratory Technologists, Pharmacy Technologists, Technicians etc. The training of doctors under the University of Nairobi and overseas - including Post-graduate Medical Training.

Training of Nutritionists - at the University and at Karen College for the Nutrition Field Workers.

Training of Hospital Secretaries at Kenya Institute of Administration.

Training of Family Health Field Educators at Kikuyu - this is now discontinued.

Other training activities overseas or locally i.e. Medical Social Workers E.E.G. and E.C.G. Technicians. Although there is a DDMS responsible for co-ordinating training activities, we also have DDMS heading M.T.C. paramedical Training.

Co-ordination is not easy - leave alone integration of all these units.

5.3.5. Medical Supplies Services. Here we have a Deputy Secretary i/c. of Central Medical Stores. He co-ordinates procurement of Medical Stores, accountability of stores or custody and distribution of Stores to all Health Institutions. He comes under Permanent Secretary whereas in all other Units - the respective heads are professionals who come under P.S. and DMS. respectively.

5.3.6. Medical Research.

Research activities are now to be co-ordinated by Ministry of Science and Technology. We have a SDDMS heading Kenya Medical Research Institute. There are other Research programmes - Kenya Medical Research sponsored by the Dutch T.B. research, Leprosy etc. Co-ordination of all these Units is not very easy.

One can see how difficult it was to get information proposals and inputs for the plan from all these heads. Even if you get 6 heads, they would not be able to control Units under them because of technical and administrative barriers that exist.

The Ministry is also organised according to the geographical regions i.e. Provinces, Districts, Divisions, locations and sub-locations. Actual delivery of services takes place in the field - so that officers who head various divisions must get information from the field. This information may not be easy to collect or the opinion of the officers and HQ. staff may differ.

The Ministry does not have a system with which to resolve such conflicts. During the preparation of the health section in 1977/78, it became clear that inputs from Medical Officers of Health at the District level was ignored: Yet it is at this level that rural Health Services are supervised.

MOH is also organised according to specific functions. We have Units such as Pharmacy Section, Clinical Officers, Radiophysicists, or Radiology Protection Unit, Health Information Unit, including vital statistics, etc. etc.

Although in theory these units are supposed to come under one of the DDMS, you find that some of these Units have greater autonomy than is realised. For the purpose of collecting materials for planning one has to approach each section head and not the overall head who may know very little of the section.

LACK OF HEALTH PLANNING TECHNOCRATS

The MOPED approach to Planning (in the writers view) is rationalistic in that planning is based on the analysis of the nation's goals as stated by Government documents such as the Sessional Papers KANU Party Manifestoes and so on. From the national Goals, objectives and policy are then drawn and operating Ministries are given their specific objectives with which to draw their priorities and policy.

This means technical knowledge and experience of making analysis and planning is necessary to be able to formulate and write up the national development plan

The quality of the plan documents produced by the MOPED reaches the level of excellence which is of international standard. MOPED's emphasis es that the operating Ministry's plans must fit cohesively to the national goals and objectives. This calls for planners who have the skills and capabilities necessary to produce such high quality documents.

In the Health Sector the need for high calibre health sector Planners/Economicsts is crucial. Crucial because, the Ministry's organisational structure is completely disintegrated With many heads of Units each having specialist knowledge and authority for his/her section, one ends up with a lot of shopping lists of activities which are unco-ordinated and fragmented from all these

Health Policy calls for capabilities and capacity that the MOH has not had for a long time.

5.7.4. It is for this reason that MOPED commented that the MOH's draft were not co-ordinated and was not incongruence with the introductory chapters or indeed with the basic needs requirements.
The World Bank also said that the plan was unco-ordinated and lacked perspective. The A.I.D. also criticised the plan as not taking into account the private sector contribution, of not being rationalistic etc. etc. In other words, it is not easy to collect, analyse and write up the health chapter without knowledge and experience of health planning technocrats.

5.7.5. It is not possible for MOH to plan on its own because we simply have to work within the parameters set by MOF and MOPED.

5.8.1. <u>Problems of the Planning Strategy</u>

1. Rationalistic approach to planning is not without its critics. Dahasses (1978) calls for a planning process which would assess the organisational capability and the (political or) institutional willingness available to implement plans. He also says that planning process should identify forces which interacts with the sector activities being planned for. In other words, rationalistic approach to planning substitutes planning process for institutional policy information process and in this way isolates the implementation capacity of the local institutions.

5.8.2. This can be seen from the fact that the MOPED, in attempt to produce an excellent plan, shifted the functions of District Hospitals from curative division to that of preventive medicine and Rural Health. This improved the quality of the document considerably. It made the health chapter logical, congruent, with

the basic needs chapter and gave the plan some perspective. It also, and this is important, ignored the organisational structure of MOH which facilitates implementation. For that reason, MOH and MOPED must work together and clearly understand one another because there is little purpose in producing an excellent plan document if implementation will be jeopardised.

5.8.3 When planning, we should take cognisance the reality of all factors that will be impacting on implementation. In this way we shall prevent planning being done in ignorance of the structures of interests and the distribution of powers in the MOH, resulting in lack of cohesion between what we recommend and the political realities of the situation dictates. In any case planning can only succeed only if those with power (including power of professional knowledge) believe that their interest will be met. In MOH this lesson need to be learnt.

These are some of the issues this workshop can address itself to.

A N N E X I

MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT SCHEDULE OF WORK FOR WRITING THE FIFTH DEVELOPMENT PLAN.

EPCA/SC 2/013(1) 2nd December, 1981

MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT
TREASURY BUILDING
P.O. BOX 30005
N A I R O B I

TO: MEPD PLANNING PERSONNEL
AND DISTRICT DEVELOPMENT OFFICERS

FIFTH DEVELOPMENT PLAN

I should bring to your attention that the Cabinet has authorized that we commence the preparation of the Fifth Development Plan. This will cover the calender years 1984-88 and the fiscal years 1983/84 1987/88. It is scheduled for publication on the 12th of December 1983. Kenya's 20th Independence Anniversary.

2. The Plan will be based on 1981 data which will first become available in provisional form in May 1982. The following schedule of work has been approved by the Cabinet

Dec. 1981 to May 1982	Preliminary work
June 1982	Approval of basic strategy by Cabinet
July 1982	Circular to Ministries with summary of strategy, tentative budget celings and District priorities.
August 1982	First meetings of Sectoral Planning Groups.
December 1982	Drafts of all macro chapters to be completed.
March 1983	Drafts of major sectoral chapters with District level disaggregations where pertinent to be completed and circulated to District Development Committees for comment.
June 1983	Comments by Districts to be returned and circulated to Ministries.
August 1983	Revisions of all macro and sectoral Chapters to be completed.
September 1983	Final approval by Cabinet.
December 1983	Publication.

3. . Between now and May 1982, preliminary work will be undertaken as follows:

3.1 reviews of economic performance under the present plan will be prepared for major sectors and all Districts;

3.2 plan-related to research projects will be identified and work initiated;

3.3 macro-economic modelling will be improved;

3.4 monitoring systems will be established;

3.5 development priorities in Districts will be identified and

3.6 a draft of development strategy and supporting policies will be prepared and submitted to Cabinet.

4. Work by sectoral planning officers on reviews of economic and social performance by major sectors should be virtually completed in conjunction with work on the forthcoming Sessional Paper (see my note of 23rd October 1981 addressed to Department, Division and Section Heads). Some expansion of this work may now be required. In particular, we require:

4.1 quantitative measures of progress and shortfalls in achievement covering the period 1970 to 1980, and

4.2 an identification of the reasons, specific to each sector, why progress has not been greater.

5. In addition to these reviews of economic and social performance, sectoral planning officers are requested to make suggestions in writing through their Department, Division and Section Heads on the following two matters:

5.1 Research projects which should be undertaken by the levant operating ministry, the MEPD, University rsonnel or others to enhance understanding of sectoral oblems and measures which will improve progress in o future. Such projects should be feasible of mpletion by December, 1982 and specific researchers ould be proposed if possible;

5.2 Modifications of the development strategy outlined in the present plan which are needed in order to facilitate more rapid development of the sector reviewed.

6. Similar work to that outlined in paragraphs 4 and 5, but focusse on Districts instead of sectors, should be undertaken by all District Development Officers. They are not, however, asked to identify research projects as in paragraph 5.1 because at this stage it will not be possible to organize District-level research. They are instead asked, in responding to paragraph 5.2, to identify specific developm

priorities for their districts broken down by responsible ministries so that these can be discussed by relevant sectoral planning officers with the ministries concerned. The DDO's together with the Rural Planning Division and field officers of the operating Ministries, will also prepare reviews of District level performance under the present plan (para. 3.1 above) and develop and implement a District level monitoring system (para. 3.4 above).

7. Deadlines for this preliminary work on the Plan are established as follows:

Paragraph	SPO s	DDOs
4.1	1-2-82	1-3-82
4.2	1-2-82	1-3-82
5.1	31-12-82	-
5.2	1-2-82	1-3-82

These deadlines will enable those in MEPD working on strategy and policies to utilize this preparatory work in the drafting of the paper for Cabinet noted in paragraph 3 [illegible]

Y.F.O. MASAKHALIA
PERMANENT SECRETARY

A N N E X II

MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT

FIFTH DEVELOPMENT PLAN HEALTH SECTOR REVIEW

DRAFT AVB 25/1 1982

FIFTH DEVELOPMENT PLAN - - HEALTH SECTOR (MOH)

QUANTITATIVE MEASURES OF PROGRESS AND SHORTFALLS IN ACHIEVEMENTS DURING THE LAST (APPROX.) TEN YEARS

Achievements should be measured against possibility to achieve stated objectives and goals. Financial, infrastructural and manpower constraints limit that possibility, and more often than never set the kind of framework against which, and within which, objectives and policy have to fight for recognition, and sometimes, survival. The budget is, for instance, a useful too[illegible] only for the purpose of planning immediate expenditures, bu[illegible] for receiving, at least, a rough indication of the limitations of [illegible]ility to achieve certain important objectives, since it contains those earlier commitments that have to be honoured, along with the new projects that are planned to be launched. Social indicators measure progress often in terms of need relative to population factors, but are often misleading, particularly at times when population growth is rapid. During such times a combination of different indicators is often required to decide whether there has been any progress or not.

Policy objectives and the budget - Policy objectives in the health sector during the current Plan period (1979-83) embrace promotive health measures and development of preventive medicine, especially in the rural areas where some 85 per cent of the population live. Development of the curative health sector, that is development of hospitals, is receiving low priority in comparison to development of rural health facilities and the furthering of e.g. mass innoculation, community health care and health education programmes. Research is considered important for the improvement of future health services, and training of manpower, particularly of those health cadres that are to be absorbed in the rural areas, is being emphasized.

In light of the Plan's theme - to alleviate poverty through creation of employment opportunities, and development of basic needs services -- development of the health sector is being stressed, since good health is considered one of the most important basic needs that there is. Consequently, it could be expected that the health sector, or the MOH, share of the GOK total voted expenditure would be expanding during the plan period, at least, relative to the previous Plan period (1974-78). A look at the table immediately below reveals that this has not been so. For purpose of reflecting actual expenditure as closely as possible, the figures represent the Revised Budget figures (Gross, if not otherwise stated), except for F.Y. 1981/82, which shows the Draft Budget figures.

F. Y.	1 MOH Recurrent Exp.£'000	2 % of Total Voted Exp.	3 MOH Devel. Exp.£ '000	4 % of Total Voted Exp.	5 1 + 3 1 + 3	6 % of Total Voted Exp.
1971/72	8,278	7.9	2,749	5.1	11,027	6.9
1972/73	9,490	8.1	2,461	3.7	11,951	6.5
1973/74	11,893	8.4	2,195	3.3	14,088	6.8
1974/75	15,173	8.7	4,022	3.8	19,195	7.2
1975/76	19,128	9.1	4,275	3.2	23,403	6.8
1976/77	22,255	8.9	7,979	5.4	30,234	7.6.
1977/78	26,915	7.8	10,740	4.6	37,655	6.4
1978/79	30,903	7.5	9,922	3.7	40,825	6.0
1973/79	126,267	8.2	39,133	4.2	165,400	6.7
1979/80	32,520	7.4	11,323	4.5	43,843	6.3
1980/81	40,957	7.6	11,405	3.7	52,362	6.2
1981/82	42,784	7.8	10,901	3.9	53,685	6.5
1978/82	147,164	7.6	43,551	3.9	190,715	6.3

The above table is in current rather than fixed prices. Thus, assuming an inflationary rate of some 10% p.a. from 1973 onwards, recurrent expenditure increased by an average of 10% p.a. during 1974/78, and only by 1.3% p.a. during 1979/81. In the case of

development expenditure, it increased by more than 15% p.a. during 1974/78, but decreased by 6.2.% p.a. during 1979/81.

In terms of 1978/79 prices, Central Government Total Expenditure for the MOH is expected to increase by some 9.6. per cent p.a.during the Plan period. Two years short of the period, the growth has been considerably less, only 6.8 per cent p.a. in current prices. Total Development expenditure has increased by 1.6% p.a. in current prices, compared to a target 10.7% p.a. in fixed prices. Total Recurrent Expenditure has increased by an average of 9.7%p.a. in current prices, compared to the expected annual increase of 9.1% in fixed prices. The MOH expenditure share during the period has been 7.6(recurrent), 3.9 (development) and 6.3 (total) instead of planned 8.5, 4.9 and 7.1 per cent respectively.

It can thus be concluded that progress, measured in budgetary figures, in the health sector has been slower than expected, and that the health sector has been allowed to develop at a rate which is not only lower than planned, but also less than that of expenditure growth, thus questioning the health sector's significance as a priority development sector.

Priority placed on preventive medicine and promotive health, rather than curative, and emphasis on development of health infrastructure in the rural areas, can also be deducted from analysis of budgetary figures. Comparison of the Development Sub-votes over the years reveals the following:-

(in K£'000)

Sub-vot__ _, .

Vote D.11

F.Y.	110	111	112	113	114	116	117	TOTAL
1973/74	---	1,676	116	81	322	---	---	2,195
1974/75	---	2,020	532	319	1,131	20	---	4,022
1975/76	---	2,202	733	113	1,216	10	---	4,275
1976/77	---	3,945	1,667	222	2,115	30	---	7,979
1977/78	---	6,549	1,489	610	1,692	100	300	10,740
1978/79	15	6,820	812	835	1,164	84	192	9,922
1973/79	15	23,212	5,349	2,180	7,640	244	492	39,133
%		(59.3)	(13.7)	(5.6)	(19.5)	(0.6)	(1.3)	(100.0)
1979/80	10	8,215	392	1,651	833	62	160	11,323
1980/81	5	8,166	190	2,070	546	28	400	11,405
1981/82	---	6,940	340	2,529	342	150	600	10,901
1978/82	25	30,141	1,734	7,085	2,885	324	1,352	43,551
%	(0.1)	(69.2)	(4.0)	(16.3)	(6.6)	(0.7)	(3.1)	(100.0)

1/ Sub-votes:
110 -- General Administration
111 -- Curative Health
112 -- Preventive Medicine & Promotive Health
113 -- Rural Health Services
114 -- Health Manpower
116 -- Medical Stores
117 -- Health Research

The table indicates that, although an over time increasing share of funds has been spent on development of health facilities in the rural areas, major development in the health sector has been, and continues to be, development of hospitals. Over the years, some 25 per cent of total development health expenditure has been on district hospitals alone, 16 per cent on provincial hospitals and almost 20 per cent on Kenyatta National Hospital. However, although district hospitals are generally curative institutions, they serve as referral hospitals for rural health facilities, and belong at least, partly, also to the preventive medicine scene.

Given the shortage of funds, generally, for development of the health sector, the MOH has been fairly successful so far in adhering to pronounced objectives, as can be seen from the above. Realization of existing implementation schedules will, further, emphasize the ministry's efforts to switch from development of curative services to preventive medicine and promotive health, and generally make health services available to the multitude of population.

Social Indicators - The most commonly used social indicators in the health sector include rates of fertility and mortality, number of practising doctors and nurses, available hospital beds and facilities. A combination of these, perhaps coupled with expectations of available funds for further development, will generally point out whether progress has been achieved or not, but on a general basis only. A regional analysis will reveal areas of weakness, and direct development to areas where concentrated efforts have to be undertaken in order to achieve set objectives and targets.

Mortality and Fertility Rates - Judging by the development of the mortality and fertility rates over the years, there ha been a considerable improvement in the status of health. Mortality has decreased from 17 per thousand population in 1969 to 14 per thousand in 1979 (total mortality rate). Going by the infant mortality rate, which, although still being quite high, has been reduced by some 30 per cent to 86 per thousand population, it can be concluded that lowered death rates indicate a generally healthier population. How much of this improvement can be attributed to better access to and improved quality of health services, compared with improvements in other sectors, is, however, difficult to ascertain. Further, the fertility rate has also increased, from 50 per thousand to 53 per thousand, indicating also a higher level of fecundity due, perhaps, to improved care of potential mothers.

During the six years between 1974 and 1980, the number of doctors and dentists has increased from 892 to 1,853, improving the ration of doctors to population from 0.07 to 0.12 per thousand. The number of nurses (registered and enrolled) has increased from 10,273 to 15,414, improving the ration from 0.82 to 0.97 per thousand population. The number of hospital beds has increased from 14,525 in 1971 to 27,691 in 1980 (--by an average of 7.4% p.a. during 1971-80--), improving the ration of hospital beds per thousand population from 1.24 to 1.74. It should be noted, however, that the growth in beds during 1975-80 was only 3.1% p.a. that is, it was slightly lower than the rate of population growth during

the same period, and the bed/population ration consequently sank from 1.78 in 1975 per thousand to 1.74

Official Statistical data referring to health facilities by provinces is available from 1978 onwards. The following table shows the number of hospital beds per 1000 population, and the number of population per health facility (hospital, rural health centres, sub-centres, and dispensaries) by each province, in 1978, 1979 and 1980. [illegible]n be seen that Nairobi, not surprisingly, is best [illegible]ipped with hospital beds (in 1980 5.8 beds per 1000 [illegible]pulation), but also it can be concluded that the facilities available in Nairobi are generally larger, and growing in size. The North-Eastern Province seems to be the worst off province when it comes to hospital beds, but in terms of number of people per facility, it is still better off than the Western Province. On the other hand, the data do not reveal geographic distances so the conclusion can be fairly misleading.

	1978		1979		1980	
PROVINCE	No. Hospital beds per 1000 pop.	No. of people per health facility	No. Hospital beds per 1000 pop	of people per health facility	hospital beds per 1000 pop.	of people per health facility
Nairobi	4.95	5,610	6.09	5,910	5.80	10,100
Central	1.66	9,680	1.71	9,690	1.86	9,410
Coast	1.86	7,640	1.87	7,540	1.80	7,970
Eastern	1.21	10,570	1.33	11,010	1.29	11,340
North-Eastern	0.87	16,320	0.93	13,850	0.89	15,640
Nyanza	1.57	12,470	1.46	14,610	1.47	12,970
Rift Valley	1.50	7,300	1.53	7,470	1.47	7,420
Western	1.34	22,240	.40	18.700	1.41	22,060
TOTAL	1.67	9,690	1.76	9,910	1.74	10,300

As above, social indicators should be coupled with population data in order to generate any meaning, and preferably on basis of regions to indicate direction of development in the future. Whatever development progress can be ascertained, however, has to be judged in consideration of also the financial means that are and have been available. During periods of resource constraints, strict adherance to policy directives will be a necessity, given that already on-going projects will be given adequate resources to be able to finish within reasonable periods of time. Undue stretching of projects of less priority is uneconomical in the long run, and only serves to create confusion in interpretation of policy during short term.

FIFTH DEVELOPMENT PLAN — HEALTH SECTOR

AN INDICATION OF THE REASONS WHY PROGRESS HAS NOT BEEN GREATER IN THE HEALTH SECTOR

I refer to the draft paper on 'Quantitative measures of progress shortfalls in achievement in the health sector during the last (approx) ten years'. This is a brief summary of the reasons for progress achieved and experienced shortfalls mentioned or hinted at in that paper, as well as certain other causes.

(i) Decisions on budgetary ceilings are, generally, made arbitrarily, and show little concern whether a sector should receive priority or not. Coupled with overall resource constraints, the health sector, or MOH, has received, in real terms, considerably less than expected over the years, and, at a decreasing rate rather than an increasing. The MOH expenditure share is smaller during the current plan period compared to what it was during the 3rd Development Plan period.

(ii) Resource constraints are, partly, responsible for development projects being stretched over too many years, since adequate funds have been lacking to 'finish' projects in due time. This has caused projects to end up being more costly than what was orginally envisaged. It has also been responsible for funds being tied too long to projects having no or little priority.

(iii) The MOH implementation capacity (involving, of course, that of the MOW) has not been up to expectation, and, consequently, responsible in part for projects 'dragging on' Further, communication and coordination between the MOH and the MOW has been inadequate at times, resulting in unnecessary delays, both with regard to planning and implementation.

(iv) Confusion has existed in the MOH as to national development policy, resulting in contradictory measures being taken. On the whole, however, effects of such misunderstandings have usually been short-termed.

(v) The rate of population growth has been and continues to be very rapid, which, in itself, calls for rethinking of development targets within different sectors, including that of the health sector. The effect of the population rate of growth on infrastructural development has made it necessary that social services be seen in a regional contex in the future, and traditional measures involving national trends be abolished, and be made to make way for more usefu measures, possibly indicating improvements in terms of bett access to facilities, for a larger part of the population than has been the case so far. Further, standards need to be reviewed.

FIFTH DEVELOPMENT PLAN -- HEALTH SECTOR

POSSIBLE RESEARCH T

(i) Optimal distribution of different kinds of health services and facilities in an area, e.g. "split" between curative (=hospitals) and preventive medicine/promotive health (=rural health centres and dispensaries) services, arriving at some kind of "formula" to be utilized when estimating e.g. the need for services in a particular district. The formula would not only take coignance of geogrpahic distances, population density and development pattern, but also of circumstances conditioning living standards and health status, as well as types of communication patterns. Development of such a formula would help deciding whether an area is under-served or not; although conventional quantitative measures (such as bed/population rations) point to a district being poorly serviced, this might not be the case should other factors be included and considered in the analysis.

(ii) In Kenya, roughly 1/3 of all deaths occur between birth and the 1st birthday. Another 20 per cent occurs between the ages of 1 and 4. The infant mortality rate is thus very high, and coupled with the next risk-group, the 1-4 year-olds, the smaller children are unnecessarily prone to untimely deaths. One of the objectives of the health sector is therefore, and naturally so, to reduce the high infant mortality, and make living conditions adequately health-safe for children to grow up in.

The total mortality rate is naturally influenced by the infant mortality rate. At present the infant mortality rate is 86 per thousand, and the total 14 per thousand. During the intercensal period 1969-79, the total mortality rate sank from 17 to 14 -- and the infant mortality rate was reduced by one third to 86. How much of the reduction in the total mortality rate was "caused" by the reduction in the infant mortality rate?.

In line with the objectives for the health sector, emphasis is being put on preventive medicine (such as innocullation programmes) and promotive health (nutrition, family planning programmes for instance) Such services are planned to be made also more accessible through construction of facilities in vicinity, at least, to where people live, that is, in the rural areas. Assuming that the programmes will be successful, the infant mortality rate will hopefully show signs of being further reduced. What impact will this reduction have on the development of the total mortality rate? And how many births, assuming that the improved health of children results in fewer deaths of children, and in further reduced total mortality rates, will have to be averted to counter-balance the effects of lowered mortality and ascertain that the rate of population growth will not increase? Is there a way to measure possible impact of different projects/programmes in terms of anticipated effects e.g. degree of reduction in mortality rates?

A N N E X III

THE INTERNATIONAL LABOUR ORGANIZATION'S REPORT ON BASIC NEEDS IN THE HEALTH SECTOR

III BROAD POLICY CONSIDERATIONS

A. Short and Medium - term Measures

Least - Cost Approach to the provision of BN Services

Indentification of Under - utilised capacity in existing Government Assets

Contribution by External Donor Agencies and NGO's to provision of BN services

Self-financing of BN services

The Role of the Private Sector and Institutional Reforms

Availability and Allocation of Resources

B Longer - term Measures

Transformationist Approach

Planning, the Public and Political leaders.

low consolidation rates in low-cost housing, and low returns to rural extension work in food and nutrition, family planning and adult literacy. Part of the problem is management; partly it is inadequately trained personnel; partly it is the high cost of overheads in relation to performance; and partly it is the ineffectiveness of monitoring in itself, and the slowness to reform policy in the light of evaluation.

Contribution By External Donor Agencies and NGOs to provision of Basic needs Services

Tackling these shortcomings is a necessary starting point, but one which runs into the problem that increasing utilisation means a shift from development to recurrent expenditures. This calls into question how far donor agencies which have traditiona directed support to BN activities can be brought to accept the necessity of supporting recurrent elements. Where an agency has a special relationship with a region or a sector over a period of years this appears to be quite reasonable. Co-ordinat of activities both in terms of policy and financing with non-gov nmental agencies is also necessary. These measures will be insufficient in themselves, however, and a selective adjustment of policy through the transfer of recurrent costs to the private sector should be instituted.

Self-financing of Basic Needs Services

Each sector has varying considerations to take into account in this regard; these are examined in more detail in the review of core basic needs that follows. Broadly, fees, taxes and rents on such items as schooling, private hospitals and drugs, low- and middle-density housing should be levied whereby a transfer of su ort can be made to the rural areas and the poor. Over the longer

term, a self-financing element for effective maintenance and additional infrastructural development should be introduced for water supply and housing. The introduction of fees at the primary level and a more efficient system of loan-recovery for higher education may be required.

The Role of the Private Sector and Institutional Reforms

This transfer of a share of the burden of essential social services to the private sector should be accompanied by institutional reforms in the public sector. Essentially this means increasing the ability of public institutions to deliver services according to rational planning objectives, and in a measurable way. The decentralisation of decision-making responsibility to the local level, together with the necessary financial autonomy and transfer from the centre to district and sub-district levels of skilled managerial and technical personnel is needed. The danger of opening the way for uncontrolled allocation at the local level must, however, be avoided by involving the community in the making and implementation of decisions in effective ways. Local government is the effective level both for undertaking responsibility for the operation and maintenance of basic services and for the supervision of their effectiveness.

At the central level, there is a substantial need for much better co-ordination between the range of ministries and parastata bodies responsible for providing basic needs services. Areas such as health, water and food nutrition cut accross sectoral areas; overlap of function and dilution of responsibility should be minimised.

For the medium-term, this institutional reform should be accompanied by a definite commitment to resource-constraint

[illegible] as fundamental, for example, to establishing a cost-effective educational policy through the operation of meaningful manpower planning. Not only are better informatic systems, work scheduling and monitoring and evaluation requir but also the flow of this information to both the public and political leaders at all levels is desirable.

Availability and Allocation of Resources:

As far as the availability and allocation of resources are concerned, there are advantages to be derived from the complement arities and linkages between different basic needs services. Education, food and nutrition, Health, Water and Housing interact beneficially. It may be desirable to reduce the weight of central and overhead costs in relation to these services by rationalising their operation to take advantage of potential linkages. The formation of a cadre of Basic Needs extension workers may help to stem the proliferation of a rural bureaucracy, and selective rationalisation amongst sectoral ministries at the centre may help to reduce costs and improve efficiency. Major donors might also be asked to provide both capital and recurrent inputs for region-ally-specific programmes of linked activities, such as health-nutrition-[illegible]-family planning, or water-food-housing.

LONGER-TERM MEASURES

Transformationist Approach

Over the long term, the interests of Basic Needs are best protected by public sector policies which concentrate on investment spending at a point substantially upstream of consume demand for such services. This means a radical shift of resourc into production areas. As regards education, it means a concentr ation on ensuring the effective quality of teachers and the relva [illegible]la to the income-earning environment. Placing social

priorities above aggregate individual demand will probably entail a school-fee system at all levels in order to protect the availability of universal primary education, adequate specialised training and the opportunity of higher education. In health, promotion and prevention represent this form of investment approach. High recurrent spending on sophisticated water-delivery systems and large-scale but inefficient schemes such as IADP should be downgraded in favour of low-input, district-level programmes.

Planning, the Public and Political Leaders

With budgetary constraint, the pre-emptive and demand planning which have characterised much of the social development in Kenya should give away to more rational and objective approaches. The problems are not so much those of policy as those of popular expectations and the nature of the political system. Resource constraint planning, and the protection of a commitment to basic needs, will not be possible without a campaign of information which enables the public and political leaders to judge that tight policies are ultimately in the best national interest. This campaign of information should be associated with the fifth National Development Plan.

VI **HEALTH**

1. Definition of BN in the Sect

2. Present Status: Performance and Shortfalls

   - Rural Health Services
   - Rural Health Facilities
   - MCH/Family Planning
   - Primary Health Care
   - Traditional Health Practic

3. Organisation and Management

4. Pattern of Resource Allocation and Utilisatio

5. Specific Policy Issues: A Summary

H E A L T H

(1) Definition of BN in the Sector

An effective health sector is one and the same time a vital basic need in a given national context and a necessary precondition for overall economic development and social progress. Health interacts with other basic needs such as education and nutrition to affect levels of productivity and incomes. Hence, if the health status of the population is satisfactory it can have a positive impact on productivity and output with income gains at the household level and poverty alleviation implications at the national level. Investment in health as a basic need, therefore, does not conflict with growth-oriented objectives of development. Conversely if health status overall is poor it can jeopardise broad development objectives of growth and social progress. Furthermore, poverty itself can be the cause of ill health through malnutrition and lack of access to adequate health services if a cost is involved in obtaining such services.

In the specific context of Kenya, the importance of health as a basic need has been recognised since independence and progress in certain areas, especially curative services, has been good. The current development plan accords a high priority to health in the context of a basic needs-oriented strategy aimed at the alleviation of poverty - the main theme of the 4th National Development Plan. According to the plan, the total of expenditures to be made available to the Ministry of Health for the provision of various services was projected to increase from 6.8% of overall public expenditure in 1978/79 to 7.4% in 1982/83. With current budgetary constraints, this latter figure has now been revised downwards to 6.8%. As we shall see later, expenditures on health have, by and large, in the past been dominated by capital

or development spending on curative services, particularly with regard to the establishment and operation of urban-based hospitals.

While this could be regarded as fundamental base required for launching simpler but more cost-effective (in terms of impact on health status) preventive and promotive health services, there may be some cause for concern (especially from the standpoint of a basic needs strategy) about the duration, limits and financial requirements of such a health consolidation programme as has been pursued in Kenya. Indeed, there now seems to be some awareness among policy-makers and planners in the sector about the need to redress the inbalances in public spending between curative services, on the one hand, and preventive and promotive services, on the other. The present climate of financial stringency calls for a more rational and cost-effective pattern of investment within the sector, and in this connection positive indications of a change of approach in health planning, as may be discerned from some on-going and proposed activities of the Ministry of Health, represent a move that is in line with the concept of basic needs.

In Kenya, like many other developing countries faced with the problem of resource constraints for development purposes, the definition of health as a basic need is extended to include control of population growth. It is well known that effective family planning (FP) in countries with high rates of population growth such as Kenya can contribute significantly to the satisfaction of basic needs in the area of health and, hence, other concerns of socio-economic well-being. For example, family planning, through its effects on family size, spacing of children and the health status of mothers and children, could enhance the consumption of basic needs goods and services within the household, while at the same time increase the productivity of working

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mothers (a common phenomenon in rural areas) and the performance of children at school which is significant in the context of human capital formation. Particularly in Kenya where population has been growing on average at an estimated rate of 3.9% per annum, a slow down in the rate of population growth would remove a major obstacle to meeting basic needs for housing, health, education, safe water, nutrition, etc, more so in period of financial stringency It should be mentioned here that in Kenya, family planning is organisationally linked to maternal and child health (MCH), and given progress made in the area of curative medicine which is now reaping good dividends in terms of impact on MCH, the present trend of declining infant mortality rate co-existing with that of unsatisfactory performance in FP could seriously jeopardise the fulfillment of basic needs in all areas of human well-being and socio-economic development through higher rates of population growth.

2. Present Status: Performance and Shortfalls

When compared with the situation at the time of independence there can be no denying that significant improvements have been achieved in the provision of health care serives in Kenya over the past two decades. Some vital indicators of health status attest to the impact of this achievement: the mortality rate dropped from 17 to 14 per thousand population between 1969 and 1979; the infant mortality rate over the same period fell from 112/1,000 to 86/1,000; average life expectancy increased from 44 years in 1965 to 52 in 1979. These improvements in health status are clearly linked to the massive investment in physical infrastructure and manpower that has characterised planned development in the sector over the past decade or so. Consider, for example, that

between 1970 and 1980 the number of hospital beds increased from 14,537 to 27,691; 210 additional rural health facilities were established: the total number of all categories of government health service workers doubled from about 14,000 to almost 28,000.

The Government has adopted the WHO-inspired target of essential health care for all by the year 2,000 - by this date every Kenyan citizen should have attained a level of health that will permit him or her to lead an economically and socially productive life. This implies far-reaching measures to eradicate, prevent and control the spread of diseases; to establish and efficiently operate a network of facilities to diagnose and adequately treat sicknesses; to promote personal hygiene, good dietary and nutritional habits, family planning and physical culture.

In terms of costs, adequate funds will have to be made available to support the attainment of a 'health for all' target by the year 2,000. However, given the current budgetary constraints it is obvious that less funds than is desirable will be provided to the Ministry of Health and other government agencies with health-related functions for their activities over the next plan period. The task ahead then will be in terms of how best to utilise available resources to attain as near as possible the stated targets and objectives of Government health policy. More innovative ways of planning, implementation and delivery of health care services will therefore be required.

A useful point of departure for assessing future prospects is to undertake a stock-taking exercise of past and current performance in relation to inputs within the sector. As alread mentioned, past patterns of investment in the health sector have somewhat favoured the urban areas where the majority of more

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sophisticated curative facilities are concentrated (e.g. the national and district hospitals in the public sector and elitist-oriented hospitals and other health care facilities in the private sector).

In the rural areas, where about 80-90 per cent of the population live and work, the provision of health care facilities which has been the responsibility of central government since 1970 has tended to lag behind that of urban areas. Similarly, by way of a causal factor, the distribution of public spending on health between urban and rural areas has been highly skewed in favour of the former. As a consequence, incidences of diseases and sicknesses have been much higher and more prevalent in rural than in urban areas. According to the results of an experimental reporting system on health status which was undertaken in three provinces (Eastern, Coast and Central) in 1975, a significantly high proportion of the rural population was found to suffer from disease such malaria, diarrhoea, bilharzia and measles, apart from malnutrition which was fairly widespread, compared with the urban population in the areas surveyed.* Similarly, the 1976 IRS revealed that about half the population of rural Kenyans were living beyond an acceptable walking distance from a health centre; no doubt the corresponding percentage in urban areas must have been significantly much lower given the concentration of curative facilities in Nairobi and provincial and district headquarters.

Rural Health Services

The Rural Health Development Programme (RHDP) which was launched in the mid 1970's, after responsibility for the provision

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Ghai, Godfrey and Lisk, Planning for Basic Needs in Kenya: Performance, Policies and Prospects (ILO, Geneva, 1979) p. 34

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of rural health services had been transferred from local to central government, was a major departure from conventional planning within the sector. It was clearly intended to redress some of the imbalances in every aspects of health care between urban and rural areas. Structurally, the RHDP consists of Rural Health Units (RHU) as its focal point for operation, each designed to serve approximately 50-70,000 rural inhabitants. Each RHU has as its headquarters a hospital, health centre or sub-centre with a number of dispensaries as the outreach of the services being provided. In terms of staffing, each RHU ideally should consist of a clinical officer as the head, community nurses, family health field educators, public health technicians and laboratory technicians. The RHDP, though originally conceived as a comprehensive network of curative services, was also supposed to emphasise preventive and promotive health services which are widely regarded to be highly cost-effective in terms of impact on health status of the population per unit of financial investment in the sector. The programme was also envisaged as an improved and efficient means of providing and delivering health care facilities and services to hitherto disadvantaged groups within the sector.

Since its inception the RHDP has expanded considerably to cover all 40 districts in the country at present, with a total of about 830 government - provided rural health care facilities of one type as another.* According to latest available figures, the RHDP is operated on the basis of 182 rural health centres, 37 sub-health centres and 611 dispensaries. In addition 23% of the 254 RHUs comprising the system have one each of the 57 district

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* In addition NGOs account for 374 health facilities located in rural areas distributed as follows: 28 health centres, 7 sub-centres and 339 dispensaries.

or sub-district hospitals in the country as headquarters; 57 per cent are based on rural health centre or sub-centre while the remaining 20 per cent of RHUs operate from a dispensary. At the upper end of the RHDP some RHUs have access to the 6 provincial by way of a referral service.

As far as shortfalls are concerned, the most noticeable weakness as regards the performance of the RHDP is that its network of constituent facilities seem to emphasize curative needs with only a modest provision of preventive and promotive services offered. While part of this tendency may be due to shortage of skilled manpower (many RHUs have still not got their required complement of community nurses, health educators and public health officers) and poor organisation and management, there seems to be have been until quite recently an inherent bias among policy makers and planners in the sector to favour curative services. A related factor also concerns deeply entrenched altitudinal biases among the majority of consumers of rural health services to regard curative services as the panacea for all health problems. This factor underlines the dire need for appropriate mass health education within the framework fo the RHDP. Even in the area of curative services the performance of the RHDP is characterised by shortfalls in terms of coverage and impact due to a combination of shortage of funds, skilled manpower and equipment and the inefficient distribution of drugs. Overall, weaknesses in technical, administrative and operating procedures and leadership and supervision combine to impair efficiency in the provision and delivery of healthcare services in rural areas.

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Rural Health Facilities

The sizeable expansion in rural health facilities (i.e. infrastructure and equipment) envisaged over the current plan period now seems unlikely to be realised if one is to go by progress achieved so far. The situation which could be summarised in terms of actual achievements in relation to planned targets is as follows. Within the framework of the RHDP, out of a planned target of 5 new health centres 3 are expected to be completed and operational by the end of the plan period in mid-1983. The plan also set a target of 40 new dispensaries, yet to date only 3 are completed and operational and 25 others are under construction; so even if all those presently being built are operational by the end of the plan period the total will amount to only 28. Some 92 health centres, 6 sub-centres and 142 dispensaries were identified in the plan for improvement and upgrading, giving a total planned target of 240 such projects; as of end 1981 only 145 were in the implementation stage with no single project entirely completed. Towards the objective of establishing at least one disease control unit per district throughout the country, the plan proposed the setting up of some new units in order to achieve this objective by 1983; under the most liberal assumptions only 7 new units are expected to be operational by then, bringing the total to 18 or a coverage of less than half the total number of districts.

Expected shortfalls in planned targets for physical infrastructure are not limited only to facilities within

the RHDP. At the district level, 17 new government hospitals were identified in the plan (including 11 self-help ones to be taken over, improved, equipped and operated by Government), but only 6 are expected to be completed and fully operational by 1983. The improvement and extension programme envisaged at the same level identified 63 projects for implementation during the plan period; by 1983 only about 18 are expected to be completed. About the only area where the planned target has been met even before the end of the plan period is the extention to the Kenyatta National Hospital in Nairobi where the recently completed Ward Tower Block has added anothe 1,200 beds to the urban areas total number of hospital beds. For the country as a whole this takes the number of additional hospital beds expected to be provided by 1983 to 1,265, leavin a deficit in relation to planned target of about the same number at 1,235 beds.

This achievement, however, reflects the bias in favour of curative services, especially of the more sophisticated types, which are concentrated in urban areas. In terms of performance, it also shows that imolementation rates tend to be much higher in projects involving the provision of curati services where the immediate output or end-product is concrete or takes the form of a visible manifestation of government's response to politicall induced demand of powerful and influentia clientele.

One other factor from the standpoint of cost effectiveness that needs to be highlighted in the context of the provision of rural health services is the activity of local self-help

groups which are active, sometimes with financial support from international and bilateral donor agencies in the building of health centres, sub- centres and dispensaries for communal use. In most cases self-help groups their activities to capital formation in terms of the provision of the physical infrastructure and in so doing pre-empt government assistance for recurrent costs. This form of pre-emptive planning, based on explicit politically-induced public spending commitment, serves to distort the rational distribution of resources and, hence, the location of health services in rural areas. In the past when there were no constraints on resources, government had responded well to this form of planning which reflects purchasing power of local communities more than actual need. As the financial situation of government became tighter in recent times and spending limits imposed on recurrent expenditures among other austerity meansures, some of these self-help built health facilities have remained inoperational due to lack of equipment, drugs and personel. The resulting underutilisation of facilities amounts to a waste of scarce resources within the sector (some of which are derived from external aid flowing into Kenya) at a time when development resources are insufficient. The absence of need-oriented, in contrast to demand-oriented, planning criteria in the location of self-help health faciltiies also mitigates against considerations of equity as demanded in basic needs-oriented development, in so far as more prosperous local communities that can afford to initiate self-help projects have been favoured in the allocation of resources to the detriment of poorer ones. Rational planning, especially

at a time of financial strigency, must respond to need rather than effective demand.

MCH/FP

Performance in the area of FP, an important health preventive and promotive activity when combined with MCH, has been disappointing by all accounts. Over the third plan period, it was targetted to reduce the birth rate from 50 per thousand population in 1974 to 49/1000 by 1979; in actual fact, the birth rate increased to 53/1000 at the end of the plan period. Since the crude death rate declined over the same period, the net effect was an increase in population growth. From the point of view of the provision of health (and other social) services, high rates of populati growth increases the demand for services while, due to a combination of shortage of requisite financial and human resources and inefficient organisation and mangement, the supply of services is growing at a much slower pace. At present rate of growth, the Kenyan population could double by the end of the century. This alone, leaving aside financi constraints, would be a major obstacle to the attainment of the target of the RHDP: "universally accessible (health care) to individuals and families in the community by means accepta to them, through their full participation and at a cost the community and the country can afford." Despite the continuir substantial investment of human and material resources of FP activities - number of clinics increased from 270 in 1979 to in 1981 - the percentage of acceptors of family planning methods has remained low ranging from 15 - 20 per cent of

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total attendances at family planning clinics throughout the country, with a declining trend in recent years. If this percentage is computed in relation to all potential clients defined, for example, in terms of women of child-bearing age who already have 2 or 3 children, the result will be a much smaller proportion for FP acceptors.

MHC performance, on the other hand, is more impressive reaching at present between 65 - 70 per cent of pregnant women and 60 - 65 per cent of new born children. Although FP and MHC have been operated as more or less an integrated health care programme since it was launched in 1974 with IBRD support for an initial period of five years, the contribution of an unsuccessful FP component and a successful MCH one has already been noted in terms of its implication for population growth. Whereas field health educators recruit an average of 70 MCH clients a year they only manage to recruit an average of 15 - 18 FP acceptors a year, according to NFWC figures. So far the rationale underlying an integrated MCH/FP programme seems to be an unrealistic one in the Kenyan context: whereas in theory a successful MCH programme is normally supposed to have a positive impact on an FP programme by reducing the desire for more children as child survival rates imrpove, what seems to be happening in practice is that MCH, far from counteracting is actually encouraging the well-entrenched attitude of desirability to have large families.

A new phase of the MCH/FP programme to cover a period of six years, 1982 - 1987, is soon to be lauched again with

IBRD support. The planning and implementation of this project would therefore offer an opportunity to direct more attention through effective health education and more of available resources to counteracting attitudes, habits and customs and beliefs which have proved to be the major obstacle to an effective FP programme in Kenya. This is, at least, one project within the health sector that will have adequate funds committed to its implementation for the duration of the next plan period, and given its relatively low overheads in terms of capital costs and its flexible nature, there seems to be no reason why the major focus and emphasis of FP could not be shifted to some extent, from the provision of facilities and equipment to the changing of attitude among the target population.

Primary Health Care

Primary health care (PHC) as a recent component of the Rural Health Services (RHS) of the Ministry of Health was introduced in Kenya on a pilot basis about three years ago with UNICEF/WHO assistance. The important feature of PHC is that it combines conventional sickness - oriented treatment facilities with innovative community-based health care. While the conventional part of the service is staffed by government employed health workers, such as clinical assistants, community and nurse, the component, as its name implies, depends mainly on the participation of the local people themselves and community level institutions for its operation. Hence, a village church or mosque or a traditional mutual self-help association may be the point of contract between the service and the people at the local level. The objective is to actively involve members of the local community in the planning and operation of services and facilities ministering

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to their health needs. This is in time with the basic needs concept of involving people in the making and implementation of decisions which affect their well-being and livelihood. Furthermore, the introduction of primary health care represents an important shift in the modality of the RHS from curative to preventive and promotive services.

Operationally, the district will be main decision-making level/health care system rather than the Ministry of Health headquarters as is the case for the RHDP. The Ministry of health will perform only a co-ordinating role with regard to government and non-government activities of primary care when the system becomes effectively operational and, to this end, it is proposed to set up a Primary Health Care Unit in the Ministry. The basic unit of operation for the system is the Health Unit Team (HUT) which, as noted earlie is a mix of both conventional and community-based health workers. There is a basic 3-month training course for most members of the HUTs which apart from emphasising preventive and promotive health care also includes some training in the organisation and management of primary health units. The objective of training is to get rural health workers to= look at the provision of health services from the point of view of health protection rather than curing of sicknesses. Furthermore, the workers trained are made to consider themselves as 'managers" rather than 'tehcnicians'. About 120 primary health workers have so far undergone this training with regard to the staffing needs of the six units that have so far been established in the country.

At present there are 17 other NGOs supported pilot project thrpughoutthe country, and in this regard recognition should be taken of the important (actual and potential) role of these organisations in the provision and delivery of health and other social services at the local level. A significant fact often over-looked is that several of the NGOs active in the field of social services are of indigenous origin and, thereby, much better placed than foreign-based ones or 'outsiders' to understand the felt needs, problems and attitudes of local communities with respect to health and other social services. By implication, they may therefore be more efficient in the delivery of services to the community. Even when local NGOs obtain financial assistance from external donors they maintain a reasonably high degree of control over decision-making and spending powers, and by virtue of their close contact with the people and better understanding of local issues they tend to take into account local views in the planning and operation of their activities. It is now part of Government health policy to expand primary health care facilities and to increase its encouragement and support for NGOs in this area.

The significance of a primary health care system from the point of view of development planning under conditions of budgetary constraints is that it is not only seeing o run while at the same time being more effective it is need rather than demand-oriented, but also its modality of operation aims essentially at preventing sickness in the first instance. The basic reasoning is that if people

through the observance of simple and relatively cheap habits of personal hygince, environment sanitation, proper nutrition based on locall available food, safe water, immunisation, physical culture, family planning and other health preventive and promotive measures, then there will be no need for them to require more expensive curative health treatments.

In terms of appropriate strategies for the health sector, primary health care can be considered as a "productive and highly cost-effective form of investment in the sense that it is designed to produce or maintain health status. In contrast, conventional curative services are generally "consumption" expenditures in that they consume human and material resources in the treatment of diseases to compensate for failure of the system to produce conditions to protect health and prevent sickness. Primary health care can therefore be seen as extremely relevant to planning in the health sector given the existing constraints on public spending. First, the delivery of PCH to the local community, if operated properly, does not need expensive and sophisticated clinical setting like a hospital or even a health centre for that matter; it can be administered at the household or community level. Secondly, it does not require highly and expensively trained personnel. Thirdly, as far as equipment is concerned, it does not call for costly and sophisticated technologies but very simple gadgets that can be used at the local level by most ordinary individuals with the minimum of training and exposure.

Traditional Health Practice

Traditional health practice can be seen as complementary to a primary health care system, both being community-based. Although there is a Traditional Health Unit at the Ministry of Health, lack of information about what goes on at the local level has in the past limited its functional utility and impaired the potential use of traditional medicine to cure diseases in a more organised and efficient manner. On-going collaborative research with both the Departments of Biochemistry and Community Medicine at the University of Nairobi should provide the ministry with relevant information and facts about traditional medicine in order to integrate in a rational way this form of health practice with primary health care and other rural health services. Use of locally available medicinal herbs, simple but effective, pre-natal, child delivery and ante-natal practices by traditional midwives are salient features of traditional medicine which if properly investigated and exploited can have important cost-saving implications with regard to the provision and delivery of health care services in rural areas.

(3) Organisation and Management

In the discussion of the different types of health services operated by the Ministry of Health in the preceding section, shortfalls in specific and overall performance targets have been identified as closely correlated with poor organisation and management of health services, particularly in the rural areas. At a general level it can be noted that managerial talent is relatively scarce at all levels of decision-making in the sector due mainly to the long established practice of relying on technicians (i.e. doctors, nurses, etc.) rather than professional managers and planners to design and implement the modalities of delivery of health care services. The situation should improve with the creation of an Administrative Support Unit (ASU) in the Ministry which is intended to improve and strengthen management capacity of health workers at all levels; already many medical doctors involved in administration and management of health services have received 'crash' training organised by the ASU. Needless to say, with better organisation and management both the availability and quality of health services being delivered to the public will improve.

There is also now within the Ministry a Rural Health Planning and Implementation Unit which could have an impact on management and organisation, and hence on costs and quality of services being offered, if run effectively. The idea behind such a unit is to better co-ordinate the activities of both technicians and administrators in a spirit of 'team work' to support more efficient and cost-effective planning, monitoring and evaluation of services and activities within the sector. However, the present limited coverage of the unit - restricted more or less to headquarters and district level employees of the Ministry - is a drawback on performance in relation to intended functions and objective.

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This deficiency may tie in with the overall need for decentralisation of certain decision-making and planning responsibilities within the sector to lower levels of health administration. Closely linked with decentralisation is the need for greater people's participation in planning and delivery of various health services at the local level; this requirement which has cost-saving implications should not be limited only to the primary health care system but transcend the entire range of Rural Health Services. However, as already observed, the organisation and growth of self-help health projects should be brought under control through greater central co-ordination of such activities, for reasons of both costs and equity.

Similarly, at the centre, the activities of the different government agencies and NGO's involved in the planning and provision of health services should be more adequately co-ordinated than is the case at present. Given the linkages and complementarities between health and other basic needs such as nutrition, water and housing, a strong case can be made out in support of greater co-ordination of policy and operational activities of the Ministry of Health and other relevant operating ministries in order to realise the cost-saving benefits of potential complementarities and linkages that are still untapped in the context of Kenyan planning.For example, improved shelter, nutrition and access to safe water all have important preventive and promotive health values which can lead to a reduction in the demand for, and hence the costs of, providing curative services.

Finally as regards the FP programme which has so far proved to be a high cost-low benefit activity, there is a need to re-organise its approach and mode of delivery. At present, it would appear that too much emphasis is placed on the supply side (i.e. the provision of facilities and equipment)

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and not enough on the demand side (i.e. on the population with a view to change attitudes regarding family size and its relationship with health and well-being).

(4) Pattern of Resource Allocation and Utilisation

As regards the allocations of resources within the section, the most obvious feature is the imbalance between curative and preventive and promotive health services. During the period 1973/74 - 1978/79 accounted on average for about 60 per cent per annum of the total health budget compared to a corresponding figure of 14 per cent for preventive and promotive services; only 6 per cent was allocated to the provision of rural health services and even in this sub-sector there was still a significant curative component in the RHDP facilities and services. Looking at the situation since 1979, when the primary health care was launched, and budget estimates for the next three years, one can find hardly any cause for optimism. Between 1979/80 and 1981/82 the allocation of the total health budget between curative, preventive and promotive and rural health services were 69%, 4% and 16% respectively. While the fall in the share of preventive and promotive services may be explained in part by the budgetary practice of excluding such services in rural areas from the listed sub-item (which means that preventive services provided within the framework of primary health care are now listed under rural health services) the total of allocations to rural health and preventive services is still only one-fifth of public spending on health for the period.

From the point of view of cost-effectiveness such a pattern of distribution leaves much ground for criticism. We have already noted that curative services as a consumption expenditure within the sector are essentially concerned with expensive treatments for sicknesses which could have been avoided or eliminated in the first instance had adequate funds

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been chanelled to preventive services. To illustrate this point of unnecessar consumption of resources in the curative sub-sector, in 1979 for the country as a whole over 22 million out-patient treatments were provided by curative facilities, from an examination of the corresponding causes for treatment it can be seen that nearly 60 per cent of all treatments were on account of only 5 common diseases (malaria, acute respiratory infections, diarrheal diseases, skin diseases and intestinal worms) all of which with the exception of respiratory infections could be effectively controlled by preventive environmental health. Similarly, 44 per cent of all in-patient admissions in 1978 were related to infectious and parasitic diseases which could be avoided by basic preventive and promotive measures.* In a period of financial stringency, there is a need to re-examine the critical imbalances between expenditures on curative services and those going to preventive and promotive services. For example, in simple terms of 'value for money', as defined according to coverage and impact on the health status of the population, one may ponder and wish to consider whether a 20 per cent share of total health budget going to the running of the Kenyatta National Hospital in Nairobi is a cost-effective pattern of investment.

Given that the 1970's could be regarded as a period of consolidation in the health sector when substantial part of public expenditure on health was spent on the development of facilities (i.e. construction and equiping of hospitals) and with this period now coming to an end, resources overall in the sector is now being shifted from development to recurrent expenditures. However, if such a shift does not reflect as well as awareness of the effects of preventive services on health status, the transfer of resources from capital to recurrent spending would have little impact on performance.

*Ministry of Health, Annual Reports, 1978 and 1979

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What is likely to result from directing the bulk of recurrent expenditures to maintaining costly urban-based hospitals could best be described as a vicious cycle in the health sector, wherein the neglect of preventive services would cause an increasing demand for curative services and increasingly higher demand (which in Kenya does not involve any 'ability to pay' consideration for public sector services) for such services would lead to the further expansion of facilities in the sub-sector.

Looking at the forward budget for the period 1981/1982 - 1984/1985, it appears that there is now some awareness of this danger - enough to start a move in the right direction. For the period being considered, the share of curative health in total health budget is expected to average about 57% per annum which though still high is a significant drop on the nearly 70% for 1979/80 - 1981/82. Looking only at the development estimates, as the period of consolidation of physical infrustructure is now coming to an end in the urban areas, the share of curative health is estimated to fall sharply from 62.4% in 1982/83 to 50% in 1983/84 and then to 37% in 1984/85. The bulk of the savings thus derived from the slowdown of capital projects in urban centres are to be directed at the rural health services where share is expected to rise from 18% in 1982/83 to over 30% in 1984/85.

Nevertheless, this should give cause for some concern, as it may signify in part an intention to spend money on a curative oriented rural health services system, with the danger of replicating what has happened in the urban areas but only on a smaller scale. If this happens within the framework of the RHDP not only will it significantly reduce the cost-effectiveness of public spending on rural health services at a time when resources are scarce, but it will also encourage the kind of demand planning which Government may have to respond for political reasons, thereby distorting

the basis of rational and need-oriented planning in the sector. A proposed US$117 million external-financed Integrated Rural Health Programme (IRHP) which is expected to start later this year should, however, provide the right type of institutional framework within the sector for building up a preventive and promotive services based system of rural health care.

From the point of view of equity, imbalances in the distribution of recurrent expenditures between urban (mainly more expensive to maintain curative facilities) and rural areas in all types of health services should be noted. Within the rural areas it has been noted that Harambee activities can have the effect of distorting planned development in an inequitable way; for example, in the health sector-this might divert resources from the needs of remote and poorly served areas to locations fairly well covered and close to urban facilities.

Within the framework of the RHDP, the 'headquarters' of RHU's range between a hospital and the top to a dispensary at the bottom. At present 23% of all RHU's have a hospital as headquarter, 57% have a rural health centre and 20% a dispensary. If this classification has any corresponding practical significance in terms of resource allocation, it should take the form of a bias in favour of RHU's based on dispensaries to make up for the disparities in the quality of facilities accessible to RHU's. There is no evidence of such an equalising pattern of funding to the RHU's within the health sector.

(5) Specific Policy Issues

The main issues of policy with regard to planning for basic needs satisfaction in the health sector under conditions of budgetary constraints

concern the impact of the investment-type on the health status of the population. In this much has been said already about the need for a shift of emphasis and resources from curative to preventive and promotive facilities and services. A number of specific measures may be relevant in this context:

i) To intensify community-based health education aimed at changing attitudes of people, e.g. to counteract established preference for curative medicine or even the desire to have large families.

ii) NGO's should be used more extensively to deliver preventive and promotive services, especially in the area of FP where the virtual absence of non-government agencies is most conspicuous, only 1% of the 374 NGO-supported rural health facilities offer FP services.

iii) Training should be geared more towards the needs of community-based preventive and promotive services.

iv) Active involvement of local people in the planning for their own health needs and the operation of services along the line advocated by the PHC system, concommitantly with greater interaction between modern and traditional medicine.

v) Need to control the expansion of Harambee projects to the extent that they are generally curative-oriented and lead to increase in demand for curative services, except in case of the most disadvantaged areas.

In terms of reducing the costs of running the health services it may be useful to explore the possibility of:

i) Introducing some charges for drugs on a carefully selective basis according to type of treatment.

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ii) Taxing elitist-oriented private sector health services, which cater mainly for the health needs of better-off groups in urban areas, to help meet the cost of health in the public sector.

iii) Using more professional managers rather than doctors to administer and organise the health services, leaving the technicians to concentrate mainly on actual provision of services.

A N N E X IV

TREASURY CIRCULAR NO. 5

PROGRAMME REVIEW AND FORWARD BUDGET 1981/82 - 1984/85

The Treasury,
P.O Box 30007,
NAIROBI.

10th July, 1981.

ES.1/04

TREASURY CIRCULAR NO. 5

TO: ALL ACCOUNTING OFFICERS

PROGRAMME REVIEW AND FORWARD BUDGET

1981/82 - 1984/85

A. INTRODUCTION

1. As stated in Treasury Circular No. 3 of 5th September, 1980, the Treasury, in co-operation with the Ministry of Economic Planning and Development, is determined to continue with the improvement of the annual exercise of Programme Review and Forward Budget. This is because the exercise is regarded as an important tool for the formulation of future budgetary requirements especially those relating to the next financial year. Last year, the preparation of the three-year Forward Budget which covered the period 1981/82 to 1983/84 using 1980/81 figures as a base, was started very late and in the end the exercise was done in a great hurry, sometimes without adequate submission of briefs by Ministries. In order to avoid repetition of this situation, the Treasury urges all Accounting Officers to ensure that this exercise is given more serious attention and that required briefs are prepared and submitted to Treasury in accordance with the time frame indicated in Appendix III of this circular.

2. The preparation of the Forward Budget should provide a perspective on future expenditures and a framework for scheduling public sector development. It is, therefore, an essential step in the process of translating the Development Plan, in the light of the current and projected economic prospects and policies, into budgetary practice. In addition, the performance of the exercise is expected to contribute to the following objectives:-

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(a) the review of on-going programmes and the implementation of priorities identified in the Development Plan,

(b) the provision of a revised base for decid on financial ceilings for 1982/83 Estimat and tentative ceilings for financial year 1983/84 and 1984/85,

(c) the extension of the Forward Budget to in 1984/85 in order to ensure that the budge perspective encompasses three full fiscal

(d) to plan for the most productive use of th foreign aid availability by increasing th Ministries absorptive capacity.

(e) the integration of planning and budgetary procedures,

(f) the introduction of modern management technique into Government activities, and

(g) the enhancing of the effectiveness of financial control.

PURPOSE OF CIRCULAR

3. The purpose of this circular is to set out:-

(a) the general guidelines to be borne in mind during the Programme Review and Forward Budget exercise, and

(b) the necessary instructions on the method of preparation and submission of forward budgets.

GENERAL GUIDELINES

4. (a) Effectiveness of Public Expenditure

While the scale of development set forth in the Development Plan is not now attainable, the pattern of development established in that document remains valid. In particular, directing development efforts for selected target groups in order to alleviate poverty throughout the nation is a

continuing objective. Serious balance of payment problems, the recession in world trade, further deterioration in Kenya's terms of trade, and a lower rate of economic growth, make it necessary to re-assess the growth in public expenditure. In these circumstances, every effort must be made to improve the effectiveness of public expenditures so that every shilling contributes constructively to national development. For your guidance, provisional ceilings for development and recurrent expenditure for the period 1982/83 to 1984/85 will be sent to you as soon as they have been worked out and will be presented as Table I and II of this circular. You should in the meantin initiate action on the basis of guidelines and instructions contained in this circular and the approved figures in 1981/82 Printed Estimates without waiting until the Tables I and II are supplied to you. It is also proposed to provide Table III which will list the donor aided projects and the known amount of foreign aid available for each project covering the period under review.

(b) Compatibility between the Recurrent and Development Budgets

The compatibility between the Recurrent and Development Budgets will be achieved by ensuring that:-

(i) the development Budgets reflect only realistic expectations of implementations; and

(ii) the Recurrent Budgets seek allocations relative to (i) only.

In this manner excess budgeting which results in underspending, will be avoided.

(c) Capacity utilisation

Resources in terms of staff, equipment, transport

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and accommodation should be related to the needs of the budgetary plan and any excess capacity should be identified and surrendered to other productive use.

(d) Foreign exchange conservation

Foreign exchange content of the budgetary needs should be reduced to the minimum by :-

(i) substituting local materials for imported materials wherever possible;

(ii) extending the life and usefulness of a. .mported capital equipment by improved maintenance;

(iii) prompt drawing of foreign aid element of any project, to obviate any need for drawing down of our foreign exchange reserve.

(e) Performance and output criteria

For efficient completion of projects, performanc criteria should be developed and the progress of projects assessed accordingly. If this results in any amendment to the time scheduling of the project, the consequential budgetary allocations should also be amended accordingly.

(f) Budgeting for Parastatals

The investment plans of the Parastatals over the Forward Budget period should be examined to ensure their technical and administrative feasibility and compatibility with the expenditure ceilings of the parent Ministry as well as any applicable profitability targets. Selection criteria of these investment plans are to be developed and endorsed by Treasury.

(g) Poverty Alleviation and Basic Needs fulfilment

In line with the Development Plan, higher priority should be given to projects/activities which have beneficial effects on the health, education, housing and social development of the five target groups

viz pastoralists, small farmers, landless rural workers, urban poor and the handicapped.

(h) Role of the Private Sector

In reviewing public sector development budgets the investment programmes of parastatals and Government participation in joint ventures, private sector activities in related areas should be considered. If the objectives of public sector proposals can be equally well achieved through the private sector, cooperatives or voluntary associations, preference should be given to the various means by which private capital can be mobilised in those endeavours.

B. PREPARATION OF PROGRAMME REVIEW AND FORWARD BUDGET 1981/82 - 1984/85

5. Ministries are required to prepare the material identified in succeeding paragraphs as contribution to the programme review and forward budget. For your guidance, provisional ceilings for development and recurrent expenditure for the period 1982/83 to 1984/85 which will be sent to you later should be regarded as a guide and not necessarily for blind compliance. It is however, a very important guide and deviations are to be treated in the following manner:-

a) if the total budget is likely to increase by more than 5% of the "ceiling", then, this must be discussed and cleared in principle with the Supply Officer, before incorporation into the budget. However, authority for inclusion of any project beyond the ceiling is not to be regarded as an assurance of its final acceptance.

b) when the total submitted budget exceeds the ceiling, projects are to be identified with the priority marking so that in the event that the ceiling cannot be exceeded any scaling down of the budget can be effected easily.

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6. In preparing detailed forward budgets as instructed below, future annual expenditure at 1981/82 constant prices (i.e prices as at 1st July 1981) of the projects and activities which are known as at 1st July 1981 should be shown. Specifically, this will mean the following:-

(i) 1982/83 and 1983/84

These budgets are already in existence; all that is required is to revalue the expenditure at 1981/82 prices and also to amend existing projects as well as to add new ones. The new projects are to be shown as a separate group on the form and headed accordingly.

(ii) 1984/85

This will be the new year to be added; as such the projects groupings should clearly show those brought forward from the previous year and those that are intende to commence in 1984/85. The price basis will be as on 1/7/81, and any deviation from the ceiling should be treated as explained in paragraph 5 above.

7. Estimates of costs for projects and programmes in the Development Forward Budget should be as realist... as possible, justified and expounded in:-

a) A programme brief covering both the recurrent and development votes separately.

b) Draft Forward Recurrent Budget specified by sub-vote and head.

c) A specification of gross expenditure and Appropriations in Aid by group of items for all heads with gross expenditure above K£500,000 or with a proposed change in expenditure for 1982/83 of more than 5%;

this should be supported by detailed programme review.

(d) Draft Forward Development Budget specified by sub-vote and head.

(e) A revised list of development projects for the plan period specified by head, sub-head and item.

Programme Brie

The R... l Budget should give an estimate of

TITLE: "PROJECT FINANCIAL REPORT" FORM "A"

	NAME	AMOUNT (K£)	DATE STARTED
DONORS:	(i)		EXPECTED
	(ii)		COMPLETION
	(iii)		DATE

PROJECT NO: _

TOTAL COST: _

GOK COST: _

1	2	3	4		5		6		7		8		9		10
	ESTIMATES		DRAWINGS BY MINISTRY		TOTAL EXPENDITURE		EXP. QUALIFYING FOR DONOR FINANCE		CLAIMS FROM MINISTRY		CLAIMS TO DONORS		DONOR REIMBURSEMENT		REMARKS
ANNUAL YEAR	GOK (K£)	DONORS (K£)	DATE	AMOUNT (K£)	DATE	AMOUNT (K£)	EACH DONOR	AMOUNT (K£)	DATE	AMOUNT (K£)	DATE	AMOUNT (K£)	DATE	AMOUNT (K£)	

A N N E X VI

TREASURY CIRCULAR NO. 2

DRAFT RECURRENT AND DEVELOPMENT ESTIMATES OF EXPENDITURE, 1982/83

ES.1/03

TREASURY CIRCULAR NO. 2

TO: ALL ACCOUNTING OFFICERS

THE TREASURY,
P.O. BOX 30007,
NAIROBI.

25th February, 1982

DRAFT RECURRENT AND DEVELOPMENT ESTIMATES OF EXPENDITURE, 1982/83

Accounting Officers are required to submit to the Treasury five copies of their Draft Recurrent and Development Estimates o Expenditure for 1982/83 not later than 25th March, 1982

EXPENDITURE CEILINGS

2. Ceilings for 1982/83 Estimates are given in Annex 1 to this Circular. As you will notice, the figures given in Annex 1 have been adjusted from the ceilings which were sent out to you with the Treasury Circular Letter reference ES.1/04 of 20th August, 198 calling for submission of Programme Review and Forward Budget for 1981/82 - 1984/85 financial year. Ceilings for individual Votes have been arrived at after detailed discussions on each Vote by the Estimates Working Groups and the Budgetary Procedures Group in the context of the general guidelines outlined on pages 2 to 6 of the Treasury Circular No. 5 of 10th July, 1981. The overall level of the ceilings was arrived at after taking into account the anticipated total revenue likely to be available in 1982/83 and the likely trend of the economy during the next financial year.

3. Given the continuing slow growth of Government revenue and the rapid rise in public debt service requirements which must have a first claim on those revenues, it is obvious that no real expansion of Government recurrent and development expenditure can be financed in 1982/83. Accounting Officers are, therefore, expect to appreciate this situation and to frame their estimates within the ceilings attached to this Circular. Where gross expenditure ceilings were agreed upon in anticipation of receipt of projected Appropriations-in-Aid, if any amount of Appropriations-in-Aid is not collected, both gross and net expenditure estimates for the affected vote must be reduced as applicable. In making your final expenditure estimate proposals, you should ensure that the cost

estimates, priority and viability of programmes agreed upon at the forward budget estimates stage are still valid and if not, they should be reviewed and if necessary, re-phased or deleted in order to confine the estimates within the ceilings.

4. In view of the continuing shortage of foreign exchange, restriction introduced in 1981/82 on purchase of replacement and additional transport and on items of major equipment will be extended through fiscal year 1982/83 unless financed by aid money and explicitly approved by the Treasury. Emphasis must be placed on servicing and repairs of the existing stock of vehicles and items of major equipment as adequate maintenance funds exist to keep them in operation. In addition, the restriction on overseas travel by public officers to trips of a very essential nature as establishe in the Office of the President's Circular Letter No. OP.1A/(104) dated 15th October, 1981 will be extended through the financial year 1982/83.

FORMAT OF THE DRAFT ESTIMATES

5. No basic changes are proposed in the Code Structure of Votes. Subvotes and Heads compared with 1981/82 Estimates and the form of the printed 1981/82 estimates should be followed in the submission of estimates to the Treasury

6. Care should be taken to ensure that the totals of both subheads and items detailed in part III cross check with the relevant head and item totals in part II. Similarly the subvote totals in part II should agree with the totals in part I.

7. Provision sought under the Personal Emoluments item must be supported by valid and accurately detailed schedules specifying numbers, designation and grade of any post or group of posts including estimates of personal emoluments.

8. The Motor Vehicle Establishment schedule for each Vot must be submitted in respect of every expenditure Head with details showing the distinctive number designating the Head, name of the Department or Section whose expenditure is accounted for under the Head and figures relating to each category of vehicles such as staff cars, passenger carriers, load carriers,

miscellaneous specialised vehicles, motor cycles, aircraft, boats and the total numbers.

9. Some Ministries may from time to time wish to make changes in the content of some of their subvotes and heads. For instance there may be need for creating a new head or amalgamating two heads. Such changes will have to be approved by the Treasury prior to the submission of the Draft Estimates. Minor changes will first be discussed by the relevant Estimates Working Groups and later by the Budgetary Procedures Group.

10. The subheads to be applied both in the Recurrent and Development Estimates are given in the Revised Government Accounting System Manual Section 3.3.3. If a Ministry wants to change the subheads in a certain head, the same procedure will have to be followed as for changes in subvotes or heads (see para 8 above).

11. The item specification in part II of both Recurrent and Development Estimates will be as in the 1981/82 Estimates, with specifications by item for each head as the general rule. A list of items is given as Annex II to this Circular. For the full specification, see section 3.3.4. of the Revised Government Accounting System Manual. Certain items will have a programme identity of their own and such items will have to be specified separately.

EXPLANATORY NOTES

12. Explanatory notes (Briefs) should be attached to the Draft Estimates submitted to the Treasury. The briefs should contain the following information:-

(a) Objective and Programme - A summary statement of the objectives should be given for each subvote. This should be followed by a short description of the work programme to be financed by the estimates provisions of each head. The programme should as far as possible be illustrated with the use of quantitative figures indicating size of the programme, e.g. the number of veterinary clinical centres, health centres or water schemes in operation, or the number of pupils enrolled at schools.

Changes in production capacity should be briefly explained either by how they relate to new units or to extension to established units.

b) Any changes in expenditure should be explained item by item. The explanation should clarify whether the change or quantity desired is caused by change in output in terms of quality or service or change in prices.

c) If specific Treasury authority has been given for changes in the Draft Estimates compared to those for 1981/82, both the reference number and date of the Treasury letter should be quoted in the relevant explanatory notes.

CAPACITY UTILIZATION

13. Resources in terms of staff, equipment, transport and accommodation should be related to the planned operational need of a Ministry. Under-utilization of capacity may arise through an imbalance in the financial allocations to the various compon of the budget. If any excess capacity cannot be efficiently utilised, it should be identified and surrendered to other prod use. The first priority in the 1982/83 budget must be given to utilization of existing capacity and the second priority to completing on-going projects before initiating new projects. Ministries, therefore, have the flexibility to propose shifts of local funds (excluding foreign aid grants and loans) from Recurrent to Development or vice versa. Such proposals shoul however, exceed five percent of the Ministry's Development or Recurrent Estimates ceiling.

FUNDING FOR ON GOING PROJECTS

14. Estimates of the costs of each ongoing project must be realistic. Every effort must be made to avoid cost overruns. If realistic cost estimates for all projects total to an amount in excess of the development ceiling for the Ministry, projects must be identified on which expenditure can be delayed until the following financial year. Projects delayed should be those:-

(a) that can be postponed with nil or least damage to the project

(b) that have the lowest stopping and recommecement cost

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(c) that have nil or the smallest proportion of foreign aid committed to them

(d) that are partially financed by highest cost sources o foreign aid

(e) that have the highest proportion of locally financed foreign exchange cost

(f) that have the highest proportion of local contribution since domestic funds are limited.

These criteria must be considered together in making recommendations on which projects, if any, should be delayed. However, if a Ministry proposes to cancel or postpone a development project, only the local cost of the project may be considered for transfer to another programme.

NEW PROJECTS

15. New development projects will not be considered for inclusion in the budget unless:-

(a) the projects have been approved by the Estimates Working Groups and

(b) all on going projects, properly costed, do not exhaust the development ceiling for the Vote or

(c) an explicit and convincing case is made for delaying on going projects.

In the latter case, the greater availability of grants and/or concessionary aid for the new projects as compared with the delayed projects will be an important factor in the consideration. Provision for new building projects will be included in the 1982/83 Draft estimates only if the Ministry of Works will confirm that construction of the projects will be started during the first half of 1982/83 financial year.

ESTABLISHMENT

16. No provision will be included in the printed estimates for 1982/83 in respect of Temporary Clerical Assistance and Works Paid Staff as these will have been re-deployed elsewhere after completion of the temporary programmes for which they had been engaged. Urgent staff needs should be met by the re-assignment of personnel from less essential duties to crucial and essential services, projects

(c) that have nil or the smallest proportion of foreign aid committed to them

(d) t

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PROCEDURE FOR REIMBURSEMENT OF EXTERNAL AID REVENUE

(a) Implementing Ministries will maintain proper record of expenditure on each project both at the spending points and at the Ministry Headquarters.

(b) AIE holders for each project must in future forward weekly, copies of all paid vouchers to their Minist Headquarters for onward transmission to External Ai Department (Treasury) together with claims.

(c) Accounts Disbursement Units within Ministry Headquarters must in future submit claims to the External Aid Department at least once a month or in case of payments in excess of KShs.10,000/= th disbursement claim must be submitted immediately.

(d) External Aid Department will in future process the claims to the donors immediately on receipt of such claims from the Ministries. No claim will be kept pending for more than one week unless it is necessa to refer claims back to the Ministries. Donors wil be requested to acknowledge the receipt of claims a indicate when reimbursement can be expected.

(e) Application to the donors by External Aid Department must be copied to the Accounts Controller (Treasury).

(f) Accounts Controller (Treasury) will follow up External Aid Department any claims which rema outstanding with any donor for over 45 days.

(g) Accounts Controller (Treasury) will inform External Aid Department weekly, of any reimbursement received through the Central Bank of Kenya.

(h) All claims will be made strictly in accordance with the terms and conditions of the Aid Agreement.

Accounting Officers are requested to ensure that the procedures set out in this Appendix are understood and adhered to strictly by officers handling both the disbursement and reimbursement of Development Revenue. These procedures come into force with effect from 1st October 1987.

7. Accounting Officers are requested to appoint a specific officer to be responsible for the submission of reimbursement claims to the Treasury. They should also take such other measures as would improve the system of monitoring the utilization of external aid funds

8. The success of the measures outlined above and the procedures set out in Appendix 'A' will depend on the co-operation of implementing Ministries. All Accounting Officers are therefore requested to take such steps as will ensure the success of this exercise. The Treasury and the Ministry of Economic Planning and Development will be available to assist implementing Ministries in introducing and implementing the proposed measure

9. Another major concern facing the Government is the slow pace of implementation of development projects in recent years, which has caused persistent under spending on the Development Budget. A circular on this subject is under preparation and will be issued shortly for your guidan

(H. M. Mule)
ERMANENT SECRETARY TO THE TREASURY

BUDGETED EXTERNAL AID AS PER PRINTED ESTIMATES 1981/8

VOTE		LOAN K£	GRANT K£	TOTAL K£
D 1	Office of the President	34,660	280,010	314,670
D 3	Directorate of Personnel Manag	100,000	151,310	251,310
D 5	Ministry of Constitutional and Home Affairs			
D 6	Ministry of Economic Planning and Development		1,465,166	1,465,176
D 7	Office of the Vice-President & Ministry of Finance	600,000	455,000	1,055,000
D 9	Ministry of Livestock Development	2,363,169	470,682	2,833,851
D 10	Ministry of Agriculture	11,119,207	3,828,220	14,947,427
D 11	Ministry of Health	372,270	2,567,510	2,939,780
D 12	Ministry of Local Government	5,495,020	852,010	6,347,030
D 14	Ministry of Transport and Communications	20,142,070	7,387,191	27,529,261
D 15	Ministry of Labour		622,000	622,000
D 17	Ministry of Urban Development and Housing	2,898,000	-	2,898,000
D 18	Ministry of Culture and Social Services	215,040	503,300	718,340
D 19	Ministry of Information and Broadcasting	2,066,300	-	2,066,300
D 20	Ministry of Water Development	2,302,066	4,612,300	6,914,366
D 21	Ministry of Environment and Natural Resources	1,664,906	512,543	2,177,449
D 22	Ministry of Co-operative Development	2,060,250	1,050,832	3,111,082
D 23	Ministry of Commerce		50,000	50,000
D 24	Ministry of Higher Education	1,556,010	2,385,324	3,941,334

SCHEDULE

VOTE		LOAN	GRANT	TOTAL
		K£	K£	K£
D 30	Ministry of Energy	1,277,131	648,060	1,925,[illegible]
D 31	Ministry of Basic Ed	1,891,520	68,897	1,960,417
D 32	Ministry of Industry	2,299,503	663,000	2,962,503
D 33	Cabinet Affairs	5,584,948	,760,135	9,345,083
		64,042,080	3[illegible] 333.500	3,375,580

PROCEDURES FOR MONITORING PROJE
IMPLEMENTATION

1. In order to streamline the procedures and also ensure that proper records are maintained by implementing Ministries as well as the Treasury, the following arrangements will be followed for all Development Projects including those with external aid components with effect from 1st October, 1981.

EXTERNAL AID AGREEMENTS

The external Aid Department of the Treasury will ensure that a copy of any signed External Aid Agreement is sent to the following:-

(a) Within the Treasury

(i) Budgetary Supply Departme
(Estimates Section)

(ii) External Aid Department
(Disbursement Unit)

(iii) Fiscal and Monetary Affairs Department
(Debt Management Unit)

(iv) Accounts Controller

(b) Implementing Ministries

(c) Attorney General's Chambers

(d) Central Bank of Kenya

(e) Ministry of Economic Planning and Development

3. FOLLOW UP ACT

(a External Aid Department will liaise with the Budgetary Supply Department at the Estimates Working Group stage to ensure that new development projects likely to attract external aid funding are included in the Programme Review and Forward Budget and Annual pment Estimates.

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(a) External Aid Department will liaise with the Budgeta Supply Department at the Estimates Working Group sta to ensure that new development projects likely to attract external aid funding are included in the Programme Review and Forward Budget and Annual Development Estimates.

(b) Ministries will complete in quadruplicate Form 'A' (sample attache for all on-going projects dating back 3 years. Commulative information on each project commenced before July 1977 must be placed on the Form on the first line and commulative information for each succeeding year should then be recorded on the form; and with effect from 1st October 1981 the information will be recorded on monthly basis

Copies of completed form 'A' should be submitted to External Aid Department and Ministry of Economic Planning and Developme (PAMU) who will open and maintain registers of all development project

PROCEDURE FOR DRAWING FUNDS FROM THE EXCHEQUER

(a) Application for Requisition of Funds form 'B' will be completed in quadruplicate by the implementing Ministry from Column (1) to (15) and 3 copies submitted to the Treasury (Accounts Controlle

(b) On receipt of the application forms the Accounts Controller will forward 2 copies to the External Aid Department for completion of Column (16) to (17) and signing of the relevant certificate before passing both copies of the application to the Budgetary Supply Department for approval or otherwise.

(c) On approval the Budgetary Supply Department will return both copies of the application to the Accounts Controller for final processing. Release of funds for any donor-aided project will depend on the Ministry providing up to date information to the Treasury on re-imbursement claims against that Project

(d) The Accounts Controller will retain one copy of the application and return the other copy together with Treasury orders for release of funds to the External Aid Department for completion of Form 'A'

(e) External Aid Department will provide data on Form 'A' on monthly basis to Ministry of Economic Planning and Development who will use it for up-dating its registe

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the expenditure required to implement the programmes within votes and sub-votes. The estimates must be based on a costing of the work programmes for the period, but trends of past expenditure may be given as additional justification. It is most important that the Forward Budget should be based on a work programme which should indicate what is planned to be achieved within the framework given by the Forward Budget. The Programme Brief will include a brief description of the work programme for the period. The Development Plan wil give the base for identifying the work programme, but it is most important that this exercise does not consist of simply copying the programme in the Development Plan. A major part of the exercise will be to review the programme in the Plan both in relation to new informatior on costs and benefits and in relation to the revised economic guidelines.

9. <u>The Draf[illegible] Recurrent Budget</u> will be submitted

'orm A comprising the following three tables:-

a) gross expenditure-by head, with sub-totals by sub-vote.

b) gross Appropriation in Aid by head with sub-totals by sub-vote.

c) Net expenditure by sub-vote. The Forward Budget will include forecasts for all expenditur- covered by the vote.

10. A more detailed explanation is required for heads which have gross expenditure above K£500,000 in any of the financial years covered or for which a growth rate in gross expenditure of 5% or more is proposed for 1982/83. The explanation will be given by completing form B. Form B contains two parts, the first being a specification of estimates by group of items and the second being remarks and programme review. Under "Remarks" special explanations may be given but the primary purpose is to get information regarding what output is planned to be produced for the funds proposed and the quantity of the output. A syster [illegible] recording

outputs from heads and sub-heads will enable the Ministry to have more efficient control of their organizational uni and the summary of plan figures will help the Treasury and Planning in evaluation of one programme against another. The establishment of plan figures for outputs will be time consuming and Ministries will only be able to establish a few at a time. The annual programme review will be the occasion to submit such plan figures to the Treasury. The Programme Review should also include the following elements:-

a) the objectives set for the activities of the head, and a statement of the need to which the activities are addressed.

b) evaluation of realized and planned outputs in relation to the stated objectives,

c) evaluation of actual and planned costs in relation to the outputs.

Additional sheets may be added to the form if is insufficient

11. The Draft Forward Development Budget will be submitted on form A, in the same manner as the Draft Forwar Recurrent Budget, by:-

a) gross expenditure by sub-vote and head

b) appropriations in Aid by sub-vote and head

c) net expenditure by sub-vote.

12. To be able to identify the development projects and programmes which ought to be given priority for detailed planning and design, it is necessary to have a specification of all investment projects and programmes for the plan period by head, sub-head and item. This will be given on form C which also includes columns for external finances, the details of which must be given in full. In this connection, it should be noted that most major projects will already hav been identified in the Development Plan and building and construction projects due to start in 1982/83 will have been specified in accordance with the current requirement for Accounting Officers to submit their building and construction

requirement to the Ministry of Works, at least twelve months before the beginning of the financial year in which work is to commence on site. (Refer to Treasury Circular No. 5 of 7th May, 1974 on Government Buildings Programme). The Ministry of Works will participate in all discussions relating to buildings and construction programmes for the period 1981/82 - 1984/85.

13. No project should be included with a foreign aid expectation which is not within the availability figure which will be sent to you later as table III to this circular. Any queries regarding commitments and accura of the availability figures, should be taken up with the External Aid desk officer - (through the supply officer concerned) so as to bring the Ministry and the Treasury records in line. Every endeavour should be made to use all available grants and concessionary loans and where this cannot be done, an explanation and the reasons must be given. Desirable projects, which can be undertaken only if external finance was available can be indicated as a separate group headed accordingly, so that the External Aid Department should endeavour in consultation with the donors to either divert any unused, unusable funds from other projects or to secure new finance. The objective of this is to achieve optimum balance between the external aid availability and the Ministry's absorptive capacity.

14. <u>Detailed Planning of Development Projects</u>

Besides getting a revised base for deciding on priorities and ceilings for the 1982/83 estimates, th objectives of revising the Forward Budget is to identi the development projects and new programmes which ough to be given priority for detailed planning and design. It is therefore important that the special procedure for project planning and design is followed for all new projects included on form C of the Forward Development Budget. The instructions given below apply to the followin development projects and programmes proposals:

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a) activities for which no financial provisions are included at present in the main Annual Estimates; they are new in the sense that a financial provision for their implementation is an addition to the requirement of the operating Ministry, as currently approved by the Treasury; and

b) the ongoing project and programme activities which require an expansion or variation of contract in the project cost previously agreed with the Treasury and a project or programme which it is proposed to extend the term of years previously agreed by the Treasury.

15. Any new development project or new programme proposal involving a total expenditure of £100,000 on the Development Estimates or an annual expenditure on the Recurrent Estimates of more than £100,000 should be accompanied by a supporting brief. The supporting brief should at the minimum contain the following:

a) Statement of the need or problem or opportunity to which the project or programme is addressed.

b) Brief description of related projects or programmes.

c) Statement of the capacity of the project and the planned changes in outputs or benefits of the programmes produced by the project

16. <u>Estimates Working Groups</u>

The Draft Forward Budgets will be reviewed and processed by Estimates Working Groups, which will include officers from the Treasury, the Ministry of Economic Planning and Development and the operating Ministries. The Estimates Working Groups, whose composition will be notified later and form Appendix I of this circular will have particular responsibilities for the following:-

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a) to revise the Estimates for 1981/82 to reflect expenditure adjustments required for ongoing projects and programmes.

b) to prepare preliminary 1982/83 Estimates within the ceilings which will be shown in Tables I and II. These should reflect the following :-

(i) requirement for ongoing projects and programmes;

(ii) requirement for new projects and programmes;

(iii) careful articulation of Recurrent and Development Expenditure.

c) to consider and approve proposals for new projects and programmes and major modifications of existing ones to be initiated in the 1982/83, 1983/84 and 1984/85 budget years; and

(i) to approve projects for discussion by the External Aid Department with external aid agencies. (The External Aid Department will not process proposals that do not have the prior approval of the relevant Estimates Working Groups).

(ii) to approve project proposals for preliminary planning by the Ministry of Works. (The Ministry of Works will not process proposals that do not have the prior approval of the relevant Estimates Working Groups).

17. <u>Sectoral Planning Groups</u>

The Sectoral Planning Groups, whose composition will be notified later and form Appendix II of this circular, will have particular responsibilities for the following:-

a) to ensure that the budgets for the three forward years are consistent with each other and reflect the pattern of development established in the Development Plan.

b) to ensure over the three forward budget years that the articulation of Recurrent and Development expenditure is improved as rapidly as possible.

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c) to identify new projects and programmes and modifications of existing ones which should be considered for inclusion in the next Development Plan.

d) to monitor progress in implementing ongoing projects and programmes particularly in terms of economic and social criteria, such as output performance, efficiency and basic needs

18. This division of responsibilities is intended to distribute the burden of work in rational manner, not to divide the exercise into two independent parts. The common membership of Estimates Working Groups and Sectoral Planning Groups should ensure that forward budgeting is an integrated and common endeavour.

19. Time Schedule for Submission of Draft Proposals

a) To enable fullest consideration being given to the draft proposals, it is necessary for the Ministries to submit their proposals as soon as possible but NOT LATER THAN 15th SEPTEMBER, 1981. It is imperative that this date is strictly adhered to, to avoid hurried consideration of the proposals which might affect the Ministries interest adversely. No deviation from this date will be allowed unless prior written authority quoting a revised date will have been obtained from the Treasury.

b) It is strongly suggested that the relevant Supply Officer be kept informed and his views sought for all queries, clarifications etc, in order to minimize any wasteful efforts either in the Ministries during the preparation of the budgets or subsequently in their consideration in the Treasury. Any clarifications with regard to this Circular should also be sought from the Supply Officer concerned.

(M. M. MULE)
PERMANENT SECRETARY TO THE TREASURY

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Form A.

DRAFT FORWARD BUDGET

1981/82 - 1984/85

Vote

K£'000'

Sub-Vote	Head	Title	1981/82	1982/83	1983/84	1984/85

DETAILS OF DRAFT FORWARD RECURRENT BUDGET

Vote

Sub-vote

Head

	Group of Item	1981/82	1982/83	1983/84	1984/85
Personnel Costs	000-099				
Other Recurrent Costs	100-199				
Equipment	200-249				
Maintenance	250-299				
Transfers, Interests	300-399				
GROSS EXPENDITURE					
Appropriations-in-Aid					
NET EXPENDITURE					

REMARKS AND PROGRAMME REVIEW.

Form C

DETAILS OF DRAFT FORWARD DEVELOPMENT BUDGET

1981/82 - 1984/85

K£'000'

Sub-Head	Item	TITLE	Estimates 1981/82	Forecasts 1982/83	Forecasts 1983/84	Forecasts 1984/85	EXTERNAL FINANCES Estimates 1981/82	Forecasts 1982/83	Forecasts 1983/84	Forecasts 1984/85	Source of External Finance

APPENDIX III

CRUCIAL DATES IN ESTIMATES PROCEDURES

Target Dates		A. - PROGRAMME REVIEW AND FORWARD BUDGET
10th July, 1981	1.	Dispatch of Treasury Circular to Ministries.
15th September, 1981	2.	Submission of 5 copies of Draft Proposals to Treasury and 5 copies to Economic Planning.
16th September, - 15th November, 1981	3.	Examination of proposals by Estimates Working Groups and Submission to Chairman, Budgetary Procedures Group
30th November, 1981	4.	Finalisation of financial ceilings for 1982/83 estimates by Budgetary Procedures Group.
10th December, 1981	5.	Submission of Cabinet Paper on Estimates Ceilings by Treasury.
		B. - DRAFT ESTIMATES
		(1) Expenditure Estimates
15th December, 1981	1.	Dispatch of Treasury Circular to Ministries.
15th February, 1982	2.	Submission of Draft Estimates to Treasury.
16th February, 1982 - 31st March, 1982	3.	Submission of proposals by Estimates Working Groups to the Director, Budgetary Supply Department.
		(2) Revenue Estimates
15th December, 1981	1.	Dispatch of Treasury Circular to Ministries.
15th February, 1982	2.	Submission of Revenue Estimates to the Treasury.
16th February, 1982 - 31st March, 1982	3.	Examination and submission of revenue proposals by Estimates Working Group to the Director, Budgetary Supply Department.
		C. REVISED ESTIMATES
1st September, 1981	1.	Dispatch of Treasury Circular to Ministries.
30th October, 1981	2.	Submission of proposals to Treasury.
1st November, 1981 - 15th January, 1982	3.	Submission of proposals by Estimates Working Groups to the Director, Budgetary Supply Department.

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A N N E X: V

TREASURY CIRCULAR NO. 6

EXTERNALLY AIDED DEVELOPMENT PROJECT

EXTERNALLY AIDED DEVELOPMENT PROJECTS
PROCEDURES FOR DRAWING FUNDS AND CLAIMING REIMBURSEMEN

1. The financing of the Development Budget for the Fiscal Year 1981/82 which stands at K£.281.84 million will rely heavily on the utilization of External Aid revenue from various sources. Included in the Budget for this purpose is a total sum of K£.166.87 million comprising external loans and grants. Of this amount a sum of K£.96.37 million is reflected in the implementing Ministries Votes against specific projects, while the balance of K£.70.5 million consists of Miscellaneous revenue initially coming in as balance of payments support and later to be reflected in the Budget as counterpart funds. It can therefore be seen that the success of our financing the 1981/82 Development Budget will very much depend on our ability to implement externall aided development projects promptly and submit reimbursement claim to donors in a regular manner during the financial year.

2. Attached to this Circular is Schedule I, which shows the total amount of external aid funds included in your Development Vote against various projects. This Schedule has been prepared to bring to your attention the amount of external revenue which your Ministry must claim from donors through the Treasury, if the affected projects are to be implemented and financed during the financial year without placing an extra burden on the Exchequer. The co-operation of all Accounting Officers will particularly be more required during this financial year than ever before if we are to realize the total External Aid revenue shown in the Schedule.

3. Each Accounting Officer is hereby appointed to personally take responsibility for ensuring that the amounts of External Aid revenu reflected in Schedule I of this Circular, and as detailed by projects in the Printed Development Estimates, will be claimed promptly from the relevant donors within the Financial Year 1981/82, as various stages of implementation of these projects are completed. Revised procedures for disbursement of funds from the Exchequer and claiming of reimbursements from donors are attached to this Circular as Appendix 'A' and should be introduced immediately for improvement and better co-ordination.

4. The extent of the low level of reimbursement of External Aid revenue can be seen from the following statistical information for the five years from 1976/77:-

Year	Budgeted External Receipts	Actual External Receipts	% Receiv
	K£	K£	
1976/77	50,987,519	41,260,421	81
1977/78	58,153,341	35,844,060	62
1978/79	56,760,952	51,684,373	91
1979/80	69,523,685	42,498,855	61
1980/81	63,983,570	58,242,099	91
	299,409,067	229,529,808	77

It can be seen from the above figures that over the past five years we have only drawn 77% of the amounts available for reimbursement. Failure to claim reimbursement promptly has the adverse effect of:-

(a) increasing the deficit in the Development Budget and consequently imposing limitations on the finances available for other development projects, ---

(b) increasing the balance of payments deficit by forcing us to draw on our reserves when foreign exchange is available from external sources.

5. The major problems which inhibit regular and timely reimbursements from external donors have been identified as follows:-

(a) Projected external aid during a particular year may be over-budgeted and may not even be related to the capacity of the Ministry to implement the projects.

(b) The majority of donors make it a condition that we must utilize our local funds first and then submit claims for reimbursement. In the absence of strong incentives or sanctions, implementing Ministries spend local funds but invariably fail to provide the required documentary evidence to the Treasury to support reimbursement claims to the donors.

(c More often than not, implementing Ministries fail to adhere to the tendering and procurement procedures set out in the various Loan/Credit Agreements.

(d) There is general weakness in financial monitoring of spending and external aid reimbursement on each project

(e) Some donors set stringent conditions which, they insist, must be fulfilled before expenditures can qualify for reimbursement.

(f) Some donors may be slow to reimburse even after conditions for reimbursement have been fulfilled.

6. There is, therefore, urgent need to institute remedial measures which should be applied strictly in order to contain the situation. Appendix 'A', which is attached to this Circular, sets out procedure which must be followed strictly by all implementing Ministries in respect of reimbursement and disbursement of Development Revenue. These procedures must be introduced immediately to ensure the speedy implementation of development projects and the prompt reimbursement of External Aid revenue. Accounting Officers are requested to strengthen and improve their respective Accounts Units to ensure efficiency and effectiveness in the monitoring of expenditure and external aid reimbursement on each project. It should be stressed that funds drawn from the Exchequer for a specific development project should be utilized to finance that particular project only and must not be diverted to finance expenditure on any other project.

(c) that have nil or the smallest proportion of foreign aid committed to them

(d) that are partially financed by highest cost sources of foreign aid

(e) that have the highest proportion of locally financed foreign exchange cost

(f) that have the highest proportion of local contribution since domestic funds are limited.

These criteria must be considered together in making recommendations on which projects, if any, should be delayed. However, if a Ministry proposes to cancel or postpone a development project, only the local cost of the project may be considered for transfer to another programme.

NEW PROJECTS

15. New development projects will not be considered for inclusion in the budget unless:-

(a) the projects have been approved by the Estimates Working Groups and

(b) all on going projects, properly costed, do not exhaust the development ceiling for the Vote or

(c) an explicit and convincing case is made for delaying on going projects.

In the latter case, the greater availability of grants and/or concessionary aid for the new projects as compared with the delayed projects will be an important factor in the consideration. Provision for new building projects will be included in the 1982/83 Draft estimates only if the Ministry of Works will confirm that construction of the projects will be started during the first half of 1982/83 financial year.

ESTABLISHMENT

16. No provision will be included in the printed estimates for 1982/83 in respect of Temporary Clerical Assistance and Works Paid Staff as these will have been re-deployed elsewhere after completion of the temporary programmes for which they had been engaged. Urgent staff needs should be met by the re-assignment of personnel from less essential duties to crucial and essential services, projects

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and programmes. Since there are areas in many Ministries where personnel available, can if properly deployed, achieve higher level of production, financial provision for additional posts will only be available in very exceptional cases. Where staff changes are essential, all proposals involving an increase in the number or the regrading of established posts should first be cleared with the Directorate of Personnel Management in the normal way. This means that the approval should be obtained in advance of the date by which Draft Estimates are submitted to the Treasury Any new proposals (which include new posts and upgradings) which have been included in the Draft Estimates without prior sanction, will be deleted. In this connection, your attention is invited to the Directorate of Personnel Management's Personnel Circular No. 2 of 14th September, 1978 and Personnel General Letter No. 14 dated 10th November, 1981 whose provision will continue to apply during 1982/83.

AID-FUNDED PROJECTS

17. Ministries are reminded that, before any aid funded projects are included in the 1982/83 Development Estimates, evidence will have to be produced from our External Aid Department to show that a firm agreement has been reached with the donor to support the projects, and that reimbursement will be effected during the financial year. Full details of such items should be given in the explanatory notes required under the 'External Receipts' column and the name of the donor country or organisation should be shown in the last column in part III of the Development Estimates. Donor countries should not be grouped together under one programme. If there are various countries which are financing a certain project, separate items should be included in the Development Estimates for each Foreign Aided programme with separate accounting codes for each project coming under the programme. Past experience has indicated the necessity of doing this in order to enable Accounting Officers to produce audited accounts for donor countries which require them, particularly where a project has more than one donor.

MINOR WORKS

18. Financial provision may be made in development estimates to cover the cost of small jobs which need urgent attention and whose cost must not exceed £.5,000. However, before Ministries include their bids in

to have cleared the estimated costs of carrying out the minor works with the Ministry of Works. For uniformity, the followin procedure shall be followed:-

) Provision should be included under Development Estimates of a Ministry under Sub-vote - General Administration-Head-Headquarters Administration Services-Item-400-Minor Works. No Provision will be allowed for inclusion in the Recurrent Estimates for a similar purpose.

b) Ministry of Works technical services will continue to be utilised to carry out the minor jobs and Ministries will not make their own arrangements. However, the Accounting Officers of the Ministry will be responsible for determining proprities as to which jobs on his list are to be done first within any financial year.

(c) Reallocation to or from the provision for minor works will be strictly controlled by the Treasury.

TIME SCHEDULE AND RESPONSIBILITY FOR SUBMISSION OF DRAFT ESTIMATES

19. Responsibility for the timely submission of the Estimates to the Treasury and for the accouracy of their details rests entirely with Accounting Officers personally. They should, therefore, issue such further directions as may be necessary to enable them properly to discharge this duty. As in the past Draft Estimates must be submitted to the Treasury under the signature of the Accounting Officer responsible for the particular Vote.

20. In the past, some Accounting Officers have failed to submit their estimates and forward budget proposals by the due date despite the fact that the Treasury had stressed in its circulars the need to stick to the time schedules set. The effect of this omission has been to delay the finalisation of the whole estimates exercise. This unsatisfactory situation must be avoided. I therefore ask all Accounting Officers to co-operate in this regard.

21. As you are aware, a lot of time has already been spent over the last two months by officials from your Ministry [illegible]

Economic Planning and the Treasury in the detailed discussions on the Programme Review and Forward Budget covering 1982/83 financial year. For this reason, I expect that a period of not more than one month is quite adequate for you to submit proposals of draft estimates for 1982/83 by 25th March, 1982. This exercise is deemed to be a continuation of the forward budget discussions recently concluded.

22. All Ministries and Departments are asked to note that there will be no Supplementary Estimates for either Recurrent or Development spending during 1982/83. Any queries or problems relating to this Circular should be directed in the first instance to the Chairman of the estimates Working Group responsible for a particular Vote.

(H.M. MULE)
PERMANENT SECRETARY TO THE TREASURY

c.c. Provincial Commissioners,
Heads of Departments,
Director of Personnel Management

ANNEX 1 - CEILINGS FOR DRAFT ESTIMATES 1982/83

VOTE NO.	VOTES Ministry/Department	GROSS RECURRENT ESTIMATES Approved 1981/82	GROSS RECURRENT ESTIMATES Ceilings 1982/83	GROSS DEVELOPMENT ESTIMATES Approved 1981/82	GROSS DEVELOPMENT ESTIMATES Ceilings 1982/83
		K£	K£	K£	K£
1.	Office of the President	48,346,090	50,875,000	10,651,189	8,542,000
2.	The State House	1,138,150	978,000	408,740	291,000
3.	Directorate of Personnel Management	4,031,152	4,155,000	560,310	695,000
4.	Ministry of Foreign Affairs	9,468,370	9,128,000	372,560	280,000
5.	Office of the Vice-President and Ministry of Home Affairs	12,182,651	12,983,000	2,637,660	3,418,000
6.	Ministry of Economic Planning and Development	2,322,210	2,400,000	2,426,060	2,543,000
7.	Ministry of Finance	8,988,250	9,928,000	20,091,460	15,784,000
8.	Department of Defence	78,901,400	80,899,000	10,785,368	9,052,000
9.	Ministry of Livestock Development	11,743,214	14,257,000	10,977,342	10,262,000
10.	Ministry of Agriculture	23,765,435	24,356,000	31,193,775	31,714,000
11.	Ministry of Health	41,531,671	46,851,000	10,301,180	13,608,000
12.	Ministry of Local Government	14,080,600	14,519,000	12,595,010	12,300,000
13.	Ministry of Works and Housing	13,396,627	16,787,000	13,147,000	13,451,000
14.	Ministry of Transport and Communications	37,664,700	39,900,000	58,077,393	67,317,000
15.	Ministry of Labour	3,839,538	3,999,000	1,006,090	952,000
16.	Ministry of Tourism and Wildlife	8,865,976	9,966,000	7,775,667	7,978,000
17	Ministry of Urban Development and Housing	-	-	-	-
18.	Ministry of Culture and Social Services	7,422,001	7,829,000	5,304,110	9,910,000
19.	Ministry of Information and Broadcasting	5,503,500	5,896,000	3,952,000	2,191,000
20.	Ministry of Water Development	8,711,295	9,266,000	20,689,220	13,066,000

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ANNEX 1 - CEILINGS FOR DRAFT ESTIMATES 1982/83

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17	Ministry of Urban Development and Housing	-	-	-	-
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ANNEX 1 - CEILINGS FOR DRAFT ESTIMATES 1982/83

VOTES		GROSS RECURRENT ESTIMATES		GROSS DEVELOPMENT ESTIMATES	
VOTE NO.	Ministry/Department	Approved 1981/82	Ceilings 1982/83	Approved 1981/82	Ceilings 1982/83
		K£	K£	K£	K£
21.	Ministry of Environment and Natural Resources	2,710,324	2,668,000	9,769,386	10,841,000
22.	Ministry of Co-operative Development	2,286,000	2,519,000	4,405,762	4,136,000
23.	Ministry of Commerce	1,872,000	1,989,000	1,257,040	462,000
24.	Ministry of Higher Education	49,717,700	54,988,000	9,505,502	9,078,000
25.	Office of the Attorney General	861,400	870,000	-	100,000
26.	Judicial Department	2,251,600	2,423,000	925,120	990,000
27.	Public Service Commission	254,000	244,000	-	
28.	Office of the Controller and Auditor General	1,020,285	994,000	-	
29.	National Assembly	1,773,700	1,976,000	-	
30.	Ministry of Energy	1,600,500	1,672,000	2,867,215	3,225,000
31.	Ministry of Basic Education	114,466,700	120,800,000	5,279,722	4,535,000
32.	Ministry of Industry	1,217,848	1,255,000	4,476,419	4,780,000
33.	Development Co-ordination and Cabinet Office	1,887,778	2,232,000	352,500	622,000
34.	Ministry of Constitutional Affairs	4,030,510	4,340,000	520,090	446,000
35.	Ministry of Regional Development, Science and Technology	8,280,692	10,195,000	14,436,064	6,673,000
36.	Ministry of Lands, Settlement and Physical Planning	9,652,749	9,949,000	5,096,446	6,272,000
	Total	545,786,616	584,086,000	281,843,400	275,514,000

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III DETAILS OF THE FOREGOING

Head	Sub Head	TITLE	Personnel Expenses 000-099	Transport Operating Travelling and Accomodation and Other Reccurrent Expenses 100-199	Transport Equipment Other Equipment and Maintenance 200-299	Transfer and other Interest Payments 300-399	Buildings Construction and Real Estimate Financial Investments 400-599	Gross Expenditure	A-in-A	Net Expenditure
			K£	K£	K£	K£	K£	K£	K£	K£
005		Provincial and District Administration								
	110	P.C. Nairobi								
	200	P.C. Central								
	210	D.C. Kiambu								
	220	D.C. Kirinyaga								
	230	D.C. Murang'a								
	240	D.C. Nyandarua								
	250	D.C. Nyeri								
	300	D.C. Coast								
	310	D.C. Kilifi								
	320	D.C. Kwale								
	330	D.C. Lamu								
	340	D.C. Mombasa								
	350	D.C. Taita								
	360	D.C. Tana River								
	400	P.C. Eastern								
	410	D.C. Embu								
	420	D.C. Isiolo								
		TOTAL K£								

ANNEX III - ILLUSTRATE LAYOUT OF PART III OF RECURRENT ESTIMATES

DRAFT RECURRENT ESTIMATES 1982/83 VOTE R1 - OFFICE OF THE PRESIDENT

III DETAILS OF THE FOREGOING

Head	Sub Head	TITLE	Personnel Expenses 000-099	Transport Operating Travelling and Accomodation and Other Recurrent Expenses 100-199	Transport Equipment Other Equipment and Maintenance 200-299	Transfer and other Interest Payments 300-399	Buildings Construction and Real Estimate Financial Investments 400-599	Gross Expenditure	A-in-A	Net Expenditure
			K£	K£	K£	K£	K£	K£	K£	K£
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A N N E X VII

MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT

CIRCULAR NO. 1

IMPLEMENTATION SCHEDULING AND MONITORING OF DEVELOPMENT PROJECTS.

MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT

TREASURY BUILDING
P.O. Box 30005,
NAIROBI

EPD/SA 67/18/018

20th January, 1982

M.E.P.D. Circular No. 1, 1982
To: All Permament Secretaries

IMPLEMENTATION SCHEDULING AND MONITORING OF DEVELOPMENT PROJECTS

I. Introduction

1. Under present and foreseeable economic conditions, resources available to the Government for development activities will be limited. The Government is concerned that these resources be used as effectively as possible. The Office of the President, the Ministry of Finance and this Ministry have agreed on an intensive programme aimed at strengthening existing procedures, and where necessary, instituting new procedures which ensure that the implementation of development projects is properly scheduled and regularly monitored.

2. The purpose of this circular is to outline these procedures. In the near future, Sectoral Planning Officers of this Ministry will be contacting planning, financial and accounting personnel in each Ministry, through meetings of Sectoral Planning Groups, to discuss, finalize and initiate improved scheduling and monitoring procedures. As the establishment of these procedures will involve considerable effort over the next few months, Sectoral Planning Officers, together with Project Appraisal and Monitoring (PAMD) personnel of this Ministry, will be prepared to assist Ministry personnel in the initial collection of information and filling out of the appropriate forms. Permanent Secretaries are asked to ensure that these efforts receive full support and co-operation.

II. Objectives

3. Operating Ministries have the primary responsibility for planning and implementing development projects. Several Ministries have developed or are developing means of more effectively scheduling and managing implementation activities, identifiying problems quickly and taking remedial action. Yet problems, bottlenecks and consequent implementation delays are too common. Delays in project implementation have several negative consequences, in addition to directly affecting the realization of development objectives. These include:

(i) the tying up of limited budgetary funds;

(ii) increases in project costs; and

(iii) delayed receipt of scarce foreign exchange for donor-financed projects.

4. Delays often stem from a lack of sufficiently thorough scheduling of the essential steps and unavoidable time lags involved in implementation processes. The Treasury and MEPD have a primary responsibility to ensure that realistic implementation plans underlie budgetary allocations, and consequently, to assist Ministries to strengthen implementation scheduling and management processes.

5. Even with effective planning, unforeseen problems and bottlenecks frequently arise. Where these became critical, or are not being resolved by Ministries acting alone, it is essential that executive action be initiated without delay. In this connection, the Office of the President has the ultimate responsibility of ensuring that Government policies, programmes and projects are properly co-ordinated and implemented.

6. Consequently, principal objectives of the procedures outlined in this circular are:

(i) to assist Ministries to initiate or strengthen scheduling and monitoring methods which result in speedy and effective project implementation;

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(ii) to ensure that implementation problems are identified as early as possible, and that where problems remain unsolved, remedial actions are initiated; and

(iii) to maintain an up-dated project registry, particularly so that the frequent needs for project information can be met quickly, and without continual demands upon Ministries from many quarters.

7. The specific objectives are to identify on a regular basis for each project:

Annually: (i) a forward schedule of implementation and expenditure targets;

Quarterly: (ii) an assessment of implementation progress;

(iii) a summary of net budgetary expenditure, appropriations-in-aid, and expenditure of non-budgetary funds;

(iv) current problems and bottlenecks;

(v) what has been done about problems identified in earlier reports; and

(vi) any actions required of other Ministries or Agencies to expedite implementation.

III. Summary of Scheduling and Monitoring Procedures

8. Procedures and guidelines are set out in greater detail in the attached Annex. Following is a brief summary of the two basic components.

A—Forward Implementation Schedule

9. The first basic component is a Forward Implementation Schedule which will be prepared annually by Sectoral Planning Groups prior to meetings of Estimates Working Groups on the Programme Review and Forward Budget. These schedules will set out specific physical or other performance targets for the current financial year, based on Development Estimates published in June, and specific expenditure and physical or other performance targets for the following three years of the Forward Budget.

10. Beginning in July of each fiscal year, Sectoral Planning Groups will be convened to

(i) assist Ministries to prepare Forward Schedules;

(ii) ensure that project implementation and expenditure schedules are both thorough and realistic; and

(iii) assess overall project expenditure and implementation plans in light of Forward Budget ceilings and make initial cuts and modifications of estimates and schedules.

This initial planning work is essential in facilitating the decisions of Estimates Working Groups and minimizing possibilities of arbitrary cuts being made. Estimates Working Groups will not consider projects for inclusion in either the Forward or the Annual Budget unless implementation targets for each project have been properly specified and scheduled.

11. Sectoral Planning Groups will be convened again in February each year to amend Forward Schedules as they relate to the next financial year. Amendments will take into account actual Forward Budget allocations, Development Estimates ceilings, and the latest Implementation Reports. The amended Schedules will provide a basis for the Development Estimates exercise undertaken by Estimates Working Groups.

B—Project Implementation Report

12. The second basic component of the procedures and guidelines is a Project Implementation Report which sets out on a quarterly basis for each project:

(i) a summary of net budgetary expenditure, appropriations-in-aid, and expenditure of non-budgetary funds for the fiscal year to date;

(ii) an implementation progress report, measuring physical progress or other performance criteria, and comparing these with the Forward Schedules established previously with operating Ministries (Para. 9); and

(iii) a description of any implementation problems and bottlenecks, actions taken problems identified in earlier reports, actions being currently initiated or propos and actions required of other Ministries or Agencies to expedite implementati progress.

13. All information contained in PROJECT IMPLEMENTATION REPORTS will be suppl by operating Ministries, except for actual net budgetary expenditure. This figure, for ea project, will be obtained by PAMD officers from copies of project FORM B which is entitl APPLICATION FOR REQUISITION OF FUNDS FROM THE DEVELOPMENT EXCHEQUER, and whi is explained in Treasury Circular No. 6 of 11th September, 1981.

14. On receipt of IMPLEMENTATION REPORTS from Ministries, PAMD officers will in net budgetary expenditure figures and Sectoral Planning Groups will be convened to dr a short SUMMARY IMPLEMENTATION REPORT for each Ministry which highlights major achie ments, bottlenecks and outside actions required. SUMMARY REPORTS will be prepared PAMD officers, as members of Sectoral Planning Groups, and copied to the Ministry respc sible. Copies of all SUMMARY REPORTS will be sent to the Permanent Secretaries of Cabin Affairs and the Treasury.

15. SUMMARY REPORTS will be reviewed by a Project Implementation Committe composed of the Permanent Secretaries of Cabinet Affairs, the Treasury and MEPD, a chaired by the Permanent Secretary, Cabinet Affairs. Where actions are requested or critic problems are identified, the Office of the President will initiate action to ensure that effecti remedial steps are taken without delay.

C—PROJECT REGISTRY AND COVERAGE

16. Copies of all FORWARD SCHEDULES, IMPLEMENTATION REPORTS and SUMMARY REPORTS will be retained in a project registry maintained by PAMD. Operating Ministries will be required to maintain equivalent registries for the projects for which they are responsible. All Reports on individual projects or project components, which originate from district-level officers of operating Ministries, will be copied to the Secretary (District Development Officer) of the relevant District Development Committee.

17. Projects to be covered in the scheduling and monitoring procedures at any point n time include all Ministry and Parastatal projects in the current Development Estimates, and all new projects in the pipeline. This latter category includes all projects for which Forward Budget or Development Estimates submissions are being or have been made, together with any new project proposals which are in earlier stages of planning.

V. Introduction of Scheduling and Monitoring Procedures

18. In introducing these procedures, every effort will be made to establish methods which are compatible with existing project management and reporting processes within Ministies, and of value to Permanent Secretaries in their management of projects and programmes. The attached Annex provides guidelines and suggested formats for IMPLEMENTATION REPORTS and SCHEDULES. Due to diversity of types of projects and of Ministry systems, initial meetings will be needed with each Ministry to discuss and finalize specific formats.

19. The target dates for initiating these procedures are as follows:

Project Implementation Reports

January and February, 1982 ...	Sectoral Planning Groups meet to discuss and finalize monitoring formats for the projects of each Ministry. With assistance from MEPD officers where needed, Ministries prepare a PROJECT IMPLEMENTATION REPORT for each project, covering the first half of the 1981/82 fiscal year.

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(iii) a description of any implementation problems and bottlenecks, actions taken on problems identified in earlier reports, actions being currently initiated or proposed, and actions required of other Ministries or Agencies to expedite implementation progress.

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March, 1982 ..	SUMMARY IMPLEMENTATION REPORTS are prepared by Sectoral Planning Groups/PAMD, distributed, and reviewed by the Project Implementation Committee.
May and June, 1982 ..	Review and modification of IMPLEMENTATION REPORT formats and procedures in light of experience with first REPORTS.
End-July, 1982	Ministries submit a PROJECT IMPLEMENTATION REPORT for 1981/82 year-end for each project.
End-August, 1982	SUMMARY IMPLEMENTATION REPORTS are prepared and distributed by Sectoral Planning Groups/ PAMD, and reviewed by the Project Implementation Committee.
Subsequently	Ministries submit PROJECT IMPLEMENTATION REPORTS within one month of the end of each fiscal quarter. SUMMARY IMPLEMENTATION REPORTS are prepared, distributed and reviewed within two months of the end of each fiscal quarter.

Forward Implementation Schedules

July-August, 1982	Sectoral Planning Groups meet to prepare FORWARD IMPLEMENTATION SCHEDULES.
September, 1982	FORWARD SCHEDULES are reviewed by Sectoral Planning Groups, assessed for realistic scheduling, tailored to overall 1983/84—1985/86 Forward Budget ceilings and brought forward to Estimates Working Groups.
February, 1983	FORWARD SCHEDULES are amended, where necessary, in light of Forward Budget decisions, Development Estimates ceilings, and latest IMPLEMENTATION REPORTS. Amended schedules are brought forward to Estimates Working Groups.
Subsequently	The above steps are repeated on an annual basis.

20. The scheduling and monitoring procedures require information which some Ministries may not be currently collecting on a regular basis. It is recognized that some time will be needed to organize related processes within Ministries. Ministries are nevertheless asked to co-operate with MEPD in completing all REPORTS and SCHEDULES *from the outset* as fully as existing information permits, while building their capacities to fill gaps as rapidly as possible.

Y. E. O. MASAKHALIA,
Permanent Secretary.

A N N E X

DETAILS OF IMPLEMENTATION SCHEDULING/MONITORING PROCEDURES AND FORMS

A. PROJECT COVERAGE

1. Quarterly monitoring and annual scheduling procedures apply, at any point in time, to the following *Ministry and Parastatal* projects:

(i) projects included in the current Development Estimates or Revised Estimates, including those with a token £10 Vote;

(ii) projects which are being included in Forward Budget or Draft Development Estimates; and

(iii) any additional new projects which are in earlier stages of planning.

Parent Ministries will be responsible for ensuring that monitoring procedures are followed by their Parastatals.

2. A list of project names and numbers (Sub-Vote, Head, Sub-Head, Item) will be finalized in initial meetings of Sectoral Planning Groups. Titles and code numbers used in printed Estimates, budgetary discussions, financial reporting procedures and implementation scheduling/monitoring procedures will be identical so that project data can be readily exchanged and compared.

3. Where budget votes involve grants, loans or equity contributions made by a Ministry to other organizations such as Parastatals, public companies or non-governmental organizations, REPORTS and SCHEDULES will be required for the individual projects which are thereby funded. The procedures also apply to all projects for which Government loan-guarantees have been made or will be sought. In practice, where Government financing or loan-guarantees are provided to "intermediary" organizations which fund many individual projects, the level of detail of project reporting will need to be worked out by Sectoral Planning Groups.

B. FORWARD IMPLEMENTATION SCHEDULES

4. Due to the wide variety of public-sector projects currently being planned and implemented, no single approach or format will be appropriate for implementation scheduling and monitoring of all types of projects. In addition, there is need for flexibility for Ministries to use those approaches which are most consistent with existing information and management processes. Attached to this Annex are suggested forward scheduling formats which have been developed on the basis of scheduling and monitoring information previously received from several Ministries. Together with the following guidelines, these provide a starting point for discussion by Sectoral Planning Groups in finalizing formats with each Ministry for each project.

5. Of about 1,250 projects contained in the 1981/82 Development Estimates, about two thirds primarily involve the construction of physical facilities. For this type of project, the recommended approach to implementation scheduling is to specify the main stages or components of the project and indicate for each stage the projected start and end dates, and the percentage of each stage to be completed by the end of the current fiscal year. Illustrative examples are provided in the attached forms (forms 1 and 2).

6. The specification of project stages will depend on the nature of individual projects, but must be sufficiently detailed to identify the main activities involved in implementation and to set out a realistic schedule of their timing. For most single-location construction projects, the appropriate combination of the following stages would be included:

—pre-feasibility study/preliminary planning.

—feasibility study/detailed planning.

—land acquisition or allocation.

—preliminary negotiation for aid or commercial loan financing (where applicable).

—first inclusion in Forward Development Budget submissions.

—first inclusion of £10 token Development Estimate.

—design, engineering.

—tender.

—first funding in Development Estimates.

—site preparation.

—machinery, equipment and materials acquisition.

—construction.

—machinery, equipment and fixtures installation.

—staffing and training.

—first inclusion in Draft Recurrent Budget submissi

—first funding in Recurrent Estimates.

—commencement of operation.

7. Several construction projects included in the current Development Estimates consist of many individual projects located in different parts of the country. For such projects, completing a highly detailed FORWARD SCHEDULE for each individual component would be unduly burdensome. On the other hand, it is not meaningful to schedule progress of a group of projects, such as Rural Health Centres and Dispensaries, without identifying individual components. In practice, Sectoral Planning Groups will need to agree on the level of individual project and geographical detail appropriate for monitoring many of the multi-component and multi-district projects. In general, sufficient detail should be included to:

(i) identify the key implementation steps and time lags involved and enable a realistic schedule of implementation progress to be set out for each project component; and

(ii) enable a comprehensive identification of project activity in the country and, as soon as possible, a clear picture of activities at the Province and District levels.

8. Almost one-third of the projects in the current Development Estimates are, in effect, on-going programmes in that they involve either the annual provision of services (credit extension, tractor-hire, training, etc.) or the annual completion of small or widely dispersed physical or construction activities (cattle dip construction, feeder road construction, road gravelling, crop or tree planting, etc.). Such on-going projects can be better scheduled and monitored in terms of annual performance targets than in terms of start and completion dates. For on-going projects Ministries are asked to specify the major project activities (services provided, facilities constructed) and to specify one or more performance measures by which implementation of each activity can be scheduled and monitored. Examples for different types of projects include:

—number of dips constructed;

—kilometres of road constructed or gravelled;

—hectares planted;

—amount of credit extended; or

—number of people trained or enrolled.

9. FORWARD SCHEDULES will then set out, for each activity, annual performance targets for the current and next three fiscal years. Illustrative examples are provided in the attached forms (forms 3 and 4). As in the case of construction projects, many service-oriented projects have provincial and district components. The same general guidelines concerning level of detail of reporting (para 7) apply. It is recognized that in many cases time will be needed to organize or strengthen processes for obtaining reports from District and Provincial Officers.

10. Study and research projects should be monitored according to performance targets (Annex paras. 8 and 9) wherever their objectives are specific enough to measure. Where this is not the case, start and end dates should be specified. Many large or complex projects such as I.A.D.P. involve both construction and service activities. For such projects a combination of physical schedules and performance targets will be appropriate.

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C. Project Implementation Reports

12. These reports will contain three types of information:

(i) a summary of net budgetary expenditure, appropriations-in-aid and expenditure of non-budgetary funds for the fiscal year to date; budgetary net expenditure data will be provided by PAMD as outlined above (para. 13); data on an appropriations-in-aid and expenditures of non-budgetary funds (commercial borrowing, contributions of local authorities, self-help contributions, etc.) will be reported by Ministries;

(ii) information on implementation progress, as measured against Forward Schedules; and

(iii) a description of problems, bottlenecks, actions taken on problems identified in earlier reports, actions being currently initiated or planned and actions required of other Ministries or Agencies to expedite implementation.

13. Recommended formats for reporting implementation progress stem from the Forward Schedule formats outlined above. In the case of physical progress monitoring, the actual percentage completion for each project stage/component will be reported, alongside scheduled percentage completion (from Forward Schedules). Illustrative examples are provided in attached forms (forms 5 and 6). In the case of project activities whose performance is scheduled on the basis of annual performance targets, actual performance will be reported against targeted performance. The attached forms 7 and 8 provide illustrative examples. [illegible] performance targets will not be required on Implementation Reports until the [illegible] of 1982/83, by which time initial Forward Schedules will have been completed.

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FORWARD IMPLEMENTATION SCHEDULE

PROJECT NUMBER ____/ ____/ ____/ ____/
SV II SH I

MINISTRY/AGENCY _____ LOCATION (DISTRICT) _____

PROJECT NAME _____

ESTIMATED TOTAL PROJECT COST (K£) _____

PHYSICAL IMPLEMENTATION SCHEDULE	SCHEDULE – INDICATE START AND END DATES FOR EACH STAGE OR COMPONENT																TARGET % COMPLETION – CURRENT FISCAL YEAR
PROJECT STAGE OR COMPONENT / FISCAL YEAR FISCAL QUARTER	19 ___/___				19 ___/___				19 ___/___				19 ___/___				
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
ESTIMATED EXPENDITURE (K£) : NET BUDGETARY																	
: APPROPRIATIONS-IN-AID																	
: NON-BUDGETARY FUNDS																	
: TOTAL																	

COMMENTS, ANTICIPATED PROBLEMS, ACTIONS REQUIRED _____

COMPLETED BY: NAME, POSITION _____
P. O. BOX _____ PHONE _____ DATE _____

FORWARD IMPLEMENTATION SCHEDULE

PROJECT NUMBER 524 / 787 / 000 / 320 /
SV H SH I

MINISTRY/AGENCY INDUSTRY

LOCATION (DISTRICT) MOMBASA

PROJECT NAME LOANS TO ABCD FOR CONSTRUCTION OF CHEMICAL COMPLEX

ESTIMATED TOTAL PROJECT COST (K£) 9,000,000

PHYSICAL IMPLEMENTATION SCHEDULE

SCHEDULE – INDICATE START AND END DATES FOR EACH STAGE OR COMPONENT

PROJECT STAGE OR COMPONENT / FISCAL YEAR / FISCAL QUARTER	1981/82				1982/83				1983/84				1984/85				TARGET % COMPLETION – CURRENT FISCAL YEAR
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
FEASIBILITY STUDY																	100
EVALUATION/REVIEW OF STUDY																	100
LAND ALLOCATION																	100
£10 DEV. ESTIMATE																	100
NEGOTIATION OF PROJECT AGREEMENT																	50
DETAILED DESIGN/ENGINEERING																	–
TENDERS																	–
DEV. BUDGET FUNDING (LOAN)																	–
SITE PREPARATION																	–
MACHINERY & EQUIPMENT AQUISITION																	–
CONSTRUCTION																	–
MACHINERY, EQUIPMENT, FIXTURES INSTALLATION																	–
STAFFING & TRAINING																	–
START-UP																	–

ESTIMATED EXPENDITURE (K£)	1981/82	1982/83	1983/84	1984/85
: NET BUDGETARY	20,000	100,000	1,000,000	880,000
: APPROPRIATIONS-IN-AID	–	–	–	–
: NON-BUDGETARY FUNDS	–	400,000	4,000,000	3,320,000
: TOTAL	20,000	500,000	5,000,000	4,400,000

COMMENTS, ANTICIPATED PROBLEMS, ACTIONS REQUIRED

COMPLETED BY: NAME, POSITION

P. O. BOX PHONE DATE AUG. 20, 1981

FORWARD IMPLEMENTATION SCHEDULE

PROJECT NUMBER 524 / 787 / 000 / 320 /
SV H SH I

MINISTRY/AGENCY INDUSTRY LOCATION (DISTRICT) MOMBASA

PROJECT NAME LOANS TO ABCD FOR CONSTRUCTION OF CHEMICAL COMPLEX

ESTIMATED TOTAL PROJECT COST (K£) 9,000,000

PHYSICAL IMPLEMENTATION SCHEDULE PROJECT STAGE OR COMPONENT / FISCAL YEAR FISCAL QUARTER	SCHEDULE – INDICATE START AND END DATES FOR EACH STAGE OR COMPONENT 1981/82				1982/83				1983/84				1984/85				TARGET % COMPLETION – CURRENT FISCAL YEAR
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
FEASIBILITY STUDY																	100
EVALUATION/REVIEW OF STUDY																	100
LAND ALLOCATION																	100
£10 DEV. ESTIMATE																	100
NEGOTIATION OF PROJECT AGREEMENT																	50
DETAILED DESIGN/ENGINEERING																	–
TENDERS																	–
DEV. BUDGET FUNDING (LOAN)																	–
SITE PREPARATION																	–
MACHINERY & EQUIPMENT AQUISITION																	–
CONSTRUCTION																	–
MACHINERY, EQUIPMENT, FIXTURES INSTALLATION																	–
STAFFING & TRAINING																	–
START-UP																	–

ESTIMATED EXPENDITURE (K£)	1981/82	1982/83	1983/84	1984/85
: NET BUDGETARY	20,000	100,000	1,000,000	880,000
: APPROPRIATIONS-IN-AID	–	–	–	–
: NON-BUDGETARY FUNDS	–	400,000	4,000,000	3,320,000
: TOTAL	20,000	500,000	5,000,000	4,400,000

COMMENTS, ANTICIPATED PROBLEMS, ACTIONS REQUIRED

COMPLETED BY: NAME, POSITION

P. O. BOX PHONE DATE AUG. 20, 1981

ORWARD IMPLEMENTATION SCHEDULE

PROJECT NUMBER 091/ 300/ 080 / 000/
SV II SH I

MINISTRY/AGENCY LIVESTOCK DEVELOPMENT LOCATION (DISTRICT) MACHAKOS

PROJECT NAME M.I.D.P. - ANIMAL PRODUCTION, ARTIFICIAL INSEMINATION AND TICK CONTROL

IMPLEMENTATION PERFORMANCE SCHEDULE PROJECT ACTIVITY AND PERFORMANCE MEASURE — FISCAL YEAR	SCHEDULE - INDICATE PERFORMANCE TARGETS - CURRENT AND NEXT 3 FISCAL YEARS 1981 /82	1982 / 83	1983 /84	1984 / 85
TRAINING - NUMBER TRAINED	450	500	500	250
BEE-KEEPING - EXTENSION FIELD DAYS	50	70	80	80
- DEMONSTRATION AVIARIES	10	10	10	-
LIVESTOCK HANDLING YARDS - NO. CONSTRUCTED	5	2	-	-
BULL CAMPS - NO. CONSTRUCTED	4	8	12	8
FODDER IMPROVEMENT - NO. OF PLOTS	27	20	10	10
TICK CONTROL - FREE DIPPING	DISCONTINUED			
CONSTRUCTION OF STAFF HOUSES - NUMBER	5	2	2	2
ESTIMATED EXPENDITURE (K£) : NET BUDGETARY	247,280	284,000	250,000	130,000
: APPROPRIATIONS-IN-AID	100,000	105,000	100,000	50,000
: NON-BUDGETARY FUNDS	-	-	-	-
: TOTAL	347,280	389,000	350,000	180,000

COMMENTS, ANTICIPATED PROBLEMS, ACTIONS REQUIRED

COMPLETED BY: NAME, POSITION
P. O. BOX PHONE DATE AUG. 30, 1981

FORM 5

PROJECT IMPLEMENTATION REPORT TO END OF (QTR, YR) ___,___/_____ PROJECT NO. ___/___/___/___/
SV H SH I

MINISTRY/AGENCY _____ LOCATION (DISTRICT) _____

PROJECT NAME _____

FINANCIAL SUMMARY (K£)

TO BE COMPLETED BY MEPD : ACTUAL NET BUDGETARY EXPENDITURE, FISCAL YEAR TO DATE _____

TO BE COMPLETED BY MINISTRY : TOTAL APPROPRIATIONS-IN-AID RECEIVED, FISCAL YEAR TO DATE _____

: TOTAL EXPENDITURE OF NON-BUDGETARY FUNDS, FISCAL YEAR TO DATE _____

PHYSICAL PROGRESS REPORT	% COMPLETION-EACH STAGE OR COMPONENT		IMPLEMENTATION PROBLEMS, ACTIONS PREVIOUSLY TAKEN, ACTIONS CURRENTLY INITIATED OR PLANNED, ACTIONS REQUIRED OF OTHER MINISTRIES/ AGENCIES
PROJECT STAGE OR COMPONENT	TARGET FOR YEAR	ACTUAL-FISCAL YEAR TO DATE	

COMPLETED BY: NAME, POSITION
P. O. BOX _____ PHONE _____ DATE _____

PROJECT IMPLEMENTATION REPORT: TO END OF (QTR, YR) 2 , 81 / 82 PROJECT NO. 524 / 787/ 000/ 320 /
SV , H SH I

MINISTRY/AGENCY INDUSTRY LOCATION (DISTRICT) MOMBASA

PROJECT NAME LOANS TO ABCD FOR CONSTRUCTION OF CHEMICAL COMPLEX

FINANCIAL SUMMARY (K£)

TO BE COMPLETED BY MEPD : ACTUAL NET BUDGETARY EXPENDITURE, FISCAL YEAR TO DATE 10,485

TO BE COMPLETED BY MINISTRY : TOTAL APPROPRIATIONS-IN-AID RECEIVED, FISCAL YEAR TO DATE -

: TOTAL EXPENDITURE OF NON-BUDGETARY FUNDS, FISCAL YEAR TO DATE -

PHYSICAL PROGRESS REPORT	% COMPLETION-EACH STAGE OR COMPONENT		IMPLEMENTATION PROBLEMS, ACTIONS PREVIOUSLY TAKEN, ACTIONS CURRENTLY INITIATED OR PLANNED, ACTIONS REQUIRED OF OTHER MINISTRIES/ AGENCIES
PROJECT STAGE OR COMPONENT	TARGET FOR YEAR	ACTUAL - FISCAL YEAR TO DATE	
FEASIBILITY STUDY	100	100	
EVALUATION/REVIEW OF STUDY	100	75	
LAND ALLOCATION	100	-	
£ 10 DEVELOPMENT ESTIMATE	100	(BEING SUBMITTED)	
NEGOTIATION OF PROJECT AGREEMENT	50	-	
DETAILED DESIGN/ENGINEERING	-	-	
TENDERS	-	-	
DEV. BUDGET FUNDING (LOAN)	-	-	
SITE PREPARATION	-	-	
MACHINERY & EQUIPMENT AQUISITION	-	-	
CONSTRUCTION	-	-	
MACHINERY, EQUIPMENT, FIXTURES INSTALLATION	-	-	
STAFFING & TRAINING	-	-	
START-UP	-	-	

COMPLETED BY: NAME, POSITION
P. O. BOX PHONE DATE JAN. 25, 1982

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PROJECT IMPLEMENTATION REPORT: TO END OF (QTR, YR)____,____/____ PROJECT NO.____/____/____/____/ FORM 7

SV H SH I

MINISTRY/AGENCY_____ LOCATION (DISTRICT)_____

PROJECT NAME_____

FINANCIAL SUMMARY (K£)

TO BE COMPLETED BY MEPD : ACTUAL NET BUDGETARY EXPENDITURE, FISCAL YEAR TO DATE_____

TO BE COMPLETED BY MINISTRY : TOTAL APPROPRIATIONS-IN-AID RECEIVED, FISCAL YEAR TO DATE _____

: TOTAL EXPENDITURE OF NON-BUDGETARY FUNDS, FISCAL YEAR TO DATE_____

PERFORMANCE REPORT	IMPLEMENTATION PERFORMANCE		IMPLEMENTATION PROBLEMS, ACTIONS PREVIOUSLY TAKEN, ACTIONS CURRENTLY INITIATED OR PLANNED, ACTIONS REQUIRED OF OTHER MINISTRIES/AGENCIES
PROJECT ACTIVITY AND PERFOMANCE MEASURE	TARGET FOR YEAR	ACTUAL - FISCAL YEAR TO DATE	

COMPLETED BY: NAME, POSITION
P. O. BOX PHONE DATE

PROJECT IMPLEMENTATION REPORT: TO END OF (QTR, YR) 2 , 81/82 PROJECT NO. 091 / 300 / 080 / 000 /
SV H SH I

MINISTRY/AGENCY LIVESTOCK DEVELOPMENT LOCATION (DISTRICT) MACHAKOS

PROJECT NAME M.E.D.P. - ANIMAL PRODUCTION, ARTIFICIAL INSEMINATION AND TICK CONTROL

FINANCIAL SUMMARY (K£)

TO BE COMPLETED BY MEPD : ACTUAL NET BUDGETARY EXPENDITURE, FISCAL YEAR TO DATE 92,028

TO BE COMPLETED BY MINISTRY : TOTAL APPROPRIATIONS-IN-AID RECEIVED, FISCAL YEAR TO DATE 100,000

: TOTAL EXPENDITURE OF NON-BUDGETARY FUNDS, FISCAL YEAR TO DATE -

PERFORMANCE REPORT PROJECT ACTIVITY AND PERFOMANCE MEASURE	IMPLEMENTATION PERFORMANCE TARGET FOR YEAR	ACTUAL - FISCAL YEAR TO DATE	IMPLEMENTATION PROBLEMS, ACTIONS PREVIOUSLY TAKEN, ACTIONS CURRENTLY INITIATED OR PLANNED, ACTIONS REQUIRED OF OTHER MINISTRIES/AGENCIES
TRAINING - NUMBER TRAINED	450	300	
BEE-KEEPING - EXTENSION FIELD DAYS	50	20	
- DEMONSTR. AVIARIES	10	7	
LIVESTOCK HANDLING YARDS - NO. CONSTR.	5	3	
BULL CAMPS - NO. CONSTRUCTED	4	1	
FODDER IMPROVEMENT - NO. OF PLOTS	27	18	
CONSTR. OF STAFF HOUSES - NUMBER	5	5 (40%)	

COMPLETED BY: NAME, POSITION
P. O. BOX PHONE DATE JAN. 20, 1982

Improve National Health Information System _____ [G & I]

This objective represents a major component of the HPIP which can be further defined as follows:

Task #1: Assist in identifying the type of data needed to support planning, management and evaluation.

Task #2: Assist in establishing procedures to collect this data on a regular basis.

Task #3: Assist in establishing a data management system which will ensure timely processing and publication of data. This may or may not include purchasing computer equipment, developing programs and training local data processing staff, as determined jointly by MOH, AID/K and Drew.

Task #4: Assist in training care-providers in using available data to strengthen planning, management and evaluation capabilities.

During Project Year II, the requirements of this Project component continued to be inadequately met due to two interrelated factors:

1. Since prior to the inception of the HPIP, the MOH's data management functions have been (and continue to be) dispersed among a variety of units.

   Aspects of data management are variously located in the MOH's Vital Statistics units and the National Family Welfare Center. Output of the Vital Statistics Unit is limited to morbidity and mortality data, and publication is backlogged by two to three years. Staff for this unit is seconded from the Ministry of Finance, and MOF computer facilities are used on a time-sharing basis. Statistics of the National Family Welfare Center primarily relate to Maternal Child Health/Family Planning (MCH/FP) data. The Health Information Systems Unit which was established with a view toward consolidation of

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various data management functions in the MOH, is yet in its formative stages and is understaffed. Data needed for planning, management control, evaluation and disease surveillance are not being treated at all. Still other entities within the system, such as the National Hospital and the Kenya Expanded Programme for Immunization, maintain independent data management activities.

This situation has complicated HPIP's task of determining an appropriate programmatic entry point. It is evident that consolidation and expansion of the existing "system" is needed. However, even in the original design of the HPIP, insufficient attention was given to critical questions such as, which of the various units within the MOH represents an essential or core capability upon which a comprehensive system could be developed, and which unit has sufficient in-place staff resources and could accommodate outside intervention.

2. Difficulties in determining an appropriate programmatic entry point have, in turn, complicated the Contractor's task of identifying a long-term technician to fill the health information position. Conversely, the absence of this HPIP staff person has impeded the Project's ability to establish a rational and clearly defined technical approach and to impact upon the existing MOH information system structures and methods.

Owing to these difficulties -- indeed, inspite of them -- the Project, during Years I and II, concentrated on developing a further basic understanding of needs and approaches. In the absence of a full-time health information systems resource, twelve (12) months of short-term

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consultancy have been expended during Years I and II on assessment and prototype development of computer programs.

During Project Year I, direction provided by the MOH emphasized the need for the Contractor's technical consultant to have a strong background in epidemiology. At that time, data requirements for disease surveillance were being increasingly recognized. While epidemiological data relates to the overall data requirements for service delivery planning and evaluation, the HPIP informally advised the MOH that an epidemiological emphasis to data systems development might prove to be too narrow. Nevertheless, an epidemiologist/physician with experience in large-scale information systems was deployed to review the MOH's overall information needs and to make recommendations on a systems development approach. Although useful in some respects, the ouputs of this consultancy clearly verified the Contractor's concern that the epdemiological approach would not sufficiently span the broader systems development concerns.

Following a slightly different track during Project Year II, HPIP concentrated major effort on testing the feasibility of associating itself with the Health Information Systems Unit and Vital Statistics Unit (as its point of entry). To this end, a data systems specialist was deployed to the field for a series of consultancies. These consultations were intended to accomplish the following:

1. Assess the in-place data criteria and data collection methods of the MOH and make recommendations for a program of technical assistance.
2. Assess the in-place data processing systems with special attention to the Vital Statistics Unit, and make recommendations regarding a program of technical assistance.

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3. If indicated, make a thorough assessment of the hardware requirements that would be needed to strengthen the overall data management system.

4. Develop prototype computer programs utilizing existing or theoretically available data, to demonstrate ways in which the MOH might approach data analysis and publication of useful statistical reports.

The outcome of these consultancies can be summarized as follows:

1. The MOH's basic statistical data gathering forms, methods and system of upward reporting are sound.

2. With minor enhancements, the type of data now being collected could serve as a basis for regular publication and utilization of health information to serve all of the critical needs in the areas of planning, management control and evaluation.

3. Existing deficiencies relate to the limited analysis of existing raw data, serious deficiencies in software and hardware needed to produce data on a timely basis, and the absence of any procedures for distribution and utilization of data at the provincial and district levels.

4. The MOH has a critical need to augment its computer hardware capability in order to improve the timeliness of data processing. However, introduction of a large-scale computer system would be pre-mature at this time in the absence of,

   - structural consolidation of data management functions;

   - further definition of data criteria needed to address all aspects of service delivery planning, implementation and evaluation;

   - establishment of a centralized data unit whose authorities would include control and coordination of computer hardware, programs, and distribution and guidance in data utilization.

5. The technical intervention that would be needed to assist the MOH with the full-scale effort described in item 4. above, would require a level of effort which was, from the outset, beyond the scope of the Project. However, significant progress can be made in these directions with the assistance of the HPIP. Within the context of the objective task earlier described, HPIP will concentrate during the remainder of its term on,

   - installation of a user-based information system to support program planning, management control and program evaluation (The user-based approach includes involvement of operational managers in defining their own data requirements and establishment of procedures and guidelines to ensure that data feedback is used in management decision-making);

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- installation of a small- to medium-scale computer processing capability (including training of personnel), to establish a prototype for systems-wide data management;
- formulation of computer-assisted programs to support planning, management control and program evaluation;
- assistance to the MOH, as appropriate, in the structural consolidation of its data management functions.

During Project Year II, progress was also made on testing out the user-based approach. For examples, during the early part of 1982, an information needs questionnaire was designed and administered in connection with the implementation planning phase of the Integrated Rural Health/Family Planning Programme. Further, the series of planning workshops conducted by HPIP in connection with development of the Five Year National Health Development Plan, also provided opportunities to address data requirements at the provincial and district levels. In this regard, a comprehensive guide for data collection to support district level planning was developed and distributed to provincial and district management teams.

Selected materials related to findings and outputs of the various consultancies and other preliminary activities related to development of user-based data criteria are attached.

However, all of the above described achievements must be viewed as preliminary. Within the context of the Project requirements, the objective of assisting the MOH in improving it health information system is considered, at this point, to be approximately 10% complete.

MINUTES TO THE MEETING HELD ON INFORMATION REQUIRED FOR PRODUCING ANNUAL REPORTS FOR THE MINISTRY OF HEALTH

SEPTEMBER, 11, 1981

Attendan(

Mr. L. Ndungu - Chairman

Dr. R. Gipson

Mr. R. Peterson

Dr. H. Mosley

There were three major Points discussed in the meeting:

(1) The Information required for The Annual Report

(2) Existing Information within the Ministry and

(3) The capacity of the Health Information System to produce the necessary information for the Annual Report.

ɔrmation Required for the Annual Report:

Generally, it was agreed that The goals, objectives, and work gramme of the Ministry should be examined in the Light of actual ievements during the reporting year. This would allow an assessment be made on each department regarding their Planned activities and ults realised at the end of the year.

Below are some examples of general headings which might appear in an ual report. Others may be included as well:

achievements during the reporting yea

- Demographic Data
- National Hospital Insurance Fund
- Environomental Health
- Communicable Diseases
- Laboratory Services
- Curative Services
- Hospitals
- Dental Health
- Mental Health
- Rural Health Services
- Health Education
- MCH/FP Services
- Nutrition
- Nursing
- Pharmacy
- Manpower
- Training
- Municipalities and County Council Health Services
- Finance (Budget)
- Physical Construction.

The overall format for presenting these topics above should simply be: (1) What was planned? (2) What was achieved ? and (3) Recommendations.

Existing Information within the Ministry of Health:

Most of the required information for an Annual Report is available

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The major problem, however, is that this information within the departments is not collected and compiled in a standardized systematic manner to allow easy retrieval. Consequently, it becomes difficult to prepare even a quanitative report, and practically impossible to make a qualitative analysis.

The Capacity of the Health Information System to produce the necessary Information for the Annual Report

In reviewing the current status of the Health Information System, it was observed that a number of problems must be solved before it can become a viable system.

(1) The two Units, Evaluation/Research Division (NFWC) and the Vital Health Statistics Unit which forms the H.I.S. continues to operate as separate entities. (They are still located in different buildings and working as before).

(2) Given the heavy work load of the V.H.S. and E.R. division in processing and avalizing data (five different forms - VHS: and Two forms - ER Division), they are constantly behind in quarter and Annual Reports. This leaves hardly no time for processing data such as manpower budget etc.

(3) Staffing: About one third of the post in HIS are filled The most senior staff member is seconded from C.B.S. While this staff member was supposed to provide technical assistance his primary responsibilities has been in the area of

administration. Thus leaving mostly junior staff to carry out the Technical work.

Proposal for the Annual Report

It was proposed during the meeting that a systematic standardized procedure be developed for collecting, processing, analizing and reporting Quarterly information . This system would cover reporting at the National Provincial and District level. This system would serve as the basis for preparing Annual Reports.

Designing and implementing this system will be a Long-Term activity. Consequently, the 1980 Annual Report will be based upon utilizing existing information from the various departments within the Ministry.

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HEALTH INFORMATION SYSTEM AT DISTRICT LEVEL.

EXISTING INFORMATION AT

A DISPENSARY LEVEL.

Number of patients treated per day, per month or per year.

2. Number of re-attendances (workload).
3. Number of personnel and their qualifications
4. State of buildings (staff houses, space etc.)
5. Equipment and their status: (inventory and stores).
6. Consumption of supplies (consolidated returns)
7. Envirometal sanitation at the dispensary.
8. Notification of communicable diseases
9. Types of diseases (Pattern of diseases - morbidity pattern).
10. Sex and age.
11. Mortality figures
12. Referals to Health Centres.
13. Register of drugs, (capsules or injection)
14. Med 26 - proforma.
17. Monthly summary sheet

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18. Mobile Clinic register at V/H

inspected, schools visited (2). (Activity report of the Public Health Technician.

19. Meetings and Barazas.

20. Coupons used (Family Health Field Educators)

21. Topics discussed (at Clinics or Barazas)?

22. Carcasses inspected and fees collected.

23. Number of Houses Constructed

24. Number of pit latrines pegged and those completed

26. Staff movements i.e. leaves visitors etc.

27. Report on availability and use of drugs.

28. Data and progress report from field staff.

29. Ante-natal and post-natal data

30. Feed back from the community

31. Co-ordination and ~~Co-op~~ Co-operation with other Ministries and ~~the~~ Ano...

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EALTH CENTRE LEVEL

1. Information and data as at dispensary level
2. Maternity patients and deliveries (utilization data).
3. Referrals to District Hospitals
4. Transport (state of vehicles and reports).
5. Coverage of MCH/FP. services.
6. Mobile clinics.
7. State of Laboratory services.
8. Number of beds
9. Health Education report.
10. Malnutrition, marasmus and kwashiorkor reports.
11. Fees collected (new cases & reattendances)
12. Patients food returns.
13. Consumption (consolidated returns).
14. Mortality data.

16 Records.

(a) meet inspection
(b) Follow up of diseases
(c) Immunisations
(d) Social workers client reports.
(e) Food Sampling reports.
(f) Legal notices
(g) Licencing
(h) report on water Supply

DISTRICT LEVEL

Besides utilizing information as at (a) and (b), district level needs:

1. Number of out patient attendances per day per month and per year
2. Number of inpatients per day per month, per year
3. Number of authorised beds; actual beds and costs.
4. Number of various categories of staff
5. State of Buildings
6. State of Equipment
7. Number and types of operations (surgical) done
8. Preventive and promotive services report (Status?)
9. Mortality rates.
10. Transport
11. Number of pathological investigations reports done per day, per month, per year.
12. Consolidated returns – on supplies & drugs
13. Financial expenditure returns and monthly expenditure permissible figures.
14. [illegible]

16. Write offs.

17. Death returns

18. Mortuary reports.

19. Workmen's Compensation returns

20. Occupational Therapy reports.

21. Statistics from other departments

22. Daily reports – verbal & written

23. Meetings and occasional visits to various departments (seminars.

24. School activity report

25. Post mortem reports.

26. Estimates

27. Tally sheets

28. Special Clinic reports

(D) DISTRICT TEAM (7)

Besides utilizing reports/data of lower level they also use.

1. Monthly reports from all departmental
2. Logistic support human and mater-
3. Information of all health Facilities Government and NGOs.
4. Finance.
5. Demography
6. Morbidity Status.
7. Social & Economic Status reports.
8. Inter-departmental interactions
9. DDC meetings
10. County Council & Municipal Council reports.
11. Herankee project reports
12. Communicating with higher authority

INFORMATION NEEDED BUT NOT EXISTING

1 Number of people suffering from different kinds of diseases at any particular time

2. Age groups.

3. Number of deliveries at home.

4. Number of deaths at home.

5 Cases of occupational diseases in factories.

6. State of buildings

7. Rate of fuel consumption

8. Personnel management

9. Annual reports ~~of~~ from Ministry of Health

10. Statistical data beyond 1948.

11. Population Census.

15. Social and E.

REVIEW OF DISTRICT HEALTH PLAN ..... DISTRICT.

Planning assignment: Development of a five year District Health Plan (1984 - 1988)

Health Sector Analysis:

a). GEOGRAPHY FEATURES

COMMENTS

i). Size
ii). Physical characteristics
iii). infrastructure
iv). rainfall

b). DEMOGRAPHIC DATA

i). population size
ii). population density
iii). population distribution
- by age
- by sex
iv). Fertility mortality

c). SOCIO ECONOMIC DESCRIPTION

i). employment
ii). nature of economy
iii). sources of income
iv). Literacy rate
v). School enrollment
vi). Social/cultural factors
vii). Dependency ratio

d). HEALTH PROBLEMS

EPIDEMIOLOGICAL SITUATION

a). Nutritional status
b). Infant Mortality rate
c). Underfive Mortality rate
d). Life expectancy
e). Maternal Mortality rate

f). Crude Mortality rate
g). Mortality causes by top 10 diseases
h). Morbidity causes of top 10 diseases
i). disability in the productive age group

a). % disabled
b). % lost days due to morbidity

j). immunizations

3. Available Resources:

a). MANPOWER

Total number by category e.g. Doctors, Registered Nurses, etc.
Distribution by facility e.g. Hospital, Health Centre, etc.
Ratios to population of various types of personnel.

	Number 1982	Shortfalls	Expected Number 1988
Specialists			
Medical Officers			
Dentists			
Pharmacists			
Clinical Officers			
Registered Health Officers			
Enrolled Nurses			
Public Health Officers			
Public Health Technicians			

COMMENTS

	Number 1982	Shortfalls	Expected Number 1988
Laboratory technicians			
Nutrition Field Workers			
Family Health Field Educators			
Laboratory Technologists			
Pharmaceutical Technologists			
Physiotherapists			
Dental Technologists			
Radiograhers			
Radiographic Film Processors			
Nutritionists			
Health Education Officers			
Hospital Secretaries			
Occupational Therapists			

COMMENTS

	Number 1982	Shortfalls	Expected Number 1988
Orthopaedic Technician			
Plaster Technicians			
Clerical Officers			
Typists			
Med. Record Officers			
Dental Therapists			

3. b). DRUGS AND EQUIPMENT

i). availability
ii). distribution
iii). shortfalls

c). TRANSPORT

i). distribution of Vehicles per facility
overall conditions of Vehicles:
- functioning
- not functioning
- can it be repaired

ii). distribution of roads in the district

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3. d). THE HEALTH BUDGET

i). allocation of development expenditure:
- amount spent on each programme

ii). allocation of recurrent expenditure:
- Staff
- Supplies costs (drugs and medicines)
- Other

iii). Comparison of Expenditures
- Curative programmes
- Preventive - promotive programmes

e). HEALTH SERVICES

i). HEALTH SERVICE SITUATION

a). availability
i). population per Health Centre
ii). population per dispensary
iii). population per doctor
iv). population per nurse

b). accessibility

i). percentage of population using existing facilities
ii). distance from nearest facility
iii). travel time to nearest facility
iv). Transport cost to nearest facility
v). traditional barriers to utilization of services

c). Utilization (actual Coverage)

i). proportion of children immunized per facility
ii). proportion of pregnant women receiving ANC per facility
iii). proportion of pregnant mothers delivered by trained personnel
iv). proportion of population using existing services by sex, age.

COMMENTS

3. e).
ii). HEALTH FACILITIES

a). Hospitals

i). number in the district
ii). distribution geographically
iii). Bed capacity
iv). ownership i.e. Government or NGO
v). Bed/population ratio
vi). Hospital population ratio
vii). Utilization pattern
viii). number planned during 1979 - 1983 plan period
ix). number completed
x). number not completed
xi). Reasons why not completed

b). Health Centres

i). number in the district
ii). geographic distribution
iii). number of beds
iv). Health Centre/population ratio
v). Utilization pattern
vi). number planned during 1979 - 1983 plan period
vii). number completed
viii). number not completed
ix). Reasons why not completed.

c). Dispensary Type I

i). number in the district
ii). geographic distribution
iii). Dispensary Type I population/ratio
iv). Utilization pattern
v). number planned during 1979 - 1983 plan period
vi). number completed
vii). number not completed
viii). Reasons why not completed.

d). Dispensary Type II

i). number in the district
ii). geographic distribution
iii). Dispensary Type II/population ratio
iv). Utilization pattern
v). number planned during 1979 - 1983 plan period
vi). number completed
vii). number not completed
viii). Reasons why not completed.

e). Nursing/maternity homes

i). number in the district
ii). geographic distribution
iii). ownership
iv). types of services rendered

f). MOBILE CLINICS

i). number of visits planned
ii). number of visits not implemented
iii). Reasons for failure
iv). Types of Services rendered by Team.

3. e).
iii). Traditional Services

i). Traditional Birth Attendants (TBAs)
ii). Traditional Healers

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COMMENTS

4. CONSTRAINT ANALYSIS

a). Support Requirements

i). manpower requirements
ii). supplies and equipment
iii). information flow

b). Financial feasibility

i). are costs at the most economical level?
ii). Internal sources
iii). external sources

c). Social and Economic Repercussions

state the possible side effects of the programme(s)

5. INTERSECTORAL COORDINATION

Mechanism for involving:

a). other ministries
b). Non-Government organizations (NGOs)
c). other actors

6. DETERMINING HEALTH PRIORITIES

The following are some of the Criteria that can be used:

a). Coverage criteria

i). - degree of accessibility of Water and sanitation facilities
ii). - % of children at risk immunized
iii). - % of population using latrines
[illegible] l of treatment of common diseases
lability and provision of essential drugs

COMMENTS

6. b). Epidemiological Criteria
   i). - infant mortality
   ii). - child mortality
   iii). - maternal mortality
   iv). - Case fatality
   v). - specific disease mortality
   vi). - morbidity of common communicable diseases
   vii). - Work absenteeism and disability among certain population groups e.g. school children

   c). Technological criteria
   - effectiveness of available technology in solving the problem

   d). public and Social Concern Criteria
   - degree of social concern about the problems identified

   e). Economic implications Criteria
   effect of the disease(s) and condition upon
   - agricultural production
   - rural and community development
   - trade
   - tourism
   - performance at school

   f). Population Health facility Ratio

   one dispensary type I to serve 4,000 - 8,000 population
   one dispensary type II to serve over 8,000 population
   one Health Centre to serve 50,000 - 80,000 people
   one bed per 1,000 population

COMMENTS

7. a). Health policy

7. b). Service objectives

a). To strengthen and carry out measures for eradication prevention and control of disease (environmental protection, vector diseases control, immunizations, early detection and treatment, health education)

b). To provide for adequate and effective diagnostic, therapeutic and rehabilitative Services for the entire Kenyan population.

c). To promote and develop biomedical and health services, research as a means of identifying improved and cost effective methods for the protection of health of people.

c). Alternative Strategies of courses of action

These should be closely related to national health policies and they include strategies that:

a). have concentration on promotive, preventive activities
b). have emphasis on applicable interventions at community level.
c). promote utilization of resources available within the Community, District.
d). are flexible to accommodate different solutions, locally suited
e). aimed at promotion of Coverage to all population in the district with primary health care
f). aimed at promotion of Community involvement
g). need minimal cost per beneficiary
h). give benefits to the largest possible number of the Vulnerable population

COMMENTS

8. SPECIFIC HEALTH PROGRAMMES/PLANS

a). Communicable disease control
b). Vector control
c). Family health
d). Nutrition
e). Environmental health
f). food safety
g). water quality
h). Waste disposal
i). Education and information
j). Family Planning.

9. PERFORMANCE STANDARDS/TARGETS

- evaluating the quality of health services

10. ACTIVITY TIME CHART WORK PLAN

- Analysis of major activities that will be involved in developing the programme.

COMMENTS

11. EVALUATION PLAN

a). mechanism for measuring achievement

b). provision for assessing original goals and objectives

12. INFORMATION SYSTEM

a). Use of existing data and their sources.

COMMENTS

12. b). New data sources

13. BUDGET JUSTIFICATION AND COST ANALYSIS

a). Development budget

b). Recurrent budget

13. c). Cost-control

d). Cost- effectiveness

e). Cost-benefit

14. <u>IMPLEMENTATION STRATEGIES</u>

a). Support from the public and political leaders

14. b). Criteria and procedures for supervision

c). Criteria and procedures for evaluation

15. Achievements since independence or since the district was formed (for the districts that did not exist in 1963).

CONSULTATIVE REPORT

Prepared for

Charles R. Drew Postgraduate Medical School

Office of International Health & Economic Development

HEALTH PLANNING & INFORMATION PROJECT #615-0187, Kenya

Joel Henderson
April 1, 1982

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LIST OF ABBREVIATIONS USED

AFYA House - Headquarters location, MOH

DANIDA - Danish International Development Agency

DOS - Disc Operating System

DP - Data Processing

HIS - Health Information System

HPIP - Health Planning & Information Project

IBM - International Business Machines

KEPI - Kenya Expanded Program on Immunization

MOF - Ministry of Finance, Kenya

MOH - Ministry of Health, Kenya

LIST OF CONTACTEES

Dr. Koinangi - Ministry of Health, Naiarobi

Dr. Moneno - Ministry of Health, Nairobi

Dr. Kinani - Ministry of Health, Nairobi

Chief of Data Processing - Ministry of Finance

Deputy Chief of Data Processing - Ministry of Finan

Programmers - Ministry of Finance

Chief of Special Studies and National Census - Ministry of Finance

Chief of Data Entry, Data Processing - Ministry of Finance at AFYA House

Statistical personnel - Kaimbu District Hospital

Chief of Nursing - Kaimbu District Hospital

District Health Officer - Kaimbu District Hospital

Statistical personnel - AFYA House/Silopark House, Nairobi

IBM Regional Director - Nairobi - Silopark House

IBM Sales representative - Nairobi

DANIDA - KEPI, Henric Olesen, Director

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APPENDIX A - MOH HEALTH DATA FORMS

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INTRODUCTION

During the period January 17 - March 5, 1982, I was priviledged to consult to the HPIP in Kenya.

My primary charge was to render an opinion on the current state of the MOH's national health information system, to identify possible areas of improvement, to make recommendations for implementation of appropriate remediations, and to advise the HPIP on the specific activities that would be appropriate to undertake in connection with its mandate, "to assist the MOH in strengthening its HIS".

CONSULTATIVE METHODS

A considerable amount of preparatory work was undertaken prior to departure for Kenya. Related project documents were reviewed, and several briefings were held with informed HPIP (headquarters) staff. I was also able to meet with and receive input from Dr. Gipson while he was in Los Angeles on other Project business during November, 1981.

It was initially clear that the MOH's current data processing capacities would need to be examined in-depth. Anticipating the possibility that data processing hardware might require expansion or upgrading, some state-side assessment was also done to identify particular equipment that might be compatible with existing Kenya-based facilities.

In Nairobi, interviews and discussions were undertaken with key personnel at the MOH and the MOF (the MOF provides MOH data processing services).

An observational tour was also made to Kaimbu District Hospital (and out-patient clinic) to develop a perspective on field-based data management. In addition, all known computer facilities in Kenya which have the potential capacity for handling national-scale data, were contacted.

FINDINGS

A. MOH Data Gathering Instruments

The forms and data gathering procedures now in use by the MOH appear to be quite adequate in terms of capturing most of the raw data necessary for an effective national information system. Data elements treated on the current forms (shown as Appendix A), encompass much of the information needed for statistical analyses/summaries related to: morbidity/mortality, immunization, epidemiological sampling, socio-demographics, etc.

Still other data elements which are directly supportive of management and administrative functions (e.g., personnel deployment, supply/equipment inventory control, etc.), could easily be installed.

B. Data Processing

Data gathering as observed in the field (at district hospital/out-patient levels), is a very structured and controlled process. Given the conditions under which staff labors, this

part of the system works quite well indeed.

Documents are sent with acceptable timeliness, to the Ministry, where they are stored in an orderly manner for processing. The following forms are routinely submitted upward.

- Discharge Sheet
- Return of Notifiable Infectious Diseases
- Immunization Summary Sheet
- Family Planning Clinic Card
- Family Planning Additional Re-Visit Card

Of these, only the Discharge Sheet becomes relevant for automated data processing purposes.* On this form, information is coded according to ICD9. Encoding is then re-checked (one hundred percent), and finally, a manual tally of all statistics is done by MOH statistical clerks before the data goes for data entry. Between these three processes, significant time elapses.

The next step, data entry, is performed from the source documents onto floppy disc. This function is housed in the MOH, but supervised by MOF personnel. (At this point, the MOH looses

* Infectious disease and immunization data (out-patient) are tallied manually and added to the morbidity/mortality statistics. Family Planning data is collected and reported, but is not currently handled by the MOH's statistical unit at this time.

control of the data processing sequence). Historically, the MOF has demonstrated a limited capacity to respond to MOH data processing needs:

- Programs are limited to production of morbidity/mortality tables.

- Processing is done on an IBM 135 (slower of the two MOF machines).

- Processing is scheduled on an ad hoc, low priority basis.

Periodically, when time permits, the MOF processes MOH data and produces a preliminary report. This run is delivered back to MOH statistical clerks who then check the run against their original hand-tallied data. If a discrepancy exists, it is researched and corrected. The corrected items, plus the rest of the old, (good) data in the batch, are then resubmitted to Data Entry and Processing. These procedures are repeated ad infinitum until the computer tally agrees with the manual tally. This validation process typically requires 3-4 corrective cycles. The report is then published.

C. Quality of Systems Outputs

The data processing sequences as described above, are time-consuming and quite inefficient from a methodological

point of view. Outputs of the HIS have thus been affected in two equally critical ways.

First of all, data processing is hopelessly backlogged. The most recent data processed is for mid-year, 1978. Unprocessed data now on deposit at the Ministry include all of 1979, 1980, 1981 and 1982. Being 3-4 years old at time of publication, the health statistics currently being generated by the MOH are obsolete upon receipt, and thus are virtually useless for health planning/management purposes. This situation cannot be ascribed to the data gathering efforts in the field. Information from the field is reasonably complete, accurate, and forwarded in a timely fashion to the Ministry. The essential problem is in the time-consuming manual checks and vertifications, the data entry mechanism, and data processing and programming.

Equally as important, the massive array of data that is being collected, (with its limitless possibilities for generating useful information throughout the MOH system), is not being utilized. Currently, the only national health statistics being generated are morbidity/mortality tables. No programs have been developed to encapsulate a wide variety of other clinically related measures (i.e., immunizations, epidemological sampling, monitoring, alert,

The computer is used essentially, as a typewriter. None of the computer's storage or editing, and few of the arithmetic capabilities are used. The program - such as it is - was written by the Finance Department some years back and there is no one now available to modify or enhance the programs.

D. Impact of Current HIS Deficits on Overall MOH Operations (and HPIP Concerns)

If one accepts the concept that a "system" defines a variety of components which generate, interact, support, sustain and perpetuate each other, current health data management (as an interactive part of the national health delivery systems), must be evaluated - at best - as formative.

For one thing, it should be obvious from discussions in preceeding sections that, although tremendous energies (and field documentation) are being generated, data is not being summarized in a form that can be readily used by either concerned reporters or national decision-makers. Although statistical data can be viewed as only one of several valid means of forming judgements (e.g., policy/management decisions), it should be recognized that the means for reliable (statistically-based) national decision-making, does not now exist on any meaningful level.

In another respect, the current system-related deficits

create a situation where by those who report the information get no reward (in the form of being able to see their data summarized and re-applied for local purposes). It is remarkable, indeed, that the essential data generation components of the HIS (in the field), have sustained their own momentum for upward reporting. Even in much more matured and stablized information systems, it has been shown time and again that if reporters do not get basic feedback on what they report, over time they will cease to collect data (reliably or validly): the importance of the exercise becomes irrelevant. although not yet an active phenomenon, the current state of affairs in the MOH's information systems has all of the potentials for further systems degeneration if current practices are not altered.

Finally, all of the foregoing observations and comments suggests that the MOH's HIS is being approached on a basis which simply maintains an earlier established, minimally productive and status quo. On the other hand this consultation has also brought to light the fact that there are a number of emerging, variously funded projects/MOH operations, whose, mandates naturally include pre-emptory concern for health statistics. These projects are either sub-sectoral (e.g., family planning, urban health care) and or service-specific (e.g., immunization). In general, of these projects have built-in data gathering (and mini data systems components). In the absence of a strong in-place

national health information system, there is the danger that these various projects could inadvertently. Impose new requirements and/or have the potential for creating duplicity or conflicting approaches upon an already tenuous national health information system. Care should be taken to ensure that a national HIS function not only addresses its own historical gaps, but is managed in such a way as to support and control design of information components of formative and future health sector projects. The following illustrate the above point:

(1) KEPI is an innoculation program sponsored by DANIDA. The program will ultimately cover the entire country. Their management feels that they will eventually need to have in place a comupterized management and information system, and they asked us if we (e.g., MOH/HPIP) can help. We replied that we thought we could, since such a system is ideally suited for the configuration we have in mind, and that their long-term requirements would dovetail nicely with the rest of the Ministry's requirements. It is in the interest of the Ministry to integrate as much as possible the various data which will be generated by various agencies under the ministries auspices. We view KEPI as the first of several national-scope projects whose data will have to be integrated into a national system.

(2) Jomo Kenyatta Hospital, in Nairobi, is the national tertiary care facility in Kenya. The Hospital (in fact) operates quasi-independently of the Ministry. During the course of my consultation, it was revealed that the Hospital was pursuing a Data Processing alternative for itself, quite independent of the Ministry. The system they are entertaining is a Hospital Information System developed in England to run on IBM gear. Many questions have to be raised about the wisdom of such a system at this time, most important of which is, "Is the hospital ready for automation of any kind at this time?" The answer is, "Not before careful examination of manual systems and the relationship of all data to national requirements is done." More thought, planning and time is needed before automation should be considered. Particularly, the clinical aspects of a Hospital Information System should not be attempted until central Ministry programs are up and operating. The capacity of the MOH/HIS to guide such matters should be clear and enforceable.

Over and above its data generation services, the HIS will need to function as a controller and coordinator of all health statistical activities and outputs. To do otherwise has the serious potential for fragmenting the limited MOH

resources available for data management, as well as making it impossible for the MOH to develop true national statistical profiles.

E. Overview of Kenya Computer Facilities

Currently in Nairobi, there is the following hardware:

IBM System 135 - 5 years old - Ministry of Finance (leased at maximum)
IBM System 138 - 4 months old - Ministry of Finance (purchased)
IBM System 135 - IBM Service Bureau
~~IBM System 3 - IBM Service Bureau~~
IBM System 4331 - American National Life Insurance

There may be other miscellaneous pieces of gear scattered around the town and country, but these are the primarily installations. IBM is the largest data processing presence in Kenya. The range of equipment offered by IBM differs greatly in Kenya from that offered in the USA or Europe. Such commonplace gear as the 145-48, 155-58, 303X has never been, is not now, and in all likelihood, will never be "announced (Announced in Kenya is IBM jargon for 'offered for sale and maintenance'.) Thus equipment that might be considered redundant and obsolete in the USA will be the latest available in Kenya. For that reason, strange configurations such as a leased 135 side-by-side, a purchased 138 is explicable if not understandable.

The more advanced 4300 series has been announced in Kenya and one box is already in private hands in Nairobi. Time can be leased on this machine. All systems run under DOS, but current users are running relatively unsophisticated applications.

RECOMMENDATIONS - IMMEDIATE

The following are recommended for immediate action:

1. That the current DP relationship between the Ministry and the Ministry of Finance be severed as inoperable, as soon as possible.

2. That the Ministry of Health develop its own data processing capabilities at AFYA house; that HPIP obtain for the Ministry of Health an IBM 4321 or 4331 processor for installation at AFYA House, Installation date - 4th quarter, 1982 or 1st quarter 1983 or sooner if possible.

3. That the Ministry itself undertake the processing of its Morbidity and Mortality statistics.

4. That programs be generated for the Ministry that will perform a full range of monthly statistical reporting and analysis functions on both in-patient and out-patient data.

5. That the resultant statistics be published monthly and that quarterly summaries be returned to the field (where they were generated) on a systematic basis.

6. That KEPI be used as a prototype for integration of Project and MOH information, that the Ministry of Health met KEPI data processing needs, and that programs be generated that respond to KEPI's management control and statistical reporting needs.

RECOMMENDATIONS - LONGER TERM

7. Requirements Definitions are to be drafted for the following systems, for installation during calendar years '83 and '84, in order of priority:

   - Personnel and manpower,
   - Transport - Equipment maintenance and status,
   - Purchasing Stores and Inventory Control,
   - Enhancements to the vital health statistics reporting system, and
   - Hospital Information System.

8. Selection and training of Kenyan Data Processing staff over the period of 18 months. Recommend,

   - Two Operators,
   - Three Programmers, and
   - Two Data Entry Clerks.

9. Structurally remove data entry function from the Ministry of Finance and place it within the Ministry of Health.

10. Put off any computerization at Jomo Kenyatta Hospital for at least 1.5 to 2 years. Give it time to get its management in shape and its manual systems working well before any serious work in hospital DP takes place.

HEALTH MANAGEMENT

INFORMATION SYSTEM

WORK PLAN

HEALTH MANAGEMENT INFORMATION SYSTEM (WORK PLAN)

1. The mortality morbidity statistics will be published on time.
   The statistics will be demonstrably correct.
   There will be feedback to the field quarterly.

2. A steering subcommittee for the computer will be established within the HMIS Steering Committee..

3. The computer will be established within the Ministry of Health.
   An operations staff will be trained to run it.
   A data entry staff will be trained and working. Key punching will be eliminated.
   A programming staff will be trained to program the IBM 4321.

4. The ICD coding will be done in the field, version 9..

5. Sampling quality control of the field generated statistics will be done at the Ministry.

6. Ministry wide management information system will be up on line and updateable in real-time. Reports will be generated regularly.

7. We will have begun work on computerizing those health statistics areas that are currently being done manually.

THE STEPS TO ACHIEVE THESE GOALS FOLLOWS

1. PUBLICATION OF THE MORTALITY/MORBIDITY STATISTICS

Time span 6 months

1. Track current system:

   From field

   In-house coding and verification

   Key Punch/Data Entry

   Programming - CBS

   Processing - CBS

   Error correction

   Repeat processing

2. Systems analysis and reprogramming for 4321.

3. Install new manual procedures for processing in-house.

4. Run parallel in-house versus CBS.

5. Sever connection with CBS for future production work.

THE STATISTICS WILL BE DEMONSTRABLY CORRECT

6. Run monthly statistics for verification, validation and quality control.

7. Set up manual procedures for control of tests.

8. Analyze test results. Make adjustments and corrections as needed. Return to step 6 until satisfied..

FEEDBACK TO FIELD OF REPORTED STATISTICS

9. Confer with appropriate parties determining the nature, form and frequency of he field feedback data--for monthly mortality/morbiditv and utilization statistics.

10. Analyze results of study. Present samples of reports for approval.

11. Firm up and finalize reports.

12. Program field feedback system.

13. Test and debug same.

14. Generate sample systems reports for approval.

15. Publish first monthly/quarterly feedback data.

16. Visit sample field sites to determine response, accuracy, comments, etc.

17. Incorporate results of field visits in systems design.

18. Reprogram systems changes.

19. Test changes.

20. Accept changes.

21. Go live. Publish final version of feedback subsystem.

2. COMPUTER STEERING SUBCOMMITTEE WITHIN HMIS

Time span 8 months

1. Establish purpose and mandates

2. Membership

3. Staff

4. Procedures

5. Responsibilities

6. Officers

7. Scheduled meetings

8. Agenda preparation and input.

9. Minutes

10. Subcommittee task forces/ex-officio, etc.

3. TO ESTABLISH A COMPUTER IN THE MINISTRY

Time span 7 months

1. Select appropriate hardware.
   a. Survey available vendors.
   b. Verify maintenance and parts availability.
   c. Compatability with existing hardward in GOK.
   d. Price it.
   e. Delivery dates.
   f. Training capabilities.
   g. Software compatability with existing facilities.
   h. Comparable hardware in region.
   i. Upward growth capabilities - speed - size.
   j. Future in the vendor's plans and capabilities.
   k. Purchase US or Kenya.

2. Systems software selection.

3. Hardware configuration selecti(

4. Place on order.

5. Select maintenance program.

6. Sign maintenance agreement.

7. Select supplies.

8. Survey vendors. See substeps in above except ~~P.G.H.I.~~

9. Purchase supplies.

10. Site selection.

11. Site preparation.

12. Security procedures established.

13. Systems software training.

14. Hardware installation.

15. Hardware integrity shake down period.

16. Systems software installation.

17. Systems acceptance and sign-off.

18. Initialize system IMPL.

19. Size: one chief operator.

20. Interview potential candidates, at least six.

21. Screen six candidates - - reduce to two.

22. Select one.

23. Introductory and indoctrination period at MOH computer site and IBM on the 4321.

24. Training in the US at Drew School, for a period to be decided, on the Drew School 4321. Emphasis on computer room, scheduling, management, safety, operations, air conditioning, site security DOS/VSE, power, VSAM, SSX, etc. systems maintenance.

25. Return to Ministry - operate computer in parallel with project team. Hands on one month or longer as required.

26. Go live.

DATA ENTRY STAFF TRAINING

27. Screen operator interviews.

28. Interview/Select

29. Train in ICCF at IBM.

30. Parallel operation in-house.

31. Go live with health inforamtion systems data.

PROGRAMMING STAFF TRAINING

32. Size: One ~~cobal~~ COBOL programmer.

33. Interview potential candidates. Six people.

34. Screen and reduce candidates to two in number.

35. Select one plus alternate.

36. Introduction and indocrination period at MOH computer site and IBM on the 4321.

37. Training and evaluation at IBM Nairobi on 4321.

38. Training in systems and cobol programming in the US at Drew School, for a period to be determined. Not to occur at the same time as the operators training.

39. Return to Ministry of Health. Start programming Health Information Systems programs in parallel with project team. Two months.

4. ICD9 CODING DONE IN THE FIELD

Time span 6 months

1. Study current in-house coding system.

2. Confer with a group of field hospital managers, get their opinions of the projected transfer of responsibility.

3. Set up workshops in the field or in-house or both, to train people to do the coding.

4. Publish multiple lists of the ICD9 coding manual by computer.

5. Set up manual procedures in-house to do 100% verification of returns from districts.

6. Run a test of returns from one district of each province, perhaps one month's data.

7. Evaluate test return thru 100% verification of the seven districts.

8. Make necessary changes in manual procedures for field coding and in-house verification to insure desired accuracy.

9. Go live with all provinces with 100% verification in-house.

5. <u>REPLACE 100% VERIFICATION WITH SAMPLING QUALITY CONTROL IN-HOUSE</u>

Time span 12 months

1. Set up test protocol and procedures.

2. Using the error rates detected during 100% verification in step 4, determine the sample sizes that would be appropriate for each district to obtain 97-99% accuracy. Ninety-five percent of the time this seems a desirable confidence interval.

3. Test a random sample of the size appropriate for each district against the same data that was 100% verified. In each district, determine if the sample error rate is significantly higher than the census error rate. If so, up the sample size and redo until the error rates are equal.

4. Repeat process for two months (1 month). Once a district has performed up to standards by sampling two months in a row, it is considered acceptable.

5. Take the data from the rest of the districts in that province and run the sample vs. census test for one month or until all districts are ok.

6. Once all districts are being sample verified, every six months run the sample vs. the census test with the sample size set at what ~~by~~ ? ~~then~~ we ULTIMATELY consider to be a good national sampling ratio, perhaps 10-12%.

7. In those districts where the test fails at the prescribed ratio, re-up the ration and redo the test until the desired accuracy is attained.

8. Each time a district fails the test, analysis of the causes of errors must be identified and corrected.

9. Publish third quarter 83 statistics as if they were year end, as a rehearsal for same. Perhaps in November '83.

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6. MINISTRY WIDE HEALTH MANAGEMENT INFORMATION SYSTEM: ONLINE UPDATEABLE, REPORT GENERATION

Time span 9 months

1. Identify each data element, in the Health Ministry, that is to be included in the Ministry wide data base and reporting system, e.g. by district:

   Health facilities, type, condition, capacity, number

   Population

   Square Miles

   Water Supply

   Sewage

   Transport

   Patient

   Demography

   Utilization

   Staff/Manpower

   Students

   Deliveries

   Etc.

2. Identify appropriate authority in each district for source data.

3. Confer with field authorities.

4. Design appropriate questionnaires.

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5. Set up regional workshops on how to fill out initial forms.

6. Set up manual in-house procedures to receive, monitor, and validate questionnaires.

7. Design data base.

8. Analyze and program system.

9. Test same.

10. Debug same.

11. Go live.

12. Generate reports by district location giving status of each element in that district as we see it at the Ministry. Make the report a turn around document so any corrections can be made on the report and returned.

13. Incorporate changes from field. This data base is considered as the most up-to-date information we have.

14. Each quarter the status report will be generated with turn around documents included. Each data element for each district will have an 'as-of-date' telling the Ministry the date we last heard from the field about this particular data element.

15. Upon demand the Ministry can know the status of any element for any district, by querying the system-on-line or perusing a monthly PRINT-OUT.

Acquire Supportive Commodities _____ [Q]

1. Office Equipment

Basic office equipment including typewriters and xerox machine have been purchased and are available to Project Staff at the work sites. Adequacy of these facilities will need to be re-evaluated as the number of HPIP and counterpart staff increase.

2. Vehicles

Authorization for duty tax waiver for purchase of two Peugot 504 Stationwagons and one Landrover, were received from the Government of Kenya, Ministry of Finance, in October 1981. Vendor selection was initiated in November 1981. During the period November 1981 to March 1982, quotations were received and an investigation was undertaken by the Drew Purchasing Office to verify registration and liability insurance requirements for operation of vehicles in Kenya. Purchase orders were issued in March - April 1982. Finalization of payments and advisement on shipment dates were completed in August 1982. Vehicles arrived at port in Mombasa in September 1982.

As of the close of Project Year II, arrangements were being made for transport of vehicles by rail to Nairobi, at which time operating arrangements including registration, insurance, petrol supply and maintenance will be finalized with the MOH.

3. Computer

During January - February 1982, a systems analysis consultant was deployed to Nairobi to conduct an investigation of MOH automated data requirements.

The substantive findings of that consultation are discussed in the Information Systems section of this report. Specifically, as regards the need for the purchase of computer equipment under the terms of the HPIP, the consultant's opinion, offered at that time, was that full development of the MOH's data management capability would require significant augmentation of existing facilities and training/re-training of MOH technicians.

The recommendation was made to proceed with the feasibility of purchasing an IBM 4321 series system with the specific contingencies that:

1) the details of a MOH data management structure, operational control and appropriate staffing could be satisfactorily established;

2) the HPIP would be extended beyond the contractual termination date of September 30, 1983, in order to guarantee the Project sufficient time to assist in the development and installation of the MOH's automated data processing capability.

To that end, in May 1982, the MOH and Drew made a joint request to AID/K for approval of a Project Year II budget that would include authorization to proceed with the purchase of computer hardware. AID's opinion was withheld until September 1982, pending the findings of an independent evaluation of the

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Project. The opinion of the Evaluation Team, which was upheld by AID/K and accepted by both the MOH and HPIP was essentially that, although the MOH's needs ultimately pointed toward development of an internally managed, large-scale computer capability, the current needs for structural definition and software development are overridding and must be addressed first.

Based on this opinion and other deliberations with MOH officials, HPIP's overall technical approach to assistance in development of the health information system and the specific issue of purchase of computer equipment, have now been more clearly defined. During the Project Year III, the long-term health information systems consultant will concentrate on assisting the MOH in establishing a user-based approach to identification of data criteria, data gathering methods and, data utilization. Within the remaining term of the HPIP contract, a mini computer will be purchased to assist the MOH in developing data program prototypes in preparation for the longer-range development of the full system. HPIP will concentrate its efforts on data elements specifically related to support of program planning, management control and evaluation.

Within the context of the Project requirements, the sub-objectives related to acquisition of office equipment and vehicles are considered to be essentially complete; approximately 90% of the sub-objective related to the purchase of computer equipment remains to be completed.

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