

14. PROGRAMMING OF PROJECTS AND PRIORITY

COMPREHENSIVE PROGRAM

Proposed interventions with respect to each strategy are integrated in a number of projects, taking into account: 1) implementability; 2) effective project linkages; and 3) functional relations among proposed interventions.

A matrix with prioritized diseases and the series of interventions under the category of area, as shown in Fig. 14.1, was used as a conceptual framework for programming those projects. As the result, a total of 37 projects are identified and proposed as a long list for improvement of the district health system on the medium- and long-term perspectives. The profiles of these proposed projects are summarized in Annex of this report.

PROJECT PRIORITY

(1) Criteria for Prioritization

The following qualitative criteria are applied for looking into the priority of the long listed projects:

- (a) Supportive or synergistic interventions to ongoing projects and programs in the line with National Health Reform Policies;
- (b) Cost effective interventions that have been already recognized in the neighboring areas or past studies;
- (c) Forming an important base for the future development; and
- (d) Leading to the strengthening capacity building and the reinforcement of the public system.

PROPOSED PRIORITY PROGRAMS

Out of the comprehensively listed projects, those meeting with the criteria mentioned above are formed as priority projects to be urgently implemented towards the year 2005.

Since the district health system cannot materialize by single project alone, but requires an integrated and balanced manner of implementation with multi-dimensional projects covering the entire health system even in the short-term. To this end, five priority project packages are proposed in the district health system structure with three dimensions of "Priority Diseases", "Health Service Systems" and "Human Resource", as shown in Fig. 14.2. The five are:

- (1) Priority Disease Program;
 - Malaria Control Project;
 - Reproductive and Child Health Project;
- (2) District Hospital Rehabilitation Program;
- (3) Rural Health System Improvement Program;
- (4) Community-based P/PHC Program; and
- (5) District Health Service Education Program.

Under the Priority Disease Program, a Malaria Control Program is proposed as one of possible individual projects, much of which will be integrated into the other proposed projects. While, ARI and HIV/AIDS control programs are developed with a Reproductive Health and Child Health Project, much of which shall be integrated into the Rural Health System Improvement Project.

The proposed District Health Service Education Program includes a program for enhancement of Continuing Education System at district level for which the responsibility should be assumed by each district.

These proposed project packages are urgent actions to materialize the planned 10 strategies discussed in the preceding chapters. Each project must have functional linkages with the others. The linkage is not of one-to-one relation, but multi-relation directly and indirectly.

Fig.14.1 Possible Interventions for Priority Diseases and Programming of Projects

Trend	Disease	Health Service					Supporting Service					Living Environment / Community / Infrastructure			
		Rehabilitation	Clinical	Prevention	Faculty	Equipment	Human Resource	Logistics	Health Information	Organization	Financing	Private and Mission Health Providers	Water and Sanitation	Pre-schools, Schools and NGO	Household / Community
▲	Malaria		Anti-malaria Drug	Bed Net		Microscope	Laboratory Technician	Anti-malaria Drug	Resistance to First Line Drug	Quality of Care and Referral	User Free		Mosquito Control		
▲	ARI		Antibiotics					Antibiotics	Risk Factors (Preventable mortality)	Selection and Management of Antibiotics	User Free				
▲	Tuberculosis		Anti-TB Drug	Complete Treatment of Latent TB Patients		Microscope X-ray		Anti-TB Drug	Compliance Rate						
▲	Measles		Vaccine			Refrigerator Vehicle	EPI	Vehicle	Immunization Coverage Rate			Support of Immunization at Inaccessible Areas			
▲	Diarrhea		ORT	Safe Water				ORLS					Safe Water and Toilet		Knowledge of Sanitation
▲	Anemia		Blood Donations / Iron Supplement			Hematology Lab Equipment			Growth Evaluation						Knowledge of Health Child
	Malnutrition			Growth Monitoring			Nutritional						Safe Water and Toilet		Nutrition Improvement and Food Diversification
▲	HIV / AIDS														Knowledge on Preventive Behavior
	HIV carrier	Counseling		Use of Condom Treatment of STD		HIV Test	Doctor Laboratory Technician	HIV Reagents Antibiotics	Infection Rate	Coordination with Other Institutions	Resource Mobilization	Exchange of Information			
	ARV	Counseling					Counselor								
	AIDS	Counseling					Counselor								
▲	Population			Family Planning											Provision of Contraceptives

Source: The JICA Study Team

Fig. 14.2 COMPOSITION OF PROPOSED FIVE PRIORITY PROGRAMS

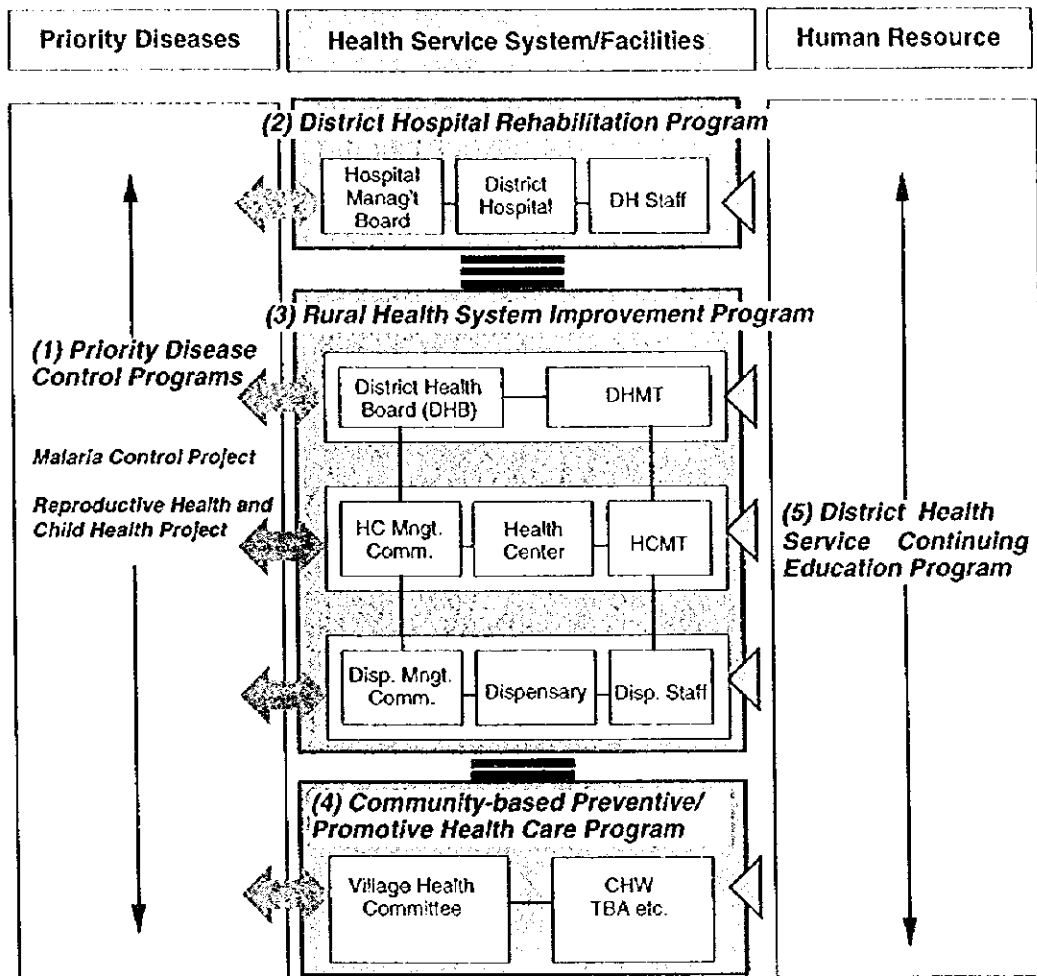
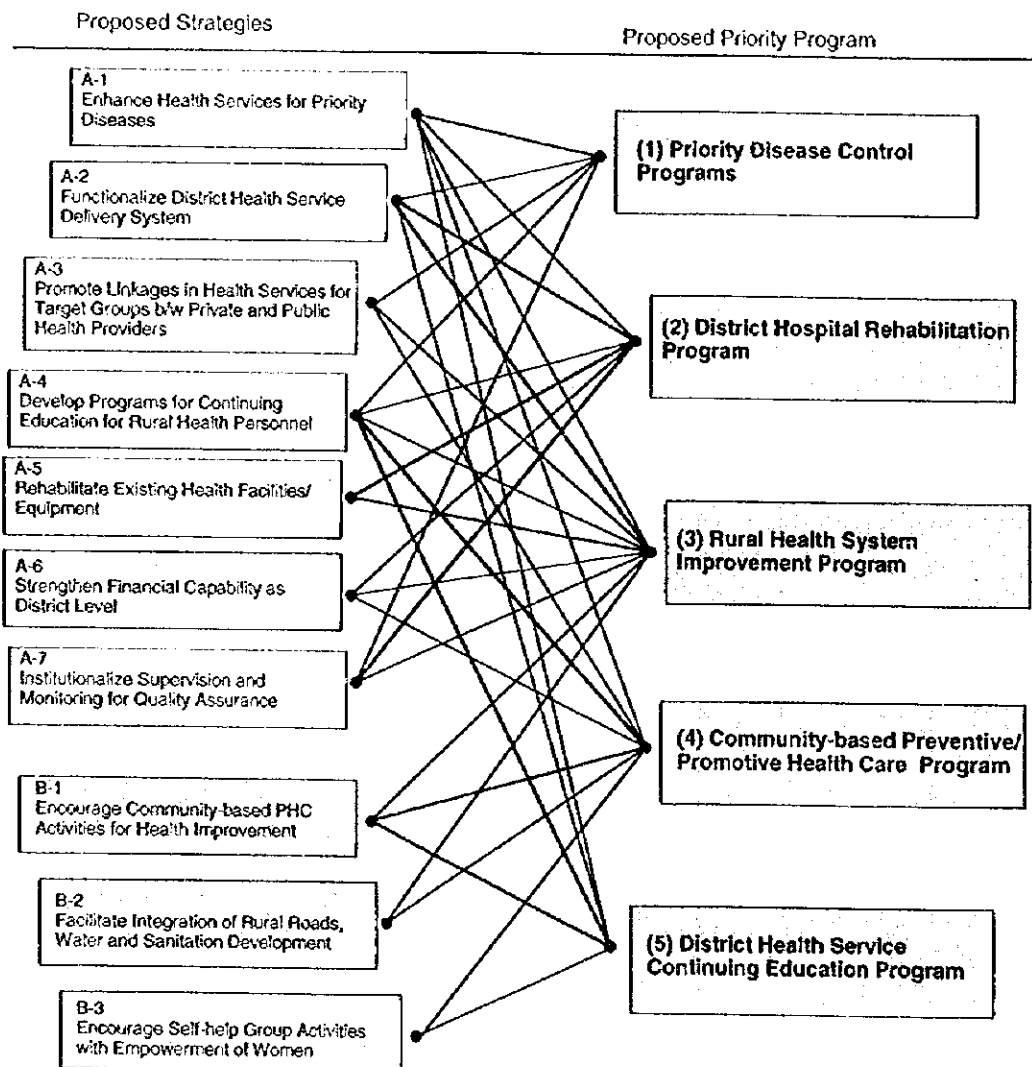


Fig. 14.3 LINKAGES BETWEEN PROPOSED STRATEGIES AND PRIORITY PROGRAMS



15. Priority Project 1-1: HIGHLAND MALARIA CONTROL PROJECT

PROJECT OBJECTIVES AND TARGET

To reduce mortality and morbidity due to malaria by 50% and 30% of its 1998 level, respectively, among the residents of Kericho, Bomet, Nyamira, Kisii and Gucha

RATIONALES

The control of malaria needs an integrated approach in optimal timing. An effective and strategic project shall be formed, taking into account a fact that highland and lowland malaria are both closely related to each other. Thus, well-coordination among province and districts is strongly required.

The Project shall integrate two streams of activities into one package: Highland Malaria Control Program and Malaria Control Initiative.

HIGHLAND MALARIA CONTROL PROJECT

Highland malaria is strategically controllable and the situation is expected to be greatly improved, should appropriate and timely measures be given, because of its seasonality of outbreak. The following are proposed to be designed for the program:

- 1) Enhancement of dissemination of appropriate information through health education by RHF's staff (e.g., PHOs and PHTs);
- 2) Enhancement of usage of adequate **anti-malaria drugs** based on periodical drug resistance monitoring and surveillance of the epidemics;
- 3) Reduction of incomplete treatment through the improvement of case-management (e.g., enhancement of blood examination and follow-up services);
- 4) Monitoring of epidemiological and meteorological indicators to prepare anticipated malaria outbreak; and

Preparation of strategic countermeasures against malaria outbreak in optimal timing through health

education, vector control, environmentally preventive measures and logistics of medicines and equipment.

MALARIA CONTROL INITIATIVE

To effectively initiate the project, emphasis should be placed on dissemination of appropriate information about malaria for the further enhancement of people's awareness through a deliberate malaria campaign. People, particularly small children in highland are sensitive to malaria. They are exposed to the danger in one or two times every year when malaria breaks.

Malaria outbreak in highland area is closely related to that of traditional malaria endemic area. Thus, an integrated method of malaria prevention and control should be conducted in both high and low areas. Therefore, the project location shall cover Nyanza and Rift Valley Province. The project duration may be 3 consecutive years with the following key activities:

- 1) Publicizing Malaria Control Campaign and information on malaria through radio and TV (in liaison with the IEC production project);
- 2) Promotion of cottage factory to produce preventive instruments (e.g. pyrethrum bar, impregnated curtain and impregnated bed-net);
- 3) Awards for proposals of community-based preventive project (official recommendation for fund)
- 4) Distribution of impregnated mosquito nets for the communities where health committee is well organized and active (1,000 x 50 communities) and for pregnant women (1000 x 50 RHF's);
- 5) Training of village health workers at poor access communities (50 communities/ week x 4); and
- 6) Outreach health talk by PHTs and PHOs (50 communities/week x 4 = 200 communities)

The campaign needs to be coordinated with relevant agencies/ongoing programs such as: Bungoma Initiative Project by USAID, WHO, USAID, IFAD, DANIDA, SIDA, KEMRI, ICIPE, AMREF, etc.

FOR THE PROJECT IMPLEMENTATION

(1) Donor Inputs

Key players of this project must be Provincial Health Office and District Health Management Teams to initiate, plan, finance and manage the project. External technical and personnel assistance from donors should be sought for:

- Monitoring and surveillance of drug resistance;
- Programming and designing of the implementation of the project; and
- Provision of necessary start-up equipment.

(2) Program Linkages

The JICA proposed projects such as 1) Rural Health System Improvement Program; 2) Community-based Promotive and Preventive Health Care Program; and 3) District Health Service Education Program should all be related to this Project. Learning from the on-going USAID projects such as Bungoma Project will be a vital input to seek the successful implementation.

Inter-governmental coordination with Ministries related to Land, Agriculture, Education, Environment, Water, Transportation, etc. and KEMRI is highly required.



Anti-malaria drugs resistance survey
(Kisii)

Priority Project 1-1: HIGHLAND MALARIA CONTROL PROJECT

1. Project No. P1-1	2. Project Title Highland Malaria Control Program				
3. Project Location Nyanza Province, Rift Valley Province	4. Target Beneficiaries 1) People exposed to malaria outbreaks 2) Community Health Workers 3) PHOs, PHTs, PHNs, RHF's staff 4) Provincial and District Health Office		5. Project Duration 5 years		
	6. Implementing Agency / Body Provincial Health Office, District Health Management Teams		7. Project Level Basic	8. Project Priority High	
9. Summary of Objectives Reduce mortality and morbidity due to malaria 50%, and 30% of their 1998 level, respectively through: (1) To improve case management of malaria patients in all health facilities (2) To strengthen governmental structure/systems to prevent outbreaks of malaria in project location. (3) To enhance people's awareness of malaria and to reduce prevalence of severe malaria cases.					
10. Justification <ul style="list-style-type: none"> - People in Highlands, particularly small children, are sensitive to malaria. They are exposed to malaria outbreaks once or twice a year. - Malaria outbreaks in highland area are closely related with the traditional malaria endemic areas. Thus, an integrated control method of malaria prevention should be conducted in both high and low areas. - Result of surveys on people's perception and health seeking behavior of malaria patients (e.g. malaria can be transmitted by bad water/soil/air, usual treatment only by anti-febrile drugs and delays to receive proper treatment) clearly show that awareness on malaria should be enhanced. - Management of curative services for malaria patients should be strengthened, inc. monitoring of drug resistance, reduction of incomplete treatment, logistics of anti-malaria drugs and inpatients services. 					
11. Expected Benefits / Outputs <ul style="list-style-type: none"> - Awareness about transmission and adequate home care for malaria is enhanced. - Vector control measures are commonly taken, particularly in low land. - Active case detection and treatment for malaria positives, particularly for small children, at the beginning of outbreak season. - Management for malaria cases is strengthened in both rural health facilities and hospitals. 		12. Verifiable Indicators <ul style="list-style-type: none"> - Reduction of delay of treatment (compared with the result of baseline data) - No. of households using preventive measures (compared with the result of baseline data) - No. and ratio of active case detection - No. of treatment completed - No. of drug resistance monitoring 			
13. Important Assumptions / Conditions for the Project Climate features will continue without fundamental change.					
14. Project Linkages / Other Sector Linkage USAID/Bungoma Project, Rural Health System Improvement Project, Community-Based Preventive/Promotive Health Care Project, District Education Program		15. Relevant Agencies to be Coordinated USAID, Ministry of Land, KEMRI			
16. Major / Key Activities		17. Major Inputs		18. Est'd Cost*	
		Personnel	Materials		Funds
<input type="checkbox"/> Monitoring of drug resistance		x	x		
<input type="checkbox"/> Monitoring of meteorological data		x	x		
<input type="checkbox"/> Local production of vector control instruments, e.g. mosquito net (cloth), mosquito coil, impregnated curtain (by revolving fund)		x	x	x	US\$ 0.1 M.
<input type="checkbox"/> Increase of microscopic diagnosis in rural health facilities, inc. continuing education for Microscopist		x	x		US\$ 0.05 M.
<input type="checkbox"/> Enhancement of active case detection in rural health facilities		x	x	x	
<input type="checkbox"/> Strengthening logistic system, inc. supply of anti-malaria drugs			x		
<input type="checkbox"/> Enhancement of curative services and follow-up care for malaria positives, particularly for patients treated with only chloroquine		x	x		
<input type="checkbox"/> Strengthening health education to community through village health committees		x	x		US\$ 0.05 M.
<input type="checkbox"/> Introduction of standard guideline for referral of severe/complicated malaria			x		
19. Estimated Total Cost					US\$ 0.2 M.
20. Necessary External Inputs/ Assistance / Arrangement					
Drug resistance monitoring supported by technical co-operation (by donors)		x	x	x	
Government puts emphasis on management of logistics			x	x	

*Only facility and equipment

16. Priority Project 1-2: REPRODUCTIVE AND CHILD HEALTH PROMOTION PROJECT

RATIONALS

According to the death registration at district civil registers in Kisii, Kericho, and Bomet, **malaria** and **acute respiratory tract infection**, especially pneumonia, are the most serious health problems for children aged under five. They account for large proportions (30 to 50%) of all diseases causing child mortality.

Following the above, Malnutrition and anemia are ranked between the second and the fourth cause of death for children under five in the all districts, and measles emerges as the fourth cause of death in both Bomet and Kisii and the seventh in Kericho. Those three diseases account for 13 to 17% of all diseases causing child mortality.

Despite the expansion of the Service Delivery Points (SDPs), immunization coverage is low, in particular measles of KEPI program. It is assumed that the low coverage of measles attributes to drop out of mother's visits since vaccination of measles usually comes 9 months after the birth.

In the Study Area, malnutrition is not only one of the major causes of death among children but also a predisposing factor to the above infectious diseases. In addition, the nutrition status is applied to one of indicators of health, economic and social development of communities. Welfare Monitoring Survey 1994 reported that 40.5% of sampled children in Kisii and 31.8% in Nyamira were stunted. The data compiled from the district hospitals revealed that the proportion of underweight children (below third reference percentile) account for 10% in Kisii and 23% in Gucha.

For those children who need nutritional rehabilitation or supplementary food, they would be theoretically referred to and followed by district nutritionists working at district hospitals. However, only few patients from remote area actually attend the supplementary food program. If food resources are once identified and available in the communities where such chil-

dren live in, it seems to be easier for community health workers to follow the patients on the advice of nutritionists and with the program support of the districts.

PROPOSED PROGRAM

Several measures deliberated at the national level have been carried out in terms of reproductive and child health so far, however, most of them are observed not to be so effective and completed in reality as planned. Based on such an observation, the Study Team proposes the most vital actions that shall form a basis of health activities for promotion of child health through development of population based information system.

(1) Development of Child Health Card

The proposed project places emphasis on the Child Health Card as a key tool for improvement of child health program. In fact, the card consists of growth monitoring and immunization part responding health problems such as malnutrition and measles. However, there is a much room for improvement of the current card system in terms of its utilization for and integration with other important health issues.

According to a direct observation at several health centres, only one tenth of mothers carried "Child Health Card". If the card sufficiently distributed to all pregnant mothers and properly recorded by health workers, it will give important information on child health to both health providers and mothers. However, in reality, there exist a chronic shortage of the cards due to the financial problem.

The proposed project is to develop a more useful Child Health Card. The design should be simple but acceptable to cultural and social background. The text and appearance should hold necessary part for recording and information for the both health providers and mothers, taking into account the information integration with the following health aspects:

For health providers: the environmental health, in particular, access to safe drinking water, and the ongoing national Vitamin A supplement program.

For Mothers: Knowledge for High Risk Behaviors such as Nutrition (Sign of Malnutrition); ARI (Care of new-born); Diarrhea (Efficacy of Oral Dehydration Salts); Immunization (Importance of compliance), and Maternal Health focusing antenatal, birth, and postnatal cares.

In order to fully utilize the card, the inclusion of community health workers and mothers should be considered as the prime users so that the improved card will be applied to community-based approach like a baby-weighing program.

(2) A Test of Making Use of Improved Child Health Care

The proposed priority health centres will be selected for testing a few kinds of improved child health card as well as community health workers. Evaluation methods and criteria for the improved card will be designed with a team consisting of the MCH officials from MOH and Districts and a MCH specialist. At the same time, a training program for health workers at the health centres and communities will be designed and implemented.

It is recommended that the community based program aims to promote the use of the improved child health card in targeting specific objectives. Identification of "nutritious foods" in community and "Baby-weighing programs" can be linked with the use of the improved child health card.

(3) Planning of a Surveillance System

Utilization of the information in the card for a periodical statistical basis should be explored in order to support a population-based programs. Weight and height will be the most simple indicators that describe the overall health status. For the purposes like this, a simple manual for the surveillance system using the card should be designed.

FOR THE IMPLEMENTATION

(1) Donor Inputs

The health policy should continuously be supportive to the proposed project.

Donor's technical supports to improve the Child Health Card System and training of relevant health workers are expected. In order to establish a sustainable financial scheme for provision of the cards, some seed funds are necessary, followed by appropriation of cost-sharing funds for the recurrent cost.

(2) Project Linkages

The JICA proposed projects such as 1) Rural Health System Improvement Project, 2) District Health Service Education Project; 3) the National KEPI and Reproductive Health Program; and 4) the National Vitamin A Supplement Program are all related for the effective implementation and the sustainable management.

Priority Project 1-2: REPRODUCTIVE AND CHILD HEALTH PROMOTION PROJECT

1. Project No. P1-2	2. Project Title Reproductive and Child Health Promotion Project			
3. Project Location Kericho, Bomet, Kisii, Nyamira, Gucha		4. Target Beneficiaries All the mothers and children in the catchment area of priority health centres		5. Project Duration 3 years
6. Implementing Agency / Body Project Management: District Health Management Teams / MCH unit of MOH Daily Project Monitoring: Health Centre Staff Management Teams			7. Project Level Minimum / Basic	8. Project Priority High
9. Summary of Objectives To improve management of reproductive and child health service through development of population based information system				
10. Justification <ul style="list-style-type: none"> Involvement of simple community-based intervention could bring benefit and motivate the caretakers of children in the region Intervention can bring about useful data and information to program design and monitoring 				
11. Expected Benefits / Outputs <ul style="list-style-type: none"> Child health card or Maternal Child Health Card developed Improved child health card / MCH Card tested and promoted Surveillance system using child health card planned and applied to program management 		12. Verifiable Indicators <ul style="list-style-type: none"> Number of caretakers involved in the development Number of applied cases of statistics produced from improved card 		
13. Important Assumptions / Conditions for the Project <ul style="list-style-type: none"> MOH/ PMO support and approve this trial as necessary step for managerial renovation Key players including caretakers within the project are well guided to the common goal 				
14. Project Linkages / Other Sector Linkage Rural Health System Improvement Program District Health Service Education Program		15. Relevant Agencies to be Coordinated National KEPI and Reproductive Health Program National Vitamin A Supplement Program		
16. Major / Key Activities		17. Major Input		18. Estimated Cost
		Man	Materials	Construction
<input type="checkbox"/> Design and develop mother friendly and useful child health card / MCH card	x			
<input type="checkbox"/> Design and conduct a development survey for improved child health card with both facility-based and community-based program	x	x		
<input type="checkbox"/> Demonstrate and evaluate the use of improved child health card / MCH card at selected health centres	x	x		
<input type="checkbox"/> Develop surveillance system by using data of improved child health card	x			
<input type="checkbox"/> Propose sustainable card distribution mechanism to improve its availability at peripheral level	x			
19. Estimated Total Cost				
20. Necessary Inputs / Arrangement				
Responsible personal from relevant unit of MOH participate in the project	x			
Technical Assistance by MCH / Social Marketing specialist (Donor)	x			



Incubator for premature baby
(Kaplong Mission Hospital,
Bomet)



Mother and baby
(Anti-malaria drugs resistance survey,
Eramba Primary School, Kisii)



Mother and baby
waiting for consultation
(Masimba H/C, Kisii)



Mother and baby
(Makimeny Village, Bomet)



Children
(Kaplong Mission Hospital, Bomet)

17. Priority Program 2: DISTRICT HOSPITAL REHABILITATION PROGRAM

RATOINALES

Deterioration of facilities and equipment hinders improving the quality of curative service provided at district hospitals. In fact, there has been no major rehabilitation over the years due to the chronic financing problem, while the demand on the hospital services exceed the capacity of the hospitals in particular Kericho and Kisii. For example, the bed occupancy rate of Kisii became almost 200% on the average and in malaria season, it reaches 550%.

Comparing Kisii DH from Kericho DH, the former has a wider potential catchment population that goes beyond its geo-political boundaries. In fact it serves more than 1million of population including a part of Nyamira, Gucha and other surrounding districts where curative services are in restriction.

Despite their wide roles and service catchment areas, the hospitals are under-funded (the financing gap was estimated 40% to the expected financing) and thus have resulted in worsening the service quality together with deterioration of building, equipment and infrastructure. Lack of proper planning for facility and building and poor maintenance spurred on the above tendency.

PROGRAM COMPONENTS

To improve the quality services provided by DHs, the proposed project should cover the following three components in an integrated manner:

- Rehabilitation of Hospital Facilities and replacement of medical equipment;
- Strengthening of the current Hospital Management System; and
- Development of a New Maintenance System.

FACILITY REHABILITATION

Hospital facilities should be all physically functional and environmentally hygienic to prevent patients from any infectious disease.

Comprehensive facility rehabilitation and replacement of essential diagnostic medical equipment are required for Kericho District Hospital and Kisii District Hospital.

Partial improvement and rehabilitation are required for Nyamira District Hospital with minor rehabilitation of roofing and facilities, and replacement of diagnostic medical equipment.

1) Kericho DH

Layout Plan: In order to make the hospital function efficiently, the functional layout plan should be rearranged according to the basic logical circulation pattern.

Facility Components: Some facilities such as Casualty, Amenity ward, and Central Supply etc. are required to be constructed in accordance with the MOH's standard. As for the casualty, since the Kericho DH is located along the major highway from the Western and Nyanza provinces, a massive number of seriously injured patients by road traffic accidents are brought in the hospital. Therefore the necessity of the improvement of the casualty function is very high.

Service Capacity: The Kericho DH accepts about 250 out-patient attendance daily with about 45 in-patient admissions on the average. The average of BOR in Kericho DH in 1997 was 106%. Though the number of in-patients are expected to increase in future, the target is to reduce to 80%, of BOR, by strengthening the capacity of staff.

Building Renovation: To keep the patients environment in good condition, most of all the facilities need to be renovated. except for the new eye ward, new eye theatre, PMIU building, which have some damages such as water leakage from the roof, damage of ceiling, doors, windows, floors, and gutters etc..

Sanitary: Some plumbing problems in water closets such as water leakage and low water pressure should be renovated, and also small water tank should be installed on the ceiling to improve the

water pressure. However, in the case of proposed new wards, water closet should be separated from wards to keep the ward in clean. In considering sustainability, the pit latrine or another system should be studied.

Water Supply: To meet the demand of 220,000 liters/day, additional water tank is needed. A rain water harvesting system should be installed to reduce their water consumption.

2) Nyamira DH

Renovation of Roofing: Measures should be taken to improve the rain water leakage to reduce the damage to the building. To put pitched roof above the existing building is one of the options.

Water Supply: The amount of water supply is short to the demand, because the water supply cannot catch up with the rapid increase of population in the Nyamira town. Plumbing work should be undertaken to repair water leakage.

3) Kisii DH

Layout Plan: As a result of the repeated expansion, the hospital has some serious confusion in its facility layout plan. In order to absorb the more patients and improve the quality of their health services, this hospital needs a functional rearrangement of the facility layout in consideration of the following:

- Rearrangement of zoning, based on the logical functional relationship to ease the congestion in the hospital and make the control of visitors easily;
- Control of visitor's flow by the construction of perimeter fence, limitation of visitors' entrance and approach, setting a regulation of visiting hours, etc;
- Building pitch with sufficient ventilation; and
- Rearrangement of the complicated piping line for water supply and wiring for electricity.

Service Capacity: To handle more than 600 outpatients daily, the OPD needs to be expanded. The current BOR of each ward varies, commonly over 100% on the average. It is clear that the hospital's space is not enough to accommodate the large num-

ber of patients. The number of nurses in wards is 163 persons, and the ratio of beds to nurse is 1.69 beds/n. In consideration of this staff capacity, around 350 beds (2.22 beds/nurse) assumed to be available to be handled by the existing staff, though it is desirable that hospital has enough bed for the patients in future.

Building Renovation: Most of all the facilities should be totally renovated. Seriously damaged buildings such as OPD and Ward 1 need to be reconstructed.

Sanitary Facilities: The Kisii DH suffers from some plumbing problems which should be renovated. When new ward(s) are constructed, such sanitary conditions should be improved.

Water Supply: To meet the demand of 180,000 liters/day, an additional water tank is required. A rain water harvesting system should be installed to supplement the water supply.

4) Equipment

Replacement of damaged medical equipment and addition of necessary medical equipment to strengthen the referral function by DHs were examined for Kericho DH, Longisa DH (Bomet), Nyamira DH and Kisii DH.

DISTRICT HOSPITAL MANAGEMENT SYSTEM

(1) Re-organization of DHMB

The District Hospital Management Board should be re-organized in such a way that a quick and timely decision-making can be made for management of the hospital in terms of budgetary and personnel arrangement.

(2) Improvement of FIF

The most significant financial source for maintenance is the facility improvement fund (FIF) coming from 75% of the collected money through the cost-sharing system. In reality, the management of the FIF needs to be further rationalized at the district level, upgrading the collection system as well as securing the fund against leakage. The fund collection system should be improved by: 1) introduction of a "Cash Registering System"; and 2) improvement of the HIS System.

NEW MAINTENANCE SYSTEM

Establishment of a well-functioning maintenance system is much more important than the physical improvement. To this end, it is vital to make Hospital Maintenance Unit (HMU) more functional in performing preventive maintenance activities as well as daily mandates. A new maintenance system is proposed to be formulated at each district hospital, involving users of medical equipment and facilities. The new maintenance system involves:

- to define work procedures for maintenance;
- to formulate an Annual Maintenance Plan;
- to involve each department of DH for maintenance activities; and
- to define documents to be filed.

Under the new maintenance system, all departments should assume their own responsibilities for daily and preventive maintenance. User departments such as Clinical Medicine, Out-patient, In-patient, X-ray, Laboratory, Eye, Dental, Physiotherapy, Pharmacy, etc. should be responsible for making specifications of equipment and facilities, while Administration

Department should have a responsibility for registration of all the equipment or facilities.

FOR THE IMPLEMENTATION

(1) Donor Inputs

Since a more comprehensive approach is indispensable, construction of new buildings in Kisii DH by the Population IV Project supported by World Bank may be finished. Instead, relevant donors should coordinate their programs to provide effectively with a) technical assistance in terms of Hospital Management, b) rehabilitation and expansion of hospital facility and provision of equipment for DHs, and c) technical assistance for strengthening the preventive maintenance system for equipment.

More importantly, the Kenya Government (MOH) should secure the counterpart budget and the recurrent budget for the Project.

(2) Project Linkages

The JICA proposed projects such as 1) Rural Health System Improvement Project, 2) District Health Service Education Project and 3) the USAID programs for Hospital Management are all related for the effective implementation and the sustainable management.

TABLE 17.1 MAJOR PROJECT ACTIVITIES FOR DHS REHABILITATION PROJECT

Activities	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Kericho DH	xxx	xxx	xxx	xxx		xxx	xxx
Longisa DH (Bomet)	xxx	xxx	xxx	x		xx	xxx
Nyamira DH	xx	xx	xxx		xxx	xx	xxx
Kisii DH	xxx	xxx	xxx	xxx		xxx	xxx

Notes:

- (1) Capacity building of Hospital Management;
- (2) Strengthening hospital accounting and recording
- (3) Establishment of client service improvement section and linkages with referred Health Centers, Dispensaries and private practitioners;
- (4) Comprehensive rehabilitation of buildings and related facilities of Kericho and Kisii DHs;
- (5) Minor Rehabilitation of the buildings and related facilities of Nyamira DH;
- (6) Replacement and addition of Medical Equipment in Kericho, Longisa, Nyamira and Kisii DHs; and
- (7) Strengthen the Maintenance Department and Establishment of preventive maintenance system. .

Priority Program 2: DISTRICT HOSPITAL REHABILITATION PROGRAM

1. Project No. P-2	2. Project Title District Hospital Rehabilitation Program					
3. Project Location Kericho, Bomet, Nyamira and Kisii Districts		4. Target Beneficiaries All residents in the catchment area of Kericho, Longisa (Bomet), Nyamira and Kisii District Hospitals.		5. Project Duration 3 years		
6. Implementing Agency / Body District Health Management Board(DHMB) and District Health Management Team(DHMT)			7. Project Level Basic	8. Project Priority High		
9. Summary of Objectives The proportion of referral cases to the total out-patient will be increased 3 times higher than the current level through: (1) To improve quality of essential curative services and extend critical diagnostic and treatment capacity of District Hospitals. (2) To strengthen referral function of DHs for RHF in the catchment area						
10. Justification <ul style="list-style-type: none"> - The capacity of Kisii DH and Kericho DH is not enough to meet the demand. - Comprehensive rehabilitation of the buildings, related facilities and replacement of medical equipment is required to Kericho, Nyamira and Kisii DH. - Many problems of the facilities and broken equipment because of few Preventive Maintenance and low morale of maintenance staff and users. 						
11. Expected Benefits / Outputs <ul style="list-style-type: none"> - Health service environment improved - Facility rehabilitated and necessary equipment provided - Quality of curative services and hospital care improved - Hospital management including financing improved - Maintenance system re-vitalized 			12. Verifiable Indicators <ul style="list-style-type: none"> - No. of appropriate referral cases - Availability of necessary diagnostic test/ treatment - Revenue increased - Maintenance Records / Operation rate of equipment. 			
13. Important Assumptions / Conditions for the Project <ul style="list-style-type: none"> - Hospital Management Board for each DH will be established and take over the implementation of this project. - Construction of New buildings in Kisii DH by Population IV project (WB) should be finished. 						
14. Project Linkages / Other Sector Linkage Rural Health Improvement / District Health Service Education / USAID (Hospital management Program)			15. Relevant Agencies to be Coordinated WB (Population IV Project)			
16. Major / Key Activities			17. Major Input		18. Est'd Cost*	
			Personnel	Materials		Construction
<input type="checkbox"/> Increase capacity of hospital management			x			
<input type="checkbox"/> Strengthen hospital accounting and recording			x		US\$ 0.1 M.	
<input type="checkbox"/> Improve curative service and hospital service			x			
<input type="checkbox"/> Establish client service improvement section and linkage with referred H/C, Dispensaries/Private practitioner			x			
<input type="checkbox"/> Comprehensive rehabilitation of buildings and related facilities of Kericho and Kisii DHs.				x	x	US\$ 9.03 M.
<input type="checkbox"/> Minor rehabilitation of the building and facilities of Longisa, Nyamira DH.				x	x	US\$ 1.67 M.
<input type="checkbox"/> Replacement and addition of Medical Equipment in Kericho, Nyamira and Kisii DHs.				x		US\$ 4.21 M.
<input type="checkbox"/> Strengthen the Maintenance Department and Establishment of preventive maintenance system in DHs.			x	x		
19. Estimated Total Cost					US\$ 14.35 M.	
20. Necessary External Inputs / Assistance / Arrangement						
Technical assistance for Hospital Management			x			
Recurrent cost for the project be secured by FIF and MOH Budget			x	x		
Rehabilitation and Expansion of facilities and provision of equipment for DH				x	x	
Technical assistance to strengthen the preventive maintenance system for equipment			x			

*Only facility and equipment

18. Priority Program 3: RURAL HEALTH SYSTEM IMPROVEMENT PROGRAM

RATIONALES

Epidemiological data reveals that communicable diseases account for the majority of the morbidity (55 - 70% of outpatients) and child mortality (55 - 80%). The diseases of most importance are malaria, ARI, immunizable diseases, tuberculosis and AIDS.

Most of these diseases could be preventable or diagnosed and treated in the rural health facilities if they were properly staffed and supplied. However, currently, the rural health facilities do not meet the community's demands and needs. Many patients, therefore, go to private facilities, traditional healers or buy drugs in shops. Others make their way to towns and crowd the District hospital outpatient departments.

There are over 300 health facilities in the study area. The designation "health center" given to many of these facilities does not follow the MOH guidelines. Many lack the staff (e.g. CO, RCN, etc), and the facilities and equipment (e.g. delivery room, laboratory, etc) essential for a functional health center and the preventive/promotive health activities are seldom undertaken or recorded.

Despite the importance of information and communication in maintaining rural health system, the information is not available for planning and the means of communication and transportation is very limited at almost all the health facilities. For example, the reporting rate of outpatient morbidity is only 7.5% in Nyamira and 48.5% in Bomet that is the best among the Study districts. Communication between DMO and Rural Health Facilities, in many cases, depends on personal comings and goings by chance.

In addition, organizational mechanism is not in place in the current district health system in terms of coordination of vertical program, supervision and monitoring of activities being done at each health facility, dialogues with the facility improvement com-

mittees and logistics and referral within the system.

As addressed in the Health Policy Reform, the direction and authority for the day-to-day operations of health care delivery systems and services shall be of responsibility of District. Therefore, functionalizing the district health services delivery system is one of the most crucial strategies in the Master Plan. This needs to integrate rehabilitation of existing health facilities and equipment and institutionalizing management and quality assurance.

A PROPOSED CONCEPT OF 'PRIORITY HEALTH CENTERS'

To improve the rural health services under limited resources available, it was proposed to concentrate on 16 health centers as **Priority Health Centers** of which the substantial functions shall be strengthened. The locations of the 16 Priority Health Centers are distributed as shown in Fig. 18.1.

These were selected on the basis of geographical location, existing facility assessment, role in the locality, level of community involvement, etc. The process of identification was based not only on the objective criteria but it also involved discussions with local counterparts and the MOH.

This concept of the priority health center can effectively function, only if the following fundamental measures are undertaken:

(1) Standardization of Rural Health Services at Each Facility Level

Type and quality of health services at RHF's should be standardized in order to have attendance recognize differences in services among dispensaries, health centers and hospitals. The existing vertical programs should be integrated since health centers are a complete unit for facility-based primary health care or so-called essential health services.

(2) Establishment of A Network of Health Facilities and Health Personnel

Improvement of health status of people is achieved by well-coordinated efforts of all health-related resources. This should lead to well-balanced distribution of the resources to be allocated into areas where most people really need the services.

The role of health centers are not only to serve the people in its catchment area, but also to be the joints of a **district referral network** intermediately connecting with dispensaries and district hospitals. In order to establish a more functional referral network, the service catchment areas of Priority Health Centers should be developed as shown in Fig. 18.2.

FUNCTIONS OF PRIORITY HEALTH CENTER TO BE ENHANCED FOR

Priority Health Centers should be improved so as to strengthen the planned functions as the complete units of essential rural health care centers in terms of:

(1) Strengthening of the Referral System

The following measures should, in particular, be undertaken for Priority Health Centers to move present constraints in the referral system:

- Strengthening the capacity of laboratories in Priority Health Centers;
- Improving transportation and communication;
- Establishing economic incentives for referral; and
- Educating the efficiency of the referral system.

(2) Re-organization of Logistics

The comprehensive logistics improvement program should be implemented through:

- Provision of training on appropriate use of drugs;
- Establishing the supply system which corresponds to the demand at the district level or a shift from the "push" system to the "pull" system; and
- Administrative linkages between drug supply policies and statistics/records in the District

Health Information System (DHIS) at the district level.

(3) Establishment of Communication Channels

The communication means among DHMTs/DHMBs, hospitals and RHF should be strengthened in terms of technical support, supervision, monitoring, sharing of information, data collection and drugs/material distribution. Priority Health Centers are expected to be the information centers to joint the communication network. In this sense, the followings are necessary to be carried out:

- Managerial capacity assessment, analysis, planning, implementation, and monitoring on existing health programs and services;
- Designing and implementation of a simple district financing management system that facilitates to increase fee collections;
- Development of District Health Information Management System with database regarding outpatient services, inpatient services, workload services, personnel, financing, logistics of drugs and equipment, health facilities, etc.;
- Development of a district supervision and monitoring list for RHF including a daily operation schedule of transportation; and
- Building a radio communication system.

(4) Managerial Capacity Building

Capacity building of health staff at Priority Health Centers is of vital intervention. This should materialize through the proposed District Health Service Education Program. The following should be started at selected Priority Health Centers and extended to the others.

- Development of a model for facility-based preventive program focusing on essential elements of primary health care;
- Development of referral protocol to sending a patient to district hospitals and receiving a patient from dispensaries;
- Formulation of outreach programs for those who do not have access to health care services jointly with the private and/or NGOs activities;

- Provision of transportation such as motorcycle(s) for the above purpose.

FACILITY REHABILITATION OF PRIORITY HEALTH CENTRES

The Study Team assessed the physical conditions of all the 16 Priority Health Centers and elaborated the rehabilitation and/or expansion plans of these facilities, employing the following criteria:

- Maximum use of existing/vested buildings and facilities;
- Rational grading of rehabilitation based on levels of the health services to be provided and the number of patients;
- Functional flow lines and zoning plans, taking into consideration the future expansion.

(1) Classification of Priority Health Centers

A classification scheme in terms of up-grading levels of Priority Health Centers is set forth, as shown in Table 18.1. Two types of facility components are proposed according to the level of service required in this stage. On the other hand, according to the existing facilities, Priority Health Centers are classified into 5 levels. The category of Health Centers in lower lines stands for less rehabilitation work, compared to H/Cs in higher lines.

(2) Facility Components

Table 18.2 shows facility components to be improved corresponding to Grade 1 and 2, in comparison with the health center standards by MOH and those by Ministry of Public Works.

The proposed facility components are based on a design principle, that is, Priority Health Centers should have:

- Delivery Room and Maternity Ward including sterilization room and nursery room;
- Laboratory;
- At least 6 beds for in-patients service for observation bases with meal provision service facilities;
- Several number of staff housing units;

- Waiting area and space for health education; and
- Water and electricity supply systems.

The facility to be renovated should be planned to minimize the maintenance work.

TABLE 18.1: CLASSIFICATION OF PRIORITY HEALTH CENTRES

Existing condition	Priority H/Cs to Upgrade to Grade 1	Priority H/Cs to Upgrade to Grade 2
Only OPD No Delivery/Maternity No Ward for IPD	Kipketion H/C	Fort Ternan H/C
OPD and Delivery/Maternity No ward for IPD		Kapkoros H/C Ekerenyo H/C Nyamache H/C
OPD and Delivery/Maternity Only one ward for IPD	Ndanai H/C Kenya H/C	Socio H/C Kercka H/C
Full facility, but very old, and total rehabilitation required		Marani H/C Nduru H/C
Full facilities, but small obstacle hamper full functioning.	Manga H/C Kitchen/laundry)	Masimba H/C (Water supply) Sigor H/C (Lack of beds) Keumbu H/C (In the process of renovation) Ogembo H/C* (Shortage of space)

Notes: * : S-DH level service is required

(3) Infrastructure and Utilities

Most of Priority Health Centers have serious problems about water, electricity and communication means. These problems constrain Priority Health Centers to poorly function.

Water supply: every Priority Health Center should have water supply system at least by a rain water harvesting system from the roof, and in addition any system by well or piped supply system.

Sanitary Facilities: Most of water closets are poor in operational. Considering the sustainability, pit latrine type will be a better option. Even in cases where there are existing water closets, they need to be renovated to be supplied with small water tanks from the ceiling..

Sewage System: Septic tank should be installed.

Electricity: All Priority Health Centers are expected to be supplied electricity by extending wiring from the nearest point, or by generator. Priority Health Centers with Grade-2 should get electricity to keep some reagents for the pregnancy test.

Communication: A telephone line is desired to install by extending the line from the nearest point. Instead, it should be studied to establish a communication system among the DHs and Priority Health Centers with Radio Communication system.

Fire Prevention Measures: Priority Health Centers which have wards need fire prevention measures.

Waste Disposal: Careful attentions should be given to waste disposal, particularly medical wastes. A centralized incineration system of medical waste is recommendable.

Access Roads: Transportation is one of the most important factors to get health centers function. As a result of survey, it is clear that the condition of roads which lead to Priority Health Centers are strongly related to the extend of the service area. Therefore, roads approaching Priority Health Centers are expected to be a tarmac road or at least gravel road.

TABLE 18.2: PROPOSED FACILITY COMPONENTS OF PRIORITY HEALTH CENTER

Department	Components	MOH		PW		PROPOSED PRIORITY HEALTH CENTER	
		Type 1	Type 2	Type 1	Type 2	Grade 1	Grade 2
OPD/MCH	Consultation Rm.			2 rooms	2 rooms		
	Treatment/Injection Room			2 rooms	2 rooms		
	Laboratory			2 rooms	2 rooms		
	Minor Surgery Rm.			1 room	1 room		
	Pharmacy			1 room	1 room		
	MCH						
	FP						
Maternity	Delivery Room, including sterilization Room.						
	Maternity ward	8 beds			6 beds	8 beds	6 beds
	Kitchen/Laundry						
IPD	Female ward				2 beds		6 beds
	Male ward	6-12 beds	12-24 beds		2 beds		6 beds
	Pediatric Ward				2 beds		6 beds
	Isolation Ward						2 beds
Staff house							

Notes:



: Explicit requirement



: Implicit requirement

Sanitary Facilities: Most of water closets are poor in operational. Considering the sustainability, pit latrine type will be a better option. Even in cases where there are existing water closets, they need to be renovated to be supplied with small water tanks from the ceiling..

Sewage System: Septic tank should be installed.

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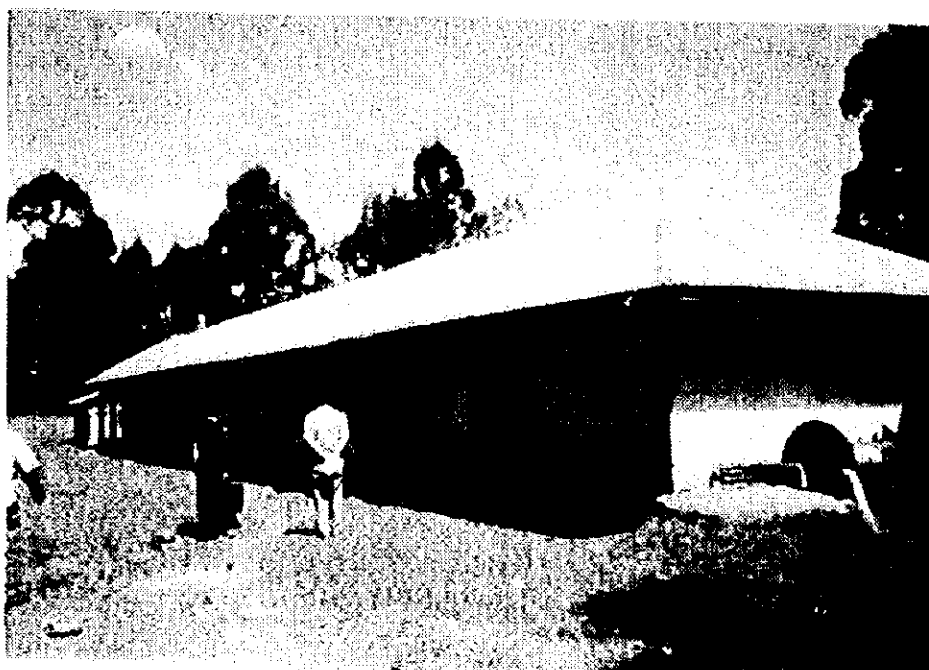
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TABLE 18.2: PROPOSED FACILITY COMPONENTS OF PRIORITY HEALTH CENTER

Department	Components	MOH		PW		PROPOSED PRIORITY HEALTH CENTER	
		Type 1	Type 2	Type 1	Type 2	Grade 1	Grade 2
OPD/MCH	Consultation Rm.			5 rooms	5 rooms		
	Treatment/Injection Room			2 rooms	2 rooms		
	Laboratory			1 room	1 room		
	Minor Surgery Rm.			1 room	1 room		
	Pharmacy			1 room	1 room		
	MCH FP						
Maternity	Delivery Room, including sterilization Room.						
	Maternity ward	8 beds			6 beds	6 beds	6 beds
	Kitchen/Laundry						
IPD	Female ward				2 beds		6 beds
	Male ward	6-12 beds	12-24 beds		2 beds	6 beds	6 beds
	Pediatric Ward				2 beds		6 beds
	Isolation Ward						2 beds
Staff house							

Notes:

 : Explicit requirement  : Implicit requirement



Main building of Ekerenyo H/C
constructed by community
(Gucha)



People waiting for consultation
(Nyamache H/C, Gucha)



Treatment room
(Nyamache H/C, Gucha)

EQUIPMENT

Upgrading of equipment should be considered based on the following:

- A binocular microscope should be supplied to the all Priority Health Centers to support malaria diagnosis.
- Equipment kits are developed for outpatient services, maternity services, laboratory, ward services and electricity for Priority Health Centers. Contents of each kit are as shown in Table 18.3.
- Ogembo HC, which is located near by a national trunk road, has become sub-district hospital where many patients are taken to as a result of traffic accidents. Ogembo HC should be equipped as a Sub DH.

TABLE 18.3: EQUIPMENT KITS FOR PRIORITY HEALTH CENTERS

Kit 1: Outpatient Services		Kit 3: Malaria Screening	
Stethoscope	2	Binocular microscope	1
Thermometer	4		
Sphygmomanometer	2	Kit 4: Laboratory Services	
Auriscopes	1	Haemoglobinometer (Sahli method)	1
Baby scale	1	ESR stand	1
Adult scale	1	Centrifuge	1
Minor surgery set	1	Refrigerator	1
Dressing/treatment trolley	1	Kit 5: For Ward	
Reflex hammer	1	Foot suction unit	1
Torch	1	Sphygmomanometer	1
Diagnostic set	1	Stethoscope	1
Kit 2: Maternity Services		Thermometer	1
Light source	1	Drug trolley	1
Baby scale	1	Infusion set	2
Adult scale	1	Resuscitation bag	1
Sphygmomanometer	1	Patient modesty screen	1
Fetoscope	1	Bed	6
Delivery bed	1	Kit 6: Electricity	
Vaginal examination set	1	Generator	1
Neonatal mouth sucker	1		
Delivery set	1		
Episiotomy set	1		
Vaginal specula, forceps	1		
Resuscitation bag	1		

MAINTENANCE

Existing preventive maintenance system for rural health facilities has been strengthened by the PMIU project. However, there are some damages still left due to lack of fund, difficulty in getting support from MOPW, and limited skill of PHOs and PHTs.

In order to link their activities, it is recommended to organize a maintenance team with the involvement of PHO and PHTs for training plumbing work, electrical work, and minor equipment maintenance. A system of backup for maintenance materials in each district should be also established to repair damages in quick response.

FOR THE IMPLEMENTATION

(1) Donor Inputs and Collaboration

DANIDA has renovated dispensaries in the study area through the PMIU Project to establish the Preventive Maintenance System for RHF. This program is expected to involve an equipment maintenance for its future project.

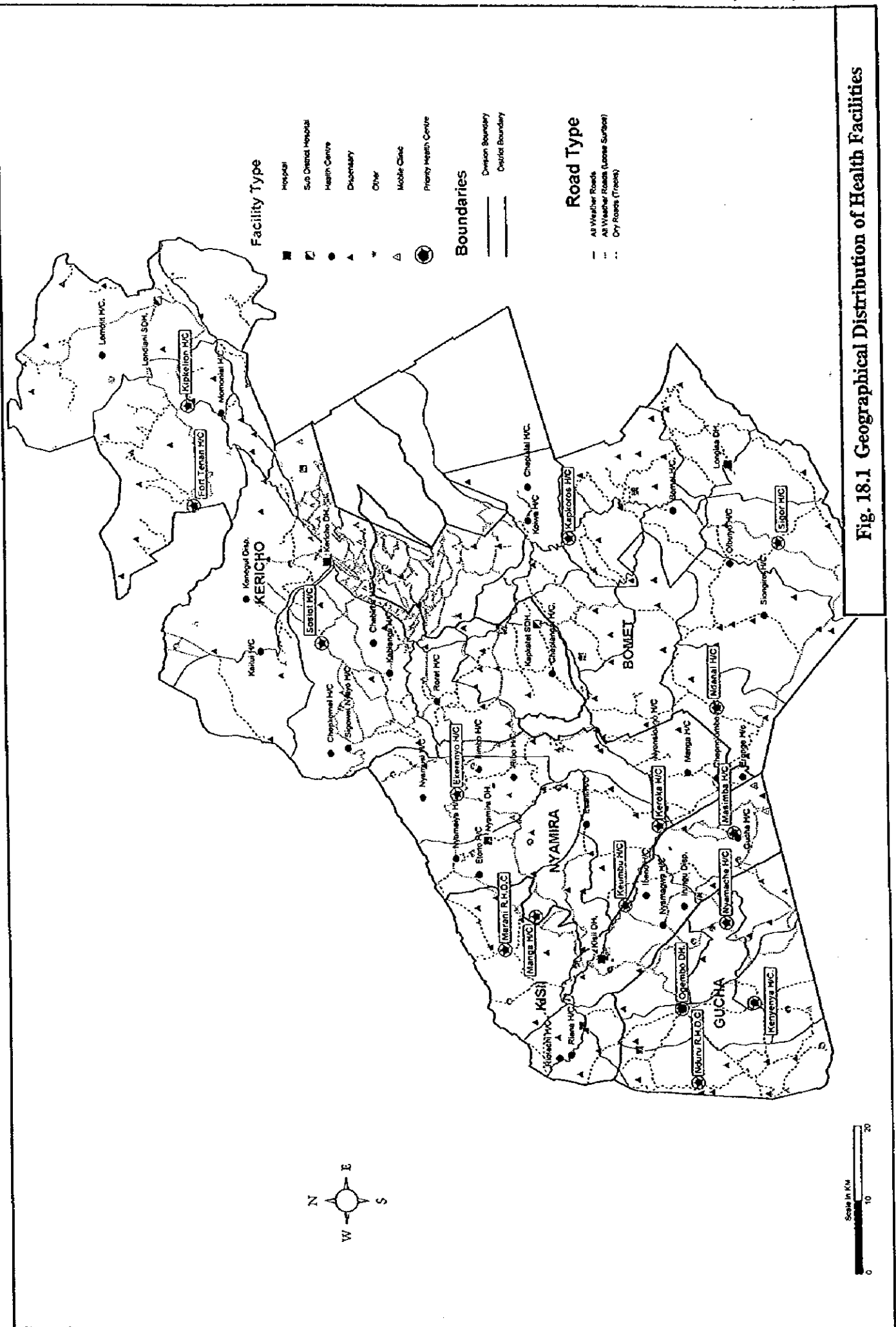
The Community-Based Distributor Program (CBD) supported by GTZ is expected to extend to the Priority Health Centers.

The STI program supported by World Bank over the country is expected to be integrated with strengthening capacity building at the Priority Health Centers.

(2) Program Linkages

The JICA proposed projects such as 1) Highland Malaria Control Program; 2) District Health Service Education Project and 3) the USAID programs for Hospital Management are all related for the effective implementation and the sustainable management.

Furthermore, on-going national vertical programs need to be linked with the proposed project. In particular, Priority Health Center may function as the rural management centers for such vertical programs at the division level.





**Fig. 18.2 Distribution plan
of Priority Health Centres**

Priority Program 3: RURAL HEALTH SYSTEM IMPROVEMENT PROJECT

1. Project No. P-3	2. Project Title Rural Health System Improvement Project		
3. Project Location Kericho, Bomet, Kisii, Nyamira, Gucha		4. Target Beneficiaries All the residents in the catchment area of priority health centers	5. Project Duration 5 years
6. Implementing Agency / Body Project Management: District Health Management Teams Daily Project Monitoring: Health Center Staff Management Teams		7. Project Level Minimum / Basic	8. Project Priority High
9. Summary of Objectives The project increase 30% of basic health service capacity through: (1) Rural health management system strengthened (2) Better quality of services extended (3) Support for catchment area dispensaries re-established			
10. Justification - RHF's need linkages and network in order to realize district organizational effort on health service delivery; - Improvement of health services at the Health Center level is likely to be most cost-effective and feasible approach.			
11. Expected Benefits / Outputs - Management capacity at priority H/Cs institutionalized; - Epidemiological and workload data utilized; - Facility and equipment improved; - Quality of essential services improved; and - Type of services including facility-based preventive activities expanded		12. Verifiable Indicators - Management schedules and monitoring lists available and used; - Epidemiological and workload data applied to logistics program and annual planning; - Number of visits / referral / FIF increased; - Improved coverage area of priority H/Cs; and - Contact between priority H/Cs and external agents increased.	
13. Important Assumptions / Conditions for the Project - MOH/ PMO continue to support the project; - Key players within the project are well guided to the common goal; and - Community cooperate to the improved quality of services.			
14. Project Linkages / Other Sector Linkage A Continuing Health Service Education Program (e.g. strengthening management / program budgeting capacity of DHMTs) /PMIU project / National (vertical) programs		15. Relevant Agencies to be Coordinated PMIU (DANIDA), Health Center Committees Keumbu H/C(AIDB)	
16. Major / Key Activities	17. Major Input		18. Est'd Cost*
	Personnel	Materials	Construction
<input type="checkbox"/> Produce management and monitoring manual on RHF s	x		
<input type="checkbox"/> Develop integrated supervision, monitoring and communication channel to the all RHF's	x	x	US\$ 1.08 M.
<input type="checkbox"/> Develop and demonstrate the use of epidemiological data and workload at priority H/Cs and the districts	x		
<input type="checkbox"/> Guide priority H/Cs committees for the project	x		
<input type="checkbox"/> Rehabilitate and equip priority H/Cs		x	x
<input type="checkbox"/> Introduce quality control methods at priority H/Cs	x		
<input type="checkbox"/> DHMTs/ Priority H/Cs increase facility-based preventive activities against selective disease / water protection	x	x	US\$ 0.14 M.
19. Estimated Total Cost			US\$ 7.33 M.
20. Necessary External Inputs / Assistance / Arrangement			
Rehabilitate and equip priority H/Cs (donor)			x
Provide vehicles / motorbikes for integrated supervision and monitoring (donor)			x
Technical assistance for facility-based preventive activities and linkage with external agents (e.g. NGO/School/Dispensary) - (donor -JOCVs?)	x		
DHMTs provide necessary information and assign tasks to all involved in the project	x		
Recurrent cost for the project be secured by PHC budget and FIF's PHC fund	x	x	

*Only facility and equipment

19. Priority Program 4: COMMUNITY-BASED PROMOTIVE AND PREVENTIVE HEALTH CARE PROGRAM

RATIONALES

Although the National Health Reform Policy strongly addresses the importance of promotive and preventive health care, the current government structure and system, on the practical ground, are not geared for promoting community-based health care as stated. There are various reasons to explain this inactivity as follows:

- (1) Low commitment for PHC by the Government;
- (2) Weakness of the government structure and system to support community-based health care (CBHC), represented by: a) inactivity of DHMT Primary Health Care (PHC) Committee; b) low moral of health workers for extension services; and c) poor communication between district and rural;
- (3) Lack of the coordination among community group activities and lack of community empowerment experience.

PROPOSED PROGRAM COMPONENTS

The community-based P/PHC activities should be strengthened with a variety of measures, mobilizing all available human resources at the district level. To this end, the following programs are proposed:

- Governance, Capacity Building and Human Development
- Organizational Setting; and
- Development of Strategies to make CBHC programs "sustainable";

GOVERNANCE, CAPACITY BUILDING AND HUMAN DEVELOPMENT

(1) Reorienting Government Personnel for CBHC

Most of government personnel in charge of community-based health care (PHOs and PHTs) are inactive and rarely visit communities, which they are supposed to serve. It is necessary to re-orient and train

them to perform their duties. At the same time, it is needed to introduce some appreciation incentives such as "Annual PHO/PHT Award" that will be given to those who achieve a tangible impact of PHC to communities.

(2) Activating the DHMT PHC

The government's capability to promote and coordinate CBHC activities depends greatly upon the capability of DHMT PHC Committee in terms of programming systemically activities, implementing the activities, evaluating the progress and planning more effective activities based on the feedback.

The PHC Coordinator needs to be trained in organizational and management skills to mobilize available budget and the government PHC staff as well as facilitating multi-sector efforts by the DDC's PHC Sub-committee members.

ORGANIZATIONAL SETTING

(1) Establishment of District Coordinating Body

Creation of a district coordinating body is proposed to initiate, organize and coordinate various activities and programs by health care groups at the district level. There are many groups at the community, but there have been little experience for the community groups to bring their resources and experiences under one umbrella organization.⁵

This organization will play the pivotal role in disseminating and replicating successful cases of some community groups to other groups by accumulating experiences and technical and managerial know-how for successful community-based projects. The

⁵ Maendeleo Y Wanawake Organization (MYWO), a leading women NGO for rural development in Kenya, has umbrella type structure covering regional-wide women groups at district, province and national levels. Because MYWO has experienced structure a mechanism to bring regional-wide women groups together, this can be a good example for the above proposed district coordinating committee/association.

management body of this grass-root organization can be composed of representatives from community groups and NGOs in district.

(2) Setting up Monitoring Indicators

Tenwek Community Health Program in Bomel district uses the following monitoring indicators. They are used to judge whether the community or the group, is capable of sustaining itself with reduced support;

- the number of the Village Health Committee meetings held in a year
- the total number of the participants in the above meetings in a year
- the number of the trained persons in the Village Health Committee
- the number of the trained Community Health Workers in the community
- the number (and the percentage) of the households in the community which have been visited or served by the Community Health Workers
- the number of environmental health facility (e.g., toilet) increased

STRATEGIES TO MAKE COMMUNITY-BASED HEALTH CARE PROGRAMS SUSTAINABLE

Through the field surveys, the Study Team identified key elements of successful community-based health care programs. These are commonly:

- based on real needs and selected by the community or group members;
- not limited to the direct medical problems, but including a variety of the health-related activities such as water and sanitation;
- motivated with a community's or group's strong will to improve their lives;
- led by disciplinary leadership of the community or group;
- managed with good book-keeping and transparency to the bank account;
- sharing fair and clearly stated rules among members;

- maintained with affordable member's obligations and contributions (e.g., membership fee, monthly deposit, labor contribution, material contribution);
- linked with income generation activities to make funds available for the groups
- yielding short-term benefits (not only the health benefit, but also the economic benefit) for the community or group members;
- under regular supervision and advice by an outsider occasionally, until the community or the group becomes self-sustainable.

Knowing these key factors, the following strategies or programs are proposed:

(1) Provision of Start-up Material Kits as A Basis for Revolving Fund

In the Bamako Initiative projects, the drugs and mosquito bed-nets were donated to the community which were to be sold and the money are to be provide a basis for a revolving fund for the future re-supply. In the proposed project, the community groups will be given the start-up material kits to start their selected activities. They will be expected to sell these start-up materials and establish a revolving fund for future activities. The start-up material kits could be the following types to suit various needs of the community:

- malaria kit (e.g., bed-net, drugs, insecticides)
- water and sanitation kit (e.g., cement, pipe, water tap, shovel, hand pump)
- reproductive health kit (e.g., TBA kit, contraceptives)
- income generation kit (e.g., sewing machine, carpenter's tools)

(2) Combining Health Promotion and Income Generation

Some groups are making mosquito bed-nets for income generation (e.g., AMREF Nyamira Office is assisting the youth groups in their Adolescent Health Program). This type of combination of income generation by producing and selling health-related products should be encouraged through PHC promotion to make the group funds available. Japanese medical entomologist also advised the production

mosquito repellent bars out of the locally available pyrethrum flowers at the community or at home.

(3) Educating Community on Health

Malaria is the biggest killer disease in the study area. According to our survey, many people in the community perceive that the causes of malaria are not only mosquitoes but also other factors such as contaminated water and food.⁶ People consider that to employ all the preventive measures to possible causes is technically difficult.

Other areas for health education which the community need are diarrhea prevention and management, nutrition especially for children (as mentioned before), reproductive health and family planning, and safe water and sanitation.

It is important to use appropriate media for health education in order to reach community people. According to our survey, radio, folk media and mass campaign are regarded as the most effective media to convey messages to the widest audience.

For sustainability, the use of folk media (such as dramas and dances) are thought to be effective. There are many experiences using community activity groups (e.g., women groups) to deliver the health message through dancing and singing in the Study Area (e.g., a HIV/AIDS campaign in Kisii district in 1997). Since folk media are based on the local people's tradition and skills, the local people already have the potential to develop and perform. Folk media provide not only education but also entertainment for the community, so they can attract the wider audience.

In Kenya, there are many national health-related mass campaign events such as National Immunization Day, National AIDS Day, National Population Day. It is proposed to organize a new district-based health campaign such as District Malaria Day/Week or School Health Day. It will be relatively easy to solicit donors and sponsors to finance the part of the

mass campaign activities, because of their high visibility in the media.

(4) Establishing 'School Health Programs'

The number of schools are several times bigger than the number of health facilities, so if schools are involved in health activities, the impact on children's health will be great. But in Kenya, education at schools is limited to providing knowledge only.

It should be recognized that education at schools includes not only providing knowledge, but also physical fitness and civic education. In Japan, every school has a school nurse and a regular physical check-up for the pupils and students. The schools where the health condition of the students are very good are awarded "Good Health School Award" in the national level. In Uganda, health education using Child-to-Child approach is integrated in the national curriculum for primary and secondary education. It is recommended for the Ministry of Health to collaborate with the Ministry of Education in order to seek for the possibility to incorporate health education in the national school curriculum as a long-term strategy.

In the district and the community, school headmasters, parents and teachers association (PTA) and the school board have the discretion to incorporate some school health activities such as regular physical check-up and health education as extra-curriculum activities. So it is important to sensitize school headmasters, PTA and the board members on the importance of school health activities.

FOR THE IMPLEMENTATION

(1) Donor Inputs and Collaboration

Existing experiences of community-based projects by DANIDA, SIDA, USAID, IFAD and NGOs (e.g., Tenwek, Kaplong and Action Aids in Bomet, AMREF in Nyamira) are all invaluable resources to learn.

Hence, external resources provided by donors and NGOs should be mobilized for Capacity building of PHC committee and DHMT through their technical assistance and material provision schemes. As for CBHC promotion, NGO's involvement for community mobilization will be crucial.

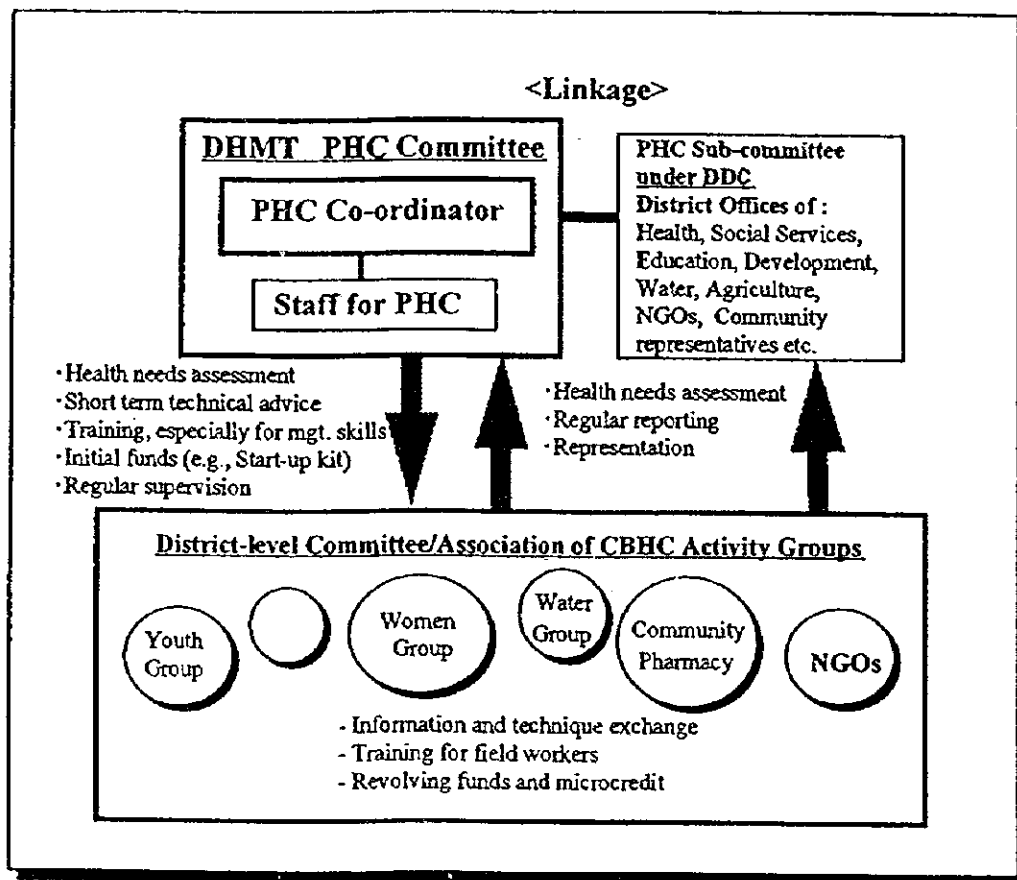
⁶ A survey on "People's Knowledge, Attitude and Practice(KAP) and Market on Goods for Malaria Prevention" was done from June to August, 1998 as well as Malaria Case Management survey. The result of KAP Survey will be included in the Draft Final Report.

(2) Program Linkages

The JICA proposed projects such as 1) Highland Malaria Control Program; 2) Rural Health System Improvement Project; 3) District Health Service Education Project are all related for the effective implementation and the sustainable management.

Important are administrative linkages in the project implementation with other line-ministries at district in terms of Social Services, District Development, Education, Water Resource and Agriculture.

FIG. 19.1 PROPOSED MACHINERY FOR THE PHC PROMOTION AT DISTRICT



Priority Program 4: COMMUNITY-BASED PREVENTIVE/PROMOTIVE HEALTH CARE PROGRAM

1. Project No. P-4	2. Project Title Community-Based Preventive/Promotive Health Care Program		
3. Project Location Kericho, Bomet, Nyamira, Kisii, Gucha Districts	4. Target Beneficiaries 1) Community 2) Community leaders/group leaders 3) Government health staff for CBHC 4) School Children	5. Project Duration 5 years	
6. Implementing Agency / Body "District Primary Health Care (PHC) Committee" under DHMT		7. Project Level Basic	8. Priority Medium
9. Summary of Objectives (1) to promote community-based health care (CBHC) activities through community (2) to activate government structure/system of CBHC activities through capacity building of PHC Committee (3) to train government staff in charge of CBHC, community leaders, and community's field health workers (4) to establish a new district-level committee/association to co-ordinate and empower CBHC activity groups (5) to establish a school health program to increase awareness of health and improve children's health			
10. Justification - Prevention of diseases and health promotion at the community level is better than cure. - Effective community resource mobilization can lead to the sustainable community health activities. - Overburden of the health facilities (especially overcrowded district hospitals) can be reduced.			
11. Expected Benefits / Outputs - Local government staff in charge of CBHC are better trained; - Community/group leaders, community's health field workers and school teacher and are better trained; - Self-sustainable CBHC projects are established; and - Government system to promote CBHC activities is strengthened.		12. Verifiable Indicators - No. of trained government staff - No. of trained community/group leaders and school teacher - No. of self-sustainable CBHC projects - CBHC Supervision Records	
13. Important Assumptions / Conditions for the Project - Decentralization process continues. (Especially bottom-up planning approach is accepted.) - Government decides to put more emphasis and resources on community-based health care.			
14. Project Linkages / Other Sector Linkage Line ministries at district: Social Services, Dev. Office, Education, Water Resource, Agriculture/livestock		15. Relevant Agencies to be Coordinated DANIDA, SIDA, USAID, IFAD, NGOs	
16. Major / Key Activities		17. Major Input	
		Personnel	Materials
		Funds	
<input type="checkbox"/> Train government CBHC staff to revitalize the PHC Committee		x	x
<input type="checkbox"/> Conduct health needs assessment and identify the target community		x	x
<input type="checkbox"/> Train community leaders and group leaders on CBHC activity		x	x
<input type="checkbox"/> Train community's field health workers (CHW, CBD, TBA etc)		x	x
<input type="checkbox"/> Provide start-up material kits as a basis of revolving funds		x	x
<input type="checkbox"/> Advise and supervise the community until they become self-sustainable		x	
<input type="checkbox"/> Establish a school health program through sensitization of school teachers, headmasters, PTAs and School Board members		x	
<input type="checkbox"/> Establish a new district-level coordinating committee/association of CBHC activity groups		x	
<input type="checkbox"/> Expand the CBHC activities to other groups		x	x
<input type="checkbox"/> Document all processes of promoting self-sustainable CBHC		x	
18. Estimated Total Cost (only facility, equipment and supply)		US\$ 0.8 M.	
19. Necessary External Inputs / Assistance / Arrangement			
Government(HQ and local) revitalizes District PHC Committee		x	
Local government's strong will/commitment to prepare required personnel, facilities and recurrent costs to secure sustainability of CBHC activity		x	x
Donor assists training, supervision, start-up kits and transportation for supervision		x	x

20. Priority Program 5: DISTRICT HEALTH SERVICE EDUCATION PROGRAM

RATIONALES

Though there is much in common in the educational needs of all Districts, there are also significant differences. These are related to the existing talent and experience of the personnel available, to the nature of the environment and the pattern of disease and also to the culture and expectations of the local community.

To increase the numbers of professional and technical staff, trained and deployed to each District, is not under the control of Districts, but is the responsibility of MOH Headquarters, Kenya Medical Training Center (KMTC), complemented by the Missions. Each District is, however, responsible for:

- 1) supervision of continued education and development of all professional and technical staff, once they have been assigned to the District;
- 2) orientation, training and development in the skills of governance of newly appointed Management Board and Facility Committee members;
- 3) training and development of community-based health care managers and workers; and
- 4) orientation of staff from health-related Ministries and organizations, involved in inter-sectorial activities.

It is well recognized that in all professional fields the basic training obtained at the beginning of professional life needs continuous updating. This is especially the case in fields such as medicine which are undergoing rapid change and development. In the last ten to twenty years such up-dating has not been available to many health staff. Those most lacking this opportunity for updating have been those with relatively simple and short basic training who are posted to rural areas. This has resulted, together with other causes, in a decrease in the quality of care to unacceptably low standards.

In the past, what training there has been in the Districts has almost always been decided at MOH headquarters. It has been uncoordinated and intermittent. There is increasing evidence from a variety of sources that occasional refresher or extension courses run by outsiders, often outside the District, have little or no effect in improving the quality of care provided. Creating change in the practice of health and medical activities requires a continuous process involving task analysis and constant supervision in addition to periodic training courses.

UNDER THE HEALTH REFORM POLICY

One of the key elements of the Health Reform Process is "decentralization". This has involved the creation of District Health Boards, Hospital Management Boards and Facility Management Committees for health centers and dispensaries. A variety of local leaders, professionals, business men and retired civil servants have been appointed to these boards and committees. Their commitment to serve is not in doubt, however, their ability to do so effectively without appropriate orientation and development is problematical. To be effective, an understanding of their roles in governance, as opposed to management, is required. It is also necessary for them to be aware of different health problems in the area, and how the health services can prevent or alleviate them.

CAPACITY BUILDING FOR DHMT

To meet fully the varying needs of local situations, the responsibility and authority for a District human resource development plan must be vested within each District's Health Management Team (DHMT). Hence, as the first step, the further development of the DHMT is an urgent matter.

For the DHMT to undertake these responsibilities they will certainly need outside help, both with their own development and with carrying out their program.

Different kinds of DHMT management training programs have already been implemented in different districts with varying degrees of success. These programs need evaluating and standardizing and then to be applied to all five Districts in the Study Area. It should be noted that all attempts at developing the capacity of DHMTs are undermined by the frequent transfers of staff, especially the MOH.

CURRENT DISTRICT EDUCATION PROGRAM

In the past there has never been any comprehensive District education program. What little has been done has been generated from outside the District. However, developing a District Education Program has recently begun in some Districts, with the appointment and training of District Continuing Education Coordinators (DCECs). These people have been selected from existing district staff such as a Public Health Nurse, Officer or Health Educator, and have undergone a training program organized by the MOH CE Unit. The training has consisted of three two-week workshops on management and teaching methodology, conducted over a period of one year. In the District a Continuing Education Sub-committee of the DHMT has been established, with the DCEC as chairman. It is currently proposed that in those Districts taking part in this program, a further group of four "core teachers" should also be given training in teaching methodology to be able to support the program.

The District Continuing Education Programs described above have concentrated on the continuing education of professional and technical staff. They have not, as yet, been directly concerned with the orientation and development of the Board and Committee members or the training of those concerned with community-based health care.

A PROPOSED PROGRAM

(1) Selection and training of DCECs

Each District will select an appropriate member of staff and the HQ CE unit will arrange their training.

(2) Needs Assessment

A comprehensive human resource development program requires an inventory of all personnel involved in the health services in governance,

implementation and community support, and a record of their previous training - an educational diagnosis.

(3) Educational Plan

Based on the educational diagnosis a District Educational Plan can be developed, taking into account various priorities. The plan should integrate all the different facets of human development.

(4) Regular Guidance and Supervision

Regular guidance and supervision of the rural health facilities will be a key activity in the continuing education program. In the past this has generally been intermittent and perfunctory. Lack of transport has been one important reason. Some supervisory staff will also need further instruction on making full use of visits, on the use of checklists, proper reports and records, and providing on-the-job training. These guidance visits will be an essential tool in upgrading staff and in determining weak areas of performance that require more extensive training.

(5) Learning/Training Materials

Based on these findings appropriate training modules will be designed (or copied), learning materials collected and workshops and refresher courses will be planned. It is critical that these are integrated with the training undertaken by the national health programs such as KEPI and HIV/AIDs. A recent MOH report on the Integration of Training (Human Resource Planning and Development Workshop July 1997) makes recommendations as to how this may be done. These recommendations must be implemented to ensure headquarter support for the District programs.

(6) Facilities, Equipment and Supplies

Many training and development activities can be carried out without special facilities or resources. This applies particularly to guidance and on-the-job training. However, the supervisor must be able to visit the health workers' place of work. This poses demands on transport to rural health facilities and community projects. Without transport available frequently and regularly, supervisory activities, which must be an essential part of human resource development, cannot take place. The costs of transport

must be balanced against the cost of failing rural health services and the resulting overcrowding of District Hospitals.

When it is necessary to bring people together, a seminar hall is required. Suitable places are not easily available in Districts, and often workshops and courses have been held in hotels, which are expensive. (see below proposal for developing District Learning Centres).

At such times simple equipment and supplies are required. A blackboard, flip chart stand and an overhead projector are appropriate. And increasingly some topics are well covered on video tapes, so a video machine and monitor can be helpful. This should be concomitant with a small library to increase the number of people interested in and capable of learning from written materials.

New developments in communication technology and tele-medicine are taking place at an increasing pace and may find a place in a District library sooner than currently imagined.

(6) Implementing CE activities

Once the staff, plans, learning resources and equipment have been acquired the program can start.

Orientation and development of the members of the main District Health Boards (DHBs) will be assisted by the PMOs office. The methods used can then be modified and repeated with the members of the health center and dispensary committees.

Refresher courses for professional and technical staff can be augmented by local consultants, but it is essential that DHMT members should take a key role.

The program for training those concerned with community-based activities - health service staff, village committees and CHWs, TBAs, etc - will be developed with the District PHC Coordinator.

The motivation provided and the management issues resolved may do more to increase the quality of service offered than any aspect of technical learning.

A PROPOSAL FOR THE DEVELOPMENT OF 'DISTRICT HEALTH SERVICE LEARNING CENTRES'

A key factor in establishing a dynamic human resource development program is the potential role of a District Learning Center. A minimum facility would consist of a seminar hall for thirty participants, a small learning resource room/library, and an office for the DCEC. The addition of residential accommodation for participants and facilitators would increase both its value and its running costs, and raise the question of sustainability.

(1) Requirement of Training Man-days

To estimate the potential use of the facility, including 'bed-occupancy' of the residential facilities, the numbers of people working with the District health services were multiplied by the number of days per year that they might be expected to undergo training.

For professional and technical staff of the government health services it was assumed that each person should have the equivalent of a week's continuing education every two years, or three days per year. For Members of Boards and Committees, 2 days per year, and for those organizing and managing community activities, 3 days per year. By multiplying the number of staff by the number of days training required an estimate of the total man-days of training can be obtained, see Table 21.1.

For all five Districts a total of **9,631** man-days are required annually. In addition to this number, the requirements of NGO, private and subordinate staff, should also be considered.

It is accepted that these estimates of the man-days of training required in each District are no more than rough approximations of the needs and that their realization depends on the necessary funding being available.

(2) Location of District Learning Centers

The following criteria were agreed for selecting the most appropriate locations for the Learning Centres.

- **Land:** Sufficient land must be available. Approximately 800 sq.m would be required for a non-residential center and 4,400 sq.m should be set aside for accommodation. (It is desirable to

set aside adequate space to be able to add residential facilities if required at a later date)

- **Adjacent Facility:** The Center should preferably be next to/attached to a functional health center where participants could observe demonstrations (e.g. immunization, sterilization, physical examination, etc.)
- **Access:** It should be reasonably central in the District and accessible by public transport
- **Water and Electricity:** Adequate water and electricity supplies are essential for a residential Center
- **Telephone:** The proximity of telephone lines and the possibility of installing a telephone are important for coordinating activities.
- **Other Users:** The running costs for CE courses, can be subsidized by renting the facility to other Ministries and organizations, when not in use. To make full use of the Centre for this type of income generating activity it must be in an appropriate locality for attracting such business.

Finally, taking into account the recommendations and competing interests of each District, the Provincial Medical Officer will have to make proposals for final approval each of the District Development Committees.

Using the above agreed criteria for selecting the locations the participants at the Technical Meetings made the following recommendations:

District	Location	Type of Center
Kericho	Kericho	Non-residential
Bomet	Kapkoros	Residential
Nyamira	Keroka	Residential
Kisii	Marani	Non-residential
Gucha	Ogembo	Non-residential

(3) Funding

The value of establishing and maintaining human resources must be considered in relation to the cost of salaries. Currently these amount to approximately

70% of the Ministry's health budget. It must be appreciated that the lack of supervision and the absence of opportunities for continuing education, results in a progressive decrease in technical know-how. This means that less benefit is obtained for the staff salaries paid.

Fund Requirement: The estimated capital cost of building and equipments for a non-residential District Learning Centre is \$170,000 and a residential Centre \$670,000

The running of a Non-residential Learning Center is a relatively simple matter, and could be undertaken by the DCEC. The costs are small and can be covered by small charges for the day use of the facility. These charges should be handled as contributions to cost-sharing funds.

The running of a Residential Learning Center, especially if it is to be managed on business lines, is more complex and would require a manager, and permanent staff (e.g. cook, cleaner, maintenance man, watchman). Based on the experience of the RHTCs (Minutes of a meeting held at Tiwi RHTC May '97) a charge of 800 KSH/ person/day should be charged for workshops and seminars, and perhaps a lower rate if pre-service students are accommodated.

The long-term viability of such an institution depends to a great extent on its occupancy rate and the efficiency of the management.

Funding Sources: The required funds may come from: 1) cost-sharing funds; 2) MOH national programs; 3) its own income generated from renting; and 4) external aid funds.

(4) Operation, Maintenance and Management

A District Learning Center Management Committee (comparable with a Health Centre management Committee) needs to be established. They would be responsible for the operation, maintenance and management. They would appoint the local staff and would operate their own finances and take the usual measures to ensure accountability and transparency.

In practice, the operation of the services could be sub-contracted to some capable NGO to assure the efficiency of program operation.

Cooperation would be established with other training institutions - local KMTCs, responsible for pre-service training, and NGOs, to ensure economic use of resources.

FOR THE IMPLEMENTATION

(1) Donor Inputs and Collaboration

Planning and construction of the District Learning Centers will require donor support. They will also require initial support until they become self-sustaining.

Continuous support will be necessary from agencies assisting the MOH CE Unit such as SIDA and also those funding some of the national health programs such as UNICEF, USAID and World Bank. This support will be for the training of DCEOs, undertaking training needs assessments, developing appropriate curricula, collecting learning materials, etc. Assistance that has been given to MOH and Districts by various local agencies such as AMREF, Aga Khan

Health Services and Foundation, and the JICA KMTC project needs to be included and extended. In particular their experience and support for training DCECs, the health service managers and community-based health workers should be utilized.

(2) Program Linkages

This project underpins all the other JICA proposed programs, and needs to be related to them as a basic condition to make them all successful and sustainable.

At the MOH headquarters it is necessary for the CE Unit to undertake the training of the newly appointed DCECs and to provide the appropriate support for them when trained. It is also necessary for the process of integration of the training programs of the national health programs (e.g. KEPI, HIV/AIDS) to be incorporated into the District Programs.

TABLE 20.1: ESTIMATE OF "MAN-TRAINING DAYS" REQUIRED PER YEAR

(1) MOH PROFESSIONAL AND TECHNICAL HEALTH STAFF

	Kisii	Gucha	Nyamira	Sub Total	Kericho	Bomet	Sub Total	Total
No. health staff	590	105	438	1133	632	264	896	2029
Man-days of Training days	1770	315	1314	3399	1896	792	2688	6087

(2) MOH BOARDS AND COMMITTEES

	Kisii	Gucha	Nyamira	Sub Total	Kericho	Bomet	Sub Total	Total
No. Boards / Coms.								
Hosp. Board	1	1	1	3	3	1	4	7
Dist. Board	1	1	1	3	1	1	2	5
H/C Committees	7	7	9	23	9	7	16	39
Disp. Committees	19	13	15	47	49	37	86	133
Total No. Board / Com.	28	22	26	76	62	46	108	184
Total No. of Board / Com. Members (average per Board / Com. 8 persons)	224	176	208	608	496	368	864	1472
Man-training days	448	352	416	1216	992	736	1728	2944

(3) COMMUNITY-BASED HEALTH CARE MANAGERS

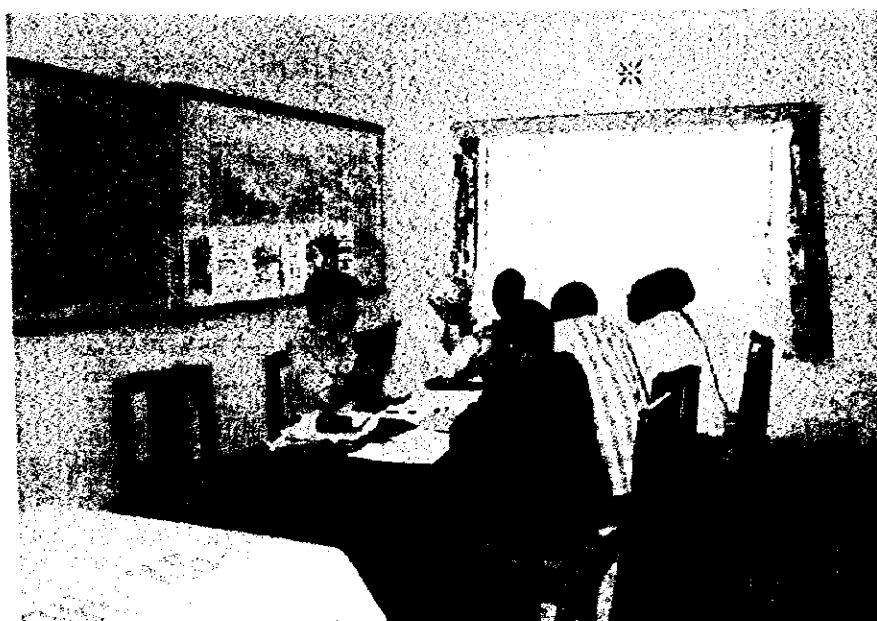
	Kisii	Gucha	Nyamira	Sub Total	Kericho	Bomet	Sub Total	Total
No. C-b HC workers	40	40	40	120	40	40	80	200
Training days	120	120	120	360	120	120	240	600

(4) TOTAL

	Kisii	Gucha	Nyamira	Sub Total	Kericho	Bomet	Sub Total	Total
Total man-days training for 1,2, and 3	2338	787	1850	4975	3008	1648	4656	9631

Notes:

- (1) Assuming each member of staff has one week of training every two years i.e.3 days per year
- (2) Assuming each Board/committee member has two days of orientation/training per year
- (3) Assuming each C-b HC Manager has 3 days training per year



Discussion between JICA Study Team and District Health Management Team (Kisii)

Priority Program 5: DISTRICT HEALTH SERVICE EDUCATION PROGRAM

1. Project No. P-5	2. Project Title A District Health Service Education Program			
3. Project Location Kericho, Bomet, Kisii, Nyamira, Gucha		4. Target Beneficiaries All health workers in the Districts	5. Project Duration 5 years	
6. Implementing Agency / Body District Health Management Teams, MOH		7. Project Level Basic	8. Project Priority High	
9. Summary of Objectives The program provide 2-3 days training/workshop for all the necessary personnels through: (1) Establish a sustainable system of CE in each the District (2) Provide appropriate training for all district health workers				
10. Justification <ul style="list-style-type: none"> - Health workers : quality of service - promotion, prevention and curative - need upgrading - Management Boards and Committees: quality of governance of the health service needs orientation and development - Community Health Workers: number and quality need to be improved 				
11. Expected Benefits / Outputs <ul style="list-style-type: none"> - Identification and training of DCECs in District - District CE program and plans produced - Facilities, equipment and learning materials for CE provided - Communications for appropriate supervision provided 		12. Verifiable Indicators <ul style="list-style-type: none"> - Number of DCECs identified and trained - District CE plans and learning materials available - CE Centers constructed and equipped - Numbers of people trained 		
13. Important Assumptions / Conditions for the Project <ul style="list-style-type: none"> - Health Reform process continues: Management Boards and Committees appointed - Districts appoints CECs and assume responsibility for all CE activities - MOH national training program (e.g. KEPI) cooperate with district program - DHMTs, Communities and trainees support program and provide increases in cost-sharing funds 				
14. Project Linkages / Other Sector Linkage MOH CE & (vertical) Health Program Units NGOs & CBOs in the District requiring or providing CE		15. Relevant Agencies to be Coordinated Donors (e.g. SIDA, USAID) / International Agencies (e.g. UNICEF, UNFPA) / National Agencies (e.g. AMREF) / & KMTC, who provide CE activities		
16. Major / Key Activities		17. Major Input		
		Personnel	Materials	Construction
<input type="checkbox"/> Train DCECs		x		
<input type="checkbox"/> Needs assessment studies for Staff/Board/C-b workers		x		
<input type="checkbox"/> Prepare program for Staff/Board/C-b workers		x		
<input type="checkbox"/> Establish monitoring and evaluation program for CE		x		
<input type="checkbox"/> Train District supervisor staff and establish schedule		x		
<input type="checkbox"/> Ensure adequate communication and transport			x	
<input type="checkbox"/> Start regular CE activities, including supervision		x	x	
<input type="checkbox"/> Confirm sites for CE centers		x		
<input type="checkbox"/> Construct and equip CE centers			x	x
<input type="checkbox"/> Undertake evaluation survey		x		
18. Estimated Total Cost*		US\$ 2.07 M.		
19. Necessary Inputs / Arrangement				
MOH CE unit (with donor support) conduct DCEC training		x		
DCECs obtain support for studies and health learning materials		x	x	
DCECs involve other agencies (e.g. AMREF, Aga-Khan) with program support		x		
Donor support for construction and equipment				x

*Only facility and equipment

