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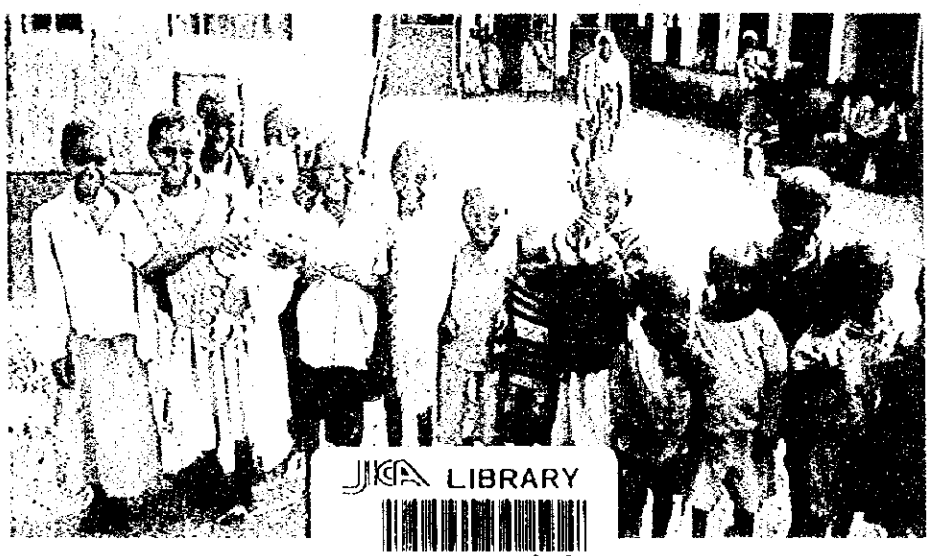
JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)
THE MINISTRY OF HEALTH
THE GOVERNMENT OF THE REPUBLIC OF KENYA

The Study on Strengthening the District Health System in the Western Part of Kenya

Final Report

- Supporting Discussion 5 - Human Resource and Proposed Project



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Pacific Consultants International
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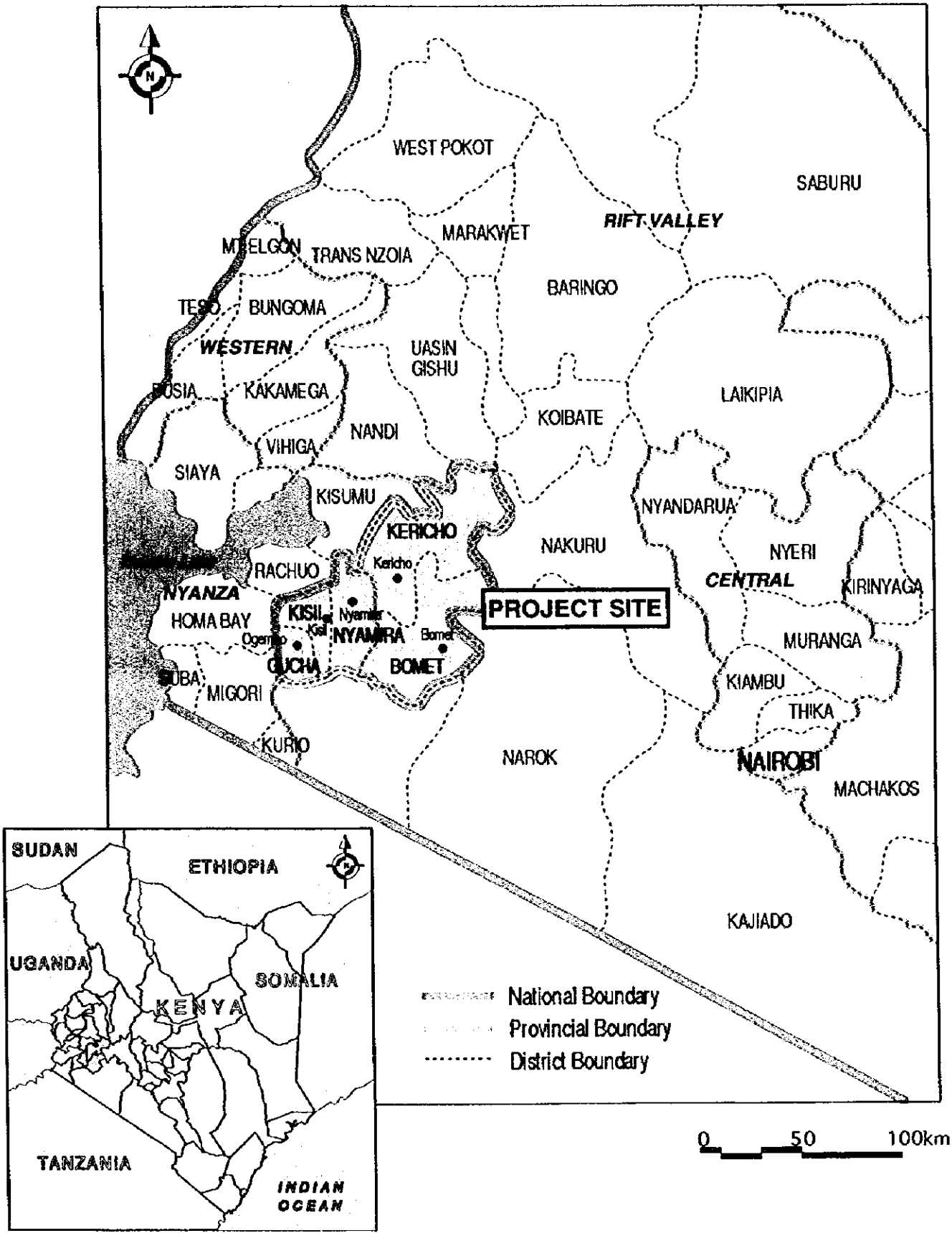
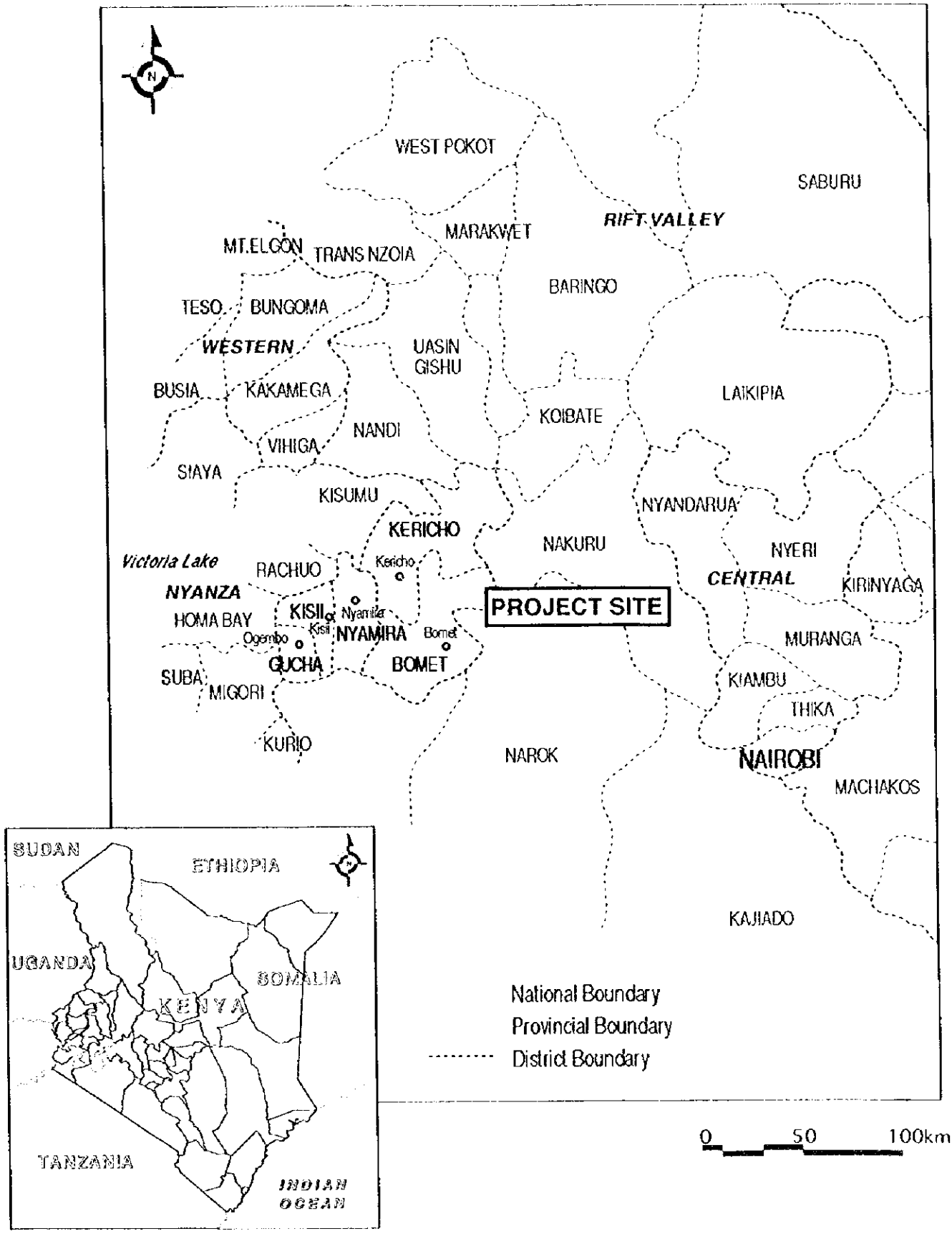
The exchange rates used in the Study are:
US$ 1.00 = 59.57 Kshs
US$ 1.00 = JY 139.60
(as of the end of August 1998)



Location Map of Project Site



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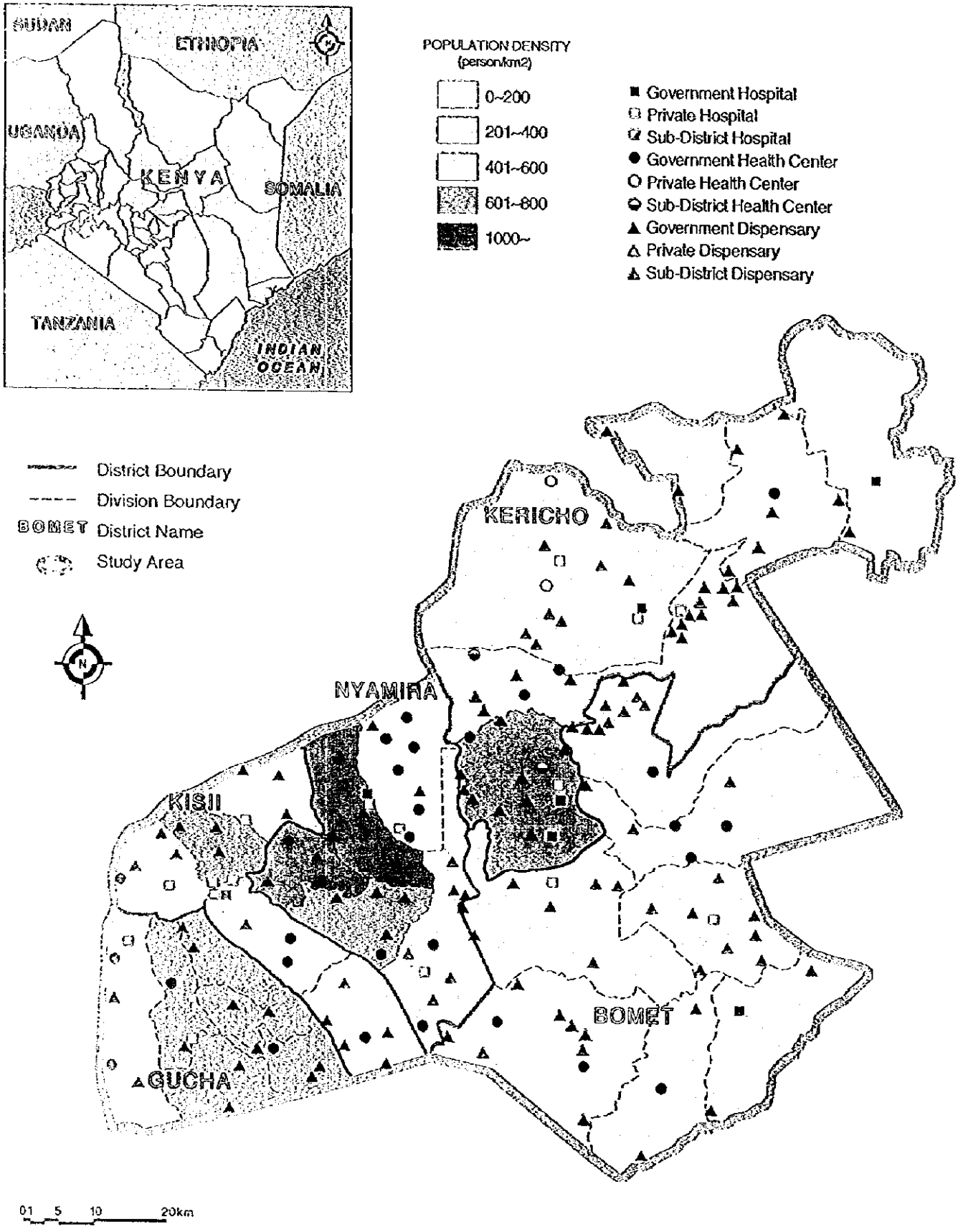
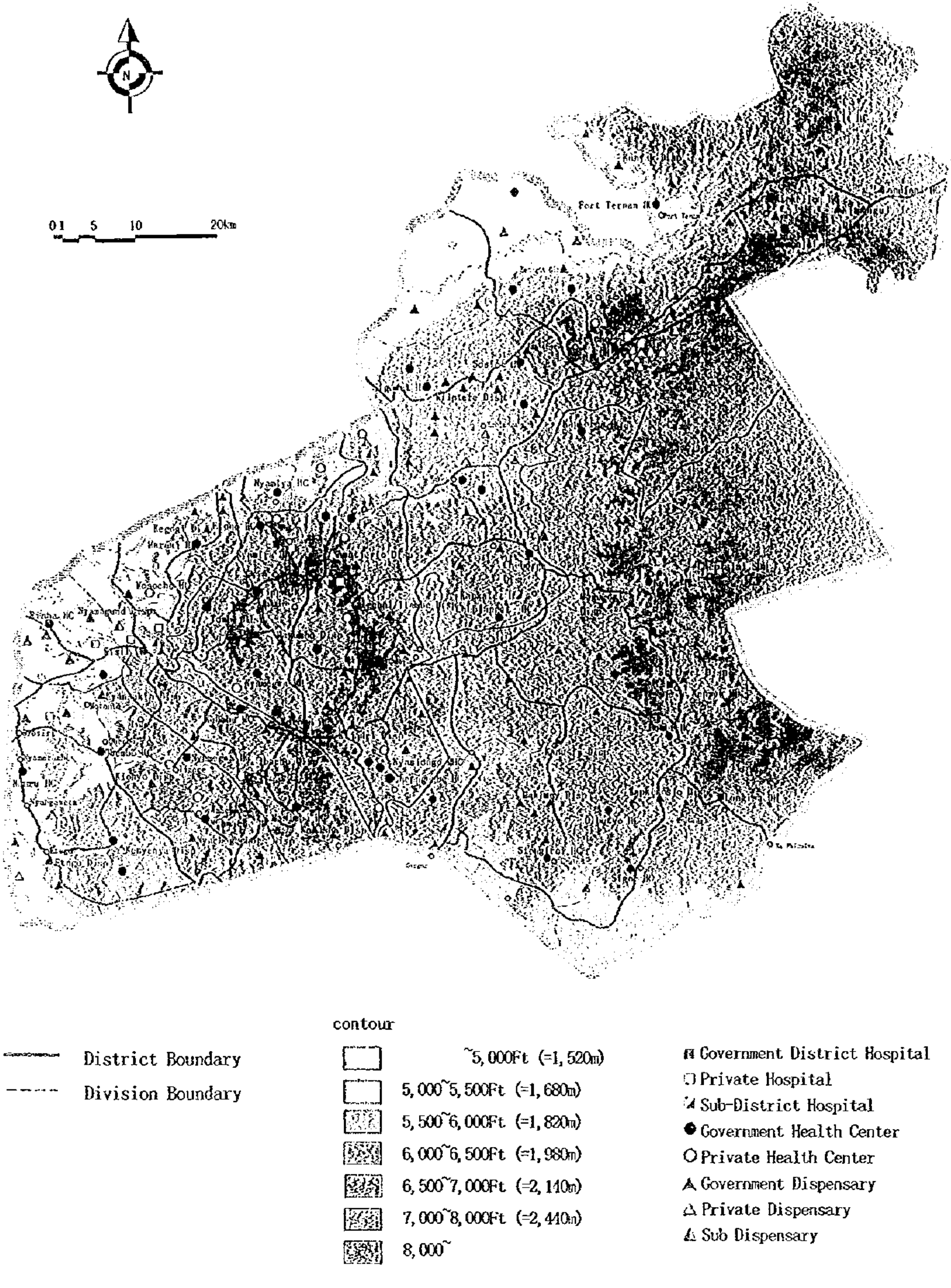

SUDAN
ETHIOPIA
UGANDA
KENYA
SOMALIA
TANZANIA
INDIAN OCEAN
POPULATION DENSITY
(person/km2)
0~200
201~400
401~600
601~800
1000~
Government Hospital
Private Hospital
Sub-District Hospital
Government Health Center
Private Health Center
Sub-District Health Center
Government Dispensary
Private Dispensary
Sub-District Dispensary
District Boundary
Division Boundary
BOMET District Name
Study Area
N
KERICHO
NYAMIRA
KISII
BOMET
GUCHA
01 5 10 20km



Distribution of Health Facilities in the Study Area

ABBREVIATION

AFD	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AIE	Authority to Incur Expenditure
ALS	Average Length of Stay
ARI	Acute Respiratory Infection
BCG	Bacilli de Calmette-Guerin
BFA	Budget and Financial Analysis
CBD	Contraceptives
CBHC	Community-based Health Care
CBS	Consumers Baseline Survey
CDD	Control of Diarrhoea Disease
CIDA	Canadian International Development Agency
CO	Clinical Officer
CPM	Capital Project Management
CSM	Cerebrospinal Meningitis
DALY	Disability Adjusted Life Year
DANIDA	Denmark International Development Agency
DCEC	District Continuing Education Coordinator
DCO	District Clinical Officer
DDC	District Development Committee
DFID	Department for International Development
DH	District Hospital
DHEO	District Health Education Officer
DHIS	District Health Information Officer
DHMB	District Health Management Board
DHMT	District Health Management Team
DMOH	District Medical Office of Health
DMS	Director of Medical Service
DPHN	District Public Health Nurse
DPHO	District Public Health Officer
DPT	Diphteria-Pertussis-Tetanus Vaccine
DSP	Dispensary
DTB	Department Tender Board
ECN	Enrolled Community Nurse
EDF	European Development Fund
EDL	Essential Drug List
EDP	Essential Drug Program
EEC	European Economic Community
FIF	Facility Improvement Fund
FINNIDA	Association
FP	Family Planning
FY	Financial Year
GOK	Government of Kenya
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
HC	Health Center
HCF	Health Care Financing
HECAFIP	Health Care Financing Program
HEROS	Health Sector Reform Secretariat
HESSP	Health Sector Support Program
HFC	Rural Health Facility Committee
HIMS	Health Information Management System
HMUs	Hospital Maintenance Unit
HPTC	Hospital Pharmacy Therapeutics Committee
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
IPD	In-Patient Department
KAP	Knowledge, Attitude and Practice
KDHS	Kenya Demographic Health Survey
KEDL	Kenya Essential Drugs List
KEMRI	Kenya Medical Research Institute
KHCFP	Kenya Health Care Financing Program
KEPI	Kenya Expanded Program on Immunisation
KHPF	Kenyatta Health Policy Framework
KHRP	Kenya Health Rehabilitation Project
KMA	Kenya Medical Association
KMTC	Kenya Medical Training College
KNDP	Kenya National Drug Policy
KNH	Kenyatta National Hospital
MCH / FP	Maternal Child Health and Family Planning
MESD	Medical Engineering Service Division
MIS	Management Information System
MLG	Ministry of Local Government
MoPW	Ministry of Public Works
MSCU	Medical Supplies Co-ordinating Unit
MTB	Medical Tender Board
NASCAP	National AIDS/STDs Control Program
NGO	Non-governmental Organization
NHIF	National Hospital Insurance Fund
NPA	Non Project Assistance
NPHL	National Public Health Laboratory
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OTC	Over-the-counter Drug
PCM	Project Cycle Management
PHC	Primary Health Care
PHMT	Provincial Health Management Team
PHO(M)	Public Health Officer (Maintenance)
PHT(M)	Public Health Technician (Maintenance)
PIH	Pregnancy Induced Hypertension
PMIU	Unit
PMOHs	Provincial Medical Office of Health
POM	Prescription-Only Medicine
PTA	Pharmacy and Therapeutics Committee
PTPP	Part Time Private Practice
PVC	Voluntary Organizations
RHTC	Rural Health Training Centre
RHF	Rural Health Facilities
RTI	Reproductive Tract Infections
SAD	Stores and Distribution
SDH	Sub District Hospital
SDP	Service Delivery Points
SIDA	Swedish International Development Agency
STD	Sexually-Transmitted Disease
TBA	Traditional Birth Attendant
TEC	Technical Evaluation Committee
TFR	Total Fertility Rate
TOT	Training of Trainers
TT	Tetanus Toxoid
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	U.S.Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization
WB	World Bank

Table of Contents

3. DISTRICT HEALTH SERVICE EDUCATION PROGRAM

ANNEXES

Chapter 1

Introduction

1. INTRODUCTION

1.1 OBJECTIVES OF THE STUDY

The Objectives of the Study consist of the followings:

(1) To establish a master plan which strengthens the district health system in the Study Area and to formulate an action programme for priority projects/programmes as a result of the master plan, and

(2) To conduct technical transfer to the Kenyan counter personnel in the course of the Study, in terms of methodologies on: 1) surveys and analyses for strengthening of the health sector; 2) people's participation in the planning process; and 3) a PCM approach to identify planning issues.

1.2 THE STUDY AREA AND TARGET

The Study Area is encompassed with five (5) Districts, namely, Kericho, Bomet, Nyamira, Kisii and Gucha. The catchment areas served by Kericho District Hospital, including part of Nandi, Uasin Gishu and Kisumu Districts, are also included in the Study Area.

As of January 1998, Nyamira, Kisii and Gucha were officially named North Kisii, Central Kisii and South Kisii respectively. However, in order to keep the consistency among the series of the study reports, old names were adopted in this report.

The area has a population of 3 million in 8,031 square kilometres of land. The master plan covers the time framework up to the year 2005.

1.3 THE STUDY SCHEDULE

The Study takes 14 months from August 26, 1997 up to the end of December 1998, being divided into two phases:

- The 1st Year Study : for the Base-line Study and Formulation of a Master Plan: up to March 1998
- The 2nd Year Study: for Formation of Action Plans and Projects/ programme from June to December 1998.

1.4 STUDY WORKFLOW

The Study was conducted in accordance with the workflow as shown in Figure 1.1.

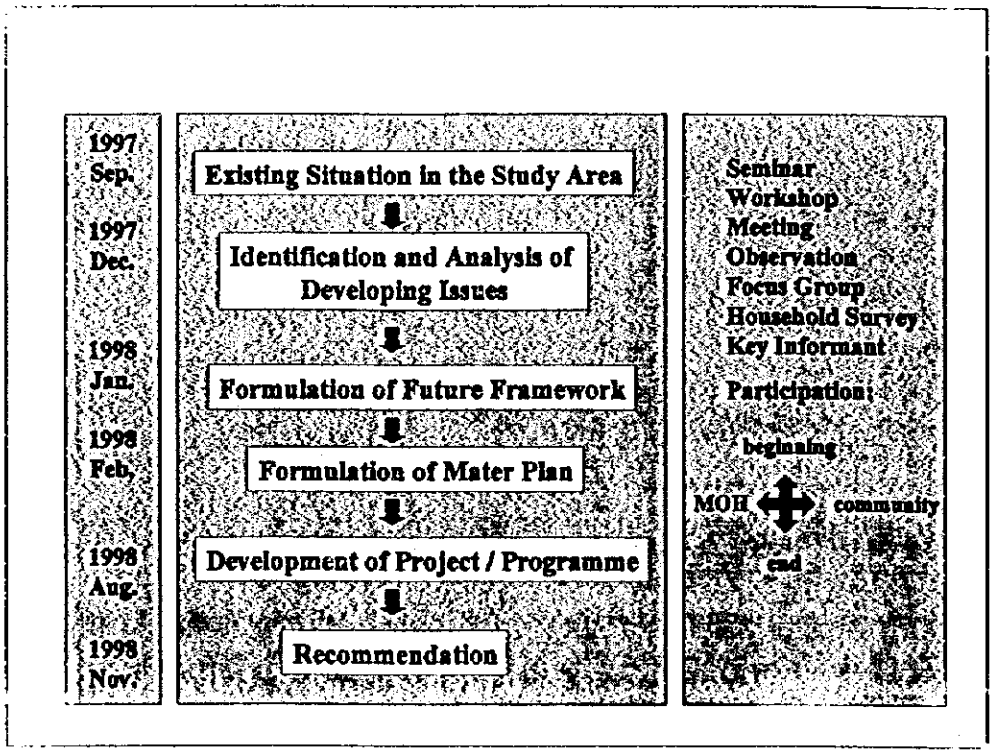


Figure 1.1 Study Workflow

Through the process of the Study, participatory approach is encouraged as much as possible from the beginning to the end of the Study as well as from the Central Ministry of Health to down the communities in the Study Area.

The Study also applied a wide variety of approaches including direct observation, key informant interviews, focus group discussion and household survey.

The products from those surveys and dialogues are brought to formulate 10 strategies in the Mater Plan aiming the following 2 objectives in the Study Area.

> To provide all the residents with universal access to minimum promotive and preventive health care as well as curative health service and upgrade the quality of the services.

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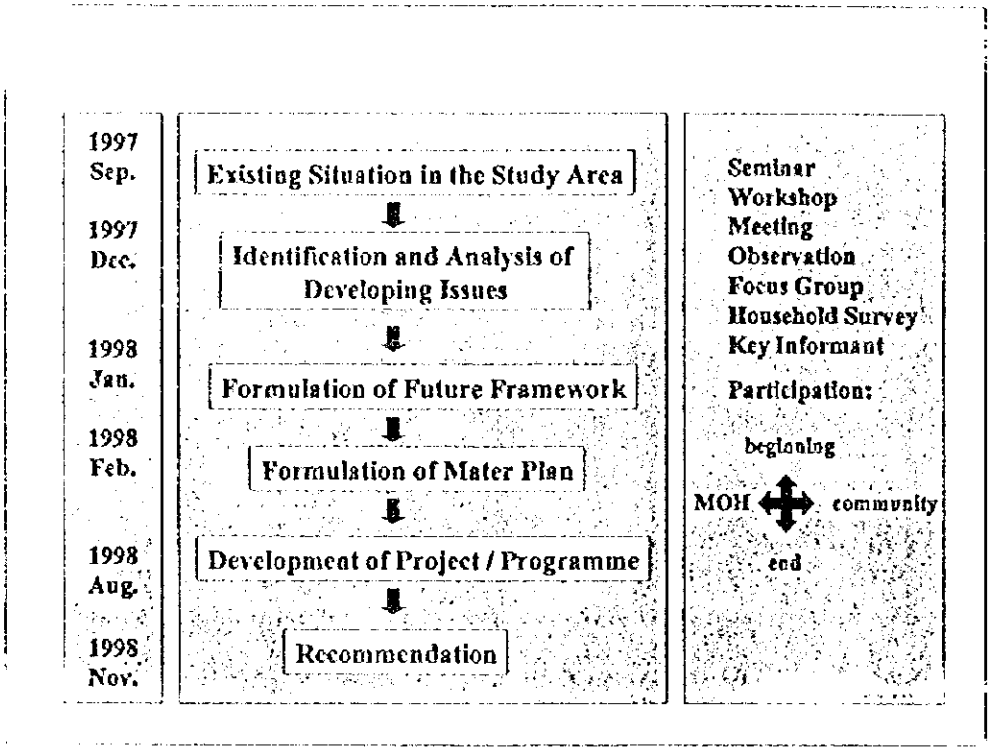

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> To provide all the residents with universal access to minimum promotive and preventive health care as well as curative health service and upgrade the quality of the services.

To strengthen linkages with other sectors to facilitate community development relating to health improvement.

Following the strategies in the Master Plan, then 5 project / programme packages were developed from 37 components of possible intervention with the criteria such as the consistency with National Health Sector Reform, cost effectiveness, and important base for the future development.

1.5 PROPOSED PROJECT / PROGRAMME

The figure 2.1 shows the composition of 5 Proposed Program Package formulated through phase I Study. Five are :

(1) Priority Diseases Program ;
(2) District Hospital Rehabilitation Program;
(3) Rural Health System Improvement Program;
(4) Community-based Preventive/promotive Health Care Program; and
(5) District Health Service Education Program.

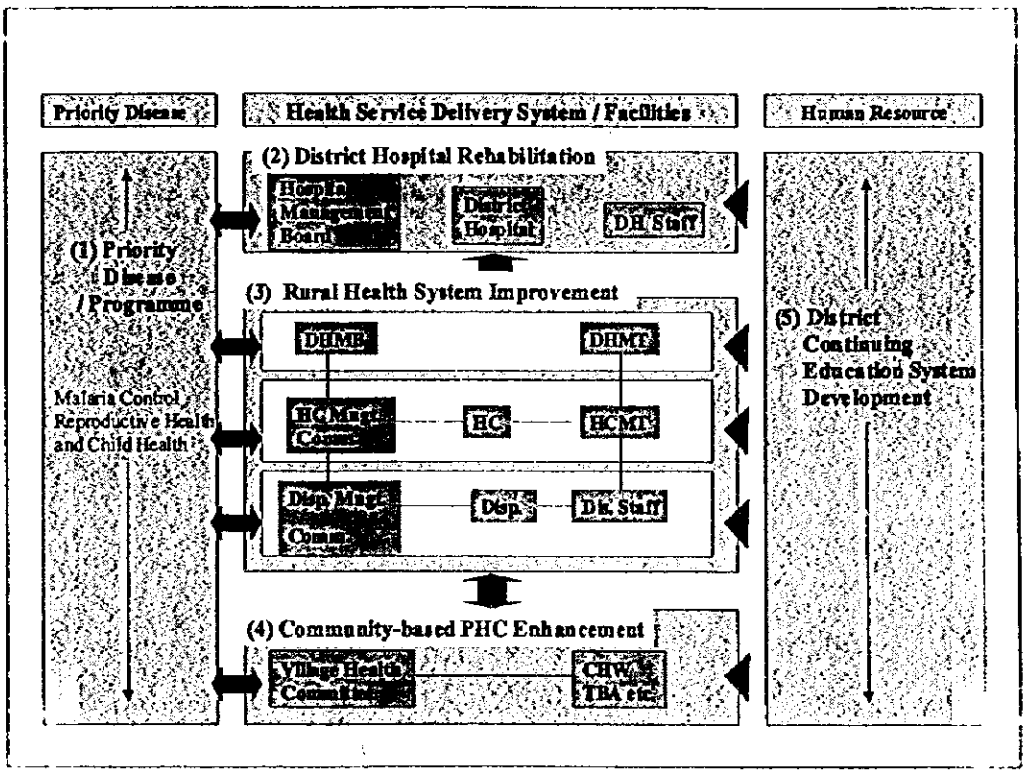

Figure 1.2 Composition of Proposed Priority Program Package

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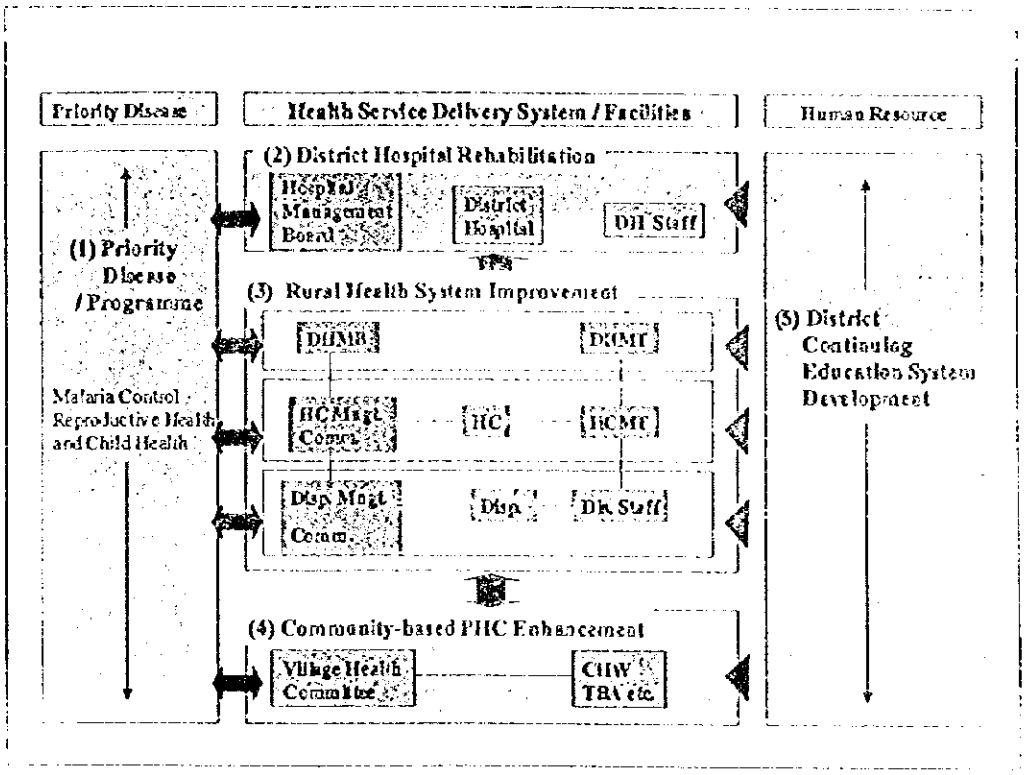


Figure 1.2 Composition of Proposed Priority Program Package

1.6 SCOPE OF THE REPORT

The Study report consists of the following volumes.

(1) Summary Report

(2) Main Report

(3) District Health Delivery System (Supporting Discussion 1: Baseline)

(4) Priority Disease and Proposed Project (Supporting Discussion 2)

- Malaria Control Project
- Reproductive and Child Heath Project

(5) Facility-based Health Service and Proposed Project (Supporting Discussion 3)

- Hospital Rehabilitation Program
- Rural Health System Improvement Program

(6) Community-based Development and Proposed Project (Supporting Discussion 4)

- Community-based Preventive/promotive Health Care Program

(7) Human Resource and Proposed Project (Supporting Discussion 5)

- District Health Service Education Program

This volume is to report (7) **Human Resource and Proposed Project** (Supporting Discussion 5).

Chapter 2

Issue on District Health Service Education

2. ISSUE ON DISTRICT HEALTH SERVICE EDUCATION

2.1 GENERAL

The shortage of appropriately trained staff has always been one of the main constraints in developing adequate health services. Over time, the reasons for staff shortages have varied.

In the past, there were not enough people with adequate general education to meet the entry qualifications for technical and professional training programmes. This is no longer a national problem but there are still parts of the country where sufficient candidates are in short supply. It is the national policy to include students from all parts of the country; but it is difficult to establish uniform minimum acceptable grades for entrants from all regions of the country, and this still creates a number of problems.

There has been a steady development of training facilities, but there is still difficulty in keeping up with demand, and some shortages of facilities and adequately trained staff to run them still exist. The Kenya Medical Training College (KMTC) runs the majority of the training programmes while mission hospitals undertake some nurses training. The Universities and technical colleges train the doctors and other graduate courses e.g. pharmacists and senior nurses.

The demand for staff has increased with the number of health facilities developed, and this has in turn, been caused by rapid population growth. At the peak of the growth rate - 4% per year - it was forecasted that the population would double in 17 years. This means that even to maintain the health worker/population ratio, yet alone improve on it, the number of health workers must also be doubled in 17 years.

A current limiting factor is lack of sufficient funds with which to pay for all the staff required. This has led to a withdrawal of the MoH guarantee of employment on completion of training (although most graduates are taken on within a few months of graduation). There are also a number of qualified nurses, trained in mission programmes, who are surplus to their training hospital requirements and are currently unemployed.

There has recently been an increased loss of trained Kenyan health workers to other African and foreign countries.

There is also a tendency to transfer from the government services to private practice. This is especially the case for doctors and clinical officers.

There are approximately 5,000 people employed in the health sector in the five study districts. About half work for the MoH, about one third are in the private sector and the remainder work at an NGO or Mission health facility. These figures do not include those outside the organised health services who are working in community based activities, for whom no comprehensive figures are available. The fact that about half of all the health workers are outside the MoH emphasises the importance of not limiting any review of the health services in the district to government services only.

Because of all the aforementioned factors that lead to understaffing, and because of a lack of a clear career structure for those employed in District and rural health facilities, the morale of many health workers has fallen and their services are well below their full capacity.

The combination of health staff shortages and the below capacity performance is probably the single most severe constraint on the delivery of an adequate health care service.

2.2 CURRENT DEPLOYMENT OF STAFF

There are no reliable statistics of health workers covering the whole Study Area.

Data were collected from a sample of 37 health facilities that were selected for this study.

Data for the MoH staff were collected from a variety of sources. In no district, except Nyamira, was there a complete record of all staff employed by the MoH. The District Personnel Officers do not have complete up-to-date lists of staff employed in their Districts. When new doctors or clinical officers are appointed to a District, they report to the District Medical Officer who assigns them to a posting. When new nurses arrive they report to the District Chief Nursing Officer and are given their assignments. The personnel officer's records are incomplete and confused. The Provincial Personnel Officer's records are more complete, but there are still serious discrepancies between their figures and those obtained in the sample survey or from MoH headquarters. These have been compared with the figures obtained in 1994 when a direct count was made at all facilities. From all these, sometimes conflicting, estimates on 'adjusted' figure for 1997 has been computed. The rationale for the adjustments made are explained in the DSA Final Report Study No 5 on Human Resources.

Data for the staff employed in NGOs, missions and the private sector are drawn from the report The Health Sector in Kenya: Health Personnel, Facilities, Education and Training (Schwarz, second edition 1996).

2.2.1 Personnel in the Sample Health Facilities

The sample of 37 health facilities selected for the study included 5 hospitals, 16 health centres and 16 dispensaries - drawn from the five districts. The sample was heavily biased in favour of hospitals. For example, 82% of the health personnel in the sample work in hospitals compared to 55% nationally.

Table 2.1 presents a summary of the data on personnel collected from the sample survey.

It should be noted that only 9 out of the 16 health centres studied had even one clinical officer, while 100 were employed in the 5 hospitals. There were only 6 registered nurses in the health centres. The 16 dispensaries had only 25 enrolled nurses between them - i.e. 1 or 2 each.

2.2.2 MoH Personnel in the Study Area

The MoH staff currently employed in the five Districts of the Study Area are shown in Table 2.2. The staff are grouped into nine major categories:

1) Medical /Dental Officers;
2) Clinical Officers;
3) Nurses;
4) Clinical support (Lab., Pharm., Radio, etc.);
5) Public Health (PHOs, PHTs);
6) Preventive and Promotive (FP., Nut., etc);
7) Administration (Accts., MRO/Ts, etc);
8) Maintenance and Support (Bldg./Ground, Cateress/cook, Driver, etc); and
9) Subordinate staff.

Table 2.1 Summary Table of Personnel in Sample Area

Cadre	Sub-Group	Facility Type						Sub-Total	Total	Percentage
		Hospitals		H/Centres		Dispensaries				
		No.	%	No.	%	No.	%			
Sub-Total: Doctors (DOC)		**26**	**2%**	**1**	**0%**			27	**27**	**1%**
Sub-Total: Clinical Officers (CLO)		**100**	**6%**	**9**	**3%**			109	**109**	**5%**
Nurses (NUR)										
	RNs	91	5%	6	2%			97		
	ENs	438	26%	86	31%	25	27%	549		
Sub-Total: Nurses		**529**	**31%**	**92**	**33%**	**25**	**27%**		**646**	**31%**
Clinical Support (CLS)										
	Lab.	95	6%	19	7%	2	2%	116		
	Phar.	11	1%					11		
	Rad.	19	1%					19		
	Other	50	3%					50		
Sub-Total: Clinical Support		**175**	**10%**	**19**	**7%**	**2**	**2%**		**196**	**9%**
Public Health (PHS)										
	PHOs	14	1%	6	2%	1	1%	21		
	PHTs	95	6%	28	10%	15	16%	138		
Sub-Total: Public Health		***109***	***6%***	***34***	***12%***	***16***	***17%***		***159***	***8%***
Preventive & Promotive (PPP)										
	FP	26	2%	14	5%	3	3%	43		
	Nutrition	29	2%	9	3%	2	2%	40		
	Other	17	1%					17		
Sub-Total: Preventive & Promotive		***72***	***4%***	***23***	***8%***	***5***	***5%***		***100***	***5%***
Administration (ADM)										
	Accts/CLOs	91	5%	27	10%	2	2%	120		
	MRO/Ts	17	1%	2	1%			19		
	Other	39	2%					39		
Sub-Total: Administration		**147**	**9%**	**29**	**10%**	**2**	**2%**		**178**	**9%**
Maintenance Support (MSP)										
	Watchmen	13	1%	10	4%	10	11%	33		
	Hou.,Coo.,Oth.	30	2%			1	1%	31		
	Drivers	39	2%	3	1%			42		
Sub-Total: Maintenance Support		**82**	**5%**	**13**	**5%**	**11**	**12%**		**106**	**5%**
Sub-Total: Subordinate Staff (SBS)		**457**	**27%**	**57**	**21%**	**31**	**34%**	545	**545**	**26%**
Total(All Staff)		**1,597**	**100%**	**277**	**100%**	**92**	**100%**		**2,066**	**100%**
Percentage (All Staff)		**82.1%**		**13.4%**		**4.8%**			**100%**	

Table 2.2 MOH Personnel (1997 adjusted Figure) in Study Area

MAJOR CLASSIFICATION and Job Category	Kisii 1997 (Adj.)	Gucha 1997 (Adj.)	Nyamira 1997 (Adj.)*	Kericho 1997 (Adj.)	Bomet 1997 (Adj.)	Total 1997 (Adj.)	Percentage
Medical/Dental Officers							
Medical Officers	10	1	3	6	1	21	
Dental Officers	1	0	0	2	0	3	
Sub-Total: Med./Den.	11	1	3	8	1	24	1%
Clinical Officers	36	3	18	46	5	108	4%
Nurses	283	36	195	*268*	94	876	34%
Clinical Support							
Laboratory	26	4	25	47	13	115	
Pharmacy	4	1	1	9	3	18	
Radiography	8	0	4	7	1	20	
Other	28	0	11	29	4	72	
Sub-Total: Clinical Support	66	5	41	92	21	225	9%
Public Health	50	33	75	*112*	*90*	360	14%
Preventive & Promotive							
Family Planning	12	6	16	14	14	62	
Nutrition	11	6	12	21	9	59	
Other	8	1	1	3	5	18	
Sub-Total: Preventive & Promotive	31	13	29	*38*	*28*	139	5%
Administration							
Accts/Clerical	54	6	46	33	7	146	
MRO/Ts	6	2	6	14	5	33	
Other	12	1	16	6	5	40	
Sub-Total: Administration	72	9	68	53	17	219	8%
Maintenance & Support							
Bldgs/Grounds	10	3	0	0	0	13	
Cateress/Cook	0	0	3	0	0	3	
Driver	22	2	8	10	6	48	
Other	9	0	8	5	2	24	
Sub-Total: Maintenance & Support	41	5	19	15	8	88	3%
Subordinate Staff	258	35	147	103	29	572	22%
Grand Total	848	140	*595*	735	293	2,611	100%
Percentage	32%	5%	*23%*	28%	4%	100%	

The total number of staff employed by the MoH in the five districts is 2,611. Doctors are less than 1% of the total. Clinical Officers are 4%, and nurses, the largest group, 34%.

There are more men (60% - 90%) in all cadres of health workers except nursing, where approximately 75% are women.

2.2.3 All Health Personnel - MoH, NGO/mission, Private - in the Five Districts

The data used to estimate personnel in the NGO/Mission and private sectors are from the DSA database produced for a national study on health personnel. The problems and limitations of these data are discussed in The Health Sector in Kenya: Health Personnel, Facilities, Education and Training (Schwarz, second edition 1996).

There are approximately 5,000 people employed in the health sector in the five study districts. The MoH employs 53%; the private sector 30%, and 18% work at an NGO or Mission health facility.

Table 2.3 presents the total data for the five districts. It cannot be disaggregated into the five districts, because the database was established before the division of Kericho and Kisii districts into the current five districts.

Table 2.3 Summary Table - All Health Personnel in the Study Area

MAJOR CLASSIFICATION and Job Category	MOH 1997 (Adj.)	1994 NGO/MIS	1994 PRIV.	TOTAL 1997 (Est.)	Major Category Percentage
Medical/Dental Officers	**24**	**42**	**154**	**220**	**4%**
Clinical Officers	**108**	**8**	**7**	**123**	**2%**
Nurses	**876**	**217**	**414**	**1,507**	**30%**
Clinical Support					
Laboratory	115	37	67	219	
Pharmacy	18	9	38	65	
Radiography	20	6	22	48	
Other	72	0	0	72	
Sub-Total: Clinical Support	**225**	**52**	**128**	**405**	**8%**
Public Health	**360**	**0**	**0**	**360**	**7%**
Preventive & Promotive	**139**	**0**	**0**	**139**	**3%**
Administration	**219**	**68**	**148**	**435**	**9%**
Maintenance & Support	**88**	**168**	**190**	**446**	**9%**
Subordinate Staff	**572**	**321**	**422**	**1,315**	**27%**
Grand Total	**2,611**	**876**	**1,464**	**4,951**	**100%**
Percentage	**53%**	**18%**	**30%**	**100%**	

This table does not include community-based workers contributing to health care. In the sample survey of 37 facilities, 135 community workers - community health workers (CHWs), traditional birth attendants (TBAs), and community-based drug distributors (CBDDs) - were reported as working with eight facilities. Tenwek hospital has an extensive community programme extending from Bomet into neighbouring districts; Kaplong, Litein and Kericho hospitals have trained community health workers; Bomet has a Forum for agencies working with community-based workers; but no comprehensive data were collected for the five districts.

If the possibility of developing a community-based programme is considered, further information will be required on existing support agencies, numbers, distribution, training, supervision, rewards, etc for all health, and health related, community workers.

2.3 HEALTH PERSONNEL ISSUES

The analysis of the staff situation is based on the application of national staffing norms presented in the Health Sector in Kenya: Health Personnel, Facilities, Education and Training (Schwarz 1995/1996). These national norms (which include staff for the MoH headquarters, KMTC, KNH teaching hospital, etc), provide a general guide but need to be adapted to district and regional conditions before detailed human resource planning can be done.

Adaptation is likely to lead to major revision in the number of doctors required and modest declines in the number of nurses and a few other cadres.

Table 2.4 shows the actual numbers and ratios of the major categories of health personnel in 1997, staffing norms, and resources required to meet the norms for the years 1997 and 2005. The right hand column shows the net annual increase for each category that is required to meet the national norms for the year 2005.

This shows the major shortages in all 'Key Health personnel' - doctors, dentists, clinical officers and nurses - some clinical support staff, and public health. The sample survey shows that the shortages are most severe in the rural health facilities.

Table 2.4 Staffing Ratios, Resources and Targets for Years 1997 and 2005

All Health Sector Personnel CATEGORIES and Major Personnel Classifications		Actual Ratios in 1997	Ratios Required to Meet Kenya Norms (per 100 beds) Current Year 1997	Ratios Required to Meet Kenya Norms (per 100 beds) Target Year 2005	Actual Number in 1997	Number Required to Meet Norms for Kenya Current Year 1997	Number Required to Meet Norms for Kenya Target Year 2005	Additional Net Resources Required (Temporary Oversupply) In Year 1997	Additional Net Resources Required (Temporary Oversupply) By the Year 2005	Annual Net Increase Required
Population:					2,559,500	2,559,500	3,307,700			
Number of Hospital Beds:					2,641	2,559	2,977	(82)	336	42
Hospital beds per 1,000 Population:		1.0	1	0.9						
TOTAL	Doctors	8	12	13	216	308	413	92	*197*	*25*
KEY HEALTH	Dentists	0.2	1.6	2	4	41	66	37	*62*	*8*
PERSONNEL	Clinical Officers	4.8	9	14	123	222	453	99	*330*	*41*
(KHP)	Nurses	59	88	93	1,507	2,261	3,089	754	*1,582*	*198*
TOTAL KHP	KHP TOTAL	73	112	123	1,850	2,832	4,021	982	*2,171*	*272*
TOTAL	Laboratory	9	8	9	219	193	309	-26	*90*	*11*
CLINICAL	Pharmacy	3	7	9	65	180	294	115	*229*	*29*
SUPPORT	Radiology	2	2	2	48	53	74	7	*28*	*4*
STAFF	Therapy	2	3	3	48	66	93	18	*45*	*6*
(CLS)	Technology Support	1	2	2	24	39	69	15	*45*	*6*
TOTAL CLS	CLS TOTAL	17	22	25	404	531	839	129	*437*	*56*
PUBLIC HEALTH &	PHO/PHT	14.1	16	22	360	410	728	50	368	46
PREVENTIVE/PROMOTIVE	Nut., FP, H. ed, etc.	3.6	6	7	139	144	219	52	127	16
TOTAL PH & P/P	PH & P/P TOTAL	18	22	29	499	554	947	102	495	62
TOTAL	Administration	17	22	29	435	555	744	120	309	*39*
ADMINISTRATION	Maint. & Support	17	19	24	446	475	625	20	170	*21*
and SUPPORT	Subordinate Staff	51	91	98	1,316	2,324	2,501	1,008	1,185	*148*
TOTAL AMS	AMS TOTAL	85	132	151	2,197	3,354	3,870	1,148	1,664	*208*
*TOTAL Staff**					4,950			2,361	4,767	*598*

*Note: The total of Inpatient and Outpatient is 50 less than the total for all personnel. This is due to rounding of figures in various parts of the working spreadsheets.

2.3.1 Personnel for Hospital Inpatient Services

The staffing norms for hospital inpatient services are based on the personnel required for 100 beds. These targets were set in collaboration with the MoH as part of the Health Sector in Kenya Study. The planning assumption is that 0.9 hospital beds per 1,000 population are adequate to meet the needs of the Kenyan population.

Table2.5 shows the hospital beds available in the five districts. With an estimated population of 2.6 million, the total 2,461 meets the required ratio for 1997 and an additional 336 will be required by the year 2005.

Table2.6 outlines the current situation in regard to personnel for hospital-based inpatient services and future requirements. Other hospital-based staff provide services for outpatients and will be considered below.

It should be noted again that the staffing norms used, especially for doctors 4.4 per 100 beds, might be high for district services. There is a shortfall of 10 clinical officers and 229 nurses. There is an excess of laboratory staff.

The overall shortage of all cadres for hospital inpatient services is 313 out of 3,032 (2,729 + 313) i.e. 11%.

Table 2.5 Hospitals and Hospital beds in the Study Area

CODE	HEALTH FACILITY	TYPE	AGENCY	DISTRICT	DIVISION	TOWN	BEDS		COTS	MOH
							GEN.	MAT		TOTAL
KISII DISTRICT										
1265	Kisii District Hosp.	HOS	MOH	Kisii	Kisii Municipal	Kisii	248			248
1266	Tabaka Mission Hosp.	HOS	NGO	Kisii	Bosongo	Tabaka Mkt.	300			300
1264	Christ	HOS	PRI	Kisii		Kisii	220		10	230
Sub-Total: Kisii District		3					768	0	10	778
NYAMIRA DISTRICT										
	ST. Joseph's Hosp.Nyansiongo	HOS	PRI	Nyamira		Sotik	52			52
1512	Nyamira District Hosp.	HOS	MOH	Nyamira	Nyamira	Nyamira	250			250
Sub-Total: Nyamira District		2					302	0	0	302
KERICHO DISTRICT										
1666	Kipchimchim Miss. Hosp.	HOS	NGO	Kericho	Belgut	Kericho	60			60
1674	St.Francis Hosp. (Ker.)	HOS	PRI	Kericho	Kipkelion	Kipkelion	40			40
1676	Central Brook Bond Hosp.	HOS	PRIL	Kericho	Belgut	Kericho	67			67
1677	Chemugundai Hopt.	HOS	MOH	Kericho	Belgut	Kericho	76		14	90
1680	Kericho Dist. Hosp.	HOS	MOH	Kericho	Belgut	Kericho Town	260			260
1681	Litein (AIC) HOSP.	HOS	NGO	Kericho	Buret	Litein	69			69
1682	Londiani Sub-Dist. Hosp.	HOS	MOH	Kericho	Londiani	Londiani	39	10	1	50
3448	St. Leonard Hosp.	HOS	PRI	Kericho	Belgut	Belgut	124			124
6176	Kapkatet Sub. D. Hosp.	HOS	MOH	Kericho	Buret	Kapkatet	124	16	16	156
Sub-Total: Kericho District		9					859	26	31	916
BOMET DISTRICT										
1624	Longisa Hosp*.	HOS	MOH	Bomet	Longisa	Longisa				0
	Tenwek (AGC) Hosp.	HOS	PRI	Bomet			299		50	349
1679	Kaplong Catholic Hosp.	HOS	NGO	Bomet	Konoin	Sotik	220		51	271
Sub-Total: Bomet District		3					519	0	101	620
GUCHA DISTRICT										
1261	Gucha District Hosp**.	HOS	MOH	Gucha	Ogembo	Ogembo	25			25
Sub-Total:Gucha District		1					25	0	0	25
Grand Total		18					2,473	26	142	2,641

NOTE:
*Longisa Hospital: Buildings and other physical facilities for 100 beds are present. Constraints to operation are water, staff & suppliers.
** Gucha District Hospital: Ogembo H/C now has 25 beds & is planned to be upgraded to a hospital with 100 beds

Table 2.6 Staffing Norms and Targets for Hospital Inpatient Services

Hospital Impatient CATEGORIES and Major Personnel Classifications		Actual Ratios in 1997	Ratios Required to Meet Kenya Norms (per 100 beds) Current Year 1997	Ratios Required to Meet Kenya Norms (per 100 beds) Target Year 2005	Actual Number in 1997	Number Required to Meet Norms for Kenya Current Year 1997	Number Required to Meet Norms for Kenya Target Year 2005	Additional Net Resources Required (Temporary Oversupply) In Year 1997	Additional Net Resources Required (Temporary Oversupply) By the Year 2005	Annual Net Increase Required
	Population:				2,559,500	2,559,500	3,307,700			
	Number of Hospital Beds:				2,641	2,559	2,977	(82)	336	42
	Hospital Beds per 1,000 population:	1.0	1.0	0.9						
KEY HEALTH PERSONNEL	Doctors	**3.5**	4.4	5	**92**	116	149	25	*57*	*7*
	Clinical Officers	**1.7**	2.1	3	**45**	55	89	10	*44*	*6*
	Nurses	**33.3**	42	46	**880**	1,109	1,369	229	*489*	*61*
CLINICAL SUPPORT STAFF	Laboratory	**3.0**	1.5	1.5	**79**	40	45	-39	*-34*	*-4*
	Pharmacy	**0.7**	1	1	**20**	26	30	7	*10*	*1*
	Radiology	**1.7**	2	2.5	**46**	53	74	7	*28*	*4*
	Therapy	**1.5**	1.5	2	**40**	40	60	0	*20*	*2*
	Technology Support	**0.7**	1	1.2	**18**	26	36	8	*18*	*2*
PREVENTIVE/PROMOTIVE	Nut., FP, Head, etc.	**11.0**	0.6	1.25	**30**	16	37	-14	*7*	*15*
ADMINISTRATION MAINTENANCE and SUPPORT	Administration	**12.5**	12	14	**330**	317	417	-13	*87*	*11*
	Maint. & Support	**10.1**	11	13	**267**	291	387	24	*120*	*15*
	Subordinate Staff	**33.4**	36	41	**882**	951	1,221	69	*339*	*42*
TOTAL Staff					**2,729**			313	*1,185*	*162*

2.3.2 Personnel for Outpatient and Community Services

The staffing norms for outpatient and community care are based on the estimated needs for 100,000 population. The outpatient services of hospitals are included with the services provided in health centres and dispensaries. For these calculations it is taken that 15% of hospital staff time is spent on outpatient care.

Table 2.7 shows the personnel required for 1997 and for 2005 together with the net annual increase required.

The table shows that there is a current deficit of 88 clinical officers, 525 nurses and 108 pharmaceutical personnel. The deficit of 68 doctors, based on a national norm, is as indicated previously, high for rural districts.

The overall shortage of all cadres for outpatient and community services is 2,059 out of 4,232 i.e. 48%. This deficit is much greater than for the hospital inpatient services (11%). It is unlikely that the annual increases required to bring the numbers up to the national norms can be met in the near future.

In general, the sample survey shows that the shortages are most severe in the rural health facilities. The shortage of appropriately trained staff has always been one of the main constraints in developing adequate health services. Over time, the reasons for staff shortages have varied. The demand for staff has increased with the number of health facilities developed, and this has in turn, been caused by rapid population growth. This means that even to maintain the health worker/population ratio, yet alone improve on it, the number of health workers must also be doubled in 17 years.

On the other hand, it must be noted that there are also a number of qualified nurses who are surplus to their training hospital requirements and are currently unemployed because their training program conducted by the Missions are not recognised by the MoH.

To address the problem of shortage of staff, training facilities are steadily being developed in Kenya and in the Study Area. The Kenya Medical Training College (KMTC) runs the majority of the training programmes while mission hospitals undertake some training for nurses, pharmacists and senior nurses. A summary of the training facilities, including those of Missions, in the Study Area is given in Table 2.8.

Table 2.7 Staffing Norms and Targets for Outpatient Services (all health facilities) and Community Professional Personnel

Out-Patient Facilities and Community-Based Professionals (hospital outpatient, H/C, dispensaries, clinics) CATEGORIES and Major Personnel Classifications		Actual Ration In 1997	Ratios Required to Meet Kenya Norms (per 100,000 pop.) Current Year 1997	Target Year 2005	Actual Number In 1997	Number Required to Meet Norms for Kenya Current Year 1997	Target Year 2005	Additional Net Resources Required (Temporary Oversupply) In Year 1997	By the Year 2005	Annual Net Increase Required
Population:					2,559,500	2,559,500	3,307,700			
KEY HEALTH PERSONNEL	Doctors	4.9	7.5	8	124	192	265	68	*140*	*18*
	Dentists	0.2	1.6	2	4	41	66	37	*62*	*8*
	Clinical Officers	3.0	6.5	11	78	166	364	88	*286*	*36*
	Nurses	24.5	45	52	627	1,152	1,720	525	*1,093*	*137*
CLINICAL SUPPORT STAFF	Laboratory	5.5	6.0	8	140	154	265	14	*125*	*16*
	Pharmacy	1.8	6.0	8	46	154	265	108	*219*	*27*
	Radiology	0.0	d in Inpatient							
	Therapy	0.3	1.0	1	8	26	33	18	*25*	*3*
	Technology Support	0.2	0.5	1	6	13	33	7	*27*	*3*
PUBLIC HEALTH & PREVENTIVE/PROMOTIVE	PHO/PHT	14.1	16	22	360	410	728	50	*368*	*46*
	Nut., FP, Head, etc.	24	5	5.5	62	128	182	66	*120*	*15*
ADMINISTRATION MAINTENANCE and SUPPORT	Administration	4.0	9	11	105	238	327	133	*222*	*28*
	Maint. & Support	6.8	7	8	179	185	238	6	*59*	*7*
	Subordinate Staff	16.4	52	43	434	1,373	1,280	939	*846*	*106*
TOTAL Staff					2,173			2,059	*3,592*	*450*

2.3.3 Summary of Staff Shortages

The suitability of applying these staffing norms, established on a national basis, to the Study Area is questionable, and further analysis is required to establish more appropriate norms for district health services. However, they do give an indication of the severity of the shortages. For example, Table 4 shows that the additional key health personnel (doctors, dentists, clinical officers, and nurses) required now in 1997 is 982 i.e. approximately a half more than the 1,850 currently present.

It can already be seen that the facilities most seriously affected by the shortages of staff are the health centres and dispensaries. Only half the health centres have even one Clinical Officer. The average number of ECNs per dispensary is less than two. These figures are based on the numbers of staff actually posted to each facility. However, there is also a high level of absenteeism, so the numbers of staff working at any given time is often less than appears from the figures. Patient care was sometimes seen to be administered by unqualified staff due to the unavailability of trained staff.

The District hospitals are also understaffed, and are particularly short of senior staff. The relative excess of clinical officers are doing the work that should be done by doctors, and are consequently not available for the Health centres.

The severe shortage of nurses leads to nursing duties being undertaken by untrained ward staff. Apart from shortage of professional staff there is also an acute shortage of artisans for maintenance work, leading to a steady deterioration of the buildings and services.

2.4 PROFESSIONAL EDUCATION AND TRAINING

As previously stated the responsibility for selection of the majority of student health workers and their basic professional training lies with the MoH headquarters. This responsibility is delegated to the Kenya Medical Training Centre (KMTC), currently being transformed to a parastatal organisation. This institution is responsible for the training of 70% of all health professionals. Doctors and other senior level staff are trained in the universities and technical colleges and some mission hospitals train nurses.

2.4.1 Basic Professional Education

An excellent summary of the national basic professional education programmes for health workers is given in the DSA Final Report Study 5 Human Resources. This describes the types and locations of all the KMTC programmes.

One of the 25 KMTC campuses, which trains Kenya Enrolled Community Nurses, is in Kisii. This school is situated, on its own compound, near the Kisii District Hospital. It has ten tutors and an annual intake of 30 students, and an output, after two and a half years, of 20 KECNs. The school has a classroom for 20 students, good equipment and teaching aids, and a small well-stocked library. There is good residential accommodation for 96 students in single rooms. Practical nursing is done in the Kisii hospital and study of community health at two Rural Health Demonstration Units at Marani and Nduru. The management of the school comes directly under the MTC and not the DHMT.

There are also two mission hospitals in Bomet - Tenwek and Kaplong - now training Kenya Registered Community Nurses. A summary of the training facilities in the Study Area is given in Table 2. 8.

Table 2.8 Training Institutions in the Study Area

Name of Institution	Sector	Programmes
MTC Kisii	Gok	Enrolled Community Health Nursing Certificate (2.1/2 years)
Tenwek School of Nursing	Mission	Enrolled Community Health Nursing Certificate (2.1/2 years); Community Health Workers
Kaplong School of Nursing	Mission	Kenya Registered Community Health Nursing Basic Diploma (3.1/2 years)
Chulaimbo Rural Health Training Centre (RHTC) (just outside the Study Area in Kisumu District)	Gok	Community Health Experience for: KRCHNs from Kisumu MTC (4 - 6 weeks) Clinical Officers from Nairobi, Nakuru & Mombasa (6 - 8 weeks)
Nduru RHDC	Gok	Community Health Experience for ECHN from MTC Kisii (4 - 6 weeks)
Marani RHDC	Gok	Community Health Experience for ECHN from MTC Kisii (4 - 6 weeks)

The District Health authorities have, currently, no control over the recruitment, training or deployment of staff to the District. This situation will change when Kenya's Health Policy Framework of decentralisation occurs. (This may have been accelerated as a result of the recent strike of nurses and laboratory staff). However, once staff have been sent to the District, it is up to the District authorities to deploy them within the various district health facilities, and to ensure that they work to the capacity their skills, and the facilities and supplies provided. This requires proper supervision, guidance and continuing education.

2.4.2 Continuing Education

During the past 30 years increasing attention has been given to continuing education by the MoH, NGOs, and donor agencies. In 1983, supported by the Swedish International Development Agency a National Continuing Education Programme was started in the MoH. The broad objectives of the National programme are aimed at improving the health status of the Kenyan population in rural areas, with special emphasis on women and children. A new cadre of District Continuing Education Officers (DCEOs) has been created and posted to the 22 districts in which the national programme has been started. The strategy is to conduct short courses for technical upgrading of health sector staff at all levels.

Other components include:
training seminars on management and PHC;
development of libraries in health facilities; and
development of health learning materials.

Kericho is the only district in the Study Area included in the 22 districts.

The critical role of continuing education is recognised in Kenya's Health Policy Framework (1994). It recommends decentralisation of CE to the districts. Elements of the strategies to be used include: 'continuing education units with full time staff in each district. A core programme based upon the epidemiological data and other assessments of training needs; adaptation of the core programme to local conditions; ongoing monitoring and performance based assessments.'

The National programme has begun but has so far made only limited progress. No National Master Plan for CE has yet been produced and current district CE programmes are still dominated by the dictates of the national vertical programmes - KEPI, MCH/FP, CDD, ARI, etc. We were told that the same people attend these seminars, and most staff from the rural facilities do not have an opportunity to go.

There is no planned programme of continuing education for all staff in any of the Districts, and those in the rural health facilities are the most neglected. The proportion of staff, in the facilities sampled, who have attended any CE in the last two years is shown in Figure 2.1.

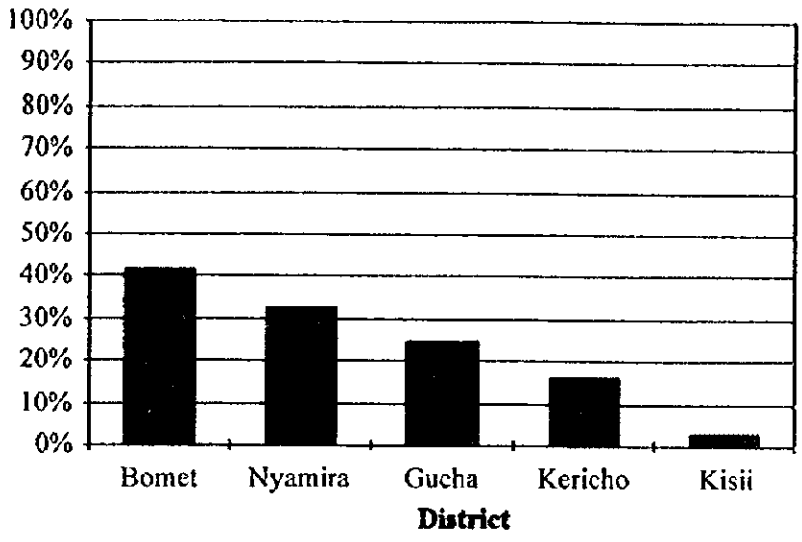


Figure 2.1 Staff Participation in Continuing Education

2.4.3 Supervision

Supervision plays an important role in the management of the rural health facilities. It also provides a critical method of assessing the overall needs for CE and determining the content of programmes. Effective supervision, with time spent on guidance, is indeed part of continuing education.

Currently the lack of transport hinders the effective management and supervision of the rural health facilities. DHMT members are not able to go out on regular supervisory visits due to lack of either transport or fuel, or to broken down vehicles. The delivery of gas cylinders (for refrigerators) and drug kits is somewhat irregular, and the number of units that have to be visited on one trip limits the time available at any one unit, thus prohibiting effective supervision. Checklists for supervisory visits are not used and records are incomplete.

One health centre visited, with a DPHN, had not been visited for four months and the DHMT were unaware that the ward was closed and the newly delivered mattresses were all in a store. This health centre (recently designated as a sub-District hospital) was clearly not relieving the overcrowding of the District hospital, which was even unaware of its non-functioning state.

2.5 CONTRIBUTORY FACTORS TO PROBLEMS WITH HUMAN RESOURCES

It is clear that the health care provided in the Districts falls short of what is needed. Though no quantitative assessment was undertaken, experienced practitioners observed that clinical histories and physical examination were seldom undertaken and multiple prescriptions were the rule.

An indirect assessment of quality of care in many of the rural facilities is afforded by the relatively small numbers of patients attending and the large numbers that bypass them and go straight to the overcrowded District hospital.

There have never been sufficient numbers of staff and the difficulties with training enough to make up the shortage has been made more difficult by the very rapid rate of population growth.

The salaries of health workers, like most civil servants, has not kept pace with the levels of inflation. A recent survey (Price Waterhouse) indicated that, on average, doctors, pharmacists, nurses and laboratory technologists in the private sector received between two and four times the remuneration (salary and benefits) of those in the public sector. This has led to increasing dissatisfaction - culminating in the current strike of the nurses, with other cadres of health workers supporting them.

Frustration has also followed the shortage of funds for the health service. Professionals complain that they have not gotten the necessary equipment and supplies to undertake satisfying work. This has resulted in large numbers immigrating to southern Africa where terms of service are more favourable.

The requirements of the structural adjustment plans (SAPs), demanded by the World Bank and IMF, have provided both opportunities for early retirement and the reduction of numbers of subordinate staff.

The overall economic situation of the health service, as well as the country as a whole, has made it impossible to hire more staff, even when they are already trained and currently unemployed - e.g. nurses trained in mission hospitals.

2.6 CURRENT REMEDIES

The reorganisation of the Ministry of Health, undertaken as part of the Health Service Reform, has created a Human Resource Planning and Development Department. The Department, together with consultants, is conducting a staff analysis, developing staffing norms, identifying staffing needs, and aiming at producing a Master Plan for Human Resource Development and Management by the end of 1998.

Recently a review of the health staff led to an adjustment of intake for various training programmes - e.g. the intake for clinical officers was increased. The first increased output is due shortly. It is to be hoped that most of these new COs will be posted to the rural facilities where they are in such short supply.

The lack of funds for continuing education is being assisted from District cost-sharing funds. However, these are not sufficient to meet the many needs. For example, a District wanted to have a two-day seminar for key members of the newly appointed Health Centre Management Boards. The estimated cost of holding the meeting in a local hotel was Kshs 75,000/-. This was not accepted by the District and the board members remain deprived of the necessary orientation and training.

The creation of the cadre of District Continuing Education Officers (DCEOs) is an important step, but as yet not all Districts have one and their activities are still not determined and funded.

The details of the decentralisation plans and how they will affect the deployment of District staff have not yet been finalised. They are likely to have a profound effect.

2.7 PLANNING VISIONS

2.7.1 Strengthening Health Management in the District

Management at the district level has always been weak.

The Health Policy Framework (1994) calls for decentralisation of many management and administrative functions, currently undertaken by the MoH headquarters, to the district. This will increase the need for management capability in the districts.

Already District Hospital Management Boards have been established, and they are required, among other duties, to oversee the collection, control and disbursement of cost-sharing activities. Facility Management Boards/Committees are being established for health centres and dispensaries. Communities in some areas have established Village Health Committees. In addition to these new community/public responsibilities the role of professional/technical management is increasing - particularly the role of the District Health Management Teams (DHMTs).

To meet these increasing needs for management throughout the districts further training and continuing support is required. Occasional intermittent short courses for isolated members of staff, given by visiting consultants, have not produced the necessary improvement.

The establishment of an appropriate local health management training facility should be considered. This should be associated with facilities required for technical continuing education.

2.7.2 Upgrading of Supervision of Rural Facilities and Development of a Continuing Education Program

It is clear that though many rural health facilities need maintenance and rehabilitation, staff housing, renewed and improved equipment, additional staff, and a regular supply of drugs, the underlying problem lies with the existing staff. Many are demoralised and providing a low level of professional knowledge, skill and behaviour.

Reorientation, remotivation, guidance and support for the rural health facilities cannot be instituted as a single intervention, but these are probably the most critical inputs if better quality health services are to be provided.

It is also generally agreed - and is spelled out in the Kenya Health Policy Framework - that without improvement of the service provided in Health Centres and Dispensaries, District Hospitals, even if upgraded, will never be able to cope with the demand on them.

While the recruitment and basic training of health staff is currently a MoH headquarter's function, the responsibility for management and continuing education of staff lies with the District.

It is not proposed to introduce new procedures. For sustainability it is important to build on what is there rather than introduce something new that may fail when support is withdrawn. An infrastructure for the health service does exist even if parts of it are very run down. What is proposed is a radical upgrading of the standard supervisory visits and increased opportunities for appropriate continuing education, for all rural health facilities.

Regular visiting for guidance and support must be provided for all rural health facilities. This should be done by the DPHN and DPHO regularly, and by the DMOH and other members of the DHMT from time to time. The visits should allow time for observation and guidance of activities as well as the use of a supervisory checklist, for follow-up and proper recording of information.

These visits need to be supported by regular in-service training workshops (refresher courses) within the district, opportunities and encouragement for distance learning and use of library facilities.

It should be noted that the continuing education proposed here is required to refresh and develop staff competence in the fields where supervisory visits have shown inadequacies. This will include management and general clinical skills. Run properly, these District workshops do more than just increase knowledge and skill. They can motivate a more cooperative team spirit, and sort out many minor management problems.

These regular workshops, run mainly by the DHMT staff, should be supplemented - not substituted - by more specialised training provided by the 'vertical' programmes e.g. KEPI, FP, STI/AIDS etc, or what follows them after decentralisation.

To implement such a programme requires continued development of the supervisory and management skills of the DHMT (see above 2.7.1) and the presence of someone on the DHMT with appropriate training in educational methods. The post of District Continuing Education Officer (DCEO) has already been created in some districts.

Availability of sufficient transport is another essential ingredient of adequate supervision. At the moment it would appear that an additional vehicle would be required for this purpose.

At the moment there are no specific health training facilities available. Each district has used hotels, mission centres, or various technical training centres for the few courses that have been held. These are not really appropriate and are often considerably more expensive than a purpose-designed facility. One or two Continuing Education Centres, along the lines of the Rural Health Training Centres, for the five Districts of the Study Area should be considered. Basing such a facility on a well functioning health centre may be more appropriate than establishing it in a town at the district hospital. Such centres should be autonomous, with their own management boards and financial control. The possibility of contracting out the management of such centres to an NGO should also be considered. The facilities could be hired out to other government or private organisations when not in use and thus assist in generating revenue for the centre.

Another critical resource for continuing education are the funds for travel, accommodation, food, and learning materials. Some funds may come from the cost-sharing budget, but for the time being these are insufficient. The possibility of an external matching fund, until local revenues increase, should be considered.

Sufficient professional expertise is required to ensure the proper functioning of such a centre. The back up of DCEOs with a full-time health/medical educator would assist in establishing the centre.

2.7.3 Development of Community-based Health Care

Whenever people cannot get access to health care provided by others, they develop some sort of care on their own. Traditional practitioners and birth attendants have always been there and more recently communities, guided by health workers, have established systems of training and supervising their own representatives - Community Health Workers (CHWs) - to provide basic health care.

The Health Sector Reform 'recognises the need to mobilise the community and provide it with a real stake in the health service provision'. The proposed organisation structure provides for the evolution of an institutional framework for this participation.

Recognition of the fact that there are, and for a long time will continue to be, a shortage of staff for the rural health facilities, emphasises the importance of developing community-based health services.

Within the Study Area a number of community-based health programmes have been initiated. In Kisii the IFAD programme (primarily concerned with improving nutrition, but also involved with health care) has been running for seven years. The best established and most extensive community health programme is that organised by Tenwek hospital. Kericho, Kaplong and Litein hospitals have also started programmes. In other areas the Bamako initiative established community pharmacies. A Forum to help coordinate community-based programmes has been established in Bomet.

Developing an 'enabling environment' and providing the appropriate support to community initiatives is not easy. To assist and coordinate existing community activities an interdisciplinary Community-based Core Support Team could be established. At first it should collect information on all the relevant activities in the five districts. It could facilitate the development of appropriate community structures. When communities are ready it could assist in the orientation and training of various community-based workers - community health workers, traditional birth attendants, community drug distributors, local environmental artisans, etc

For such training appropriate curricula and learning materials would have to be collected and/or developed. Some of this training is best undertaken in villages or at the nearest health centre or dispensary. However, some training-of-trainers could be done in the same facilities established for the continuing education programme.

2.8 SUMMARY OF PLANNING VISIONS FOR HUMAN RESOURCES

The Development Study has indicated many shortcomings in the district health services - in funds, programmes, facilities, equipment and human resources. A number of solutions are proposed. Most of these contain a critical element of human resource development - management training for senior staff, further technical training for professional service providers, and basic training for community workers.

It is sometimes assumed that if the physical resources are provided the human resources will somehow develop and catch up. Experience shows that this haphazard approach to development frequently fails and potentially successful programmes founder on lack of sufficient attention to the planned development of human resources.

This is the basis for the three 'planning visions' presented above. They are not separate, isolated visions but fit into a comprehensive proposal for planned development of human resources at all levels.

A training (human resource development) centre that provided a facility for on-going management training, technical training and community development, and a base for the technical expertise necessary to get the programme established could turn out to be the critical input that led towards the overall goal.

Chapter 3

District Health Service Education Program

3. DISTRICT HEALTH SERVICE EDUCATION PROGRAM

3.1 ESSENTIAL INFORMATION

Project Objectives

To establish a sustainable system of Continuing Education (CE) in the districts.
To provide appropriate training for all district health workers.

Project Location

Kericho, Bomet, Kisii, Nyamira, Gucha

Target Beneficiaries

All health workers in the Districts

Project Duration

5 years

Implementing Agency / Body

District Health Management Teams and MOH Hq.

3.2 PROJECT RATIONALE

Personnel play a key role in all aspects of the health service - its governance, its implementation and its support by the community. There have to be adequate numbers of people in appropriate positions, and they must have the required knowledge and skill and be properly orientated and motivated.

The process of decentralisation, which the Health Service Reform Policy requires, necessitates the appointment of many local citizens to the new Hospital Management Boards and District Health Management Boards, and to the Health Centre and Dispensary Management Committees. Finding suitable people and providing them with the necessary orientation and training is an urgent necessity.

There is currently a shortage of trained professional and technical staff throughout the country. This shortage is aggravated by mal-distribution of the limited numbers available - many senior staff wishing to remain in the capital city, and many others preferring District towns to rural areas. This national shortage is reflected to varying degrees in each of the Districts of the Study Area. A further aggravating factor is the low morale of a large number of the MOH staff, so that their performance is often below their capacity.

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

1) the supervision continued education and development of all professional and technical staff once they have been assigned to the District.
   In addition some members of the subordinate staff e.g. drivers, ward attendants, untrained community staff assisting in dispensaries, also need some training.

2) the orientation, training and development in the skills of governance of the newly appointed Management Board and Facility Committee members.

3) the training and development of community-based health care managers and workers.

4) the orientation of staff from health-related Ministries and organisations, involved in intersectorial activities

3.2.1 Professional and Technical Staff

It is well recognised that in all professional fields the basic training obtained at the beginning of professional life needs continuous updating. This is especially so 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. The poor quality of work observed in many facilities (e.g. poor history taking, scanty or non-existant physical examination, polypharmacy, lack of patient education, etc) is exacerbated by poor morale and lack of motivation. Indeed, on occasion, professional staff may be absent from a facility and leave their work to unqualified staff (who may also need training). Poor quality of service in the rural facilities forces people to go to towns in search of medical care, and this is one of the major causes of overcrowding at the District hospitals.

While the most severe effects of lack of continuing education is seen in the dispensaries and health centres, the effect of lack of maintenance of the human element of the health service is seen everywhere - in the hospital wards, laboratories,

pharmacies, out-patient departments, etc - and in offices where senior staff administer health programs. There is no group or person in the health service immune to the effects of continuing professional neglect! A program of continuing education and development for all health and health-related staff is essential. This must include both health and medical technology, as well as the management skills required to implement them effectively.

3.2.2 Members of Management Boards and Committees

One of the key elements of the Health Reform Process is decentralisation. This has involved the creation of District Health Boards, Hospital Management Boards and Facility Management Committees for health centres and dispensaries. A variety of local leaders, professionals, business men and retired civil servants have been appointed to these Boards and Committees.

While their commitment to serve is not in doubt, their ability to do so effectively without appropriate orientation and development is problematical. To be effective, an understanding of the role of governance, as opposed to management, is required. It is also necessary to have some knowledge of the extent of different health problems in the area, and how the health services could prevent or alleviate the major ones.

When a recently appointed Chairman of one of the hospital boards was asked, rather discreetly, whether he thought there was a place for orientation or training for any of his board members, he replied emphatically that he needed training himself, and so did every other member of his board! In another District, a workshop had been held for the Management Committee members of two health centres. The misconceptions and problems uncovered convinced the Medical Officer of Health, and others, that such workshops were essential for all members of the new committees if they were to function effectively.

Thus, both the need and acceptability of training for community members given the responsibilty for governance of the District health services is clear.

3.2.3 Community-Based Health Workers

For many years the Ministry of Health has accepted the policy of Primary Health Care as outlined in the Alma Ata Declaration. Its potential for revolutionizing health care by preventing, instead of just curing, diseases has led to numerous protective interventions such as immunisation, provision of clean water and a more sanitary environment, and community health education. Support for this policy to strengthen community-based health care has been re-confirmed in the Health Reform plans.

It is, however, extremely difficult, from headquarters (the top) to promote what is, by definition, a community, or bottom-up activity. With decentralisation the responsibility for this promotion now lies with the District Health Management Team

(DHMT), who have a District Primary Health Care Co-ordinator (DPHC Co-ordinator). In areas where community-based activities have been most successful three levels of orientation and training have been identified:-

1) Members of the DHMT and health centre staff - and NGO equivalents

2) Members of Village Health Committees (VHCs) who are organising community activities

3) Community-based health workers and artisans e.g. CHWs, TBAs, water technicians, etc.

To establish effective, functional community activities it is essential that training, and the necessary follow-up supervision, is provided to all these groups. At the same time this must be complemented by adequate means of transport and start-up resources.

It is the aim of this project to create the capacity within each District to undertake all these requirements for comprehensive human resource development.

3.3 PROJECT COMPONENTS

3.3.1 Appointment of District Continuing Education Coordinators

For the District to take full responsibility and manage their continuing education programme it is essential that they should have a person in charge of the programme. If it is left to the DHMT as a whole, without a responsible person, it will not function effectively. Therefore, each District will select a suitable person from their existing staff - one who is respected professionally and is expected to be a longtime resident of the District - and they will be given further training in managing and implementing continuing education programmes. This training will be undertaken by the MOH Hq. CE unit and follow the existing pattern.

Initially these District Continuing Education Coordniators (DCECs) will undertake their CE activities in addition to their present duties. However, as the programme developes it may be necessary to have full time District Continuing Education Officers (DCEOs).

3.3.2 Develop District Education Plan Needs Assessment

A comprehensive human resource development programme requires an inventory of all personnel involved in the health services - for governance, implementation and community support - and a record of their previous training. A simple "Needs Assessment" is then necessary before a plan of action can be prepared. The plan should identify the priorities and integrate all the different facets of human development. Develop

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. It is essential that these recommendations are implemented to ensure headquarter support for the District programs.

3.3.3 Implement Educational Plan

a. District Health Management Team

For the DHMT to fulfil their responsibilities they will certainly need outside help, both with their own development and in carrying out their program. As a first step, the further development of capability of the DHMT is an urgent matter. Different kinds of training programs have already been implemented in different districts with varying degrees of success. These programs need evaluation, standardisation and application to all the five Districts in the Study Area. It should be noted that all attempts at developing the capability of DHMTs are undermined by the frequent transfers of staff, especially the MOH.

b. Professional and technical staff

Some of the continuing education will be in the form of multi-disciplinary workshops and some as technical courses for individual cadres. Regular guidance and supervision of the rural health facilities will be a key activity in the CE program. In the past this has generally been intermittent and perfunctory. Lack of transport has been one important reason. Some supervisory staff will 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. It is proposed that to begin with all professional and technical staff should have atleast one one-week refresher course every two years - i.e. 3 days per year.

c. Management Board and Committee Members

In the past District training programs have not been concerned with the orientation and training of those appointed to Boards and Committees. The Provincial Medical Officer's office shall assist in the orientation and development of the members of the District Health Boards (DHBs). The methods used can then be modified and repeated with the members of the health centre and dispensary committees.

It is proposed that in the early days of decentralization all members of Boards and committees should have two days per year for orientation and training.

d. Staff for Community-based Programs

A 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 Co-ordinator (see Chapter 20 Community-based Promotive and Preventive Health Care Program).

For calculating the amount of training required an arbitary figure based on three days training for forty community-based managers for each District per year has been assumed.

3.3.4 Establishment of "District Learning Centres"

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 ensuing overcrowding of District Hospitals.

When it is necessary to bring people together, a seminar room/hall is required. Suitable places are not easily available in Districts - especially the new Districts - and often workshops and courses have been held in hotels, which are expensive.

At such times simple equipment and supplies are required. A blackboard, flip chart stand and an overhead projector are appropriate. Increasingly, some topics are well covered on videotapes; hence, 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/resource centre sooner than currently imagined.

a. Training Requirements in "Man-days"

Estimates of the number of "Man-days" of training required for those involved in the governance, implementation and community support of theDistrict health services are shown in Table 3.1. It can be seen that 9,631 man-days are required for the five Districts.

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

To address these needs for training facilities, equipment and supplies, the establishment of "District Learning Centres" is proposed. A minimum facility would consist of a seminar room/hall for thirty participants, a small learning resource room/library, and an office for the DCEC. The addition of accommodation for participants and facilitators would increase Centre's value. However, it would also increase the complexity and running costs and raise the question of sustainability.

b. Location of District Learning Centers

It is proposed to establish a Learning Centre in each of the five Districts. It is suggested that one of the facilities in the three Kisii Districts and one in Kericho/ Bomet should also have residential accommodation.

The decision as to where such facilities should be located depends on a number of criteria:

Table 3.1 Estimate of "man-training days" required per year by District

1. MOH Professional and Technical Health Staff (1)

	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 (2)

	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	224	176	208	608	496	368	864	1472
Training Days								
Man-training days	448	352	416	1216	992	736	1728	2944

3. Community-based Health Care Managers (3)

	Kisii	Gucha	Nyamira	Sub Total	Kericho	Bomet	Sub Total	Total
No. C-bHC 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

(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-bHC Manager has 3 days training per year

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 realisation depends on the necessary funding being available.

However, based on these rough estimates it is provisionally suggested that a minimum non-residential facility would be a major asset to each District. It is further suggested that one of the facilities in the three Kisii Districts and one in Kericho/ Bomet should also have residential accommodation.

3.4 MAJOR ACTIVITIES

- Each DHMT in the study area would identify and appoint a District Continuing Education Co-ordinator (DCEC). The MOH CE Unit would conduct a training programme for them - three two-week workshops spread over six months. (Additional DCECs from other Districts might be included in this programme)
- On return to their Districts the DHMT would establish a Sub-committee for Continuing Education, with the DCEC as chairman. The DCEC would initiate the preparation of a District educational plan, based on an inventory of all involved in the health services, including their previous training and stated needs. A needs assessment study would be undertaken, starting with priority groups from the governance, implementing and supporting personnel. The plan would give a detailed programme for immediate implementation and tentative long-term proposals.
- The location for the District Learning Centres would be confirmed and plans drawn up.
- Taking into account the agreed criteria to be used for selecting the locations the participants at the Technical Meetings made the following recommendations: -

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

- Plans and instruments for the monitoring and evaluation of the programme would be prepared.
- There would be a workshop for Supervisors of the rural health services and checklists, records and schedules prepared. This would coincide with the provision of adequate transport for the revised schedule of supervisory visits.
- Education programmes designed and health learning materials assembled for professional and technical staff
- Board and committee members
- Community-based health staff
- Priority training would be undertaken
- Establish management committee for Learning Centre and set up procedures for handling receipt of funds
- Construct and equip Learning Centres
- Undertake mid-term evaluation of project

3.5 PROJECT OUTPUTS/INPUTS

Major Input

Constructing and providing equipment for the Learning Centres

Donor Inputs and Arrangement

The implementation of a project involving many people in the Ministry of Health Headquarters, PMO's office, DMOs office and in the community requires co-operation from many quarters, including other donors and agencies working in the same areas.

It is critical that the process of decentralisation continues so that all the projects concerned with strengthening District health systems are given the authority to implement the activities.

At 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 programmes of the national health programmes (e.g. KEPI, HIV/AIDS) to proceed so that co-ordinated support and finance can be provided to the District programmes.

It will be necessary for those agencies assisting the MOH CE Unit e.g. SIDA and also those funding some of the national health programmes e.g.UNICEF, USAID and World Bank to provide continued support.

Assistance that has been given to the Ministry and Districts by various local agencies e.g. AMREF, Aga Khan Foundation and Health Service, 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 utilised.

The revitalisation of the human resource development programme depends on the ability to communicate with all concerned. This requires improved transport facilities and proper maintenance.

The planning and construction of District Learning Centres will require donor support though once built they will become self-sustaining.

Expected Benefits / Outputs

Identification and training of DCECs in District
District CE programme and plans produced
Facilities, equipment and learning materials for CE provided
Communications for appropriate supervision provided

Verifiable Indicators

Number of DCECs identified and trained
District CE plans and learning materials available
CE Centres constructed and equipped
Numbers of people trained

Estimated Cost

US$ 2.07 million (Only facility and equipment)

3.6 OTHER PROJECT MANAGEMENT ISSUES

Project Linkages / Other Sector Linkage

MOH CE & (vertical) Health Programme Units
NGOs & CBOs in the District requiring or providing CE

Relevant Agencies to be Co-ordinated

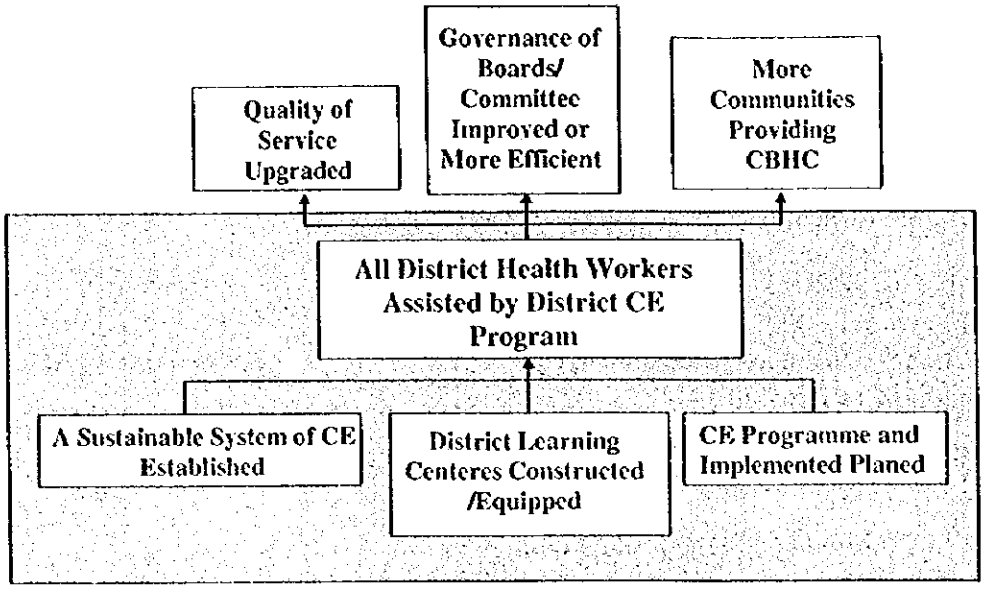
Bilateral Donors (e.g. SIDA, USAID)
Multilateral Agencies (e.g. UNICEF, UNFPA)
National Agencies (e.g. AMREF & KMTC)

Important Assumptions/Conditions for the Project

Health Reform process continues: Management Boards and Committees appointed: Districts appoints CECs and assume responsibility for all CE activities
MOH national training programme (e.g. KEPI) cooperate with district CE programme: DHMTs, Communities and trainees support programme and provide increases in cost-sharing funds

3.7 PROJECT IMAGE

As a result of the proposed project implementation (grey area), the quality of service will be improved, governance of Boards/Committees will function more efficiently, and more communities will be involved in primary health care activities.


Quality of Service Upgraded
Governance of Boards/ Committee Improved or More Efficient
More Communities Providing CBHC
All District Health Workers Assisted by District CE Program
A Sustainable System of CE Established
District Learning Centeres Constructed /Equipped
CE Programme and Implemented Planed

Priority Program 5: DISTRICT HEALTH SERVICE EDUCATION PROGRAM

1. Project No.	2. Project Title		
P-5	A District Health Service Education Program		
3. Project Location	**4. Target Beneficiaries**	**5. Project Duration**	
Kericho, Bomet, Kisii, Nyamira, Gucha	All health workers in the Districts	5 years	
6. Implementing Agency / Body		**7. Project Level**	**8. Project Priority**
District Health Management Teams, MOH		Basic	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

- 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	**12. Verifiable Indicators**
- Identification and training of DCECs in District	- Number of DCECs identified and trained
- District CE program and plans produced	- District CE plans and learning materials available
- Facilities, equipment and learning materials for CE provided	- CE Centers constructed and equipped
- Communications for appropriate supervision provided	- Numbers of people trained

13. Important Assumptions / Conditions for the Project

- 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	**15. Relevant Agencies to be Coordinated**
MOH CE & (vertical) Health Program Units NGOs & CBOs in the District requiring or providing CE	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**
❑ Train DCECs	x		
❑ Needs assessment studies for Staff/Board/C-b workers	x		
❑ Prepare program for Staff/Board/C-b workers	x		
❑ Establish monitoring and evaluation program for CE	x		
❑ Train District supervisor staff and establish schedule	x		
❑ Ensure adequate communication and transport		x	
❑ Start regular CE activities, including supervision	x	x	
❑ Confirm sites for CE centers	x		
❑ Construct and equip CE centers		x	x
❑ 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

Annexes

Annex 1: Concept Papers Used for Discussions

Annex 2: Sketch of Learning Centre

Annex 3: Study on Human Resources (Dec. '97)

JICA Study Team
July 2nd '98
CHW

Concept paper for discussion:

Developing Human Resources in the District

Introduction

There is general agreement that the development of human resources plays a key roll in strengthening district health systems. Currently the recruitment, basic training and deployment of health staff is the responsibility of the MOH Hq. and KMTC. The district is, however, responsible for:-

1) the continuing education/development of health staff once they have been posted to the district
2) the orientation, training and development of those members of the community selected to serve on the Health Service Boards and Committees
3) the training and development of community-based health workers

In the past training at the District level has been mainly directed from MOH Hq., particularly by the national health programmes such as KEPI, CDD, MCH/FP, etc. This has generally been intermitent and uncoordinated.

In line with the Health Reform Process of decentralization it is proposed to develop a system to strengthen District management of their own training and development needs. This requires appropriate policies, programme, staff, facilities and funds.

Policy

There is no need for any change in basic policy. There is however need for change in interpretation and implementation of responsibility. The District must plan its own programme. This should be comprehensive and based on a needs assessment. National programmes and others involved in training within the District must coordinate and fit in with the District plans.

Programme

Human resource development is concerned with much more than a series of refresher courses. There is evidence that refresher courses unaccompanied by local support and appropriate follow-up, do little to improve the quality of care. HRD is concerned not only with knowledge and skill but with motivation and the systems within which people work. Developing a comprehensive HRD programme requires a needs assessment for all categories of people

involved with the district health services. A register should be kept of all involved, their previous training and future training needs. Priorities must be set for the cadres most requiring development, the particular activities that need upgrading, the most efficient methods to be used (these will include on the job supervision and training, distance learning, study visits, etc as well as refresher and extension courses). The frequency, and duration, of the required interventions should be planned.

Staff

The responsibility for developing such a programme lies with the DHMT. However, an effective HRD programme is unlikely to take place unless a specific person is given this responsibility. In some Districts (including Kericho) these tasks have begun to be undertaken by the District Continuing Education Coordinator or Officer. This officer (generally a Health Educator, Public Health Nurse or Officer) selected by the DHMT is given further training, arranged by the MOH Continuing Education Unit. The roll and authority of such officers needs further defining and strengthening.

It is considered imperative that a DCEC/O is appointed (and trained) in all districts covered by the planned JICA programme.

Facilities

Many of the elements of an HRD programme can be carried out without any additional designated facilities. The DCEC/O requires office space and room for appropriate learning resources (library). S/he, and others undertaking training or capacity building activities e.g. a PHN giving on the job training in a dispensary, must be able to visit the rural facilities on a regular basis. Unless the necessary transport is available for these visits, occasional refresher courses will have little effect.

For some training activities it is necessary to gather people together where there is a class or seminar room, with a capacity for 20 - 30 people. Some of these training activities can be broken down into segments that can be accomplished within a day, however, others take longer - a week or two.

The resources/logistics for these longer training sessions are difficult. The problems of daily transport, from home to a training centre, for those living in rural areas are currently almost impossible. Courses depending on such daily attendance are repeatedly interrupted by lateness and absences.

In the absence of an appropriate residential training centre, many district training activities are held in expensive hotels. This quickly exhausts the limited funds available.

There is a need for training facilities in all districts. To be cost effective they must be well used. A basic non-residential facility would consist of a class/seminar room for 20 - 30, a small learning resource room(library), and perhaps an office for the DCEO. A residential facility would, in addition to the teaching/learning space, also include single-room accommodation for 20 - 30, a dining-room and lounge, and perhaps a manager's office. A key question for discussion is the relative merits of non-residential or residential facilities. Figures will be presented at the time of discussion giving an estimate of the number of 'training days' that might be needed in each district.

A possible suggestion might be a non-residential facility at one of the priority health centres in each district with a residential facility added to one of these centres for the Kisiis and one for Kericho/Bomet.

Organization and management

It is suggested that the training centre (particularly a residential centre) should have a separate budget and management committee from its adjacent health centre. The possibility of contracting out the management of the centre should be considered.

Funds

The costs of a continuing education/development programme must be contrasted with the costs of continuing to pay the increasing salaries of people whose up-to-date knowledge and skill, and often motivation, is declining.

Currently the majority of funds available come from the training resources of the National 'vertical' health programmes KEPI, HIV/AIDS, etc. These training activities are generally narrowly focussed on the specific aims of the individual programmes, and omit topics of immediate local importance. (A workshop was held in July 1997 to consider how some of this training could be integrated)

More recently some funds derived from the cost-sharing revenue have been directed to CE. It is expected that these funds will increase and that the centre would contribute to raising cost-sharing funds by renting the facility to other Ministries and organizations when not in use.

In addition there have been limited donor funds specifically for CE.

Proposal

In order to bring about a radical change in the casual approach to HRD and establish an active District-centered programme the

following interventions need to be considered:-

* Each DHMT (in the target area) to appoint a DCEC/O

* MOH CE unit to train the newly appointed DCEC/Os

* Construct a class/seminar room and DCEC/O office and learning resource space at one selected prority health centre in each district

* Construct a 24 bed hostel at two of the above five priority Health centres (one for the Kisiis and one for Kericho/Bomet).

* Provide transport (or availability of transport) to each district CE programme

* Develop appropriate curricula for each type of training. These curricula should not be just teaching time tables for courses, but include on the job training, independent study projects, study visits etc.

*Acquire appropriate teaching equipment and learning resources..

* Plan regular supervisory and guidance visits to each health facility. Design appropriate checklists and record system for such visits.

*Design and implement a system for monitoring

Human Resource Development
- points for discussion

JICA Study Team
July 6 - 10

District . . . . . Participants . . . . . .

Intro. Confirm need for CE for
1. ALL health staff
2. Board and Committee members
3. C-bHC workers

Policy. District in charge

Programme.
Who? register
What? needs assessment
Plan - priorities
Refresher courses +
? Supervision
frequency, regularity, checklist, records

? Correspondence
? Other

Make list of what has been done

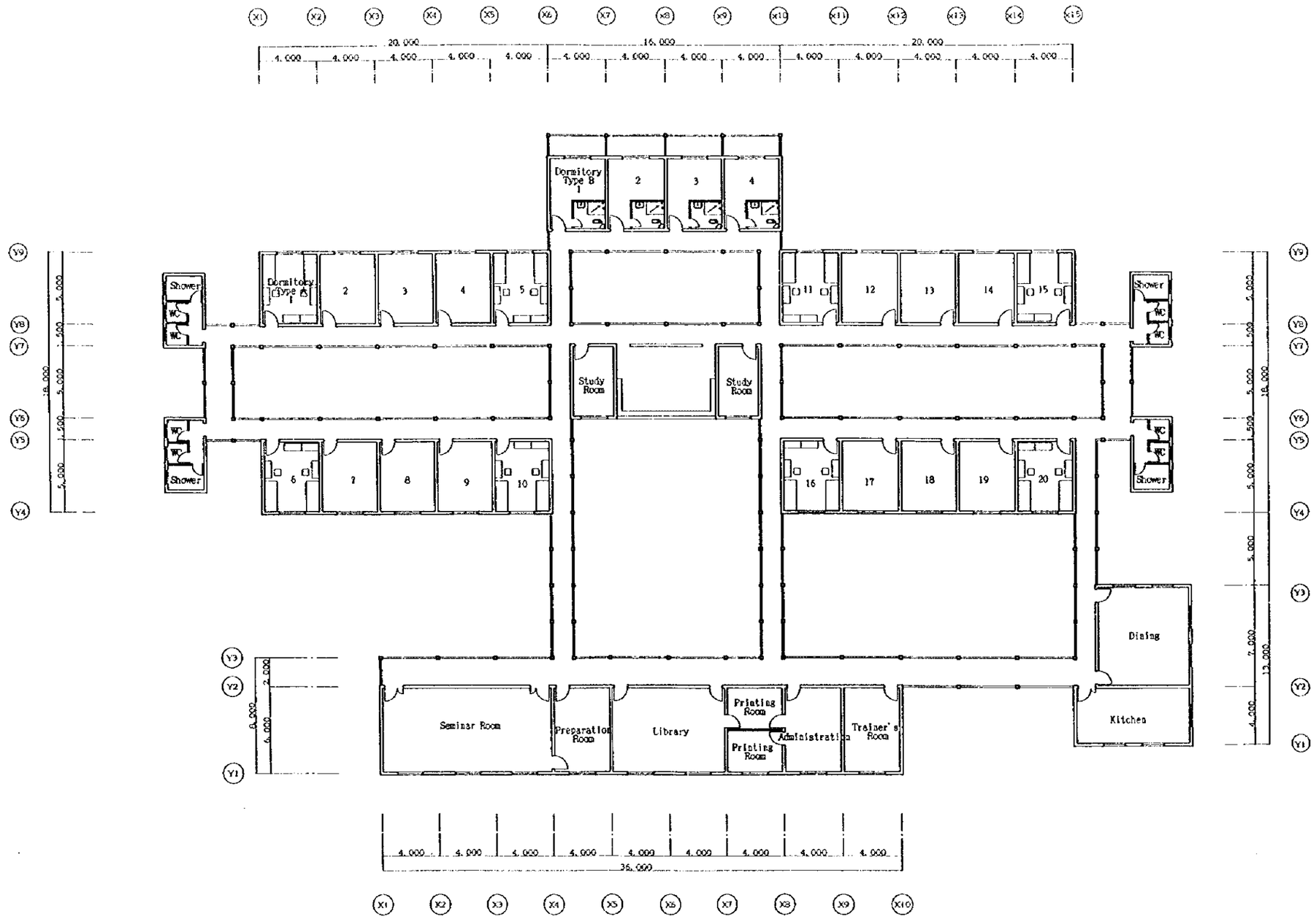
Staff. ? DCE C/O Availability of extras
Who?
What training?

Facilities. What do you have?
. . . . . Cost?
. . . . . .
What would you like?

If a CE centre ? organization.
Who would run it? ?? a manager
Who would control it? ?? its own board/committtee

Funds. District budget? ?? CE line item
FIF ?
Others ?

Other comments and suggestions.



PROJECT TITLE		SCALE	FACILITY	DWG. NO.
THE STUDY ON STRENGTHENING DISTRICT HEALTH SYSTEM IN THE WESTERN PART OF KENYA	PACIFIC CONSULTANTS INTERNATIONAL IC-NET LIMITED	1:300 DATE SEP. 1998	DWG. TITLE **DISTRICT LEARNING CENTRE**	