HEALTH THROUGH DISTRICT FOCUS

Phase III Mid-term Review, Kenya-Finland Primary Health Care Programme

Review Mission:

Malcolm Segall, Bryan Haddon, Tuuliki Hassinen-Ali Azzani, Lasse Topo

Volume II

Reports prepared by Health Management Teams and Programme Components for the Mid-term Review

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TABLE OF CONTENTS

These reports were prepared by staff of the Kenya-Finland PHC Programme and Provincial and District Health Management Teams of Western Province for the 1990 Mid-Term Review Workshop.

The final section is the proposals prepared by working groups for the concluding session of the workshop. A separate report of the workshop proceedings is being prepared by the K-F Programme.

ENVIRONMENTAL HEALTH AND SANITATION PROGRAMME

This report is mainly centred on the activities which have been carried out or accomplished in the five programme reference areas i.e. Moding, Kabuchai, Bumala "B", Navakholo and Kigama Kivagala.

1. OBJECTIVES AND STRATEGIES

-- Improve sanitation to reduce disease transmission by:

  -- Demonstrating V.I.P. latrines in target areas

  -- Promoting V.I.P. latrine construction by providing 32.000 slabs and community mobilization in target areas

-- Develop sanitation technology

-- Reduce malaria through mosquito control initiatives

-- Carry out other activities in food and drinking water control. demonstrating healthy households. spring protection and occupational health.

-- Support the DHMT in promoting VIP latrines and other activities.

-- Collaborate with the Water Project. especially in health education.

2. SANITATION

Implementation.

DEMONSTRATION VENTILATED IMPROVED PIT LATRINES IN THE PROJECT REFERENCE AREAS

DISTRICT	ALLOCATION 1989	1990	TOTAL ALL.	TOTAL UNDER CONSTR.	TOTAL COMPLETED	BALANCE
KAKAMEGA	342	100	442	58	500	-
BUNGOMA	130	40	170	28	260	-
BUSIA	386	60	446	27	396	23
TOTAL	858	200	1058	113	1156	23

Demonstration V.I.P. latrines are located in school compounds, churches, village polytechnics, training colleges, local administration offices, coffee preparing factories, tea bandas and health institutions.

INDIVIDUAL SLABS CASTED & DEMONSTRATED TO THE RELEVANT COMMUNITIES IN THE FIVE REFERENCE AREAS.

DISTRICT	ALLOCATION 1989	1990	TOTAL ALL.	NO. CASTED	NO.OF SLABS DISTRIBUTED	BALANCE TO BE CASTED
KAKAMEGA	700	650	1350	1041	801	309
BUNGOMA	850	450	1300	1050	950	250
BUSIA	800	900	1700	1200	950	500
CENTRAL WORKSHOP KAKAMEGA	858	500	1358	1138	1059	220
TOTAL	3208	2500	5708	4429	3759	1279

The Component has the task of preparing estimates of materials required making arrangement for procurement and transportation of the same and ensuring that the correct quantities of materials are delivered at the casting yard or on site for construction of demonstration V.I.P. or slab casting.

The Component ensures that the proper quality of slabs are casted and distributed to the individuals within the catchment in accordance with the of beneficiaries selected by the Community Health Committees.

In supporting the districts, the Component similarly finances materials and transports the same to the catchment areas or destinations suggested by the District Health Management Teams.

Pit Latrines.

Currently 60% of households in the province have pit latrines of all types while the corresponding percentage in the project reference areas is approximately 84%. Individuals who are unable to build modern latrines due to their low economic status have been encouraged to construct ordinary pit latrines without any subsidy from the programme.

SEMINARS HELD BETWEEN JANUARY & SEPTEMBER 1990

SEMINAR.	NO.HELD	PARTICIPANTS.	NO.
1. Opinion Leaders awareness seminar	28	- Party officials - Church Leader - Village elders - Members of the C. Committee	1459
2. Local Artisans on V.I.P. latrine construction	11	Mason Carpenters	367
3. Production of Sanitation manual (workshop)	1	Project sanitation component officers	4
4. Water Handling and household sanitation	8	Women Group Leaders	350
5. Mosquito control	3	P.H.O's, P.H.Ts and Lab. Technicians	146
6. Practical construction of VIP latrines	4	P.H.Os and P.H.Ts.	210
7. Sanitation orientation seminar for health workers and social workers.	1	P.H.Ts and Social workers	50
8. Sanitation awareness seminar for members of Community Health Committee.	5	Official Village Health Committee	191

The Component staff participated in the following jointly conducted seminars with Rural Health Service as resource persons.

1. Primary Health Care awareness seminar for Journalists and Information Officers.
2. Locational Intersectoral seminar for local leaders.
3. Teachers seminars on Primary Health Care awareness.
4. Primary Health Care orientation seminars for clinical officers.
5. Role of leaders in Primary Health Care implimentation attended by Chiefs and Assistant Chiefs.

3. COMMUNITY INVOLVEMENT

We have realized that proper community involvement and participation in planning and decision making is vital if the implimentation of Environmental Health and Sanitation Programme sustainability is to be achieved when the project is phased out.Consequently in all our project areas the communities have been sensitized and mobilized and have formed community Health Committees right from the grassroot level (Village level, sublocational level and locational level.

These committees have performed the following roles and functions, identified and selected local artisans to be trained on the construction of the modern latrines.

- Decided how much the individual will pay to the local artisans for construction of different types of V.I.P. latrines.
- Selected illegible member of the community to be issued with slabs and other V.I.P. latrine components.
- Organized local meetings when necessary.
- Decided on the venues for local seminars and made the necessary arrangements.
- Received visitors, briefed them and entertained them.
- Supported the community health worker in performing his work.
- Participated in surveys.
- Given feedback to the community at the grassroot level.

4. SUPPORT TO THE DISTRICTS:-

In working with the districts the Component has offered support as follows:-

- Procured, transported and distributed materials for Latrines Construction and slab casting.
- Provided, transport for distribution of slabs.
- Organized and held seminars for staff on low cost sanitation technology to improve their know how.
- Assisted the district to start activities in the new catchment areas.
- Participated in seminars e.g. training of Local Artisans and conducted by the DHMT as resource persons.

- Guided the districts in processing their imprest requirements and scrutinized the expenditure on various items.
- Monitored their activities to ensure that the standard expected is maintained.
- Participated in formulation of Questionnaires and testing.
- Developed a cheaper and less heavy V.I.P. slabs which have been replicated by the districts.

CONSTRAINTS

AFFORDABILITY FOR HOUSEHOLDS

The issue of affordability is closely linked with social, cultural and economic factors. The compulsory cost that the head of a household must bear in order to build one of the three options of V.I.P. latrine we have developed is indicated below:-

TYPE	COST	COST PER H/HOLD/MONTH	COST PER HEAD PER MONTH
Temporary	810	4.50	0.56
Permanent (blocks)	2808	15.6	1.95
Permanent (Bricks)	2088	11.60	1.45
Semi - Permanent	3000	11.60	2.08

The above table reflects the average cost of different options of V.I.P. latrines. The initial cost may appear exorbitant for the rural community but taking into consideration the fact that latrine pit of size metres deep and (1x1) metres square being used by an average household in Western Province has a life span of above 15 years; and therefore the cost per household per month or the cost per head per month is neglible. Above all the slab and other permanent materials are reusable.

- Some communities pull their resources together, are better organized and have income generating activities that assist them in meeting this expenses.

Impact and Usefulness

REFERENCE AREA	LATRINE COVERAGE %
KIGAMA/KIVAGALA	83.9
NAVAKHOLO	61
WEST NALONDO	71
MODING	65
BUMALA 'B'	62
AVERAGE %	68.6

N.B.

- Average latrine coverage was 44% in 1984

The above table indicates the current latrine coverage regardless of the type in the project reference areas.

- Demonstration V.I.P. latrines built by individuals mashrooming in schools, business plots in the rural market places, and even in households in areas where the programme is not carrying out sanitation activities.

3. OPERATIONAL SURVEYS

Implimentation

	TITLE OF SURVEY	REFERENCE AREA COVERED
1.	Sanitation follow up - - - - - - - - -	West Nalondo
2.	Environmental Health and Sanitation follow up. - - - - - - - - -	Bumala 'B'
3.	Baseline survey - - - - - - - - - - - -	Navakholo
4.	Environmental Health and Sanitation follow up - - - - - - - - -	Moding
5.	Worm Infestation survey - - - - - -	Schools chosen at random Kigama, Navakholo, Moding, Bumala 'B' and Kabuchai.

Constraints

Plenty of time and effort is required to prepare a team to collect reliable data, analyse, interpret it and prepare the report. Knowledge on survey methodology is very low.

Impact

The findings have been directed towards solving target problems on dealing with deficiencies in particular target groups setting new priorities and alternative solutions.

Future Directions

- There is need for more or less standardized baseline survey questionnaire to facilitate comparison of the survey findings..
- The communities concerned must be given adequate feedback.
- A short course be organized with special emphasis on survey methodology.

OTHER CONSTRAINTS

Project Financing

- Late arrival of funds, has a negative effect so that the implimentation period is reduced by several months and at the end of the year many activities in the Operational Plan have to be carried forward.

- Funds allocated for slab casting for individual V.I.P. latrine is usually insufficient to make the slab casting yards operate at full capacity and we can therefore meet the community demand which has been grouping steadily with time.

- The extent of impact on training and seminars held during the period under review is not known.

- Most of the V.I.P. latrines have been built by households which already had a traditional latrine while those households which had no latrine at all are shying away from V.I.P. latrine.

5. COOPERATION WITH THE WATER PROJECT

Achievement

Cooperation between the two sister projects has been generally good. The following activities have jointly been carried out:-

- Community sensitization seminars.

- Women groups activities in reference Health Centre catchment areas.

- Siting of water points in relation to pit latrines in schools, churches etc.

- Construction of Demonstration V.I.P. Latrines in areas where the water point is operating.

- Sharing of film shows that are of common relevance to the two projects.

Constraints

Poor timing during the planning of community sensitization seminars made participation by some officers difficult.

Some people in the Water Project areas, posing as employees of Kenya-Finland PHCP, go round collecting money from the community members as advance payment for V.I.P. construction. This has tended to kill peoples morale.

Impact

In Water Project areas where we have demonstrated the V.I.P. latrines, some schools have built additional latrines and a few individuals have also imitated the new technology.

Future directions:-

The two projects should plan jointly in areas of common interests e.g. community sensitization to avoid overlapping of activities.

For purposes of demonstration V.I.P construction Kenya-Finland PHCP should be involved in the initial mobilization stages. This will assist in communicating the programme's policy on demonstration V.I.P. latrines clearly.

The Programme should also consider providing slabs to people within certain radius who use the water from a particular water point.

4. OTHER COMPONENT ACTIVITIES

- Identification and improvement of healthy homesteads through health education.
- Purchase and distribution of malarial (mosquito) control equipments.
- Activities geared towards food and water quality control through sampling.
- Assists the community in siting and protection of springs by providing technical expertise and supervision.
- Assisting the districts in occupational health control activities. This activity has not yet started.

Constraints

- Late arrival of funds can not allow the smooth implementation of all these activities.
- Few demonstration homesteads per village do not serve the community adequately.

- Lack of laboratory facilities for food and water quality control within Western Province.

- Few springs are protected due to limited community resources.

Impact

- The activities have assisted in the construction of V.I.P. latrines within their villages.

- The community trained is participating in the identification of slab beneficiaries and also participated in their distribution.

- There is notable difference in the homesteads surrounding a health homestead this has been noted by the provision of dishracks and kitchen gardens.

- The community has also been able to protect springs through their own efforts.

Future Plans

- The Districts will be left to organize their activities with very little assistance from programme officers.

- More health homesteads will be identified per village so as to give a better representative example.

- KAP survey on mosquito control will be carried out first followed by the actual implementation activities.

- The Component hopes to finance partly spring protection activities in organized communities were the Western Rural Water Supply Project is not operating.

MID-TERM REPORT OF CONSTRUCTION AND MAINTENANCE COMPONENT

1. Introduction

The Project Document for Phase Three states that the major objectives of the construction component are 'to improve the health facilities by renovating, constructing and supporting the existing health units in cooperation with other agencies and to establish a self-sustained recurrent maintenance system to maintain the health facilities and equipment in health units'.
The Components share of the Programmes budget is about 31,5% which covers the construction of new health centres and dispensaries and their renovation and maintenance. This budget allocation covers also equipment and furniture.

2. Surveys

The Project Document gave a task to carry out two surveys, which were completed in 1989.

Construction Survey was to find out the conditions of all the health centres and dispensaries in the Province whether governmental or NGO, to study the accessibility, utilization etc. of these facilities and based on the findings determine the needs for construction and renovation and to make a proposal on the selection of the construction sites for Phase Three and maintenance required.

The time allocated to the survey was not enough to study all the details, but the data of utilization and population served had to be based on information from the staff of the facility.

The survey report contains valuable information that should have been available before starting any new construction site.

The survey gave recommendations for new sites but the decisions are to be made through normal procedure of the Kenyan Government.

Maintenance Survey was to find out the present maintenance systems and to develop plans for the future maintenance activities.

During the survey it was found out that there are several donor aided projects trying to develop maintenance of health facilities in Kenya. The survey made it possible to establish links to other projects to enable the cooperation and coordination between the projects on district level.

3. Construction Method

The Second Phase of the Programme constructed most of the sites using Labour Only contracts; the contractor provided the labour and the Programme provided the material. The reason for that selection was to enable small local contractors to quote for the works. Most of the sites took more time than expected and the contracts accumulated to the end of the Second Phase which created material flow beyond the capacity of the Project's stores.

The method for construction during the Third Phase is as follows:

New construction sites and large extensions are given as full contracts using the normal Government procedure.

Renovations of the existing facilities are done by the staff of the Programme.

The control of material flow is done by using computerized stock control system, which has been developed by the Programme.

The maintenance of the facilities constructed or renovated by the Programme is done by the Programme's staff.

It is estimated that the full contracts will be more economical in large scale construction, even though the contractors cannot buy material free of duties and taxes. The savings will come from less wastage of material and smaller construction organization of the Programme.

The full contracts will however benefit the larger contractors, which are mainly from outside the Western Province.

Facility Construction

The activities for the Construction Component during the Third Phase are listed in the Project Document, as

- To complete the construction activities belonging to Phase Two.
- To construct 4 new health centres, to construct or replace 15 dispensaries and to renovate 10 dispensaries. These numbers may be altered within the budget limits.
- To extend the existing offices for the staff for Phase Three, to provide them with adequate space and conference room, to further improve the existing workshop.
- To establish a maintenance workshop in every District and to provide them with equipment, tools and spares.

Annual Operational Plans for 1989 and 1990 indicate the plans for these years as follows:

- To complete the construction of the facilities belonging to Phase Two.
- To design and start the construction of three health centres and five dispensaries and the renovation of one dispensary.
- To construct office and workshop extensions and staff houses.
- To start the construction of one maintenance workshop.

During the years 1989-1990 the following construction activities were carried out or will be completed by the end of 1990:

- Completion of Navakholo, Naitiri, Mautuma, Matayos, Sio

Port and Sirisia Health Centres, Maternity Ward at Provincial Hospital and Ipali Health Centre renovation.

- Renovations of AIDS laboratories in Kakamega and Bungoma District Hospitals.
- Renovation of Hamisi Health Centre.
- The renovation of Sirisia Seminar Centre.
- Construction of Office Extension, Workshop Extension, Central Slab Casting Yard and extension of the site at main offices, repair of the road leading to the offices.
- Design of standard health centre and dispensary for Phase Three and further modification of the design as per each individual site.
- Construction of Kitchen and Laundry for Bungoma District Hospital has started but will be completed during the first quarter of year 1991.
- Development of cost control system.

The construction activities belonging to Phase Two were not completed by the end of the phase.In the beginning of 1989, the construction of six health centres, Maternity Ward and some renovations were still going on and it took almost the whole year 1989 to complete the health centres. Some facilities belonging to the previous phase (Hamisi Health Centre and Kitchen and Laundry) are still under construction. This is mainly due to the difficulties to commence the works at early stage of the phase (cooperation between MoH, MoPW and the Programme was difficult) and to the poor performance of the contractors chosen.

5. Maintenance.

The Project Document of the Third Phase gave the objective concerning the maintenance as

- to establish a self sustained recurrent maintenance system to maintain the health facilities and equipment in health units.

The following maintenance activities are defined in Project Document:

- the acquisition of space and movable workshops for each district including spares, planning for the training and recruitment of adequate personnel by the end of 1989
- selecting the candidates to undertake the courses specified above
- training of personnel and placing them in their respective health units by 1990.

Annual Operational Plan 1990 indicates following maintenance activities for 1990.

- to carry out major maintenance in facilities constructed by the Phase One of the Programme.

- to start the construction of one maintenance workshop.

During 1989-1990 the following maintenance activities have taken place:

- Maintenance of Kabuchai, Bumala B and Moding Health Centres, minor maintenance activities in almost all the facilities of Phases One and Two.

- Equipping the maintenance vehicle, establishing the cooperation between the Programme and the Maintenance Engineers and Technicians posted to the Districts by MoH.

- Renovation of temporary workshops to MoH Maintenance Teams in Kakamega and Bungoma and providing them with a hand tool set.

- Designing and printing of forms necessary for maintenance operations and providing the Teams with them and other stationeries.

- Regular meetings with the Maintenance Teams and consultations to solve their organizational and administerial problems.

The Programme is trying to transfer the responsibility of the maintenance activities to Maintenance Teams of the Ministry of Health. Several problems are hindering this process; Busia has not yet got a team, the organizational position of the Teams has not been determined, maintenance is done by many different organizations without coordination, different donor aided projects are not properly coordinated, the decisions of interministerial cooperation have not been made, etc.
Major problem which MoH maintenance teams are facing is the lack of funds for maintenance of the facilities for which the Programme has no fund allocation.

Proposals

The component will carry out the activities according to the Project Document. However, it is obvious that all the aims set in the Project Document cannot be achieved within the budget allocations.

The Programme will construct one health centre for each District. It should be noted however that due to low utilization of the Inpatient and Maternity Units these will only be designed and the space for these will be reserved but the construction will be postponed. New dispensaries and renovations of existing facilities will be carried out within the budget allocations.

More and more attention shall be paid to the maintenance activities. Therefore, the maintenance workshops for the Districts should have a priority when scheduling the construction activities. Further training for the workshop staff shall be arranged and the workshops shall be supported financially by the Programme to guarantee the availability of proper equipment and spare parts.
More responsibility on the maintenance activities will be carried

by the MoH Maintenance Teams and the Programme will only provide support to the Teams. This change of scope requires small changes in the Project Document.

7. Conclusions

The construction survey report should be fully utilized when the sites for new facility or renovation are selected.

Land acquisition should be ready before the designing of a facility can commence.

The Programme is not able to construct all the planned facilities within the budget allocations.

The new health centres will be designed as Health Centre type 1 (modified), but constructed without maternity and in-patient block.

Maintenance of the health facilities will require more attention when their number grows and the fund allocation for maintenance should set the ceiling to the number of health facilities.

The organizational constrains of the maintenance work should be cleared and the coordination of different maintenance projects/organizations should be more efficient.

The definition of maintenance in the Project Document should be changed according to present development.

REPORT OF RURAL HEALTH SERVICES COMPONENT

This report covers a period of twenty (20) months from January, 1989 to September, 1990. It reflects on activities coordinated, supported and/or implemented by the Rural Health Services (R.H.S) Component at Provincial (Programme), District, Rural Health Facility and Community levels.

OBJECTIVES AND STRATEGIES

The main objectives of the R.H.S component are:

1. To update the professional knowledge and skills of health personnel operating at District and health centre levels through inservice training (seminars/workshops) with a view to enabling them effectively reach communities and sensitize and mobilize them to participate in P.H.C. activities;

2. To train identified and selected members of the community as grassroot P.H.C. motivators and service providers to the local communities.

   This includes training of Community Health Workers (C.H.W.s) and Traditional Birth Attendants (TBAs) at village level.

3. To foster intersectoral coordination and collaboration with key sectoral personnel operating within our target areas through coordination and implementation of sectoral meetings and seminars.

4. To assist and support District Health Management Teams (DHMTs) and Rural Health Centre staff through provision of technical knowledge and advice, resources such as stationery, equipment and transport.

5. To intensify P.H.C. awareness amongst community members including school going population through implementation of Health Educational mass media activities such as video/film shows, songs and drama, radio programmes and public meetings (barazas).

THE MAIN ACTIVITIES OF R.H.S COMPONENT:

The main activities of the component can be grouped into:-

1. Training
2. Support to DHMTs and Rural Health Centre staff
   i) support visits and meetings
   ii) Procurement and supply of Equipment (including of AIDS)
   iii) Processing of imprests (acquisition and surrender)
   iv) Transport
   v) Technical support and facilitation at District training activities.
3. Intersectoral Coordination and Collaboration
   i) Cooperation with Water Programme (KFWWSP)
   ii) Coordination with other Governmental and NGOs.
4. Community Awareness/Mobilization, Participation and Involvement
5. Other component activities.

IMPLEMENTATION OF R.H.S COMPONENT ACTIVITIES 1989 AND 1990

Tables below show summaries of activities implemented by the component during the material period.

TRAINING ACTIVITIES JAN. - DEC. 1989

PROGRAMME/PROVINCIAL LEVEL

Health Personnel Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. P.H.C. Orientation for Clinical Officers	2	69	10
2. P.H.C. Orientation for Family Health Educ.	3	107	15
3. F.P. Research Feedback for Health Workers (Nurses)	1	29	5
TOTAL	6	205	30

Intersectoral and Community Members Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. Curriculum Review for TBAs, CHWs' Training	1	23	5
2. TOT Course for CHWs' Trainings	1	34	13
3. PHC Orientation for Journalists & Information Officers	1	29	5
4. PHC orientation for Locational Leaders/Workers	4	175	12
5. KANU/MYW Leaders (jointly with KFWWSP	1	218	1
6. KANU Locational Leaders on Water and Sanitation (joint with E.H.S. & Water)	2	120	6
7. PHC orientation for Traditional Herbalists & Healers	1	50	5
TOTAL	11	651	47

SUMMARY (1989)

Total No. of Seminars held at Programme level = 17
Total No of participants = 856
Total No. of working days spent = 77

BREAKDOWN:

Seminars for Health Personnel 6 out of 17 (35%)
Seminar for Intersectoral/Community members 11 out of 17 (65%)

(Percentage of working days spent for seminars 30%).

JAN. - OCT. 1990

PROGRAMME/PROVINCIAL LEVEL

Health Personnel Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. T.B.A.s TOT Course	1	34	5
2. MCH/FP Seminar for Nurses	1	35	5
TOTAL	2	69	10

Intersectoral and Community Members Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. Training of CHWs in Reference Health Centres	4	145	200
2. CHWs curriculum review	1	30	5
3. Communication skills for Intersectoral Ext-workers	1	38	5
4. CBDC Workshops for TBAs and CHWs Reference H/Cs	2	55	6
5. Refresher for CHWs	2	34	10
6. Seminar for Primary School Teachers	1	25	5
7. PHC orientation for Journalists and Information Managers	1	31	4
TOTAL	12	358	235

SUMMARY (1990)

Total No. of Seminars held at Programme level = 14

Total No of participants = 427

Total No. of working days spent = 245

BREAKDOWN:

Seminars for Health Personnel 2 out of 14 (14%)

Seminars for Intersectoral/Community members 12 out of 14 (86%)

Percentage of working days allocated for seminars (excluding pre- and post seminar tasks) 90%

SUMMARY OF DISTRICT TRAINING ACTIVITIES - RHS

JAN. - DEC. 1989 (as per Annual Progress Report)
(Details of types of seminars, participants, objectives elsewhere)

KAKAMEGA DISTRICT

Total No. of Seminars	=	19
Total No. of Participants (where specified)	=	354(+)
Total No. of days spent on seminars	=	47

Breakdown

Seminars for Health Personnel 2 out of 19	=	(10.5%)
Seminars for Intersectoral/Community Members 17 out of 19	=	(89.5%)
Percentage of days spent on seminars (excluding pre and post seminar tasks)	=	18%

BUNGOMA DISTRICT

Total No. of seminars	=	14
Total No. of participants (where specified)	=	208
Total No. of days spent on seminars	=	35

Breakdown

Seminars for Health Personnels 1 out of 14	=	(7%)
Seminars for Intersectoral and Community members 13 out of 14	=	(93%)
Percentage working days spent on seminars	=	13.5%

BUSIA DISTRICT

Total No. of seminars	=	4
Total No. of participants (where specified)	=	157
Total No. of days spent on seminars	=	20

Breakdown

Seminars for Health Personnel	=	nil
Seminars for Community Members (TBAs)	=	4
Percentage of working days spent on seminars	=	8%

NOTE: The Seminars include one day Nutrition Awareness Seminars where total number of participants have not been specified in both Bungoma and Busia Reports.

Most of the District Seminars (all three Districts) have been on TBAs (about 40%) of all the Intersectoral and Community Members Seminars. If you exclude the eighteen one-day Seminars for Kakamega and Bungoma, the total percentage on TBAs' seminars is about 80%.

(During 1989 therefore, the DHMTs trained a total of 520 TBAs through 13 seminars)

JAN. - OCT. 1990 (as per Activity Reports Submitted not up to date)
KAKAMEGA DISTRICT
Health Personnel Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. P.H.C. orientation Seminar for Clinical Officers	1	25	5

Intersectoral and Community Members Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. T.B.A.s Seminars	6	242	30
2. Teachers Seminar	1	13	3
3. One day awareness Seminar for Herbalists	3	58	3
4. Refresher for CHWs	3	77	9
5. VDSs Seminars	2	77	6
6. PHC - Echa for Women Leaders	2	65	2
7. Growth Monitoring for CHWs, Women Managers	4	100	12
TOTAL	21	632	65

SUMMARY:

Kakamega DHMT carried out 22 seminars including one day ones), reaching 675 participants over a period of 70 working days.

Breakdown

Health Personnel Seminars 1 out of 22 = (5%)

Intersectoral/Community Members Seminars

21 out of 22 = (95%)

BUNGOMA DISTRICT

Health Personnel Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. P.H.C. orientation for Clinical Officers	1	15	5
2. Enrolled Nurses (FP) on Family Planing	2	not yet given	4
3. Enrolled Nurses (MCH) - Immunization	2	not yet given	4
4. CBDC for FHFEs	1	22	4
TOTAL	6	37+	17

Intersectoral and Community Members Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. TBAs Seminars	3	121	15
2. Traditional Healers/ Herbalists	1	48	5
3. Traditional Healers/ Herbalists	1	52	3
4. One day Awareness on Immunization for Women Groups	2	145	2
5. One day Awareness for Drug Vendors	1	43	1
6. Nutrition Awareness Seminar	7	680	14
7. Seminar on Nutrition for CHWs and Women Groups	5	205	9
8. Growth Monitoring Seminars for CHWs and Women Group Leaders	2	63	8
TOTAL	22	1357	57

SUMMARY (1990)

Bungoma DHMT carried out 28 seminars (including one day ones) and reached 1394 participants taking 74 working days.

breakdown:

Health Personnel Seminars ----- 6 out of 28 (21%)

Intersectoral and Community Members Seminars 22 out of 28 (79%)

BUSIA DISTRICT (some training activities not reported to programme yet).

Health Personnel Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. P.H.C. orientation Seminar for Clinical Officers	1	15	5

Intersectoral and Community Members Seminars

TYPE OF SEMINAR	NO. OF SEMINARS	TOTAL NO. OF PARTICIPANTS	TOTAL DAYS
1. TBAs Seminars	4	157	20
2. TOT Course for Intersectoral CHWs trainers	2	unspecified	13
3. Training of CHWs	2	38	20
4. FP for KANU/MYW Leaders	1	14	3
5. One day Community Mobilization	4	unspecified	4
TOTAL	13	209 +	60

SUMMARY:

Busia DHMT implemented a total of 14 seminars covering 224 + participants/audience over 60 working days.

BREAKDOWN

Health Personnel Seminars 1 out of 14 = 7%

Intersectoral and Community Members Seminars 13 out of 14 = (93%)

NOTE: From the figures given, it is noted that both at Programme and District levels, the largest percentage of training activities (Seminars, Workshops etc) are directed at Intersectoral and Community Members.

TOTAL NUMBER OF SEMINARS, PARTICIPANTS AND WORKING DAYS (BY NOS AND PERCENT) - 1989 AND 1990

RURAL HEALTH SERVICES - (20 MONTHS)

A. PROGRAMME/PROVINCIAL LEVEL

Total Seminars 41 (Health Personnel 20%;
Intersectoral/Community Members 80%)
Total Participants = 1283
Total No. and Percentage of working days spent/allocated for seminars=322 days (60%)

B. DISTRICTS

KAKAMEGA

Total No. of seminars = 41 (Health Personnel 7.3%;
Intersectoral/Community Members 92.7%
Total No. of Participants = 1011
No. of days/percentage spent on seminars 117 days (22.5%)

BUNGOMA

Total No. of seminars = 42 (Health Personnel 17;
Intersectoral/Community Members 83%)
Total No. of Participants = 1602
No. of days/percentage spent on seminars 109 days (21%)

BUSIA

Total No. of seminars = 18 (Health Personnel 7%;
Intersectoral/Community Members 93%).
Total No. of Participants = 366
No. of days/percentage spent on seminars 80 days (15%).

OBSERVATION/CONCLUSION

Component personnel at Provincial level allocate/spent about 60% of working time on Seminars of which 80% are for Intersectoral and Community.

Districts are spending (on average) about 20% of their time on seminars of which (on average) about 90% are for Intersectoral and Community Members.

1. IMPACT OF TRAINING ACTIVITIES

Without a thorough Evaluation of each specific type of training activity giving adequate implementation period in months and years, it is difficult to determine impact of any training effort. It is not easy to qualify and quantify impact. However, the following are impressions and observations and information on results and/or impact of KF-PHCP decisive contributory role through training.

A. From training of Health Personnel (through inservice seminars):

i) Increased utilization of our Health Facilities due to delivery of comprehensive (curative and preventive) Health services and better management by P.H.C. oriented and motivated Clinical Officers.
   - Increase in out-patient attendance figures
   - Infant Mortality Rate in Western Province is going down (before 1984 average IMR in W. Province was about 160 per 1000 with Busia leading at 198/1000; Kakamega 142/1000; Bungoma 140/1000) now average IMR in the Province is estimated at about 100 per 1000.

- Immunizing coverage ---------- no recent surveys have been conducted. Prior to 1984 it was about 35%; now (with Bungoma having done survey in Mid 1989 and finding coverage of 53%), the trend is very favourable. (We still have a problem of reporting from immunizating SDPs).
  With Family Planning - no impact yet.

B. From training of TBAs

- Gross reduction of Neonatal Tetanus cases because of improved home deliveries - i.e. hygienic handling of the cord.
- Reduction in health facility deliveries (despite high delivery rate in the province).
- Reduction of cases of ruptured placentas (a situation which was common e.g. in Bungoma District prior to 1984 due to labour - inducing herbs by TBAs).
- Increase in registration of births.
- General reduction of Maternal Mortality.

C. From CHWs training

In our Project areas, this group is still very inadequate (only about 34 serving and only about 145 still in training about to qualify). However, the CHWs are contributing positively in raising Community awareness on key aspects of P.H.C.

D. INTERSECTORAL COORDINATION/COLLABORATION TRAINING IMPACT

Not yet measurable in specific terms. Our impressions are that different sectors are aware and conscious of KF-PHCP and the need for their collaborative contribution. Different sectors are members and contributors to the Programme's initiated Committee formation/ activation strategy from Village Health/Development Committee level, Health Centre Committee level upto District Health Committee level. There are many sectors involved.

CONSTRAINTS ON TRAINING

1. TIME (Self-created by planning too many training activities taking a large part of working days).
   This waters down the desired quality of training and allows no room for follow-up to assess performance at operational level.

2. Inadequacy of skilled (trained) trainers. We have only trained trainers at Health Centre level (for TBAs and CHWs); the rest (with a few exceptions are not trained in training especially Pedagogics and Adult learning Methodology).

2. SUPPORT TO DHMTS AND HEALTH CENTRE TEAMS AND THE COMMUNITY (1989 AND 1990

2.1 SUPPORT VISITS AND MEETINGS

Most meetings and visits to DHMTs, Reference Health Centres and the Community were not recorded.

The few recorded include:

28.6.89 - meeting with Bungoma DHMT ---- to discuss H.E. Plan on Water and Sanitation, Bungoma District.

Meetings with Reference H.C.s:

Moding Health Centre (together with Busia DHMT) ------14.1.90

Bumala 'B' Health Centre (together with the Busia DHMT) ---- 7.2.90

Many meetings have been held at Community level (jointly with some PHC core team members, Health centre staff) in reference catchment areas focussing on Community Mobilization and involvement on formation/reactivation of Village Health/Development Committees, roles/functions and selection of Community Health Workers.

2.2 PROCUREMENT AND SUPPLY OF EQUIPMENT

This activity is implemented jointly with Construction Component. During 1989 and 1990 Equipment including those from UNICEF were procured and supplied to ten (10) Health facilities namely Naitiri, Bokoli, Chwele, Kapsokwony, Sirisia, Navakholo, Mautuma, Sio Port, Matayos and Ipali. One hundred beds and accompanying lockers have been supplied to new Maternity Ward at Kakamega P.G. Hospital. Forty-six (46) new bicycles have been supplied (30 in 1989 and 16 in 1990) to rural health facilities.

AIDS Laboratory Equipment and screening/confirmatory materials supplied to the three Government Hospital laboratories.

2.3 PROCESSING OF IMPRESTS

The DHMTs have been assisted to get and surrender imprests for implementation of their P.H.C. activities.

2.4 TRANSPORT

The component has assisted DHMTs and Rural Health Centre staff to facilitate their movement during implementation of their activities including training.

2.5 TECHNICAL SUPPORT AND FACILITATION DURING DISTRICT AND COMMUNITY SEMINARS

Component Officers have provided needed technical guidance in planning and budgeting of seminars and also acted as resource persons/facilitators as and when invited by DHMTs and Health Centre/Community Teams.

3. INTERSECTORAL COORDINATION AND COLLABORATION

Intersectoral training activities have been reported elsewhere under training.

Many intersectoral meetings have been attended by component staff but not recorded. Coordination with Water Programme (KFWWSP) is through the TECHNICAL COMMITTEE in which the component is represented by the M.O./Head of Component (Chairman) and one component officer. Areas of cooperation with Water Programme include:

i) Provision of water to the renovated/constructed Health facilities
ii) Production of Newsletter on P.H.C. and water
iii) Collaboration in facilitation of seminars and Health Education activities.
iv) Operational Research and Surveys - e.g. women's development activities; relation of water and water-related diseases.
v) Establishment of a joint Resource Centre at KF-PHCP

Through formation/reactivation of committees, the component is coordinating and collaborating with relevant sectors and the communities. Formed are intersectoral Village Health/Development Committees and Health Centre Committees.

4. COMMUNITY AWARENESS/MOBILIZATION, PARTICIPATION AND INVOLVEMENT ACTIVITIES

a) Public Meetings (barazas)

Many have been held and the general awareness on P.H.C. in target areas is increasing steadily. No record of specific number of public meetings and audiences/participants reached.

b) Video/Film Shows

The films/video shows cover topical issues such as Family Planning, AIDS, Nutrition, V.I.P. (modern) latrine construction and use and general Primary Health Care.

YEAR	TOTAL NO. OF PUBLIC SHOWS	TOTAL AUDIENCE REACHED
1989	3	1360
1990	18	9650
TOTAL	21	11,010

Because the Programme has some locally produced video tapes, the shows have been very popular and demand is still very high and our impression is that the education benefit to the viewers is high compared to those produced abroad.

One video recording has been made and is in final stage of editing and will be available soon.

A few video/film shows have been organized by the District Health Education Officers.

c) Radio Programmes

Five radio programmes on P.H.C. activities and sustainability have been produced locally and aired to the intended audience. Some educational folk songs have been recorded.

d) Development of Health Education Materials

This activity has lagged behind, partly because the design, pre-and-post testing and printing of materials is time-consuming.

As at now (Mid-October 1990) two (2) posters in full colours and four (4) in three colours have been designed, pretested and sent for printing. In process of development soon are:-

- Posters on Nutrition - two sets in full colours and three sets in three colours.

- Modern (V.I.P.) latrine - (depicting the three prototypes)
- 1991 Calender depicting all P.H.C. elements
- Local video production focussing on:
  - CBHC and Community Participation and Involvement activities.
  - Family Planning
  - Immunization
  - Community - Based Nutrition Project (Bungoma District).

5. OTHER COMPONENT ACTIVITIES

a) RESOURCE CENTRE:

Established for use jointly with Water Programme. Available Equipment and Materials include:-

Equipment:

Film Projector	-	1
Video Monitor	-	1 set
Overhead Projectors	-	2
Slide Projectors	-	2
Flip chart board	-	2

Materials:

- Posters (from Health Education Unit) three types on Sanitation, AIDS, Malaria.
- Sets of slides on water and Sanitation.
- Films and Videos --- on PHC; VIP technology, AIDS etc.
- Pictures and Photographs

A librarian is needed.

b) ASK SHOWS AND EXHIBITIONS

1989 - Programme staff attended Kakamega and Bungoma shows

1990 - Programme has sponsored Health Centre teams, DHMTs and Programme to the following shows:

SHOW	PARTICIPANTS	NO OF OFFICERS.
Eldoret Show	Bumala 'B' H.C. Staff and Health Centre Committee Representatives	9
Meru Show	Programme Officers	5
Nakuru Show	Programme Officers	4
Mombasa Show	Programme & DHMT staff	24
Nairobi Show	Programme & DHMT staff	38
TOTAL 5 SHOWS		80

IMPACT

While the activities have been useful it is difficult to elucidate qualifiable and quantifiable impact as at now.

3. CONSTRAINTS AS OBSERVED/EXPERIENCED BY THE RHS COMPONENT

1. Too wide scope of coverage as reflected in terms of overall goal, objectives, targets, tasks and activities when compared with resources at the Programme's disposal in terms of time and personnel at all levels (Programm/Provincial, District & Health Centre levels). Inadequacy of staff in certain Ministry of Health sections (for example Health Education Officers at District and lower levels).

2. Integration between the KFPHCP, PHMT and DHMTs not yet at its best. Integration mechanisms need to be strengthened and there is apparent overload on the part of DHMTs.

3. The shortage of Community level workers (motivators and service providers) particularly Community Health Workers. (So far less than 20% of our Project areas have CHWs).

   Also, the economic sustainability of the few existing CHWs and those to come/graduate remains a major constraint in the absence of Community ability and commitment to support and sustain CHWs and also absence of income-generating projects for CHWs.

4. Shortage of trained facilitators to implement the many planned training activities which take, on average over 50% of time of the Programme and District PHC core team members leaving no time for follow-up to assess performance.

5. Lack of an effective and useful documentation system (Activity recording, record keeping and reporting system) of the many Programme activities at all levels (Provincial, District, Health Centre and Community levels) to the extend that we have no statistics, facts, figures to monitor and assess progress and impact.

4. FUTURE FOCUS - R.H.S.

1. Concentrate on fewer but key plans, objectives and activities which are likely to create more impact.
   Possible areas for intensification include:-
   a) Effective Health Education and Communication on PHC- "Action focussed"
   b) MCH/FP
   c) Nutrition
   d) Sanitation (complementary to E.H. & S Component)
   e) School Health Programme
   f) Immunization
   g) Community Involvement and Participation
   h) Operational Research

2. Increase support to DHMTs, and through them to Health Centre teams and the community. Focus on reaching the community.

3. Reduce training activities by about 40 percent and increase follow-up of personnel (from health, intersectoral and community) who have attended our many training seminars/workshops during 1989 and 1990.

4. Improve and support documentation/health information system) to equip the Programme with statistics, facts and figures.

5. Consider and possibly change the selection and training formalities for TBAs and CHWs aiming mainly at sustainability of the CHWs by the Community through, among other strategies, income-generating projects.

ES/EK.

PLANNING AND ORGANIZATION

INTRODUCTION

One of the key area in any system is planning and organization. Without a strong organization base, the planning process is weakened and implementation will take a slow pace. Consequently, the benefits of the planned activities will not be seen. Bearing in mind that the districts are the key links in implementation of P.H.C. activities the Programme endevours to:

a) Support the districts to improve the planning process

b) Support the district in strengthening the organization and implementation of PHC activities.

IMPLEMENTATION:

- The Ministry in conjunction with KF-PHCP appointed a Planning Officer in June, 1989.

- A Provincial health planning survey was undertaken in August, 1989 to establish area of strengthen in planning and organization-

- A planning seminar on planning district health services was held and in this seminar, strategies were drawn by the DHMT, PHMT and the Programme on how to strengthen the organization and carry out support and supervision activities. Although the survey found out that other important issues needed to be addressed e.g. operational planning, health information, logistics and financing, community participation in planning etc., the districts strongly felt that the issue of organization, support and supervision was a priority. Targets were set on how to implement this (see seminar document).
- The District continued with the same planning process which had greatly improved due to guidance from the Programme, various Finnida Missions and District own initiatives.

- A short course was undertaken by the Planning Officer at IDS. In addition one more officer from the Project and one from one district benefited from the course. The aim was to assist the district and the KF-PHC Programme strengthen the planning process.

- It is worth noting that although the Planning Officer was appointed in June, 1989, he was part-time dealing with sanitation activities. He was fully deployed to the planning position in June, 1990.

ACHIEVEMENTS

Targets have been set on how to improve organization, support and supervision.

Summary

PROVINCE	MEETINGS		COMMITTEES		SUPPORT VISITS	
	PLANNED	DONE	PLANNED	DONE	PLANNED	DONE
KAKAMEGA	52	10	4	3	43	13
BUNGOMA	110	21	6	5	3	0
BUSIA	76	24	5	4	6	0
PROVINCE	40	5	2	1	12	4

- With support of the Programme and Finnida Missions, the District wrote up the 1989 Operational Plan (see plan). They are now in the process of writing up the 1990 operational plan.

- The Districts have been able to implement the planned activities as shown.

	1989	1990	EXPECTED
KAKAMEGA	71%	60%	90%
BUNGOMA	77%	50%	90%
BUSIA	22%	47%	75%
KP-PHC	60%	55%	70%

More will be implemented by the end of 1990 (expected in table)

- There is a very encouraging positive response from the Districts and Province when called upon to get involved in the planning activities of the Kenya- Finland P.H.C programme.

- The KF-PHC had been able to hold meetings as planned: Coordinating Group twice a month, Project Meeting once a month.

IMPACT

It is very early to judge the impact of planning and organization process started within one year. However, planning and organization has improved compared to previous years. The improvement has been noted in:

- Situation analysis and problem identification
- The quality of reports produced in this workshop and degree of participation.
- Incase of KF-PHC there has been effective monitoring of activity and immediate solving of a number of problem which might have affected the smooth running of the Programme.

(It is hoped better services will be seen in future as a result of good organization and planning.)

CONSTRAINTS

- Co-ordination of activities related to organization, support and supervision in the absence of Medical officer of Health or the P.M.O. These officers are very busy due to pressure from various quarters. This disrupts scheduled activities when the office responds to immediate needs. To some extent, this also applies to some implementing officers. The implementing officers although more free than the M.O.H. or the P.M.O. fail to organize themselves and call the necessary meetings in the absence of the Team Leaders (Things don't move). This creates a very weak organization not only for implementing purposes but also for solving impending problems. There is also poor planning, and low morale.

- In some instances there is limited delegation of duties and the officer mentioned in the Operational Plan tend to do all the work. This creates overloading and the officer feels pressed. This include activities which could be easily handled by the health centre staff or any other selected person. (Thing don't move without the implementing officer).

- The staff at various levels are demoralized when they do not receive a supervisory visit from their supervisors. This demotivates them and majority tend to neglect their duties.

- The figures given by the Districts and Province leave a lot to be desired. Something has been done but there is room for improvement. The surppot and supervisory visits should be purposefully and benefit the staff visited. Use of checklist on such visits should be encouraged. It may be tiring but is worth trying, in the long run, it will be internalized and will be seen to be useful in planning and focussing on the future.

- The D.H.M.T.s members rarely share tasks, as a result they are viewed as individuals representing a given profession whenever they visit the health facilities.

- Unplanned demands from the National level.

- The plans have been over ambitious and unrealistic in some instances. The time available taking into consideration effective implementation and preparation has not been seriously considered in the plans.

- There has been little emphasis on the measurement of impact and effect of activities done. It is good to have new activities implemented but it is also important to know where we are, where we are going, how to reach there and what are the benefits of undertaking the journey. Convincing answers to those questions can be given with measurable indicators and specific targets.

- **There is some feeling that the districts have been pushed through agendas and guidelines by the KF-PHC programme. They have been put into a responding positions and they have little time to think and develop their own motivation and plans. However the pushing has had some benefits taking into consideration other district activities. The district have produced plans which they have followed and implemented and it may be argued that there is 70% success.**

- **The Programme has not yet given a vehicle to the Districts for support and supervision activities.**

- The co-ordination of activities between the project and the Districts province has been weak partly because of the weak organisation in the province and the Districts.There is also a weak communication between the parties concerned. .

- The Health information system tries to gather too much data,so it is poorly collected. incomplete, unreliable, not analysed much and rarely used for planning. Feedback is never given to the staffand facilities that send in the data.

FUTURE FOCUS

- Development of of a single plan in the District which will link the Programme plans with the Districts. This type of process should come out with an integrated plan of the districts priorities and will include all the activities the districts will undertake under the Ministry of Health, Kenya-Finland Primary Health Care Programme, and NGO's implementing PHC activities. The KF-PHCP Project Operational Plan becomes an Annex to this integrated plan. This kind of integrated planning process had been proposed in the district planning survey report of 1989. It is proposed that preparation meeting of the District Health Coordinating Group and Provinical Health Coordinating Group should take place in 1991/92 and by February, 1990 a start shoulöd be made at all levels (see planning survey report). This calls for strengthening of the planning capabilities in the District, assisted by the Programme and the Province.

- More emphasis aimed at analysis of impact of what has been done. New ideas should be put into practice after closely analysing the process of implementation and the expected benefits.

- The Province and the Districts to select someone who will cordinate matters related to planning, organization, support and supervision activities. The senior officers should effectively delegate to other people working under them as need arises.

- More emphasis on getting organization, support and supervision activities working more effectively in future plans. To realize an effective and self sustaining planning organization process will take 2-3 years and therefore, surpport is need from the Programme and the Province.

- The Programme and the Province identify key data in the health information system and concentrate on this. to assist the districts come out with consolidated information which is easy to understand and use.

- The Kenya-Finland P.H.C. staff to work more closely with the districts by frequently attending meetings and where possible joining them in the support and supervision visits.

- The Ministry of Health Headquarters to honour the plans of the districts and the Province and channel their initiatives through the Provincial Health Coordinating Group or the District Health Co-ordinating Group. They should not go directly to the implementing officers.

GM EK.

RESEARCH IN KENYA FINLAND PRIMARY HEALTH CARE PROGRAMME

INTRODUCTION

In accordance with the World Health Organization research strategy for health for all by the year 2.000 of 1986 and Kenya Government Research Strategy. A research strategy document was prepared for the K.F.P.H.C.P. in 1989. The document was approved by FINNIDA. However, the document has not been thoroughly studied by the programme to see whether the areas recommended are appropriate for research in facilitating the operations of the programme. The delay in studying the document was due to lack of a Planning Officer and a Social Development Officer in the programme.

OBJECTIVES AND STRATEGY

The research implemented or supported by the programme is expected to:-

1. Support the achievements of the objectives of the programme.
2. Support the implementation of Health related activities of the districts and communities.
3. Develop research capacities of Kenyan Health Adminstration.

Following the Kenya Government Research strategy and the Kenya Finland Primary Health Care Programme Research strategy, emphasis has been on operational research, mainly in form of baseline studies and surveys. having been done at the community level. Studies have also been done at Provincial and district level.

The main objectives of research at the community level are:

1. To enable the community identify the underlying causes of health and related problems prevailing in the communities.
2. To improve the management of the community based health care programmes within the communities.
3. To identify the available resources in the community so as to enable them solve their health and health related problems.
4. To enable and test new interventions and alternatives in solving health and health related problems.

The criterion for research in according the priorities of the districts health management teams and the programme components, in areas they feel they need certain understanding to facilitate their operations and services. The programme document could be used as a basis of selecting areas of research although it is not exhaustive.

IMPLEMENTATION

The research in the progamme has been carried out by the Kenya Finland Primary Health Care Programme staff. the district health staff. short term consultants as well as a combination of programme staff and consultants. The following are the studies carried out by the programme components.

1. RURAL HEALTH COMPONENT

i) Rural Health Component has some dental health care studies being carried out by the Bungoma District Hospital Dentist.

ii) A utilization survey has been carried out at Bumula Health Centre and the analysis is being done on the data.

2. CONSTRUCTION COMPONENT

Construction Component carried out a survey throughout Western Province to determine the existing health facilities and their conditions.

3. SANITATION

Sanitation Component carried out several surveys as follows:-

i) A survey on sanitation follow-up at Nalondo

ii) Environmental and sanitation follow-up in Bumala B.

iii) Baseline survey in Navakholo

iv) Baseline survey in Navakholo

v) Worm Infestation survey in Kigama, Navakholo, Moding and Bumala B and Kabuchai.

4. PLANNING

In planning a research was carried out to explore areas where the districts needed strengthening in their activities.

CONSTRAINTS

1. Mainly the studies have been carried out by the programme staff who have other duties to perform. They therefore carried out the studies along with many other activities and could not concentrate enough on the studies. If reliable data is to be collected then plenty of time is required.

2. On the other hand the time given for the surveys was so limited. The survey team had to rush through and some very important areas of study were left out, e.g in the construction component, the survey teams sometimes visited over seven sites a day . Important areas could not be covered such as community involvement, utilization of the facility, geographical and social economic factors and accessibility to the facility.
3. The people conducting the surveys in the programme in some components had low understanding on research methodology.

IMPACT

1. The surveys in the sanitation component have come up with useful information in setting new priorities and alternative solutions.
2. The research on the District Health Planning needs has helped the district to re-organize themselves and identify areas where they need strengthening. They have even been able to come up with target areas of strengthening in their activities.
3. The construction survey carried out by the construction component helped to rationalize the selection of facilities in need of renovation and other improvements. it has also facilitated in site selection. for new health facilities in the districts.

FUTURE DIRECTIONS AND OPTIONS

The decisions on support of district studies will be handled according to the objectives defined in the research strategy. To ensure careful planning of the studies and the utilization of results, all new research ideas will be processed through the normal planning systems.

- Before the decision on a study is made the project must find out, if similar kind of studies have been done before and if the results are applicable to the programme. There should be better distribution of information gathered from the studies, so that the component can make use of it. The community concerned should get the feedback of the study be it in form of improved service, more community involvement etc.
- There is training need for the programme staff in research (survey and studies) methodology, planning and implementation of studies. There should also be good coordination in team work during preparation of studies to be carried out.

There is need for major investigations in key major areas as follows:

1. There should be long term plans for health facilities to be studied together with the districts. The plan for the studies should include staffing , equipment, time required and other facilities. There should be funds set aside for small scale studies to be done during the year as the need arises.
2. Investigate current rural sanitation including the impact of the VIP latrines strategy. Promotions and possible sanitation strategies for the future, taking into account household coverage, especially amongst poorer families.
3. Investigate key health problems in the province in terms of maternal child health, malaria, malnutrition, to identify strategic potential interventions by the programme.
4. Investigate further community participation in health planning.

OVERVIEW OF KENYA-FINLAND PRIMARY HEALTH CARE PROGRAMME:

R. W. WALUKANO

1.0. Introduction

The Third Phase was formerly launched on 10th March, 1989 when the two Governments signed the Agreement. The activities commenced in January. 1989 while those of construction were postponed till end of May 1989. There are specific differences between this Phase and the previous two:

- intensification of activities in Districts whereby the Districts were given the choice in planning and implementation.
- construction and Maintenance activities required the participation and decision making of the communities (land issue and location).
- the Districts will receive transport to strengthen supervisory visits and implementation.

2.0. Objective

The developmental objective for Third Phase remain the same as that of the two previous Phases:

"improvement of the Health of the Rural Communities through improved Environmental Health and Sanitation and Health Delivery System or improvement of the health of rural population in Western Province through improved services."

Therefore the activities which were started in 1984 have remained more or less the same, but laid more emphasis on participation of communities and Districts thereby supporting the District Focus Policy and the National Health Goal of attainment of health for all by the year 2000.

2.1. Components

The three Components (R.H.S., C & M and E.H.S.) concentrated their activities in the field and focussed on:-

- provision of materials for latrine construction.

- training at various levels and for different purposes.
- improve water and food quality control systems in Districts.
- construction and Maintenance activities focussing on sustainable systems for mainly maintenance of all health facilities.
- research activities.
- AIDS activities

These Components will in future advise the Districts and not physically carry out the activities.

2.2. Implementation

- Our approach to Primary Health Care in the Province has been on selective basis depending on the localities. However, our main concern has been focussed on four elements:-

- wholesome adequate water supply and sanitation.
- Education concerning prevailing health problems.
- appropriate treatment of common diseases and injuries.
- Maternal Health and Family Planning.

The awareness of communities has not reached the required degree and concerted effort to strengthen it must be made as it forms the backbone of Primary Health Care implementation. The support from other sectors such as Agriculture, Information, Social Services, Water and Provincial Administration will be needed. The training of both informal and formal Community Leaders should be a continuous process at all levels if the required tempo is to be maintained. The other elements are left entirely at the discretion of the respective District Health Management Team to implement. The responsibility of monitoring the pace of implementation by the Districts is vested with the Provincial Health Management Team.

2.2.1. Changes

The Programme switched its implementation role and left it to be undertaken by the District Health Management Teams.

This is true even in areas of reference health centres because those implementing activities at the operational level are the Ministry of Health personnel and community members.

The planning of the Phase was by the Districts and the Programme had to synthesise the proposals and finalize the Project Document.

2.2.2. Possible Solution

In order to facilitate effective adherence to the strategy and let the Districts implement all the activities in all areas, specific adjustments must be made between now and 1992. The areas to be considered are that:

- the Programme Officers will liaise closely with their professional counterparts at the Districts with a view to ensuring that the implementation is uniform and monitored by the District Officers.
  Provincial Health Management Teams for supervisory work.
- the activities being implemented and supported by the Programme at the reference health centres should be fully handed over to Districts by mid 1992.
- there is need to adjust certain parts of the Project Document to clarify specific roles of the above teams since the running of the Programme should be as specified in Job Descriptions and strategy.
- the Programme should consider in special cases specific support for the Districts in meeting the lunches taken in the field to enhance supervisory physics.
- the Provincial Health Management Team should make more regular visits to the Districts for the purposes of assisting the members of the Districts in implementing Primary Health Care.

2.2.3. Transport

The vehicles are available for the Districts and drivers have been recruited for this purpose. The process of recruiting the right drivers was slow and hence delay in releasing the vehicles to the Districts. The Districts have been requested to submit their monthly programmes before these vehicles are released.

The Programme will assess the Districts needs with regard to other operational costs particularly possible support in stationery. The Programme will fuel, maintain, pay drivers salaries and allowances. The Programme will further discuss these issues with the Ministry to see whether there are other possibilities of improving the reimbursement issue for the District Health Management Team members. The question that will still require an answer is, what happens to the operational level staff who undertake both outreach and other field activities away from their homes?

2.3. Strategy

The strategy used for the Phase focussed on several major areas which took into account the strengthening of the Districts and sustainability. Among these were:-

- integration of the Programme into existing Ministry of Health structures where implementation is carried out by the Ministry of Health personnel at all levels.
- support of the District focus policy by getting the priorities from the District Development Committees representing the rural communities. This was also meant to strengthen the District Health Management Teams.
- support community decision making process and involvement by training and using C.H.Ws, TBAs and Traditional Healers. It is assumed that the base for operational village development committees continue to pause operational problem and lower level.
- strengthening the planning capabilities of the Districts and in identifying in a research options.
- consultative role of the Programme and support to health cadres in planning implementation and evaluating their own action particularly those engaged in training CHWs, TBAs and Herbalists.
- direct funding by FINNIDA to speed up the implementation.
- recruitment of experienced Finnish personnel who are to provide consultative role for the Districts.

The Programme will assess the Districts needs with regard to other operational costs particularly possible support in stationery. The Programme will fuel, maintain, pay drivers salaries and allowances. The Programme will further discuss these issues with the Ministry to see whether there are other possibilities of improving the reimbursement issue for the District Health Management Team members. The question that will still require an answer is, what happens to the operational level staff who undertake both outreach and other field activities away from their homes?

2.3. Strategy

The strategy used for the Phase focussed on several major areas which took into account the strengthening of the Districts and sustainability. Among these were:-

- integration of the Programme into existing Ministry of Health structures where implementation is carried out by the Ministry of Health personnel at all levels.
- support of the District focus policy by getting the priorities from the District Development Committees representing the rural communities. This was also meant to strengthen the District Health Management Teams.
- support community decision making process and involvement by training and using C.H.Ws, TBAs and Traditional Healers. It is assumed that the base for operational village development committees continue to pause operational problem and lower level.
- strengthening the planning capabilities of the Districts and in identifying in a research options.
- consultative role of the Programme and support to health cadres in planning implementation and evaluating their own action particularly those engaged in training CHWs, TBAs and Herbalists.
- direct funding by FINNIDA to speed up the implementation.
- recruitment of experienced Finnish personnel who are to provide consultative role for the Districts.

2.4. Achievements

In the past 20 months having taken the above into account, we have so far achieved the following:-

- completion of the seven health facilities constructed.
- completion of five rural health facilities renovated.
- completion of the office extension and workshop.
- construction of demonstration and individual V.I.P. latrines.
- training of artisans.
- training of TBAs, Herbalists and CHWs.
- training of the Opinion Leaders, Women Groups, Health Workers etc.,
- provision of bicycles to the field staff.
- support to various surveys on the environmental sanitation.
- health Education activities.
- training of vital supportive staff.
- purchase of three vehicles for the Districts.

3.0. Impact

The Programme in general has created an everlasting impact in the minds of the communities and the political system. However, in Primary Health Care, impact of various elements takes long time to take root and this fact must be realized from the on set.

In considering some of the facts that may affect the impact should take into account:-

- the general attitude of the community and the health workers.
- General leadership at various levels and guidance.
- studies and research on beneficiaries to develop new strategies.
- the Socio-economic and cultural factors that influence the communities where the Programme operates.

Therefore, the assessment of the impact of this Programme will be quantified after **specific baseline indicators** have been selected. The selection of these indicators will commence in 1991 and will be done by the District Health Management Teams assisted by the Programme staff. This will enhance uniform application of the indicators within the Programme areas.

When selecting the specific indicators, particular attention should be paid to the Primary Health Care workers at village level which will include CHWs, TBAs, Herbalists, Health Worker and the communities themselves.

4.0. Finance

The current system used in financing activities should continue as it enhances faster implementation of activities. At the same time the Government must at all times endeavour from onset consider the recurrent costs and sustainability of the Programme.

The total cost for the Programme is FIM 75million (Ksh. 420 million.) Most of the budget is consumed by the construction activities and balance for other Components activities.

5.0. Constraints

- the high turn over of the District Managers.
- lack of effective District support to the members of the Co-Teams in implementing Primary Health Care.
- lack of effective and constant involvement of the communities at various levels and non-committal participation of the current local leaders.
- non functional District Health Committee and effective operational Village Development Committees at various levels undermined the participation of other sectors.
- lack of constant meetings between the Province, District, Programme and the Operational levels.
- poor attitude of health providers in implementing various elements of Primary Health Care. (Immunization and Family Planning).
- lack of adequate funds from the Ministry to the Districts to maintain the Health Centre vehicles and other maintanance activities.
- poor disciplinary system in the Ministry.

- non functional multi-disciplinary, multi-sectoral approach and appreciation to Primary Health Care implementation.
- lack of measure of impact and appreciation of the fact that impact in Primary Health Care is slow and painful requiring patience.

5.1. Future Plans

There are specific lessons that the Programme has learnt in the process of implementing Primary Health Care since 1984. For the past twenty months, specific issues have arisen and will require to be addressed for the benefit of future plans:

- the officers from the Programme working in the Districts should directly fall under the respective District colleagues.
- the staff should develop right attitudes and cope with the demands of the communities. This has undermined the implementation rate of activities and utilization of some of the existing health facilities.
- total commitment from the health providers and strong support to them from their supervisors including the Ministry Headquarters should be guaranteed at all times.
- construction of new facilities should be discouraged and instead encourage renovations of the existing dilapidated old buildings.
- maintanance of both equipment and buildings should be given priority when providing new facilities and equipment. Training of this cadre of staff be maintained.
- research activities of whatever design should answer the needs of the implementors and beneficiaries.
- the role of the communities in any development should be understood by the implementors, the decision makers and the communities themselves if Primary Health Care is to be realized since their participation and involvement is crucial to its success and sustainability.

- the system used for identifying practising TBAs will need closer look and overhaul to avoid the token issue. This be extended to CHWs to take care of not more than 10 households.
- staff development should be taken as a continuous process and specialized training be offered according to merit.
- future Phase should pay close attention to the elements of Primary Health Care other than construction activities. The change will need a new strategy to counteract the political influence that prefers static facilities. This is the only sure way of ensuring that communities sustain their own health.
- provision of latrines should be encouraged under all cost and those concerned should ask themselves the basic questions,
  - " do beneficiaries understand why they should have latrines"?
  - " do those beneficiaries who use the latrines actually use them properly or not and what of the maintenance?"
  - " has proper usage of a latrine got any economical gains or is it merely a symbol?"
  - " is affordability an issue at the moment or is it an issue that is tied up to economical factors that suits certain individuals?"
- the women should have adequate knowledge with regard to proper usage of water and what happens if improperly used.
- provision of food and nutrition should take into account the socio economic factors of the communities and they should understand the value of eating the best and selling the best but not sell the best and eat the worst.
- the issue of impact of Primary Health Care on the community should not be taken for granted but be properly planned and implemented. Those implementing must understand that impact needs time.
- health education is a must at all levels and by all sectors but not merely Ministry of Health personnel. This must be taken in totality not in piecemeal.
- staff incentives should not be taken for granted if the tempo of morale and pace implementation is to be implemented.

5.3. Long term future of the Programme

The Programme should be regarded as part of the existing Ministry of Health infrastructure.

The majority of the implementors must be Ministry of Health if the sustainability is to be achieved. Careful selection of the staff should get the priority. The effective staff be maintained to carry out the implementation.

The integration of activities with the Districts should be done during the planning period of the Fourth Phase and this will determine the number of staff that will be required for the Phase in question. There is need to start the move by having the staff from Rural Health and Environmental Health operating directly with the Districts starting mid 1992.

At the moment the activities should continue being implemented and funded in the same manner while total integration takes a slow but sure process which will guarantee less interruptions of service and gap.

The Districts should with the assistance of the Programme identify themselves with the activities that are being supported as being theirs and not merely for the Programme. At the same time, FINNIDA and GOK must ensure that such good Programme should have adequate transitional period.

/JL

KENYA-FINLAND PHC PROGRAMME

Interim Statement of Expenditure 1 January - 30 September 1990

	Kenya shillings	% of total
Management	11 910 585	17.6
Rural health	8 905 520	13.2
Env.health & sanitation	5 127 231	7.6
Construction & maintenance	35 751 139	52.9
Transport/vehicles	4 821 896	7.2
Contingencies	1 034 059	1.5
Total	67 550 430	100%

Note: 'Consultancy fees' (Finnish salaries, overheads, consultants etc.) of KSh11.66 mn have been proportionally allocated to the first four items.

K-P PECP | BUDGET CONTROL REPORT SEPTEMBER 1990 | RATE PIN: 0.170 | Listed 29/10/90

Budget code	Annual Budget PIN	Percentage of Budget	Used January-September KES	Used January-September PIN	Balance PIN	% Used
1 Management	2,000,000	10.3%	7,244,331	1,306,206	693,794	65.3%
2 Rural Health Services	2,700,000	14.0%	6,572,393	1,164,276	1,535,725	43.1%
3 Env. Health and Sanitation	1,800,000	9.3%	3,960,668	704,108	1,095,892	39.1%
4 Construction & Maintenance	6,500,000	33.9%	32,251,449	5,777,696	722,304	88.9%
5 Consultancy Fees	2,900,000	15.0%	11,665,635	2,072,273	827,727	71.5%
6 Transport/Vehicles	1,400,000	7.2%	4,821,896	861,167	538,833	61.5%
7 Contingencies	2,000,000	10.3%	1,034,059	175,803	1,824,197	8.8%
TOTAL:	19,300,000*	100%	67,550,431*	12,061,528*	7,238,472*	62.5%

BUSIA DISTRICT JAN.1989-AUGUST,1990.

INTRODUCTION:

Busia District is in Western Province along the Kenya-Uganda Border. It is bordered by Bungoma District to the North and East, Kakamega District on the East, Siaya District on the South, and Uganda on the Western Side.

Currently the projected population for 1990 is estimated at 487,204 The Official Census figure for 1989 is not yet out.

The top five diseases for year 1989 for out patients are

1) Malaria (37%) total
2) Diseases of the respiratory system (19.8%).
3) Disease of skin including ulcers (9.5%)
4) Diarrhoel diseases (8.5%)
5) Intestinal worms (8%).

The top five diseases for in patients are (1) Malaria (30%) (2) Anaemi (14.5%) (3) Diseases of the respiratory system (13.2%) (4) Accidents burns (12.2%) (5) Diarrheal disease 11.4%

The national target for full mimmunization coverage is 75% in the under fives. The immunization coverage for Busia District is 44% as compared to the average for Western Province of 50.4%(KEPI SURVEY-1987).

Review of our records for 1989 show that for BCG in the under 1yr the coverage was 113.4%, and for Measles 55.6%.

For 1990, January to August the coverage in the under 1yr for BCG is 68.8% and for measles is 57.3%.

It may be difficult to determine the exact coverage for the district due to the inflow of clients from the neighbouring Uganda, hence the need for an Immunization coverage survey.

The main objectives for the last 20 months has been:-

1. To reduce the incidence of water and vector-borne diseases in the community through training of the health personell, health education to the community; construction of demonstration VIP latrines, casting and distribution of slabs.

2. To reduce morbidity and mortality in the underfives and mothers of child bearing age by strengthening and expansion of MCH/FP services.

3. To involve the community in the improvement and sustenance of their own health through formation of village health committees; training of CHWs; THAs, traditional healers; nutritional awareness seminar, demonstration kitchen garden.

4. To improve intersectoral collaboration in the implementation of PHC by intersectoral training of TOTs; teachers seminars.

5. To reduce the distance for the Community to the nearest health facility by construction:- of new health facilities.

The overal implementation rate for 1989 was 22.1% , and for 1990: January - August it was 47%, on Activities funded by the K-F Programme.

PLANNING AND ORGANIZATION.

A total number of 76 meetings week planned for 1990; but only 38 were held.

A total number of 40 dispensary which were planned; but only 10 have been done upto date. The check- list is ready to be tested now.

A total number of 5 committees were formed, and it is only one committee which has not met at all.

Health Planning activities carried out for the year. Other than the programmes. 1990 are:- 7 in number.

Impact:- Strengthened relationship among staff at the health centres.
- Spread up and reminder for the activities.
- Strengthen relationship between health centre staff and DHMT MEMBERS.

Constraints: (a) Delay in release in release of funds for implemantation.
(b) Lack of collective responsibility among the DHMT members + Project members.
(c) Hight staff turn over especially the office of DPH & MOH office.
(d) Lack of adequate planning capebility for implementing officers.
(e) Too many committee, that may duplicate the work.
(f) Transport
(g) Facilities- stationery, duplicating machine
(h) Inadequate support from some programme Officers due to the small numbers in the programme.

Training:

Objective: To raise the knowledge and change the attitude and practice of the people on preventive, promotive and rehabilitative services.

ACHIEVEMENTS.

COMMUNITY:

Activities.	No Of Workshops.	No.of Partcipants.
TBAs	9	364
CHWs	6	192(80)
Kanu/Women	5	180
Local leaders/Kanu	4	120
Youth Groups	1	25
Nutrition Awareness	7	-
Trainne Follow ups	6	200
TOTs	1	20(2more phases)
Health Workers:		
C.Os	4	25(30)
Nurses	1	6
TOTs Intersectoral	1	20
P.H.T.S		
P.H.Os		
Drivers		
Nutritionists.		

Impact.

- Reduced over load in Mat. Wards.
- Hygiene deliveries conducted in the Communities
- Recognition of TBAs roles.
- NOTIFICATION OF ALL new borns.
- MOTIVATION OF MCH/FP clients, within the communities through active participation in health education by the people in the communities that have gone through P.H.C. trainings.
- Improved water for consumption through 3 pot water storage, bore-hole pumped water.
- Dish racks rubbish composit pits clothes lines are provided in the homes.
- Road to health cards are kept by clients are available on demand.

- Increased a number of expectant mothers attend clinic in health units before, delivery.
- More deliveries done in homes. Neonatal tetanus not being diagnosed in our health units as before. The last case of neonatal Tetanus diagnosed in Busia D.Hospital was 1986.
- Ante-natal, cases with complications are refered in health units early.
- Health workers have developed good relationship with the Community people.
- There is Community involvement and participation in the provision of resources to felt needs e.g. spring protection, water pump maintanance.
- There is Community organization skills where by groups come t together to organize income generating activities e.g. in pottery.
- More than 85% of the under 3yrs attending MCH services are within normal weights as per growth monitoring results.

However we still see a few cases of measles much so in those les than 6 months.

There is Community demand for health services especially for immunization.

Constraints:

Planned follow up not done due to lack of transport (fuel).

- Overload of work for TBAs in the Communities with no token of appreciation by the Community people.

- Overload for health workers due to hight demand for their services in the communities as well as in health units, with no morale uplift with token such as stipends for luches or fares incurred on public transport.

- The DHMT members are over loaded with activities to coordinate especially so the M.O.H DPHN and Hospital administrat

- The activities are so involving time consuming that the implementors feel that their efforts are not rewarded for furthe motivation through things exchange visits and even promotion.

PUBLIC HEALTH OFFICE.
MID TERM REVIEW MISSION WORKSHOP

1.0. STUDIES AND SURVEY

F.A .P. Survey on Mosquito control was carriedout in Busia District. Dental survey and Breastfeeding survey not done. This is to help us lay strategies for Mosquito control in the District.
The impact has not been felt.

1.11 CONSTRAINTs- Expertise personnel was needed on the analysis of the F.A.P survey.
Technical Manpower needed on research on Malaria needs to be carried out to control the incidence of Malaria. More money is needed to sustain this exercise.
The survey was limited on F.A.P only.

NB. On Dental survey and Breastfeeding survey experts were alimitation.

2.0. LATRINE CONSTRUCTION

A total of 500 slabs were constructed out of 800 i.e. in 1989 and 1990
A total of 98 Demonstration latrins constructed out of 200. 12 VIP latrines under construction.
Total number of latrine coverage is 45 % for Sio Port and Matayos.

NB. Total Number of households with latrines not yet determined. Reason is Latrine coverage survey has not been carried out in the District.
Impact is that all slabs casted have been taken by members of the community. It has also been observed that some people outside the Target areas have obtained slabs for construction. There are many inquiries on the VIP latrines constructed implying that people are responding positively to VIP constructing.
constraits include the affordability of the materials for construction as some community members cannot afford.

At the moment we are not able to assess the impact in terms of goal of prevention of Disease which we shall do later after carrying out the survey.

Continued on P. 28

3.0. TRAINING

A total of 50 out of 65 health personel and 83 out of 120 artisans have been trained on PHC and VIP construction respectively. Total of 80 opinion leaders have been trained The artisans have managed to construct VIPs in the community within the target areas and homesteads.

The Health personnel have been able to guide and supervise artisans in construction of VIPs. There is increased improvement of VIPs in Market places from 40-50% due to work by health personnel.

The artisans have reduced the clients coming to look for technical assitance of VIP construction.

3.2. CONSTRAINTS

The artisans trained are not employed permanently and as such dropout rate is very high.

This calls for more training of artisans.

The house holds in the Project Areas Matayos & Sio-Port :-

11,000 approximately.

The total No. of latrines constructed 500.

The Coverage is 8% V.I.P by Programme.

Other type of latrines are about 30% coverage.

CONTROL OF AIDS:

The Programme Supplied UNISCAN Reedew and pippettes.

We have already presented a proposal for an extension of the laboratory to create space for blood donor service and aids screening.

- For Jan-October 1990, the total no. screened is 2,553, 627 positive by ELISA (25% postivity) is 2,553,627 positive by ELISA (25% positivity) and 243(32%) confirmed cases by Western blot.
- Impact:- Control of transmission thro' blood transfussion.

2) Increased capacity in term of speed of getting result.

Constraints:

1) Lack of space.
2) Water distiller.
3) Refrigerator for reagents.
4) Refridgerator for storing screened blood
5) Inadequate counsellors.
6) Lack of supportive health Education materials e.g. transport, visual aids.

CONSTRUCTION/RENOVATION AND MAINTENANCE.

There are a total of (26) health facilities.
There is 1 referral district hospital,
4 hospital,
12 Health Centres and 10 dispensaries.
Out of these the programme he constructed/renovated 4 health centres.
Maintenance works is going on in 2 of these health centres.
Proposals for 1 new Health Centre, and renovation for 3 health centres has been approved.

The impact has been on:-

1. The improvement of accessibility to the health facili--ties.
2. Staff morale elevated by provision of good accommodati working space and equipment.

Constraints: (1) Interference with sites chosen by DHMT at DDC level.
(2) M.O.H not involved by M.O.W at site meetings about buildings so that positive corrections are not done.
(3) Poorly constructed sluice sinks.

FUTURE FOCUS

3 top constraints:-

1. Work- overload - for MOH & BPHN
2. Logistic support and evaluation.
3. Technical and moral support from the programme officer.

Strategies:

At District level:-

1. The implementers to ensure that activities are carried out as planned.
2. Effective supervision and feed back.
3. Frequent meetings to review the plan.

From K-P- Programme:-

1. Logistic support
2. Technical assistance in the field.

Ministery Level:

1. Post of Medical Superintendent to allow MOH more time for planning, and carry out PHC activities.
   2nd public health Nurse :- 2 more Health Education Officers.
2. Coordinated plans from the District to the Headquarters and vice verse.

REPORT FOR PRESENTATION DURING THE REVIEW MISSION WORKSHOP TO BE HELD AT GOLF HOTEL FROM 28/10/1990 TO 31/10/1990

REVIEW OF KF/PHCP ACTIVITIES UNDERTAKEN DURING THE PAST 20 MONTHS - BUNGOMA

1.0 INTRODUCTION

During the last twenty months under review, the District Health Management Team has been actively implementing Primary Health Care activities with support from Kenya-Finland Primary Health Care Programme. The main objectives of the activities is to improve the health of the rural population through improved services. The District Health Management Team has been working hand in hand with the KF/PHCP. In view of being partners in progress, the Programme usually gives support to the D.H.M.T. with special focus on the following objectives:-

i) To encourage and empower individuals and communities towards participation and self responsibility in Primary Health Care services to the people by encouraging proper provision of health facilities

ii to improve the accessibility to the rural folk and effective manpower development

iii to promote the activities aimed at improvement of environmental health and sanitation

iv to strengthen capability of the District Health Management Team in planning by proper training of the members and other staff

v to intensify activities in AIDS and HIV prevention and control in the community.

The District Health Management Team has plans to solicit for continued support in provision of means of transport, professional consultation, funds for carrying out activities and assistance in improving the health facilities. In respect of these, the DHMT will be able to achieve their objectives.

2.0 TRAINING

Community & Intersectoral Team

2.1 Achievement - 165 workshops were held with a capacity of 3,834 participants.

2.2 Impact

i. Trainings have created a high demand for more similar courses to untrained Traditional Birth Attendants; Traditional Herbalists; Healers; Circumcissors; Artisans and Women Groups.

ii. The bed occupancy in rural health facilities maternity wards has not increased despite increase in population because mothers can be safely delivered at home.

iii. Some women groups have now been able to start income generating projects to improve their own health and children.

iv. Traditional Healers/Herbalist are now able to freely share ideas/experiences with modern health providers for the benefit of their patients.

2.3 Constraints -

i. The demand for remuneration has risen following high workload on the side of the few trained TBAs, and CHWs.

2.4 Health Personnel

2.4.1 Achievements:-

- 19 seminars were conducted with a capacity of 467 participants involving various cadres of personnel.

2.4.2 Impact:-

- The health workers are now able to train the community e.g. TBAs, CHWs, Women Groups, Sanitation Artisans on P.H.C. as a result of improved knowledge.

- Health workers e.g. PHTs, Nurses and Nutrition field workers among others are able to demonstrate to the community on how to:-

- cast slabs for VIP latrines, and the construction of the latrines
- prepare weaning diet
- kitchen gardens,
- mix oral rehydration salt solution due to improved skills

2.4.3 Constraints:-

i. Increase workload has been created calling for a high degree of commitment and dedication.

ii. Low staff morale due to increased workload without subsistence allowance.

3.0 STUDIES & SURVEYS

3.1 Achievements;- 5 surveys have been conducted on various aspects of P.H.C.

3.2 Objectives;- To determine the nature and magnitude of the problems pertaining to various health variables.

3.3 Impact;- Health Workers have been able to plan and institute proper action to solve the problems facing the target groups.

3.4 Constraints;-

i. Surveys require a lot of time, dedication and commitment therefore, those concerned tend to lose interest.

ii. Analysis of too much data collected is tedious to analyze, hence discouraging to those involved.

4.0 LATRINE CONSTRUCTION

4.1 Achievements;-

i. 700 V.I.P slabs were made and 700 vent pipes and fly screens were issued to the community members

ii. 132 demonstration V.I.P. latrines have been put up in strategic public places for the community to copy and adopt technology.

4.2 Objectives;- To improve the hygienic modern latrine coverage by providing technical know-how and provision of materials.

4.3 Impact:-

i. Latrine coverage has increased from 63 - 65% for project areas (63% is the average for the District)

ii. Currently 12% of the community in the target areas have provided and used modern (VIP) latrines.

4.4 Constraints:-

i. There has been lack of continuous and follow up to ensure complete and proper use of construction materials issued due to lack of inadequate staff in some areas and transport.

5.0 CONSTRUCTION/RENOVATION & MAINTENANCE

5.1 Achievements:-3 Health Centres have been completed in construction work and 2 were renovated.

5.2 Objectives:- To improve the accessibility of health services to the people.

5.3 Impact & Usefulness

i. Comprehensive health services are now closer to the people in the target-areas

ii. Community participation has been improved especially in provision of land and prioritization of needs and decision making.

iii. The workload of District Hospital ward staff has been minimized due to less referrals from Rural Health facilities.

iv. The referral system of very sick patients has improved especially from the rural health facilities to District Hospital.

5.4 Constraints:- The construction of beautiful health facilities has increased high demand of similar structures by other people in and outside the District.

6.0 OTHER P.H.C. ACTIVITIES

6.1 Achievements:-

i. Regular supply of reagents for H.I.V. testing

ii. Support of AIDS week day whereby six hundred community members were informed and educated on control and prevention of AIDS and H.I.V.

iii. 1 Uniscan AIDS + HIV laboratory machine has been provided by the Programme.

6.2 Objectives:- To promote AIDS + HIV prevention control and surveillance activities in the District.

6.3 Impact:- The support on AIDS activities has enhanced the AIDS surveillance of antenatal mothers and other groups.

6.4 Constraints:- Improper coordination of AIDS activities by AIDS

Programme secretariat. Provincial Aids Committee and KF/PHCP has delayed the implementation.

7.0 PLANNING & ORGANIZATION

7.1 Achievements:-

i. 132 meetings and various types were planned and 16 were conducted.

ii. Five committees were planned and four were formed. The changes made in committees and teams formation were:-

- A psychiatric Nurse and Physiotherapist were added to the list of DPHCCT as coopted members.
- A Maintenance Technician as a coopted member has been included on the list of the District Hospital Executive Committee. Otherwise influential community leaders have been excluded from the list of the District health Care Coordinating Committee to avoid political interference.

7.2 Objectives:- To improve the Organization and Management of health services.

7.3 Impact:-

i. There is improved intersectoral collaboration.

ii. A good chance has been created to review/discuss the strategies of P.H.C. implementation.

iii. The dangers of ambitious plans have been learned by the D.H.M.T.

iv. DHMT members gained an insight and were able to identify and coopt other members with vital roles to play in Primary Health Care.

7.4 Constraints:- There was little time to implement the planned meetings.

8.0 CHECKLIST

8.1 Achievements:- Nil

8.2 Objectives:- To asses the performance of staff rural health facilities.

8.3 Impact:- Not known yet.

8.4 Constraints:- There were too many activities to carry out and transport was a hindrance.

9.0 FUTURE FOCUS

9.1 Lack of involvement of community at the grassroots in health planning.

9.2 Transport has been a major constraint.

9.3 Inadequate funds for subsistence and purchase of stationery.

9.4 Uncoordinated/improper coordination of vertical programmes.

9.5 Low staff morale.

10.0 STRATEGIES

10.1 Self

- Make proper and realistic plans
- Plan well coordinated and combined field trips
- Improve community participation, especially in health planning.

10.2 KFPHCP

- To make transport available for DHMT
- Provide adequate funds for activities + purchase of stationery.

10.3 M.O.H.

- Introduce proper and well coordinated vertical programmes
- should offer good salaries for staff
- introduce good schemes of service to those who don't have
- should provide funds for subsistence of field staff.

Prepared By:

S.O. Danda
FOR MOH - BUNGOMA

/EK.

KAKAMEGA DIATRICT - BACKGROUND

Size	:	3520 sq kms
Rainfal	:	1250 - 200 mm pa
Temperature	:	Hot and humid (20°C - 30°C)
Administration	:	Division - 13 Location - 46
Population	:	1,448,994 (1979) 0 - 59 months - 321,387 (CBS Kakamega)
Crude Birth Rate	:	28 per 1000
Crude Death Rate	:	9 per 1000
Infant Mortality Rate	:	143 per 1000 (1979 census)
Number of Households	:	442,000

I N T R O D U C T I O N

The future of a country, and of her population, depends on its children. For children to grow into healthy, able adults, they need good food, clean water, medical care, education.

The infant and maternal morbidity and mortality rates are of major concern in healthCare in this district. The estimated infant mortality rate is 107/1000 (1989 estimates).

Preventing illness is more effecient, and less costly, than curing people once they are sick. However, with inception of Prmary Health Care strategy, infant mortality has reduced from 142/1000 in 1979 to 107/1000 in 1989.

O B J E C T I V E S

GENERAL

To reduce infant and maternal morbidity and mortality through Primary Health Care strategy with emphasis on improving the health of the rual communities focusing on mothers and children.

STRATEGIES TO ACHIEVE THE STATED OBJECTIVE

- Construction of new health centres and dispensaries and or renovation and extension of the existing health units.
- To increase improved pit latrines which are affordable by the people in rural areas.
- Training of Health Workers and Traditional Birth attendants, community Health Workers, Women Groups, Opinion leaders and artisans.

- Morbilizing communities to enlist their support involvement and participation in Primary Health Care.
- To carry out surveys and research for better planning and evaluation.

This report is based on Primary Health Care activities carried out by Primary Health Care/Core Team members, Kakamega District between January 1989 and September, 1990.

T R A I N I N G

ACHIEVEMENTS:

	Planned	Implemented	No. of participant
Community	107	96	3,661
Health Workers	29	15	470

IMPACT

- P.H.C has played a substantial role in the dramatic reduction of infant mortality in Kakamega from more than 142/1000 1979 live births to less than 107/1000 in 1989.
- Women in their child bearing years using family planning contraceptives has increased to more than 11.6% (CPR modern methods 1989).
- Immunization coverage rate has increased from 35% in 1984 to 54% fully immunized in 1989.
- Number of deliveries at the rural health facilities has reduced tremendously.
- The demand for water from protected sources has increased.

CONSTRAINTS

- Lack of transport to follow up participants after training to ensure whatever was taught is put into practice.
- Practical demonstration on some of the activities we teach the community to carry out afterwards.
- Some groups for example, TBAs and CHWs would like to be given some token in appreciation for their good work.

STUDIES AND SURVEYS

ACHIEVEMENTS

PLANNED	DONE	TIME TAKENT
8	2	30 days eache

IMPACT:-

- The findings of the Base-line survey of 1989 on latrine acceptance show that there is a demand on modern VIP latrine and therefore there is need to reach those communities outside the project target areas.
- The findings of the same base-line survey further enabled the DHMT to plan implement for other health education programmes geared towards environmental sanitation in other parts of the District.

CONSTAINTS:

- Takes a lot of time to collect data analyse and report.

CONSTRUCTION, RENOVATION AND MAINTENCE

ACHIEVEMENTS :

NEWS	RENOVATION	UNDER CONSTRUCTION (RENOVATION)
3	3	1

IMPACT:

- Construction and renovation of health units has improved accessibility by the people to health services,
- Siting of these health units was based on the community's choice and the District selection considering the population served and/or to be served, disease pattern and distance from the existing facilities.

...../2

- With regard to construction of new health units, the DHMT appreciates the role played by KF-PHCP but then suggests that there is need to put up Dispensary type I and thereafter upgrade it to health centre status at a later stage,

- With respect to the existing health units, the DHMT would like the KF-PHCP to renovate all the old health units as opposed to construction of new ones.

- However, the entire Kakamega District population has appreciated new health facilities and those renovations done and most important, if I may put words into their mouths, they would like KF-PHCP to work on each and every health facility in the District.

CONSTRAINTS:

- Some politicians push health units to be constructed at the site of their choice.

- Some of the health centres constructed by KF-PHCP are too big to be manned and maintained by the existing number of health workers considering the present staffing norm by the Ministry of Health.

OTHER PHC ACTIVITIES

A I D S A C T I V I T I E S

ACHIEVEMENTS:

	PLANNED	DONE	NO OF PART
H.Workers	17	3	60
Community 6666	-	6	180
Councelling	-	40	40

IMPACT:

- The use of condoms by men has increased tremendously.
- Clients are now coming forward for counselling without fear.
- Many people are inquistive to find out it there are intervention measures aimed at controlling the problem.

- The programme is very useful because it allays fear amongst people.

CONSTRAINTS:

- Lack of adequate funds for training
- Lack of adequate condoms.

LATRINE CONSTRUCTION:

ACHIEVEMENTS:

a. Homesteads with latrines (all types) 82%

b. VENTILATED IMPROVED PIT LATRINES CONSTRUCTED AND IN USE:

Demonstration Pit latrines	Individual in project target	Individuals outside the Project target area
149	103	1453

SLAB CASTING:

No. Planned	Number Cast	Slabs In-situ by Individuals
800	200	1413

IMPACT AND USEFULNESS:

- Households with latrines and are using them have increased ... from 65.3% in 1986 to 82% in 1989.
- Households with VIP latrines and are using them have increased from 692 in 1988 to 1556 in 1990..
- 51.5% of the people who collected cast slabs (200) have completed VIP latrines and are using them.
- As to now, 1453 VIP latrines have been constructed by individu outside the project target areas and the demand for cast slabs quite high.
- Those individuals who have constructed VIP latrines have appre them because they can be constructed close to the living house

CONSTRAINTS:

- In places where slabs have been cast, it has been sometimes b difficult for the individuals to transport them (cast slabs) from the casting yard to their homes on their own.
- [illegible]
- Materials for slab casting have not been readily available al for, example, Cement.

PLANNING AND ORGANIZATION

A	MEETINGS	PLANNED 59	IMPLEMENTED 10
B	COMMITTEES	4	2 -
C.	SUPPORT & SUPERVISION	48	13
D.	PLANNING	6	4
E.	CHECK LIST	1	1

IMPACT

The DHMT has been able to decide on how best the limited financial resources can be utilized.

The DHMT had the opportunity to interract with health centre team in a relaxed atmosphere, listening to their problems, observing their performance and advice where necessary.

The DHMT was able to set objectives for the activities to be undertaken

The check list is a useful tool which acted as a reminder on what to look for while visiting health facilities.

CONSTRAINTS.

Too many activities

The District is too large with many H/F/ it takes at least 30 working days to visit each and every facility in the District.

Lack of stationery for reports.

Lack of adequate funds for transport.

Lunch travel claims, manitenance.

Shortage of working vehicles to carry out support and supervisory visits

Co-ordination and communication is weak amongst the DHMT, HMT and MTC.

FUTURE FOCUS:

1. MAIN CONSTRAINTS FOR ORGANISING DISTRICT ACTIVITIES AND GETTING HEALTH SERVICES TO WORK PROPERLY

There is a severe shortage of funds for recurrend and development spending.

Un co-ordinated activities between the health facilities im the District and between the District and the Ministry of Health Headquarters.

In adequate staff houses and clinic space in some health units.

2. KEY STRATEGIES FOR IMPROVING HEALTH SERVICES

(a) • The DHMT members should plan their activities at the beginning o every year.

• Regular support and supervisory visits to health facilities and project areas.

• Regular DHMT meetings, at least once every month.

(b). The KF-PHCP should provide funding to help Renovation, constructi and maintenence of health facilities.

The KF-PHCP should continue funding training and follow ups to both health workers and the community.

The KF-PHCP should assist the District to establish an organized Health Information system.

(c). The Ministry of Health should provide adequate funds for recurren spending.

The Ministry of Health should co-ordinate the activities of the District so that they do not overlap.

Provincial Medical Headquarters,
Western Province,
P.O. Box 359,
KAKAMEGA.

26th October, 1990

THE PROVINCIAL HEALTH MANAGEMENT TEAM'S APPRAISAL REPORT ON PRIMARY HEALTH CARE ACTIVITIES IN WESTERN PROVINCE FOR THE PERIOD STARTING JANUARY 1989 ENDING OCTOBER 1990

INTRODUCTION

The P.H.M.T's role is very important in the provision of Health Services in the Province. The office forms a link between the Ministry Headquarters, the Districts, other Government Departments, Non-Governmental Organisations and Private Medical Institutions. It also supervises, co-ordinates and evaluates the implementation of Health Programmes and activities in the Province through the National Guidelines for implementation of PRIMARY HEALTH CARE through the District Focus for Rural Developement strategy. Each member of the P.H.M.T deals with specific elements of P.H.C. according to his qualifications and specialization. They also do staff development, deployment and discipline.

During this period the team experienced successess and drawbacks in the implementation of their planned activities. The DHMTs had similar experiences. The most outstanding constraint was lack of time for accomplishment of these activities due to interruption by other unplanned for activities in Nairobi etc.

OUR ACHIEVEMENTS

Our achievements were as follows:-

1. Training seminars/workshops for health workers in P.H.C. activities and Aids awareness;
2. H.I.V. screening for laboratory workers.
3. Acquisition of H.I.V. testing machines for Kakamega Provincial General Hospital, Busia and Bungoma District Hospitals and Western Blot confirmatory test machine for P.G.H.;
4. We held two P.H.M.T meetings and went for two supervisory and support visits to Busia and Bungoma, and two joint PHMT & KFPHC meetings.

5. One intersectoral Seminar was held where we formed the intersectoral Primary Health Care Committee whose chairman is the Provincial Commissioner.

6. We formed a provincial and District Aids Monitoring Committees whose chairmen are the Provincial Physician and the District Medical Officer of Health respectively;

7. We developed a Master Plan for H.I.V. counsellors training programme and 2 trainers of trainers of counsellors and 3 counsellor's training courses were held rspectively; and

8. We had appointed a co-ordinator to coordinate the remaining 1990 activities and beyond.

NB

We could not do more than those because aof certain constraints.

CONSTRAINTS

We could not accomplish our plans because of the following constraints:-

(a) Lack of adequate funds for petrol and subsistance,
(b) Lack of reliable transport for supervisory/supportive visits
(c) Lack of time for over-planned activities and interference of external meetings in Nairobi etc.
(d) Lack of a co-ordinator to liase with KFPHCP and Districts for planned visits and meetings.

NB: These constraints will be overcome using the following strate

STRATEGY FOR OVERCOMING THE ABOVE CONSTRAINTS

(i) To make less ambitious and more realistic plans for 1991.
(ii) We will have to appoint deputies/assistants and to delegate duties to ourselves in cases of absence of other members.
(iii) The appointed co-ordinator to liase with respective officers for planned activities.
(iv) We shall appoint PHC component implementers who will work closely with the PHC co-ordinator and the K.F.P.H.C. Programme.

(v) KFPHCP to provide the PHMT with sufficient funds and transport in support of the P.H.C. Programme.: due to our complimentary roles.

The PHMT's 1991 proposed activities are in Annex 1 and items for discussion in appendix 2.

CONCLUSION

The PHMT notes with alot of satisfaction and pride the good work K.F.P.H.C.P. has done in constructional/renovation of Rural Health facilities, V.I.P. latrines and casting of slabs in the community, training of:

(a) Health Workers abroad and locally;

(b) T.B.A's;

(c) CBHWs;

(d) the community and their leaders.

This has led to improved knowledge for Health Workers and created awareness in the community with an increase demand for V.I.P. latrines and reduction in neonatal mortality rates due to Neonatal tetanus because of improved T.B.As practices and increase in Antenatal refered cases. We have noted that cholera outbreaks have been eradicated in Busia though there are still sporadic typhoid fever outbreaks in Mount Elgon in Bungoma and measles and malaria outbreaks in Kakamega. These two districts' Health teams need to intensify on their Health Education , surveillance and improve in immunization and cold chain management respectively.

Lastly we feel that Finida should not wind up their assistance soon. Instead they should stay longer and assist to renovate other Health Facilities and train more Health Workers, TBA's and CBHWs which/who are not in the current programme areas as some of these are less previleged. Long live Finida, Long live Kenya, Long live Primary Health Care.

(L. I. MBOKU)
for: PROV. H. MANAGEMENT TEAM
PROV. MED. OFFICE KAKAMEGA

APPENDIX - 1

THE PHMT's 1991 PROPOSED ACTIVITIES

1. Regular PHMTs meeting at once monthly to discuss:
   (a) Allocation of specific duties
   (b) Advisory meeting
   (c) Disciplinary meeting
   (d) Posting committee
   (e) One PHMT meeting in November 1990 to discuss transport.
2. Monthly PHMT/KFPHCP meeting
3. Monthly meeting PGH/PHMT
4. Joint PHMT/KFPHCP visit to District with emphasis to programme areas every 3 months.
5. PHMT supervisory/supportive visits to P.G.H.every 3 monthly
6. PHMT visits to DHMT every 3 months
7. 2 joint PHMT/Provincial Health co-ordinating committee meeting Biannally.
8. Executive expenditure committee meeting regularly when need arises.
9. One joint meeting KFPHCP/PHMT on staff deployment, development, discipline and decision making and co-ordination links.
10. Enhancement of Rural Lab. services at main Health Centres
11. KFPHCP to provide transport for all R.H.Fs.

APPENDIX - 2

1. Training of P.H.C. workers, TBAs, CBHWs in Alupe, Sirisia and Mbale Health facilities.
2. Sustainsion/strengthening of intersectoral collaboration.
3. Increased training courses of Health Workers in P.H.C..
4. Collaboration between K.F.P.H.C. and KEFINCO at community level.
5. Emphasis on C.B.H.C. activities.
6. Step up/improve Rural Lab services through provision of lab facilities and staff at all main Health Centres in the Province.

COMMENTS ON THE MID-TERM REPORT OF CONSTRUCTION AND MAINTENANCE COMPONENT

1. Construction Survey

Since the Fourth Phase of the Programme will be a consolidation period according to the present information, the team considers that no specific, additional survey will be required to collect the information concerning Construction Survey reports. The information concerning population distribution and utilization will be provided by the Province and Districts with the help of Programme's SDO. Construction Survey reports already included maps showing the distribution of the facilities, furthermore new maps including this information are being printed at present and will be provided by Kefinco. Once the above information and reports by the DHMT's are available, the DDC's will be able to make the selections for the facilities constructed or renovated by the Programme.

2. Land Acquisition

The Programme will mobilize for a specific site, only after the site belongs to MOH. Title deeds showing this shall be provided for the Programme.

3. Maintenance of the Facilities

DDC's should channel the funds in such a way that money allocation for the maintenance of the facilities exists. When doing this, all the activities by both Government and donors should take into account. This may result in reduced number of construction sites, the balance of funds being reserved for the maintenance of existing facilities. For this purpose the Districts should work out projected development plans with rough estimates and priorities.

Communities around the health facilities should be mobilized to carry out some basic preventive maintenance (e.g. to keep the gutter clean) thus reducing the demand for maintenance. In some health centres a system of collecting funds from the patients for the maintenance works has been adopted. DHMT's should study the community involvement further.

MOH Head Quarters should be contacted in order to find some financial support for facility maintenance.

The Districts feel that the policy that the Programme will only carry out maintenance related activities without any new construction will raise a political issue.

The organizational problems in maintenance units should be brought for DDC's consideration in order to enable the development of full cooperation between MOH, MOPW and Donors. The team feels that this could be made locally without the decisions from Nairobi.

4. In-patients and Maternity Wards of Health Centres.

The need for these wards should be carefully studied by DHMT's case by case. If good grounds can be presented, the provision of the wards may be considered (as the case might be with Malaba). The communities around these sites should be surveyed to find out the acceptance for in-patient services.

The main reasons why the existing wards are not utilized were considered to be the poor services they provide, lack of some equipment (laboratory equipment) and lack of transportation (ambulance). The DHMT's should concentrate on the staff development in this matter.

5. Coordination between the Donors

The coordination between the donors and the ministries should be developed in the Province level e.g. the standards for renovations carried out by Lake Basin, the Programme and MOPW should be the same.

Team:	Dr. Kayo	PMO		
	Ms. Okoti	PHN	-	BUNGOMA
	Mr. Amisi	PHMT	-	
	Mr. Walumbe	PHN	-	KF/PHCP
	Mr. Lomperi	CM	-	KF/PHCP

/EK.

ENVIRONMENTAL HEALTH & SANITATION GROUP CONCLUSIONS

MEMBERS OF THE GROUP

Mr. R. W. Walukano - - - - - Chairman
Dr. Ogondo
Mrs. P. Wandera
Mr. John Kener
Mr. Daniel Ogutu - - - - - Secretary

1. Members of the Group concurred that the programme should continue supporting slab casting for individual latrines and that casting yards should be used to full capacity.

2. The task team agreed that all households among the 40% who have not built any latrine to date be assisted in one way or another as suggested below:-

   - we anticipate that 10% of the households among the percentage mentioned above will be the very poor disabled or the aged who have nobody to look after them. These people should be assisted to build their V.I.P. latrines both by the programme and the Community Health Committee. The community will be responsible for providing the list of the poor and disabled. Assist them in digging the pits, providing materials for superstructure and erecting the superstructure. The programme will provide the latrine slabs and the vent pipe.

   - the rest 30% be motivated through Health Education at the grassroot level by the health workers at that level and Community Health Workers.

   - Public Health Law be applied to those individuals who are capable of building V.I.P. latrines but who just do not want put up latrines.

- Publicity should be intensified and the centres for slab casting and the cost be advertised so that those who want to build the latrines and are capable of meeting the expenses can purchase slabs and other latrine components. Dissemination of message be intensified to ensure that all households have a latrine.

The Group also recommended that the programme should continue researching and testing slabs with an aim of producing a safe and affordable slab to the rural household. It was suggested that chicken mesh reinforced slabs be tested and certain adjustments on the slab be made. Project catchment area should be covered 100% first followed by the rest of the areas.

3. Each Public Health Technicians will be assigned to an implementation area to cover (sub-location) and a token will be given to any PHT who is able to ensure that his catchment area is covered 100%. Similarly a Chief who will provide assistance and ensure that his area is covered will be eligible for a trophy. A Divisional P.H.O. whose division is covered be publicly given a certificate of recognition.

- the Group felt that the students earmarked for admission to the University or other Colleges can be utilized to assist the community to provide free services including assisting the under-previlledged build latrines.

4. Malaria control - the team compromised that mosquito control activities should with immediate effect be intensified since at the moment malaria ranks top among the top ten diseases with very high morbidity figures in the Province. It was also noted that community involvement is crucial for the success of these activities and for any tangible impact to be created and for sustainability to be realized. It was also observed that in cases where individuals have intentionally refused to comply despite health education legal action under the Malarial Control Act be instituted.

DOO/JL

30th October, 1990

COMMUNITY PARTICIPATION AND SUSTAINABILITY

The Problem

1. Inadequate community participation in Primary Health Care activities.
2. - sustainability of the ongoing P.H.C. activities when the donors pull out.

Issues to Address

1. There is need to review the planning process with the community special focus on the following:-

   (i) identification and prioritisation of community needs by the community itself.

   (ii) identification and definition of specific roles of the community members.

2. There is need to remobilize and resocialise community members in order to raise their level of participation in P.H.C. activities.

3. There is need for assessment of the training needs and approaches especially those of TBAs and CHWs to achieve sustainability in their activities in future. For TBAs the areas of focus are:-

   (i) review the method of selection of genuine TBAs

   (ii) review the TBAs kits sustainability by encouraging expectant mothers to have essential items for delivery in the homes.

   (iii) encourage the TBAs and CHWs to join organized groups and venture into viable and feasible income generating activities.

(iv) the communities should identify people who have accepted to volunteer to serve the community and who are self - sustaining.

4. The process of establishing functional village health development committees should be reviewed since the Provincial Administration line has a bearing on the success or failure of community participation.

5. Understanding of the proper concept of P.H.C. by operational health workers should be clearly reviewed to ensure systematic implementation of P.H.C. strategies, especially community participation. This will avoid conflicting approaches by different health providers.

6. There is need for self approach in sustainability and maintenance of health facilities by the community e.g. bush clearance.

/JL