MEETING THE NEEDS OF THE COMMUNITY

A Study of health care in Kenya

Anne Lowes

Kim Roberts

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ACKNOWLEDGEMENTS

North East Thames Regional Health Authority

South East Thames Regional Health Authority

King's Fund College

Mr M Hardie, Director General International Hospital Federation

Special Trustees King's College Hospital

SUMMARY

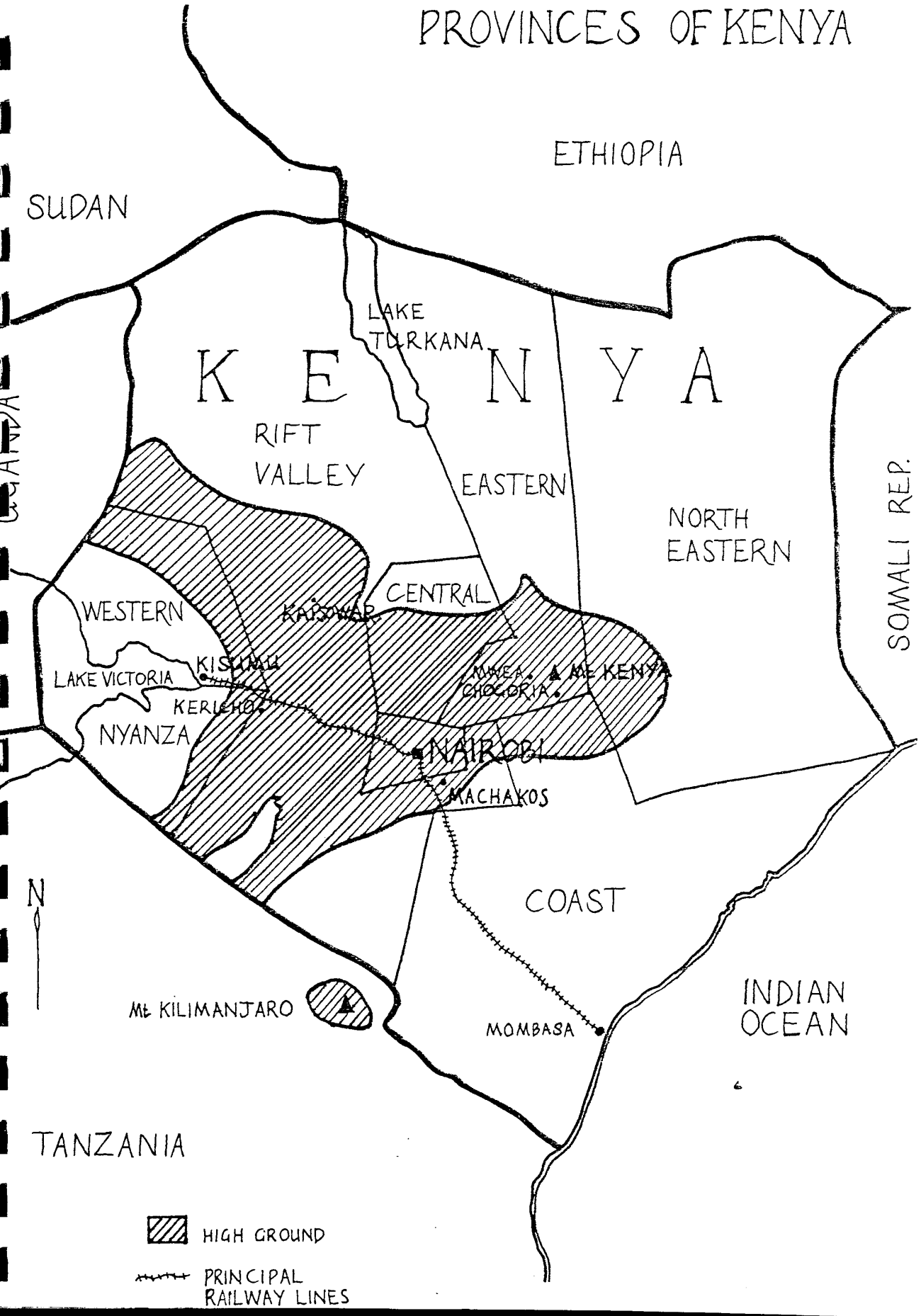
Having joined the National Administrative Training Scheme in September 1981, we were given the opportunity of exploring alternatives to the former three-month attachment at our Area Health Authority for the summer of 1982. We were consequently able to arrange a three-month attachment in Kenya to develop our interest in both community health care and health care provision in a developing country.

Our aim was to develop a general appreciation of the organisation of health services in Kenya. More specifically, we wished to gain an insight into the problems facing a developing country and areas of relevance to the British system.

In connection with out interest in coummunity care, we undertook research for the International Hospital Federation on the role of the hospital in promoting and supporting primary health care.

On our return, we submitted detailed reports on specific community projects to the I H F; these are attached at Appendix A. In the main body of this report, then, we have a detailed description of the Kenyan system, necessary to an understanding of the developments currently taking place. We have then concentrated on our area of particular interest, that of innovative approaches to community health care. Comments on and suggestions for future attachments in Kenya by trainees are attached at Appendix B.

PROVINCES OF KENYA



INTRODUCTION

Kenya became an independent Republic in December 1963. President Daniel arap Moi now leads a one-party state, with the democratic election of representatives every five years. He favours a mixed economy and international commerce is by no means foreign to Kenya; it is unusual amongst many newly-independent African states in that European and Asian businessmen have been encouraged to remain in the country.

Agriculture remains the dominant sector, accounting for one-third of the G D P, with coffee, tea and pyrethrum, a natural base for insecticides, being the major export items. Many of the population are, however, subsistence farmers and much attention continues to be paid to creating employment for the peasant population, partly to stem the flow to the urban centres.

Since Independence, public services in all parts of the country have been expanded in an attempt to provide comprehensive education and health facilities and an adequate water supply. Although the years since 1963 have seen a marked rise in the standard of living for many Kenyans, with higher incomes and better food and housing, the alleviation of poverty and improvements aimed at the well-being of the population remain the country's dominant aim. The aim is given priority in the 1979 - 83 National Development Plan; the plan acknowledges that the majority of citizens are still very poor and services to them below the desirable level. Like many other countries, however, Kenya is feeling the effects of the recession; at present the balance of payments constraints and the falling price of the major export items are slowing economic growth and progress towards the Plan's stated aims will obviously be slowed.

FACTORS INFLUENCING HEALTH CARE

1. Demography

90% of Kenya's 16.4 million people live in rural areas. The population is, however, unevenly distributed; the west of Kenya, for instance, supports one of the densest rural populations in the world, whilst the arid desert to the north is sparsely populated by nomadic tribes.

The last few years have seen an enormous population explosion; traditional fertility beliefs and improved health care since Independence have combined to give Kenya an annual population increase of 4%, the highest in the world. Figure 1 below analyses the age structure of the population:

Figure 1

Age Group	% of population
0 - 4	20.8
5 - 14	30.3
15 - 49	39
50+	9.7

Source: World Bank
Population, Health and Nutrition Department

With the infant mortality rate standing at 87/1000, more children than ever before are surviving into adulthood, a situation which has had a dramatic effect on the age structure of the population; children under 15 now constitute 50% of the total population.

2. Poverty

The degree of poverty obviously depends to a large extent on the fertility of the area. The arid near-desert land to the north, for instance, supports a nomadic and extremely poor population and famine is not unusual. Most of the subsistence farmers in the more fertile areas depend almost entirely on the cultivation of maize and beans; with average family size at seven or eight children, the farmers produce little surplus. What little there is, however, has a relatively low market value and is usually bought by the Government for K S 130 per 90 kg sack of maize and K S 330[1] per 90 kg sack of beans. The money raised in this way usually represents a family's sole disposable income to cover such out-goings as school fees of K.S 500 a year for every child in secondary education (the first five years' primary schooling are free) and the cost of house improvement, health care if the area relies on missionary services and various fund-raising projects

1. Kenyan Shillings are roughly equivalent to the old British Shilling, with approximately K S 19.5 to £1 Sterling.

known as 'harambees' which will be discussed in greater detail later. In practice many families struggle to grow enough food just to support the family and most children receive no secondary education.

The urban poor of Kenya are perhaps one of the most deprived groups, as they obviously cannot grow food on which to live. The country has no unemployment benefit system; those without work in urban areas live in crowded shanty towns and must either make articles to sell on the streets or resort to begging in order to survive.

3. Communications

Due to the extreme climatic and geographic conditions of both the mountainous and the near-desert bush areas of Kenya, much of the country remains remote and isolated. An intensive road-building programme is underway; at present, however, routes other than those between the major centres consist of unmade roads which makes travelling a time-consuming and difficult undertaking. The extreme climate, changing from intense heat to heavy rains means that roads already in existence rapidly deteriorate without constant maintenance. During the rainy season unmade roads become almost totally impassable; remote areas can become completely cut-off. In delivering health care, services thus have considerable difficulties in terms of communications to overcome.

ORGANIZATION OF HEALTH CARE

In examining health services in Kenya, it must be remembered that the country has only been independent for 20 years. Although a great deal has been achieved in this relatively short period of time, the Government is still in the process of building up a national health service and Government facilities are indispensably supplemented by other agencies.

1. Government Health Services

The Kenyan Government, through its Ministry of Health, aims to provide a comprehensive health service which is free to its users at time of use. In its current Development Plan, the Government defines its major health objectives since Independence as:

- strengthening and carrying out measures for the eradication, prevention and control of disease

- provision for adequate and effective diagnostic, therapeutic and rehabilitative services for the whole population - offered at hospitals, health centres, dispensaries and mobile units.
- promotion and development of biomedical and health services research as a means of identifying methods for the protection of health.

Until recently the hospitals and urban areas have received a major share of resources. Current emphasis, however, is on strengthening and developing rural health services, with slightly under half the total budget intended for rural areas. Preventive and promotive health care has been allocated 10% of the budget.

In trying to build up a comprehensive Government health service the Kenyans have many problems to overcome, in particular the limited number of trained professionals and difficulties in communications in many parts of the country. To overcome these difficulties and to try to spread services throughout the community, Kenya has developed a 'chain' structure comprising different services and facilities to which patients are referred according to their needs. The patient's first point of contact in the community thus offers very limited diagnostic facilities, but staff are trained to refer patients to the next link in the chain if they are unable to deal with a certain problem.

To convey an impression of how the system operates in practice, it will be helpful to describe a patient's progress along the chain, outlining the facilities and services offered at each stage. This is portrayed in diagramatic form in Figure 2.

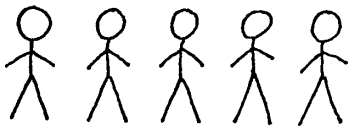
Stage 1 : Dispensary

Beds	:	Nil
Doctors	:	Nil
Specialist staff and facilities	:	Nil

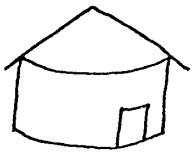
This is the first contact with formal health services for most Kenyans; when someone falls sick they will walk to their nearest dispensary to seek treatment. The Government aim is for each dispensary to cover a radius of about 5 miles so that everyone has a dispensary within walking distance; this aim is, however, far from implentation in the more remote areas.

A dispensary is usually staffed by a nurse and two assistants. Until recently this nurse possessed no extra qualifications to those of a hospital enrolled

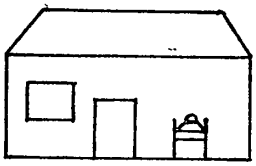
REFERRAL SYSTEM



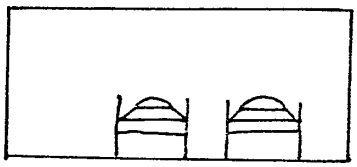
COMMUNITY



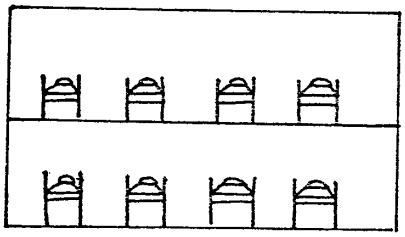
DISPENSARY



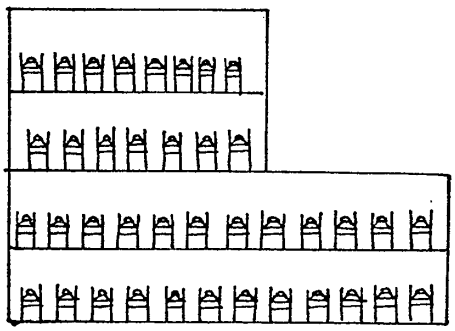
HEALTH CENTRE



DISTRICT HOSPITAL



PROVINCIAL HOSPITAL



KENYATTA NATIONAL HOSPITAL

FIGURE 2

nurse. In 1974, however, the Central Nursing Council introduced a new 3½ year training, comprising public health, maternity and general nursing training, including community and diagnostic work to cover diseases such as malaria, diarrhoea, chest and skin infections. These nurses are now known as Community Enrolled Nurses and are trained to run a dispensary with the minimum of supervision from a district hospital.

On arrival at a dispensary the patient will be seen by the Community Enrolled Nurse, who may prescribe one of the drugs held at the Dispensary to cover common diseases. If nurses feel that the problem is beyond their scope, they will advise the patient to go to the nearest health centre or district hospital. In practice not all patients act on this advice, as getting to a health centre may involve a long journey on foot or by public transport on bad roads.

Perhaps more important than its curative function are the preventive and promotive health roles of a dispensary. The nurse runs Mother and Child Health/Family Planning (MCH/FP) clinics, offering ante-natal and post-natal care, immunisation, infant welfare clinics and family planning. Many dispensaries become involved in health promotion and education by creating demonstration kitchens and 'shambas' (small plots for cultivation), teaching mothers about nutritious foods they can grow, how to give their family a balanced diet and how to cook safely and hygienically.

At dispensary level, then, the Government is providing preventive and promotive health care in addition to curative care. Staffed by only one nurse, the efficiency of a dispensary obviously varies according to individual skills and personality; a well-run dispensary, however, demonstrates the flexibility and breadth of services that can be achieved without spending vast amounts of money on highly trained professionals. After 3½ years training the nurse is equipped to diagnose common diseases and is able to prescribe treatment, meaning that many patients will not need to be referred to a health centre or to a doctor at a district hospital. Moreover, the service provided is extremely flexible; with the emphasis on promotive health care, the nurse can identify local problems and devise means of educating and encouraging people to care for themselves. As the nurse is often a local person, he/she is well-fitted for this task, possessing personal knowledge of the area and its difficulties and able to relate well to the local people. The dispensary is therefore potentially a cost-effective means of providing preventive and curative health care at village

level.

Stage 2 : Health Centre

Beds	:	12 Maternity
		5 General
Doctors	:	Nil
Specialists	:	Nil

If dispensary nurses are unable to treat, they will refer the patient to a health centre. These usually serve a population of about 70 thousand people, although in Turkana in the remote north there is one health centre provided for every 166 thousand people.

Even at health centre level there is no doctor; health centres are usually staffed by two clinical officers, four nurses and a midwife. Clinical officers are the backbone of rural health services. After a four year training they are competent to deal with most general medical problems and many also specialise in areas such as paediatrics, ophthalmology, dermatology and maternity. Originally clinical officers were accepted for training with O-levels; now it is unlikely that anyone would be accepted without A-levels.

At local level the health centre has become a focus for maternity care, providing a full range of ante-natal and post-natal clinics and a limited number of beds, where deliveries are assisted by the midwife. As with a dispensary, a health centre gives both curative and preventive health care, offering the following services:-

Maternity Care
Mother/Child Health Clinics
Family Planning
Immunization
Mobile Clinics
School Visits
Curative Out-patient Clinics

Curative and preventive care is integrated wherever possible: children attending immunization clinics will be treated at the same time for any illness which presents itself; patients waiting in out-patients will be given a lecture related to local health problems.

Stage 3 : District Hospital

Beds : Approximately 225

Doctors : 5

Specialists : in many district hospitals there is a surgeon

Patients needing to see a doctor or to be admitted to hospital will make their way to the nearest district hospital and wait to be seen. They arrive throughout the day and may face a considerable wait; it is not unusual to see long lines of people waiting patiently on benches in the out-patients area.

Each district forms what is termed a Rural Health Unit comprising the District Hospital and the community services of its catchment area. The District Medical Officer of Health, based at the hospital, is responsible for the management of this Rural Health Unit; his duties extend outside the hospital to include supervisory visits to community projects, health centres and dispensaries. In the hospital itself the Medical Officer of Health is supported by four medical officers, all qualified doctors and one of whom may be a surgeon. The majority of routine clinical work, however, is carried out by about twenty clinical officers; they will screen all patients on arrival at the hospital, before referring to a doctor if necessary, and also undertake ward rounds.

The workload of a district hospital is largely curative; the hospitals are extremely overcrowded and it is commonplace to find two patients to a bed or patients sleeping on the floor in wards. Attempts are being made at integration of curative and preventive care, however; MCH/FP Clinics are held in the hospital and are managed by nurses; a Public Health Officer and a community nurse will be based at the hospital with responsibility for community health and the co-ordination of services in the community.

As the local point of curative care at local level, the District Hospital experiences a great number of problems. The enormous numbers of people using its services stretch its facilities to an extent where it becomes impossible to deliver the highest standard of care to all patients. Out-patient departments do not operate any form of appointment system, but are always open to the public; those people living near the hospital obviously go straight there instead of first to a dispensary and health centre, thus burdening its already overstretched facilities with minor problems which could be treated elsewhere. Kenya operates a highly

centralised system; drugs and equipment for use in a district hospital are ordered by the Ministry of Health and distributed via the provincial centres. In practice this means that the Provincial Hospital absorbs a major share and insufficient stocks actually find their way to the District Hospital. This inefficient distribution system means that a hospital may run out of essential drugs or equipment and have to wait several days for a vehicle to negotiate unmade roads to collect the items needed. Corruption does sometimes occur in Kenyan administration and some drugs may never reach their intended destination.

Stage 4 : Provincial Hospital

Beds	:	Approximately 500
Doctors	:	25
Specialists	:	ENT
		Obstetrics and Gynaecology
		Dermatology
		Surgery
		Paediatrics
		Psychiatry

If doctors at a district hospital feel that the opinion of a specialist is required, they will refer a patient to the nearest Provincial Hospital.

There are seven provincial hospitals in Kenya, operating in much the same way as, and offering similar services to, a district hospital. A provincial hospital, however, is larger and better staffed and equipped, delivering more specialist curative care. In addition to their hospital work, the specialists have responsibilities throughout the province and visit the district hospitals at least once a month to see any in-patients needing specialist treatment.

Like the district hospitals, the provincial hospitals are under tremendous strain. With no ambulance service, transferring patients from a district to a provincial hospital presents great problems. Although designated 'referral hospitals' , in practice provincial hospitals act as both referral hospitals and district hospital for the immediate vicinity. Many provincial hospitals have been expanded to offer a greater range of specialist facilities; the development itself often creates problems, however, as staffing levels and revenue allocations are not increased sufficiently to cope with the extra workload. As provincial hospitals are designed to be

centres of specialist medicine, many are built or developed with funding from foreign governments; in such cases the hospitals are usually designed by the foreign Government's architects and are not always of the most suitable design for Kenya's climate. One hospital, for instance, was funded by the Russians, who, used to combating arctic temperatures, ran the sewage pipes inside the walls of the building to give extra heat; in Kenya temperatures this was understandably disastrous and the building had to be almost totally rebuilt.

Stage 5 : Kenyatta National Hospital

Beds	:	1200
Doctors	:	353
Specialist Staff and Facilities	:	Renal Unit
		Cardiothoracic Unit
		Orthopaedic and Trauma Unit
		Neurosurgery
		Anaesthetists
		Plastic Surgery
		Ophthalmic Surgery
		Radiotherapy
		Intensive Care Unit
		National Research Laboratories
		Radiology

The Kenyatta National Hospital is the Central Referral Hospital for patients throughout the country requiring treatment in the specialties listed above.

Over the years the Hospital has grown out of all proportion. The opening of a huge new ward block in 1980 and the opening of its doors to the general public of Nairobi for use as a district hospital in 1981 swelled its workload to almost unmanageable proportions. In addition to its functions as the Central Referral Hospital, the Kenyatta is a teaching hospital, a provincial hospital and a district hospital rolled into one, as well as supporting primary health care in Nairobi.

The Kenyatta is the only source of treatment for many illnesses; this puts a strain on both the hospital and the people who have to travel vast distances to receive the specialist medical treatment. The Hospital encounters similar problems of overcrowding to those of the provincial and district

hospitals; in the wards patients often have to share a bed and the clinic areas are packed with people waiting to be seen.

The Kenyatta is managed by a Board of Directors under the direct control of the Ministry of Health. Responsibility for the day-to-day management of the hospital lies with the Medical Superintendent (his title is Chief Administrator), the Senior Hospital Secretary and Matron. Unlike the present British Hospital Management Teams, the medical representative on the team is not elected, but appointed to the post of Medical Superintendent. He is the official leader of the team and the other two members are accountable to him. This means that the Hospital Secretary has dual accountability: to the Chief Administrator at the Hospital and to the Chief Hospital Secretary at the Ministry of Health. In some ways, however, the team concept in Kenya is more developed than in many British hospitals; in hospitals at all levels - the Kenyatta, province and district - the three members of the team invariably have adjoining offices and meet daily to discuss current problems.

Having developed to such a vast complex, the Kenyatta places a tremendous burden on resources; in 1978 it swallowed 15% of the total health budget. Its size creates problems for the operation of services. Although the most up-to-date items of medical technology can be found at the Kenyatta, improvement of essential supplies such as water has not kept pace with development and shortages often affect the delivery of services. Maintenance of medical equipment is also a problem at the Kenyatta; large-scale equipment such as that used in X-ray is purchased from international firms, although sometimes maintenance contracts are not arranged and local engineers are unable to maintain the equipment.

The Ministry of Health

Health services in Kenya are centralized and come under the direct control of the Ministry of Health. The tripartite management team of doctor, nurse and hospital secretary at hospital level is represented in the Ministry by the Director of Medical Services, the Chief Hospital Secretary and the Chief Nurse, who work under the Permanent Secretary. The Director of Medical Services heads this team; the members work individually and as a team to co-ordinate and manage health services. Their control is a very real one; as part of their work they undertake supervisory visits throughout the country to assess the work being done and to appreciate particular needs.

The Ministry is the central employer for all staff working in the Health Service; this has implications for all staff. Hospital secretaries are directly accountable to the Chief Hospital Secretary at the Ministry; after their training secretaries are moved around the country at his discretion. Although they will never be without a job, they have very little control over future placements.

In a developing country it is obviously important to have some form of centralized planning system to try to ensure even development and allocation of resources throughout the country. The centralized system is rather unwieldly, however, and decision-making slow as approval has to be sought at each stage in the bureaucratic chain. In the National Development Plan the Ministry itself perceives the major constraints of the centralized system as;

- unsatisfactory utilisation of equipment and transport because of financial and managerial problems relating to operation and maintenance
- shortage of drugs and other essential supplies due to an inefficient distribution system.

It would seem that essential functions such as supplies, transport, pharmaceutical buying will have to be delegated in some form if resources are to be used efficiently.

2. Missionary Organizations

Missions established during the colonial period continue to provide health care in Kenya; mission hospitals in fact account for 30% of the total hospital beds. Although the hospitals are non profit-making, they have to raise money in order to continue in existence. They therefore charge a fee for service; this income is supplemented by a Government grant, which provides for about 25% of the hospitals' needs, and by donations.

Missions have tended to develop on an ad hoc basis in the past. As there are still many areas of the country with extremely inadequate services, working side by side with the Government has not been a problem; the Government has tended to concentrate on those areas with little existing provision. The future relationship between the Government and missionary organizations, however, remains uncertain and is one of the current issues in health care; missions fiercely defend their autonomy and regard the payment of anything more than the current Government grant as a threat to their independence.

Liaison between the Ministry of Health and missionary organizations at national level is informal; in 1979 attempts were made to establish a standing committee of three Catholic and three Protestant members and three Ministry representatives to discuss joint planning matters, but this initiative came to nothing. At local level individual mission hospitals are usually represented on the District Planning Team. It seems likely that as health care development progresses some more formalised method of joint planning will be established.

Unlike the Government Health Service, individual mission hospitals operate independent of any form of central control. They have grown up over the years as part of larger mission stations, providing a church, hospital and school, which were established during the colonial era. More recently missionary organizations have created their own head office in Nairobi, which acts in an advisory capacity to hospitals of its denomination and as a liaison between individual hospitals and the Government, usually distributing the Government grant between services.

Mission hospitals usually have between 150-250 beds with three or four doctors; invariably the doctors are salaried by an overseas church. Nurses are paid by the hospital itself and many now train their own nurses. The hospitals provide curative care on a fee for service basis; as they are non profit-making, charges are low and sometimes reduced still further if a patient genuinely cannot afford to pay. Many hospitals are now trying to support a primary health care programme with the money they make from curative care and with the aid of outside donations. They define their own catchment area and try to meet the health needs of this community; often they meet local leaders to define local needs and to motivate the people themselves to build a health centre or dispensary for preventive as well as curative clinics, which the hospital will then staff.

Some mission hospitals have retained a very traditional role; their major aim is obviously to spread Christianity, but some remain rather rigid in their approach, failing to adopt their faith and knowledge to the needs of the Kenyan people. As with non-Government organizations in Britain, however, the mission hospitals have the flexibility to play an innovative role and many have been running experimental community participation projects. These will be discussed in a later section; it is important to realise, however, that the missions can provide an important source of new ideas.

3. Private Organizations

Private health care in Kenya takes three main forms: large profit-making hospitals in Nairobi and other urban centres; private general practitioner consultations; health services organized by large firms for their own employees, such as the Brooke Bond Hospital located on the tea plantations in the Kericho area.

Our experience of private hospitals was limited to the Aga Khan Hospital in Nairobi. The Aga Khan caters for the middle classes and aims to provide high quality and effective health care; it is not the most expensive private hospital in the city, but its prices are nonetheless beyond the reach of the majority of its inhabitants.

The Hospital's facilities and medical specialists are comparable to those of a provincial hospital. Incorporated in its out-patient and emergency departments, however, is a general practitioner service, which enables patients arriving at the Hospital to see their own doctor who has treated them in the past, either in an emergency or by appointment.

Although all the Hospital's services are profit-making, the paediatrician has started a free epilepsy clinic in the Mathare Valley, Nairobi's worst slum area. The Aga Khan funds a full-time social worker to perform home visits and drugs are donated either by drug companies or by the Association for the Welfare of Epileptics. The clinic aims to control the seizures of epileptic children through the use of drugs and to educate local people and schools about the illness, emphasising that these children are not retarded and will cope with a normal education, given understanding and the right treatment.

4. Voluntary Organizations

International and national voluntary organizations make an important contribution to health care in Kenya; they may make specific grants to support certain health projects or supplement existing services with their own facilities.

At local level voluntary input is extremely marked in Kenya; the national motto 'Harambee', meaning 'pulling together/self-help', has a widespread significance. Many villages and communities organize 'Harambee' fund-raising events, using the proceeds for local development. They may build a dispensary or health centre themselves or contribute towards the cost of

a full-scale hospital.

As an example of the contribution international aid organizations can make it, will perhaps be valuable here to describe the work of one such agency, African Medical and Research Foundation (AMREF), which plays an important role in health care in Kenya.

AMREF's work started twenty-five years ago with the idea of providing general surgery in remote rural hospitals by the service now known as the Flying Doctors. Since then the Flying Doctor Service has expanded and the work of AMREF spread to many other areas. A two-way radio communication network co-ordinates the airborne programme. AMREF now has 100 stations throughout Kenya with a two-way radio; as well as making urgent requests for a flying doctor over the air, rural hospitals can ask for instant medical advice if in difficulty. In many remote places where overland travel is impossible at some times of the year, local communities have pooled resources in the Kenyan spirit of 'harambee' to build airstrips, enabling Flying Doctors to provide a service in the area.

The type of work undertaken by Flying Doctors has extended beyond general surgery; there is now a doctor who does established airborne rounds to perform leprosy and reconstructive surgery, the only specialist in this field in Kenya. The services operate in collaboration with Government health services; a senior Government surgeon is flown by AMREF to district hospitals on a monthly basis to undertake surgical work which would otherwise have to be referred to the Kenyatta National Hospital.

AMREF concentrates its work on some of the remotest areas in Kenya; one general practitioner completes regular rounds in the Bagun Islands, paddling between them by canoe; ground mobile medical services provide for the Maasi tribes of Southern Kenya, reaching out to people who would otherwise remain unserved. In its work AMREF tries to balance the need for trauma work with the need for prevention; great emphasis is placed on the eradication of infectious diseases through immunization and better living conditions.

Training is also given great emphasis in AMREF's work. Since 1974 AMREF has been involved in training clinical officers to give competent and safe anaesthetics; until AMREF started this work, Kenya was producing only one or two fully-qualified anaesthetists a year. The foundation does not just train professionals, however; community-based voluntary health workers are trained in an attempt to improve basic rural hygiene. Courses on

direct teaching and communications methods are also run for professionals who wish to train volunteers in their own hospital's catchment area. In addition to these practical training facilities, teaching material is produced and a correspondence course on communicable diseases is available.

An integral part of AMREF's work is research and monitoring. There is continous feedback on the work carried out by doctors in remote areas and on the local people's response, from which future projects are planned. The taboos and customs of particular areas are closely studied so that appropriate advice and training on how to approach health problems can be given.

AMREF thus constitutes an important source of expertise and innovation in the health field, complementing Government health services by concentrating on under-provided areas. An essential ingredient in its success must be its emphasis on adapting its methods to the needs and customs of different communities to ensure that professionals do not operate from their own definition of need, but respond to actual needs of the people.

5. Traditional forms of health care

Traditional medicine continues to play an important role in rural areas. This form of care has become the focus of much attention recently; it is felt that some traditional remedies may be worth promoting, whilst certain practices, such as female circumcision, are extremely dangerous. The line dividing modern and traditional medicine has become increasingly blurred over the years. Many traditional practitioners now incorporate medicines into their treatments; this has led to problems, with the modern medical sector increasingly presented with resistent forms of disease as a result of ineffective use of drugs by informal practitioners. In order to establish the positive elements of traditional medicine and attempt to counteract its dangerous practices, it is planned to found a Traditional Medicine Research Unit in Nairobi to determine the importance and relevance of traditional medicine and explore possible links with Government institutions.

MEETING THE NEEDS OF THE COMMUNITY?

This description of formal services shows that Kenya has adopted the pattern of health care evident in developed countries; the emphasis is still very much on hospital provision and curative care, with limited resources devoted to prevention. As overburdened hospital services struggle to meet the needs of patients, this traditional approach is being questioned in many countries. The following sections examine aspects of health care and morbidity in Kenya and will question whether this conventional conception of health delivery is in fact meeting the needs of the community.

1. Distribution of hospitals and doctors

Although 90% of Kenya's population is a rural one, most hospitals are situated in urban centres. Doctors are also unevenly spread; the distribution of Government doctors is in fact in direct antithesis to that of the population with 90% of doctors working in urban areas. Qualified doctors are a scarce resource in Kenya, compared to the number working in Britain. The country only began to train its own doctors in 1968 with the opening of the Faculty of Medicine at the University of Nairobi and postgraduate training commenced four years later in 1972, so specialists are still extremely few. In Government institutions, for instance, there are eighty paediatricians to cover eight million children throughout the country. The availability of qualified doctors isthus restricted to a limited section of the population seeking secondary care in hospital.

2. Pattern of Disease

In a report by the Director of Medical Services at the Ministry of Health which appeared in June 1981, six main diseases were identified:

- Malaria
- Infectious diseases e.g. measles
- Acute respiratory infections
- Skin diseases
- Diarrhoea
- Intestinal worms

These diseases are all preventable; their prevention, however, demands a different approach to health care. The curative approach will cure one incidence of the disease each time it presents at a hospital; by

adopting a preventive approach, however, and seeking to eradicate the cause, an infinite number of incidences of the disease can be prevented. Eradication of causes of disease requires a multi-disciplinary approach and obviously involves the work of other sectors as well as health services.

3. Financial implications of a hospital - weighted service

At a conference sponsored by the Aga Khan Foundation and the W H O at Karachi in 1981, Dr H Mahler, Director - General of W H O, commented:

> "Future historians writing about health services in the twentieth century will undoubtedly often refer to the extraordinary equation: health care = hospital care. As proof they will make reference to the fact that in many countries roughly 80% of the total health budget goes to hospitals."

Hospitals, as concentrated pools of medical technology and professional staff, absorb a huge slice of the total health budget of any country; Kenya is no exception, with 15% of the health budget spent on one hospital alone, the Kenyatta National Hospital, in 1978. As previously discussed, the majority of the Kenyan population does not have access to hospitals; resources are not therefore equally distributed among the population.

4. Implications for health care

It would seem that a shift in health care delivery is needed; resources are inadequately distributed to meet the needs of a largely rural population and overcrowded hospitals are struggling to treat preventable diseases. In its National Development Plan for 1979-1983 the Kenyan Government acknowledges that health coverage of the population is inadequate and uneven due to insufficient delivery points and unsatisfactory utilization of manpower.

Hospitals are obviously necessary; people will always fall ill and need specialist medical treatment. The declaration of the International Conference held at Alma Ata, USSR in 1978 asserted, however, that primary health care is the key to attaining health for all by the year 2000. This goal emphasizes the role of health services in promoting health as well as curing disease; judged by this standard medical services everywhere found themselves wanting. Dr Maneno of the Ministry of Health in

Nairobi has acknowledged that change is needed:

> "Upon endorsing the world-wide social objectives of the attainment of all nations of the world by the year 2000 of a level of health that will permit all their people to lead socially and economically productive lives, the Government recognised that it was unlikely that its rural health strategy would enable it to reach this objective."

The awareness of the need for a new approach to health care is spreading and initiatives to tackle health problems outside medical institutions are being attempted throughout Kenya. In Britain too hospitals find they are spending a considerable proportion of their time treating preventable diseases and yet the inertia of the present distribution of resources between hospital and community restricts the scope of new prevention-orientated approaches. As a developing country, Kenya receives grants from international aid organizations to support experimental projects; moreover, the relative scarcity of professionals means that new ideas meet less opposition in the form of entrenched professional interests. Health services in Kenya thus have greater flexibility than would perhaps be possible in Britain and the concept of community-based health care is currently exerting a great deal of influence; initiatives in primary health care and new approaches to health problems will be the dominant theme of the remainder of this report.

COMMUNITY-BASED HEALTH CARE

Health care in Kenya can be divided into three distinct categories illustrated in Figure 3 below:

Figure 3

Hospital Care	Community-orientated	Community-based
Curative	Curative Preventive	Preventive
Professional	Professional	Participation

Hospital care is curative and delivered by professionals. Until recently all initiatives towards preventive care fell into the community-orientated category. In community-orientated care, professionals define the needs of the community and, based at a health centre, dispensary or mobile clinic, usually provide immunization facilities, ante-natal care and some health education. The community is, however, dependent on professionals; if the mobile clinic ceases its services preventive care will no longer be delivered. In addition to professional services such as immunization, a more lasting form of prevention is obviously needed; this depends on the commitment of the people, on community participation and forms the third category of community-based health care.

In his village health care handbook, 'Where There is no Doctor', David Werner asserts that basic health care should not be delivered, but encouraged. Community-based care works on the realisation that the providers of primary health care are first of all the family and the community. Their resources include: many of their traditional practices; their knowledge and understanding; their degree of organization and the strength of community groups; the support and services of medical facilities and other community level programmes managed by other sectors.

The role of formal health services in community-based health care is therefore not only to provide back-up medical facilities, but to motivate the community to define their problems and to accept responsibility for tackling them. The hospital can fulfil an important function in supporting and co-ordinating community projects and training any necessary staff.

If primary health care seeks to sustain health - and this involves promoting and maintaining, as well as restoring health - then its comprehensive approach must rest on the joint resources of family and community action, formal preventive health services such as immunization and family planning, the involvement of other sections and the accessibility of curative medical services. Summarizing the Ministry of Health's new strategy to enable progress towards the Alma Ata goal of health for all by the year 2000, Dr Maneno recognised the importance of this combined approach and a departure from the traditional structure of health services; the strategy aims for:

- increased accessibility of basic services in terms of scope and distance
- increased emphasis on the preventive and promotive aspects of health care with an associated stress on intersectoral integration.

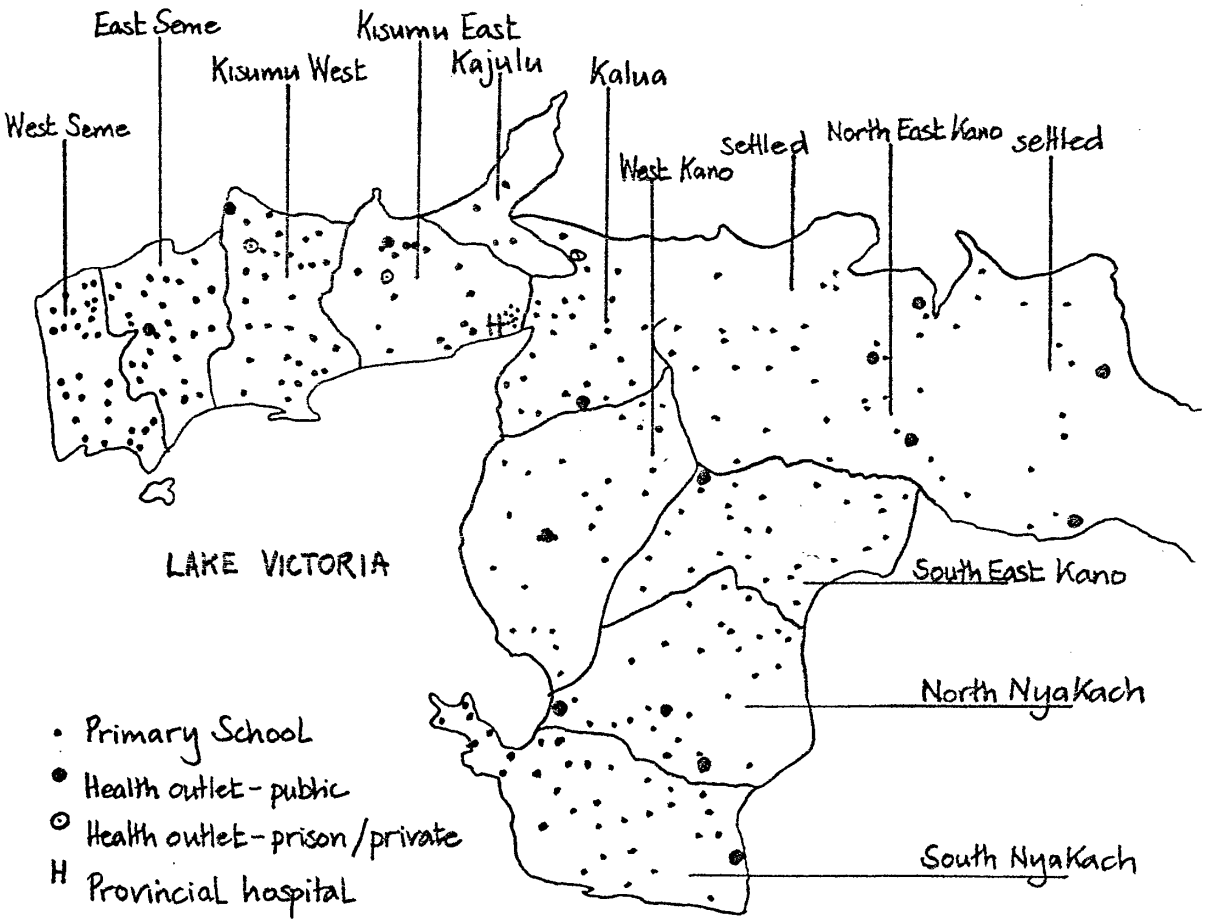
- increased emphasis on community praticipation and on health-promoting activities which are based on community efforts.

Community-based health care, then, necessitates the joint committment of the community and multi-disciplinary support services. Before discussing ways in which community participation projects are being tackled the contribution which other sectors can make should be examined.

(a) Schools

Schools can make a significant contribution to health promotion by incorporating relevant areas in the curriculum: health education, with the emphasis on basic family hygiene, youth counselling and family planning. Primary schools are much more evenly distributed throughout rural areas than health care delivery points as Figure 4 below demonstrates.

Figure 4 - Health facilities in Kisumu



The majority of children in Kenya now have access to primary schooling; national coverage of the population is 80% and already 100% in Central Province. The great majority of primary schools offer seven years' education, of which the first five are free; as half the Kenyan population are under 15, primary schools thus have an unrivalled opportunity to reach people and teach an understanding of hygiene and self-care. Teachers enjoy tremendous respect in the community and usually possess a high standard of public health knowledge; they represent, therefore, a valuable resource of health education, which can be exploited without the need for extra finances.

For schools to fulfil a greater health education role, however, commitment on the part of education authorities at national level is required to change the balance of the curriculum. Although health science is taught at present, schools are forced to devote the majority of teaching time to preparing children for examinations and non-academic subjects are often ignored.

(b) Agriculture

The Ministry of Agriculture has a vital role to play in achieving better land use and thus raising the living standards of rural populations. The effectiveness of irrigation schemes has been demonstrated by the Mwea Rice Irrigation Scheme, created on the plains at the foot of Mount Kenya twenty years ago. By exploiting the mountain rains, 12,400 acres were irrigated and converted to paddy fields; these were then rented out to people who had been rendered landless as a result of colonial appropriation of farming land. The scheme now supports a population of 48000 and further rice irrigation schemes are being created.

(c) Social Services

Although there is no unemployment benefit system in Kenya, Social Services are nonetheless involved in welfare services and health promotion activities. At ten locations throughout Kenya, Family Life Training Centres have been established to educate mothers about nutrition. Mothers of malnourished children are referred to the centre, together with all their children under 5 years old. They live there for three weeks and during this time are taught how to grow basic foods such as maize and beans, about nutritional requirements and about kitchen hygiene, such as boiling untreated

water before consumption. The scheme has proved very successful; mothers are followed up at home after they have left the centre and few have to be referred for a second stay.

(d) Other Agencies

At present most rural families collect water from the nearest river and seldom boil it before consumption. Water authorities thus have an essential role to play; the provision of safe drinking water to every household would virtually eradicate mortality from water-borne diseases.

Similarly, sewage and refuse disposal systems would significantly reduce the spread of infection.

Housing improvements are also an integral part of health promotion programmes; the building of latrines and larger homes divided into rooms is essential to the effective control of infection and disease.

(e) National Policy

The scope of improved public services at local level is dependent on commitment at national level and the provision of any necessary funding. Moreover, on a broader level Government commitment to the alleviation of poverty and distribution of wealth is essential if the living standards of the rural population are to be significantly raised.

Community-based Health Care Projects

Throughout Kenya a number of projects have been established to motivate the community to accept responsibility for their health problems. Such schemes can have significant impact on the health status of a community, but are not without problems; their success depends largely on the way in which professionals approach the community and on their ability to stimulate and involve local people, then allowing them to make their own decisions.

Although each project is obviously individual, most adhere to a similar broad outline.

1. Impetus from hospital

Organized community action usually depends on some form of trigger; in many cases it is hospital professionals who go out into the community and provide the initial impetus. Once a scheme has been established, villages in the surrounding area often approach the hospital in their turn and ask to be included in the project.

2. Approach to influential members of the community

It is important to obtain the involvement and support of influential members of the community such as Government officers, Church leaders, headmasters. This is usually achieved through informal discussion; with the collaboration of community leaders tentative plans can be laid to establish a village health scheme and approach the community itself.

3. Baraza

'Barazas', meaning 'village meetings' are forums for public discussion. For a community project to be effective, the community must define its own needs. Knowledge itself does not immediately lead to the adoption of healthier habits; this is demonstrated in Western countries where doctors and nurses continue to smoke. Commitment and acceptance of responsibility on the part of the people to overcome their health problems is therefore essential. The WHO Regional Office in Brazzaville stresses this point:

> "The execution and implementation of activities must be the result of a decision made by each community; professionally trained staff should enlighten the community on technical aspects, national policy and the rational use of available resources".

With this principle in mind, a baraza aims to:

- stimulate informal discussion about health problems
- encourage the local people to try to identify the causes of problems
- enable professionals to give simple and brief explanations about the medical or scientific causes of any health-related problems raised
- stimulate an interchange of ideas about the prevention of problems.

4. Formation of Health Committee

As a result of the barazas a village health committee is often established; this will include community leaders, a representative of

the local people and sometimes a hospital representative. The committee takes on responsibility for dealing with local health problems; it will instigate local initiatives, supervising and co-ordinating their progress. Such initiatives range from building a dispensary to organizing the election of village health workers.

5. Election of Voluntary Health Workers

The health committee's first task is often to elect suitable members of the community to be village health workers, undertaking health education and basic health care at local level. There will usually be about ten such workers elected by each committee; volunteers are usually between 30 and 45 years of age, predominantly female and married with children. Literacy, although preferred, is not essential. The stated desire to work in and for the community over a long period of time is considered essential, however, as sustained effort is an important factor in the acceptance and success of health education programmes.

6. Training of Village Health Workers

The hospital can play an important role in training the village health workers for the tasks they will perform in the community. The key to the successful implementation of this kind of training is the trainer; trainers must be aware of the real world of the prospective village health worker, as well as possessing the relevant technical knowledge. They must then connect the two so that throughout the training programme technical knowledge is building up a meaningful picture for those being trained.

The trainers of the Machakos Public Health Aids Programme go into a particular community and stay there throughout the three-month training period. Their courses have no fixed syllabus, with the content determined by what the women want to learn. As they then know that everything they are learning is relevant to their families and communities, they learn more easily. The trainers are adamant that they should not impose their perceptions, but respond to the needs and difficulties of the health workers; they stress:

> "We teach nothing that the women have not expressed a need to know ..... the progress is at the pace of the community - they move slowly and we have time to go slowly".

Communication skills are of paramount importance in motivating, and creating genuine understanding in, the volunteers; the trainer has a very important role in setting a good learning climate. The trainers should ideally speak the same language as the women, although in a multi-lingual society such as Kenya this is sometimes not the case. Many training schemes use the psycho-social method, developed for work with adults who have experience and knowledge upon which to draw. The members of the local community know its life and problems by direct experience and constitute a resource for each other. The trainer must therefore do less talking and more facilitating of discussion within the group, experimenting with brain-storming and role-play sessions. In turn, communication skills should be practised with the trainees themselves; they must be helped to impart the knowledge they have gained in a way appropriate and acceptable to their community.

7. Work in the Community

Once the course is completed the health workers return to their communities and define their own area of work. They will conduct home visits to educate and advise, provide assistance at Mother and Child Health Clinics and undertake follow-up visits on patients treated at dispensaries. Some health workers hold a small stock of basic medicines which they dispense where necessary. This can lead to problems, however, with local women regarding health workers merely as an easily accessible source of drugs, and the health workers, anxious to remain popular in the community, not exercising sufficient discrimination. This is a situation which volunteers could be prepared for in their training.

Although volunteers, some health workers are paid a small honorarium by the hospital for their services. Other projects have tried to avoid this "top down" system of payment by creating a pool of money to which community members contribute a small amount each month; the committee then decide how much to allocate to the health worker for her work.

Supervision and support are an integral part of a village health worker scheme; hospitals often provide a full-time co-ordinator (usually the trainer) to supervise the work of volunteers in the community. Chogoria Hospital has developed a Community Department

where Community-based Health Care Facilitators are based; these are responsible for a certain area and liaise with the committees, supervise the work of volunteers and provide help and advice where needed. This gives the health workers a vital sense of involvement and a valuable point of reference when in difficulty.

Reorientation of professionals

If the initial impetus for community participation projects often comes from hospital professionals, it is essential that they should be aware of the potential and methods of initiating, such schemes; this often necessitates training for the professional who will co-ordinate community-based health care. The Kenyan Government has demonstrated its commitment to expanding the scope of primary health care by creating Rural Health Training Centres, with the aim of providing such training for staff working at health centres. The Ministry of Health has trained a number of clinical officers, nurses and public health technicians as Rural Health Tutors and issued a training manual detailing course content.

Each centre operates a three-month training for Health Unit Teams; these comprise:

1 Clinical Officer
4 Nurses
1 Public Health Technician
2 Village Health Workers
1 Clerk

While the team are at the centre, relief staff run their health centre in their absence.

The course aims to teach staff how to work together as a team, how to adapt services to the needs of the community and how to involve the community itself. It comprises four basic stages:

1. Team Building

2. Community-level co-ordination

   The Team go out into their health centre's catchment area and compile an inventory of resources available e.g. nutrition, water, economy etc. They are then taught how best to approach the community, by first identifying problems and taboos, then practising communication skills.

3. Application of solution

The team approach influential people in the community and plan with them. Village health committees are set up.

4. Proficiency

A refresher course in the professional skills of each member of the team is given on an individual basis.

Once staff have returned to their health centres, Rural Health Tutors assess their progress in the community and try to evaluate the success of the training. It is hoped that the training will stimulate on-going collaboration with the community, with the emphasis on community participation and supporting the local population to help themselves.

CONCLUDING COMMENTS

Kenya is a young country still in the early stages of development. In view of the competing demands of education and communications, a tremendous amount has been achieved in the health field since Independence.

As a new country and former colony, Kenya largely adopted the models of health care available in the developed world. This has meant that much of the last 20 years has been devoted to building up an infrastructure and hospital facilities for the treatment of disease and only more recently has attention been focused on the fields of prevention and primary health care. Hospital facilities are obviously essential, both for the treatment of serious diseases and as a back-up service for primary health care programmes; people will always fall ill and require the specialist knowledge of a doctor.

The situation in Kenya and elsewhere demonstrates, however, that a hospital care orientated health service is not alone sufficient to meet the health needs of the people. In a country such as Kenya, where the level of morbidity of the general population far outweighs that in Britain and where an illness such as diarrhoea is the greatest single child killer, the need for prevention and a change in emphasis on the part of the health service is even more acute. As this realisation has spread amongst health professionals in Kenya, new approaches have been attempted, the results of which can provide lessons for developed countries.

One such lesson is that a great deal has been achieved in Kenya by people without high qualifications. In remote, deprived areas the scarcity

of resources means that people have to be given the minimum of formal training necessary to do a job. In a remote location such as that of Kapsowar Hospital, the training of village health workers to carry out preventive work in their own village is a cost-effective means of reaching the scattered population. Moreover, a member of the village community is the person best qualified to do the job, as they speak the language of the people and understand their customs.

Applying this to the situation in Britain, some of the work currently undertaken by doctors could be delegated. In hospitals, nurses could perform many routine tasks. In the community, GPs complain that their time is largely devoted to social rather than medical problems; again this situation could be improved if 'nurse practitioners' and social workers took part in the surgeries, referring to the doctor if necessary.

The need to speak the same language as, and understand the customs of, the local people is becoming increasingly important in Britain. For health education to be highly effective amongst the ethnic minorities living in Britain it must be delivered by one of their own people; this person need not be highly qualified, but should have been taught the necessary knowledge and skills to pass on. More generally, it is important that any health education officer is able to speak on the same wavelength as the people he/she hopes to influence; a professional telling people how to look after their health from a professional point of view will not have the same impact as someone who is able to tailor the educating process to local attitudes.

Kenya is a country with very varied climatic and geographic conditions which affect the pattern of disease in different parts of the country. This has meant that health professionals have begun to try to adapt services to local needs, as is demonstrated by the creation of Rural Health Training Centres, where staff are taught to diagnose problems in their catchment area and devise solutions. Even in temperate Britain, however, communities have individual characteristics and epidemiology is becoming increasingly important. Certainly primary health care staff should be adapting education and prevention programmes to local needs. Health centres have experimented with patient consultation in some areas; after all, why is the service there, if not to meet the actual needs of the local people?

The Rural Health Training Centres can also teach professionals in Britain about team working. The health centre concept is spreading in Britain; in some centres, however, the basing of staff under one roof has had little

effect on breaking down professional barriers and achieving genùine team-work. At Rural Health Training Centres in Kenya the staff of health centres undergo a course together, including training for team-working. This team includes everyone working in the health centre, not just professionals, but the clerk and volunteers as well. This is very important in motivating staff and therefore maximising the potential of each individual in the team and creating flexible working relationships.

In conclusion, it is important to realise what can be achieved with limited resources in a developing country such as Kenya. In a time when resources are becoming scarcer in Britain it will be increasingly necessary to assess needs and devise cost-effective ways of meeting them. In Britain too we are learning that expensive professional and technological approaches are not always those that will best meet local needs and that innovations in community-based health care may present the most appropriate way forward.

APPENDIX A

COMMUNITY HEALTH PROJECTS

CURRENTLY OPERATING IN KENYA

ANNE LOWES
KIM ROBERTS

NOVEMBER 1982

Chogoria Hospital Community Health Programme

Chogoria Hospital, run by the Presbyterian Church of East Africa, is situated in the fertile region at the foot of Mount Kenya. With financial aid from Family Planning International Assistance (F P I A), it has established a community health programme covering the catchment area of the hospital, an area 10 miles wide and 25 miles long, with a population of a quarter of a million.

The impetus for a community health programme came initially from the hospital; staff approached influential members of local communities and encouraged them to define, and accept responsibility for, their health needs. People from the local communities formed themselves into Area Health Committees of which there are now thirteen.

The programme is based on a network of twenty-six rural dispensaries, built by local people, and is co-ordinated by a Registered Public Health Nurse based at Chogoria Hospital. Two Community-based Health Care Facilitators (an enrolled nurse and a midwife) supervise the staff at dispensaries and liaise with the committees.

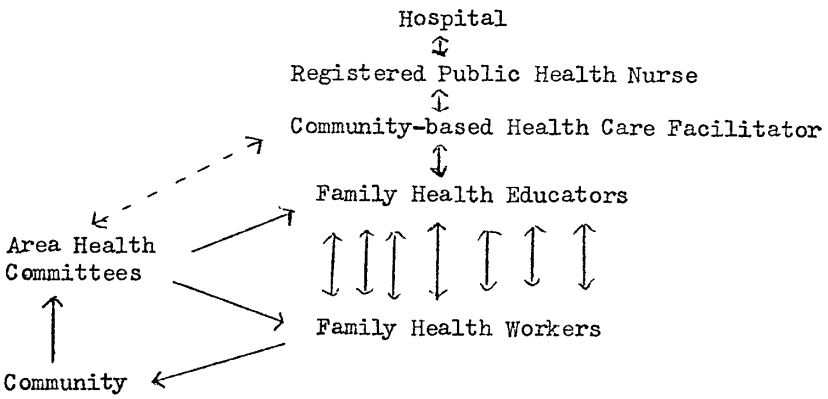
Staff working at the dispensaries are:

1 Community Enrolled Nurse

1/2 Family Health Educators

Voluntary Family Health Workers

The Family Health Educators are local people who have undergone a three-month training at the hospital and are paid a small salary; their work consists mainly of training Family Health Workers and motivating and supervising them once they are working at the dispensary. Family Health Workers are elected by the Area Health Committees; once trained they visit local people in their homes giving advice on health-related matters, as well as undertaking specific follow-up visits on patients who have attended the dispensary for treatment. The aim is for each Area Health Committee to have ten voluntary Family Health Workers.



One of the reasons behind the success of the programme is its combination of community participation and the input of full-time staff based at the hospital. Commitment and impetus from the community is achieved through the Area Health Committee and the election of local people as Family Health Educators and Family Health Workers. Advice and encouragement from the hospital is built into the programme, however, in the role of the Community-based Health Care Facilitator; this gives staff working at dispensaries a vital sense of involvement and a source of advice when needed.

The community programme incorporates a youth programme funded by the Church of Scotland. The programme aims to provide health education for children in the District's 150 primary schools and 33 secondary schools by training local teachers.

A large component in both the general community programme and the youth programme is family planning advice and services; the programmes have achieved remarkable success in this field, with 15% of the women of reproductive age living in the catchment area now using family planning methods, compared to a national average of 5%.

Contact - The Medical Superintendent
P C E A Chogoria Hospital
P O Chogoria via Meru
KENYA

Epilepsy Clinic, Mathare Valley, Nairobi

In February 1982 a paediatrician at the Aga Khan Hospital opened an epilepsy clinic for children in Mathare Valley, one of Nairobi's worst slum areas. The clinic was intended as an initial nucleus for the Association for the Welfare of Epileptics, which hopes to develop branches throughout Kenya. By July 1982 the clinic already had 25 attenders and a number of children on the waiting list, demonstrating the need for such a service in the Mathare Valley.

The clinic aims to both educate families and schools about epilepsy and to control the seizures of epileptic children through the use of drugs. The doctor hopes that epileptic children now being educated with mentally handicapped children because of their illness will eventually be returned to normal schools as a result of their treatment and a better understanding of the nature of epilepsy on the part of schools.

The project was started on extremely limited funds; the weekly clinic is held in an existing Mother and Child Health Clinic and drugs used are donated either by the Association for the Welfare of Epileptics or by drug companies. The doctor gives his services free and is helped by a full-time social worker funded by the Aga Khan Hospital.

The social worker is the key to the success of the project; she is able to visit homes two or three times a week if necessary to undertake home assessments, follow-up visits on clinic defaulters, to educate the family and to ensure that drugs are being taken correctly. She also forms a vital link with schools, trying to create understanding on the part of teachers about the problems that epileptic children face. Teachers are asked to note the performance of children attending the clinic and send a report to the doctor. Accurate information about the progress of the children is therefore easy to obtain and reports received show the work of the clinic to be highly successful.

Contact - Dr Miyanji
Consultant Paediatrician
Aga Khan Hospital
P O Box 30270
Nairobi
KENYA

Mathari Hospital Community Programme

Mathari Hospital is a Catholic Mission Hospital in the Central Province of Kenya. It is one of many hospitals now operating a $3\frac{1}{2}$ year training leading to the Central Nursing Council (Government) qualification of Community Enrolled Nurse. This training aims to equip nurses to work both in the community and the hospital; it is a comprehensive training and includes the following components:

Medicine

Surgery

Midwifery

Out-patients work

Management of Mother and Child Health/Family Planning Clinics

Home visiting

Psychiatry

The Community Enrolled Nurse training marks a significant departure from traditional nurse training; its emphasis on preparing nurses to work in the community reflects the growing preoccupation with primary health care in Kenya.

At Mathari Hospital the training is well-established and 40 students are recruited each year. The training involves attachments at a health centre and a dispensary, as well as extensive home visiting. Each student undertakes 20 - 30 home visits; reports are made on visits and kept at the hospital, to enable a more accurate picture of the local community to be compiled.

In addition to its community training programme, the hospital has recently set up a Marriage Encounter Service; this aims to bring couples together for group discussions and to give individual counselling where possible. The scheme is run in conjunction with the Marriage Encounter Association and to date has had contact with 400 couples.

Contact - Sister Lia
Mathari Hospital
Nyeri
c/o Mr J Kweri
Kenya Catholic Secretariat
P O Box 48062
Nairobi
KENYA

Tiwi Rural Health Training Centre

Tiwi Rural Health Training Centre, situated in Coast Province, is one of six such training centres established by the Ministry of Health; ultimately there will be one centre in each province. The centres offer in-service training for staff working at health centres; the aim is to help the staff work effectively as a team and to teach them how to approach and involve the community.

Rural Health Training Centres are purpose built and form part of a normal health centre. The Ministry has trained a number of clinical officers, nurses and public health technicians as Rural Health tutors and issued a training manual detailing course content.

Since 1980 Tiwi has been running a 3 month training programme for Health Unit Teams working in health centres in the Province. The team live at the centre for the duration of their training, with relief staff operating their health centre in their absence. A Health Unit Team will usually include:

1 clinical officer

4 nurses (these may be Community Enrolled Nurses)

1 public health technician

1 clerk

2 village health workers.

The course has four major components:

- Team building
- Community-level co-ordination: the team go into the catchment area of their health centre and compile an inventory of available resources including water, nutrition, economy etc; they then learn how to approach the community, by identifying problems and taboos and practising communication skills.
- Application of solution: the team approach influential people in the community and plan with them; village health committees are set up
- Proficiency: a refresher course in the professional skills of each member of the team is given on an individual basis.

Once the Health Unit Team has returned to its own health centre, tutors from Tiwi visit staff to ascertain their progress and evaluate the success of the training. Since 1980 twelve Health Unit Teams have been trained.

The opening of the training centres demonstrates the Government's commitment to widening the scope of primary health care. The scheme aims to maximise the potential of staff already working at health centres by training them to operate as a team and to encourage community participation by teaching staff how to motivate, and plan with, the community.

Contact - Clinical Officer in Charge
Tiwi Rural Health Training Centre
c/o Provincial Medical Officer, Mombasa,
Coast Province, KENYA

Machakos Public Health Aids Programme

This programme was started in 1978 by Sister Geraldine Huising and Mrs Beata Ndunge in Yatta Division, Machakos District, with the backing of the Catholic Secretariat in Nairobi. A need had been identified for a programme of health education; the response was to establish a three-month training for groups of local women who would then become their villages' health educators.

Sister Geraldine's and Beata Ndunge's method of training is to go into a particular community and stay for three months, training approximately sixteen women - one from each of the surrounding communities. There is no fixed syllabus for the training course; the content is determined by what the women want to learn. At the outset the owmen list the problems they encounter in their villages, problems concerning health, agriculture or social and domestic difficulties, for instance; if the programme organisers are unable to give advice, other people competent in the relevant areas are invited to give a day session. Sister Geraldine and Beata Ndunge are strongly in favour of developing a syllabus in response to the women's needs and interests; as the women know that everything they are learning will help their families and communities, they learn fast and well. The method of instruction known as the psycho-social method is used, developed for work with adults who already have knowledge and experience upon which to draw.

Once the course is finished the women return to their communities and define for themselves their own area of work. They are expected to work three afternoons a week; their activities include group meetings, home visits, clinic assistance and occassionally home deliveries. Supervisory visits are made once the women have become health educators and periodically there are one-week seminars and workshops to provide the women with further training.

The programme's motto is:

go to the people
live among them
learn from them
create a better society to live in

To date forty-six women have been trained in three courses.

Contact - Mr J Kweri
Kenya Catholic Secretariat
P O Box 48062
Nairobi
KENYA

Kakamega Pilot Community Project

This pilot project, funded jointly by UNICEF and the Ministry of Health in Nairobi, was started in 1977. Dr Miriam Were of the University of Nairobi approached the Ministry of Health for approval to undertake a PhD involving the creation of a community project to train village health workers. The Ministry decided to support the project with personnel and make it a pilot study.

By training local women to be health workers Dr Were hoped that basic health-related problems could be overcome. The pilot project covered two divisions of Kakamega District and aimed to train a village health worker in every community within the divisions.

The first step was to seek the involvement and support of all Government officers concerned; this included the Provincial Commissioner, the District Commissioner, the District Officers for the divisions and finally the Chiefs of each location.

Once the approval of the Chief of a location had been obtained, a baraza (village meeting) was held. Each baraza aimed to:

- stimulate informal discussion about health problems
- encourage the village people to try to identify the causes of the problems
- enable professionals to give brief and simple explanations of the medical causes of any of the health problems raised
- to stimulate an interchange of ideas about the prevention of health problems.

After each baraza the community elected three people to be trained as village health workers. The project organisers then assessed their understanding and ability and selected one of the three to be the group leader.

The newly-elected village health workers then undertook a $2\frac{1}{2}$ month training at a local health centre, organised by nurse trainers employed by the Ministry of Health. The course comprised:

- 1 month based at the health centre learning theory and teaching methods and observing the problems dealt with at a health centre.
- 1 month in the community with a trainer, identifying problems and undertaking home visits.
- evaluation of training and retraining if necessary.

The emphasis throughout the training was on teaching the village health workers how to approach local people and how to help them identify and solve their own problems.

Once working in the community, the village health workers carry a small stock of drugs. Although these drugs are donated free by the Ministry of Health, the village health workers make a small charge when they prescribe

drugs and pay the money into a community account. At the end of each month the community decide how much they will pay the village health worker for her work from this account.

The success of the project is due largely to its approach; the emphasis throughout is on motivating the people to take their own decisions, whilst giving them the necessary support to do so. Moreover, communication is the key to any community participation project; the Kakamega project is supervised by a local clinical officer and all those involved in the project are local people possessing an understanding and knowledge of the area and people.

The project's success has gained it a high reputation. In 1978 it was awarded the UNICEF prize for the best UNICEF-sponsored project in the world; this was the first time the prize had been awarded to an African country.

Contact - Ms Fanice M Khanali
Project Supervisor
CBHC Project
P O Box 359
Kakamega
KENYA

RECOMMENDATIONS FOR FUTURE ATTACHMENTS BY NATIONAL ADMINISTRATIVE TRAINEES IN KENYA

Any future trainees visiting Kenya will obviously have their own areas of interest and ideas about how they would like to organise their time, but as a result of our study visit we have outlined some of the problems that are likely to be encountered and made recommendations which may be of use.

When making arrangements for our study tour of Kenya our initial contact was with the Ministry of Health. After lengthy correspondence we were given assurance of attachments in both urban and rural settings. We therefore incorporated four weeks attached to the Ministry of Health in the programme we had finalised for ourselves in England.

On our arrival we were greeted warmly, but experienced considerable difficulty in actually arranging attachments. The lack of public transport in remote areas made it impossible to reach those places which the Ministry felt would usefully supplement the programme we had arranged. In future, trainess would be wise not to rely on the Ministry to arrange attachments. In Kenya the Health Service is centrally organised and all medical supplies and equipment have to be sent out from the Central Medical Stores in Nairobi. Consequently the Ministry transport is under tremendous pressure and scarce resources are stretched to their limits. It is therefore an unfair request that the Ministry provide transport for visits to rural hospitals and health schemes.

The co-operation of the Ministry of Health must, however, be obtained at the outset and written permission received before arriving in Kenya. When visiting Government institutions or schemes, a letter of introduction is essential. It is highly frustrating to visit a Government institution without receiving official permission.

The following notes outline the procedure we would recommend any future visitors to follow:-

1. Establish diplomatic relations with the Ministry of Health.
2. Get a letter of introduction from the Ministry.
3. On arrival in a province, take the letter to the Provincial Medical Officer.
4. P.M.O. will write a letter of introduction to specific hospitals - usually it is necessary to wait one or two days before this letter can be collected.
5. With P.M.O.'s letter Government hospitals can be visited without prior arrangement.

This procedure may seem a little long-winded at first, but as it follows the official channels it operates very smoothly in practice and is much more rewarding than sitting in Nairobi waiting for visits to be confirmed in advance. Arrival in Kenya involves of necessity a certain degree of culture shock; integration is not facilitated by a somewhat frustrating initial wait for the Ministry to arrange attachments in rural areas.

In retrospect we feel that our programme was not ideal. As already mentioned, we spent four weeks in Nairobi, then moved on to a series of attachments in various parts of Kenya. By Kenyan standards our travelling programme was ambitious, especially as we had planned relatively short stays in each place; a great deal of time was this spent travelling, leaving only a few days to get to know the area and meet people working there. We feel that it would have been more beneficial for the Kenyans and ourselves to have spent periods of three weeks at certain hospitals after the introductory period in Nairobi.

We would recommend, therefore, that any future visitor to Kenya spend a short period in Nairobi. followed by attachments at two or three hospitals. To obtain as complete a picture as possible of health services in Kenya, both a Government institution and a Mission Hospital should be included.

From our own experience, we feel that the following places would provide interesting visits/attachments and the visitor would be well received by the staff.

Nairobi -

- establish contact with the Ministry of Health
- Kenyatta National Hospital
- large, private hospital - Aga Khan
- voluntary organisations - AMREF
- Mission Central Offices - Catholic Secretariat
  - Protestant Churches Medical Association

Government District Hospital -

- Homa Bay, South Nyanza District
  including within relatively easy reach
  Isebania Rural Health Training Centre
  Nyanza Provincial Hospital, Kisumu
  Kakamega Community Health Project (highly successful Government/Unicef project)

Mission Hospital -

- Chogoria Hospital, P.O. Box 35 Meru District (Presbyterian Church of East Africa)
  The hospital has a thriving community programme with 26 dispensaries and a well-established scheme for the training of community volunteers. Mr. Murunge, the Administrator, expressed his willingness to receive one or two administrative trainees and give them administrative work to do in the hospital. Guest quarters are available.

The hospitals recommended above are both in relatively accessible and fertile areas. In addition it would probably be of value to incorporate a stay in a more remote and poorer area. Loitokitok Hospital on the Tanzanian border or Lodwar Hospital in Turkana are Government possibilities; Ortum Catholic Mission in West Pokot would be a Mission alternative. Transport to these three places would be difficult, but not impossible; and any one would offer a stark contrast to experiences in other parts of Kenya. When visiting the Government hospitals mentioned above, it is advisable to give them prior warning so that accommodation can be arranged, but this can be done on arrival at the Ministry of Health. Visits to Mission hospitals must be arranged in advance before arrival in Kenya.