INSTITUTE OF SOCIAL MINISTRY

TANGAZA COLLEGE

CATHOLIC UNIVERSITY OF EASTERN AFRICA

FACT FINDING REPORT

PRIMARY HEALTH CARE/COMMUNITY BASED HEALTH CARE PROGRAMMES

by

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome.
TOT	-	Training of Trainers or Trainers of Trainees
CHWs	-	Community Health Workers.
CSW	-	Commercial Sex Workers.
GTI	-	Gilgil Telecommunications Industries
HIV	-	Human Immune-Deficiency Virus
NGOs	-	Non Governmental Organizations.
PHC	-	Primary Health Care
STD	-	Sexually Transmitted Diseases
TBA	-	Traditional Birth Attendants.
VHC	-	Village Health Committee
WHO	-	World Health Organization
UNICEF	-	United Nations Children' s Fund
CBHC	-	Community Based Health Care
AMREF	-	African Medical Research Foundation
DHMT	-	District Health Management Team
PHC/BI	-	Primary Health Care/Bamako Initiative.
K.A.P.	-	Knowledge, Attitude and Practise
CIDA	-	Canadian International Development Agency
DANIDA	-	Danish International Development Agency
FINIDA	-	Finland International Development Agency
IFAD	-	International Finance for Agricultural Development
KEPI	-	Kenya Expanded Programme Immunization

CHAPTER 1

PRIMARY HEALTH CARE-BAMAKO INITIATIVE.

(P.H.C.-B1) GILGIL DIVISION.

1.0 Back Ground to Primary Health Care Programme.

The World Health Organization (WHO) and UNICEF leaders held a conference in Alma Atta a Russian town in 1977 and resolved to attain health for all by the year 2000. In 1978 they again held a second conference in Africa in a town called Bamako the capital of Mali. In this conference they met with Health ministers and Heads of states from various governments in Africa. The primary Health Care Concept (PHC) with it's various ELEMENTS were discussed.[1]

It was noted that for this concept to succeed, the Health Care delivery system should change it's delivery format. Instead of services being provided from the government through the ministry of health down to the community, the strategy should be reversed. The delivery system it was decided, should start from the village or home level upwards, and the government or Ministry concerned should take a supervisory role.

Primary health care is a new approach to health care which integrates, at the community level, all the factors required for improving the health status of the population. It contains eight elements, which are described as the Essential Health Care. They are as follows:

(i) Promotion of food supply and proper nutrition.

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[1] AMREF, Training Guidelines for Health Care, (Nairobi: 1995) pg. 63-64.

(ii) An adequate supply of safe water and basic sanitation.

(iii) Maternal and child health care, and family planning.

(iv) Immunization against infectious diseases.

(v) Prevention and control of endemic diseases.

(vi) Appropriate treatment of common diseases and injuries .

(vii) Supply of essential drugs.

(viii) The Kenya Government added three more concepts (as below) to make 11, namely:-

a) Dental Health

b) Mental Health

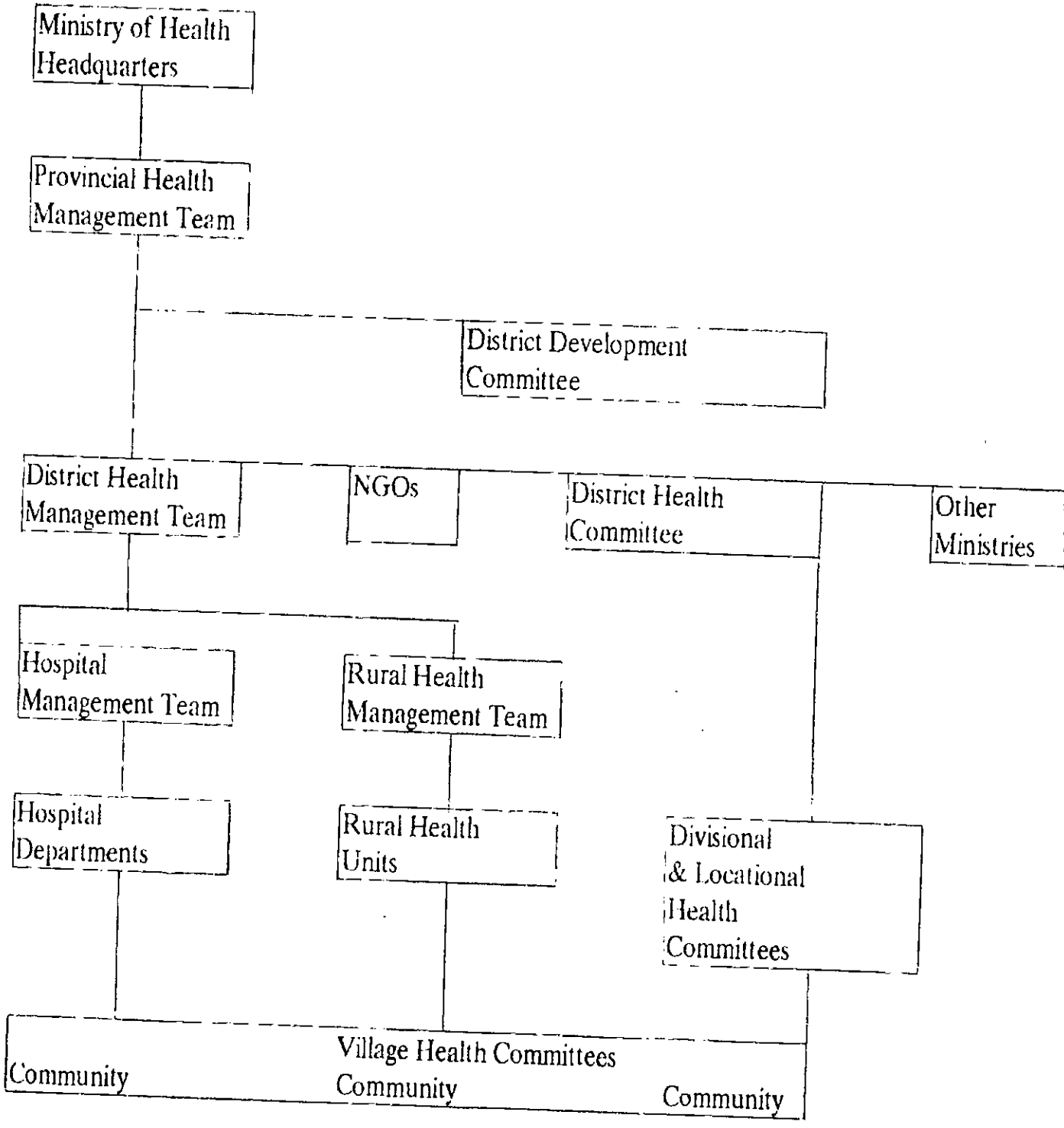
c) Community Based Rehabilitation

This pre-supposes services that are both simple and efficient with regard to cost, techniques and organization, that are readily accessible to those concerned and that contribute to improving the living conditions of individuals, families and the community as a whole.

Primary health care is based on principles of equity, wider coverage, individual care and community involvement and intersectoral collaboration. It is a radical departure from conventional health care services of the past. While it integrates promotive, preventive and curative services, it is also conceived as an integral part of the overall country' s plan for socio-economical development.

ANNEX I

The structure is shown below:



1.1 Background Information on Gilgil Division

Gilgil Division is an administrative division which is in the eastern part of Nakuru district. It has an area of 1,039sq Km. The township is on the southern part of Nakuru District along Nakuru/Nairobi highway which is the Trans-highway connecting the Eastern part of Africa to the central region countries. Long distance truck drivers use the town as a stop over en-route to the western region and neighboring countries. The division comprises Gilgil, Karunga, Miti Mingi and Kiambogo locations, which in turn are subdivided into 8-sub locations. The division head offices are at Gilgil.

In 1996 the projected population estimate for Gilgil Division was put at 80,943 (source District Development Plan 1994-1996) and comprises largely of people of different ethnic groups such as the Kikuyu, Maasai, Turkana, Kalenjins, Luo and others. The concentration of the population is mainly in the township and the market places like Karunga, Gilgil town, and Kiambogo. Other areas with population concentration is due to availability of essential commodities. The rest of the population is sporadically distributed in the four locations where peasant farming is practiced.

Gilgil is a semi-arid Area with bimodal rains spread from march to June (Long rains) and October to December (short rains) with the average rainfall raging from 500mm to 1100mm.[2]

[2] Cf. Mr. Kaviti, District Officer, interviewed by Mary Munyua on 15th of July. He lives in Gilgil.

The community largely depends on these short rains of October to December to grow vegetables and other short season's crops for sale. Others are pastoralists. Due to low agricultural outputs people have migrated from their farms to the township and markets in search of job opportunities which are hardly available. Many of them end up being employed in bars, hotels and lodgings, where the females supplement their earnings with Commercial Sex Work.. N.B. A lot of soldiers in the barracks with free money to spend on entertainment. This encourages prostitution. The township has over 21 bars and lodging houses. **Concerns over their role in the spread of sexually transmitted diseases (STD).** This concern has become more urgent due to the following reasons. The advent and spread of Human Immune-Deficiency Virus (HIV), which is mainly transmitted through sexual intercourse, is an extremely serious development with grave consequences.[3]

The prevalence of HIV infection among prostitutes currently ranges from zero in some areas to 85 percent in many African cities. Since HIV infection is incurable and has a long incurable period, prostitutes may therefore have a huge capacity to transmit the infection. Commercial Sex Workers (CSW) do not see AIDS and STD as most important problems in their lives. They instead see police harassment, low wages, high room rents and dispute with clients over payments as bigger more urgent problems to handle.

[3] Public Health Co-ordinator, Mr Njoroge. Oral interview by Mary Munyua, on 12th July 1999. He works in Gilgil Health Centre.

The town also has different types of workers accommodated in several institutions. These include the National youth service, Anti stock theft unit, Gilgil telecommunications Industries (GTI), Ndume factory and Army Barrack (5th Battalion and 2nd Brigade). The town also provides a stop over for long distance truck drivers and their assistants. Some social or economic groups practice certain behaviors as their "Norms" due to the peer pressure. Some of these behaviors put the group members at an increased risk of acquiring and transmitting STDs. These groups are referred to a high risk groups and include: Long distance truck drivers, Commercial Sex Workers, Uniformed Personnel, Youth in and out of school and Patients attending STD clinics.[4]

1.2 Gilgil Primary Health Care (PHC)

Training of Trainers (ToTs) in Gilgil has arisen out of growing demand of training community health workers. In any community development and health care ToTs take a central role. They create awareness among communities, assist communities to assess and analyse their resources. They also train community own resource people, e.g. community health workers, elders, leaders, traditional birth attendants, shop-keepers village health committees, artisans and traditional healers.

ToTs have a role in continuing education and supervision. Most important is the role of community mobilization, motivation, stimulation and innovation. ToTs must therefore act as role models. They must, for example combine technical knowledge and training skills to enable them educate, communicate, inspire and motivate the community.

[4] ibid.

The present ToT cause drew participantsfrom various locations and health units majority of who were local people. The selection focused more on local people due to the increasing problem of professional staff turn-over which hinders continuity of most programmes. Unlike most groups, this was very enthusiastic group with a lot of experiences from the community. Combination included young and old people.

I worked within these group for two months and through my observation, the group showed a very high level of mutual understanding, desire to learn from each other and cordial relationship among the participants and facilitators. By the end of two months, the participants came to understand that around Gilgil division most of the problems/diseases observed were solvable. Diseases presented were preventable by the communities through facilitation from the Location and the Division.

1.3 Health Services

Gilgil division has health services provided by both government and non governmental/private facilities. It has a total of 17 facilities offering static services and four outreach services. These are:

1.3.1. Catholic Mobile Clinics

Gitare community based health care

Rocky hills

Kasambara

Eburu Top

Elementaita dispensary

Olo jorai

Mahiga

Kahiga

Gilgil catholic dispensary

Government institutions

Gilgil General and Psychiatric Hospital (MATHARE)

National Youth Service Dispensary

Anti stock theft dispensary

Regional hospital (2nd Brigade)

SKR Dispensary

Kiambogo dispensary

Eburu dispensary

Miti Mingi dispensary

Kongasis Health Center

G.T.I Clinic

1.3.2 Mobile Outreach Services.

1. Life water

   Inter Aid

   Christian Community Services (A.C.K)

   Catholic Church

1.3.3 Private Clinics

Market Medical Clinic

St. Anne's Clinic

DR Patel's Clinic

Afya Clinic (Gitare, Langalanga)

Daktari Medical Clinic

Dr. Ben's Clinic

Vinet Nursing Home (opp G.T.I)

Lusop Clinic and many others

Table (1) - Existing Organized Groups.

GROUP	GILGIL	KARUNGA	MITI MINGI	KIAMBOGO
Women groups	25	14	17	10
Christian groups	6	1	9	7
Youth groups	6	1	3	2
Sports groups	4	2	3	3
TBAs	3	0	1	1
C.H.W's	3	0	1	1
Secondary schools	5	2	2	2
Other institutions	7	2	2	2

1.4 The Purpose

Gilgil Primary Health Care was initiated with an express purpose of:

a) Equipping the population or community with necessary knowledge and skills to maintain good health.

b) To bring services as close as possible but also promote the utilization of these services by the community.

c) To allow people to participate in the delivery system. In this way they will be able to determine what types of services they need and how this services will be delivered.

d) To make services be affordable both financially and time wise. Services that cost so much or take up too much time are not affordable.

e) To make health care appropriate and relevant to the main health problems of the area. To ensure appropriate services, the user must be involved in the design and decision making.

f) Making the community (Beneficiaries) be actively involved and participate in the decision making, implementation, monitoring and evaluation of the programmes that are meant to improve the quality of their lives.

g) To help people to take an active share in shaping their own lives.

h) To incorporate dignity, justice, freedom, caring, sharing, building community, building a kingdom or right relationship based on their Christian values or beliefs.

CHAPTER 2

Below are the factors necessary to achieve the improvement of Primary Health Care by the year 2000. See General Goals in Table 2.

Wheel of Health

Table 2. General Goals of GPHC

	INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL Reduce STD/HIV incidence within Gilgil Division, Nakuru District	* Reduction of new cases of STD * Stabilization of HIV Seroprevalence * Reduction of Syphilis cases	* STD tally sheets * Anonymous unlinked HIV Screening of ante natal samples * Syphilis screening of ante natal mothers	* STD patients will attend the Health centre outpatient services * Health workers will fill in the tally sheets properly * Ante natal clients will be a true representative of the general population.

Table 3: Sub-Goals

SUB-GOAL Target populations in selected areas practice safe sex and utilize effective and sustainable STD control services	* Proportion of individuals seeking STD care in health facilities * Proportion of individuals adopting condom use	* Health facility records * Records of condom distribution * Number of CSW changing profession	* Individuals in selected areas will seek medical care for their STD problems.
RESULTS 1. Improved STD case management in Gilgil	Proportion of STD patients Properly managed	* Hospital records * Surveys	* Drugs available for managing STD patients and contacts. * STD patients will seek medical care * Health workers will be competent in managing STD
2. Collaboration with commercial sex workers	* Number of CSW actively involved in STD control activities * Proportion of CSW adopting Condom use * Reduction in the number of clients by CSW	DASCO report on CSW activities	
3. The community being fully involved in STD/HIV control activities	* Number of community oriented STD control activities * Number of Condom outlets established at community level	DASCO report on community activities	Community willing to participate in STD control activities
4. Improved material Syphilis screening and Opthalmia	* Number of Ante natal mothers screened for Syphilis	* Ante natal records * Labour ward records	* Ante natal mothers will attend clinics * Eye Ointment

Neonatorum prophylaxis	* Number of Syphilis Seropositive treated together with their contacts * Number of newborn babies instilled eye ointment within one hour of delivery		available in delivery unit * Trained TBAs will have TEO and instill to all babies they deliver
5. Established programme management at the Health facility and community level	* Formation of an AIDS/STD Task force at community level * Formation of an AIDS/STD core team at the health center level	* Monthly meetings of task force team members, Collaboration with Core team * Monthly meetings, collaboration with task force team members	* Community willing to participate

2.0 ACTIVITIES

For Gilgil Health Care to realise its objectives, the following activities are put in action:

a) *Training of Trainers* - Training of Trainers is a person trained to train others in the community e.g. CHWs in order to improve their standard of living. She/he is selected from the community or an institution, may or may not be living in the community.

His/her qualities are the following:

- Available

- Responsible

- Capable

- Social

- Patient/understanding

- Influential

- Honest

- Competent. knowledgeable

- Role Model

-Good Leader

He/she is given knowledge and skills on how to do the following

- To initiate CBHC programme

- To unite the Community

- To co-ordinate the activities of the community.

- Collaborate with others.

- Plan, monitor, evaluate the development in the community.

- Assist the community to participate in planning and taking responsibilities.

- To follow up in order to make the project sustainable.

- Writing reports.

- Training

- Update knowledge by attending seminars/workshops.

b) *Training of Community Health Workers*

- Community Health Workers were trained in the following areas:

- Curative care of Malaria, diarrhea, worms, conjunctivitis, anemia, scabies and fever, dispensing drugs - chloroquine (tablet and syrup), paracetamol, acetysalicyclic acid, tetraycline eye ointment, Ferrous Sulphate, folic acid, bezylbenzoate and mebendazole - as well as family planning devices and ORs.

According to my observation, the Ministry of Health has standing orders for the work of rural health workers. Community Health workers are trained in the diagnosis and treatment of common diseases, and through supervision, are constantly checked for their accuracy in this regard. Considerable effort was directed towards making the public aware of the rational use of drugs, through continuos educational work. This was the main focus of attention in social mobilization efforts.

These was the list of drugs approved by the Ministry of Health for by Community Health Workers.

Community Health Workers were allowed to distribute the following drugs:

- Chloroquine

- Ferrous Sulphate/FolicAcid
- Acetysalicylic acid
- Vitamin A
- ORS Sachets
- Benzyl Benzoate
- Whitefields Ointment
- Tetracycline Eye Ointment
- Prazinquatel or Metrifonate
- Mebendazole
- Paracetamol
- Magnesium Trisillicate
- Chlorpheniramine
- Cotrimoxazole Syrup
- Community Health Workers also distribute condoms and oral contraceptives.

c) *Training of Traditional Birth Attendants*

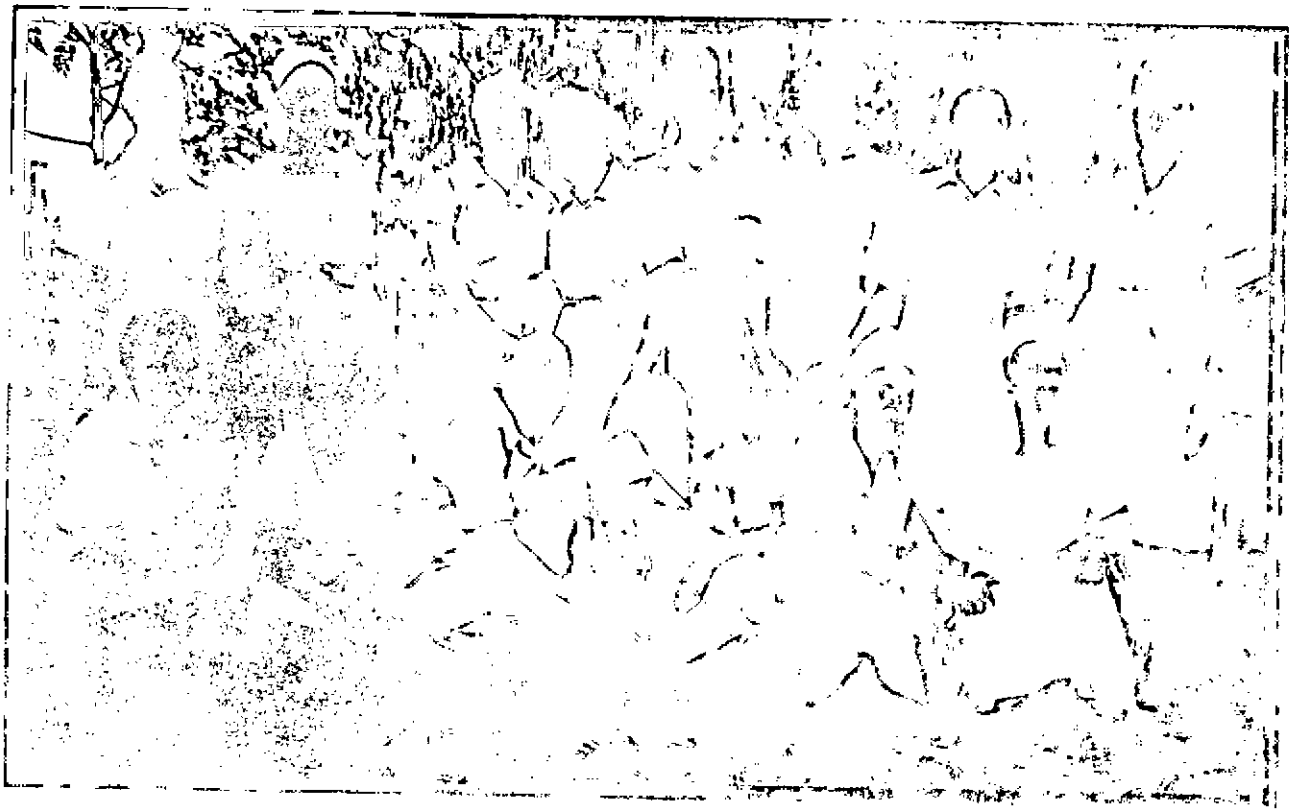
- They assist in delivery at home of pregnant mothers.

GILGIL PRIMARY HEALTH CARE

TIMETABLE FOR TRAINING CHW'S/TBA'S PART 1

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9.00 -9.30 a.m	O E	V	O	T I	O N
9.30-11.00 a.m	OPENING ORAL POST HEALTH EDUC. TEST (NAOMI)	PHYSICAL REHABILITATION OCCUP.HEALTH COMM.BASED REH. (RUNNO)	MCH/FP ANC/IMM. (NAOMI)	U.R.T.I & RING WORMS (Group Discussion) (Ombegoh)	GEN.SANITATION & HYGIENE (NJOROGE)
11.00-11.30 a.m	B	R	E	A	K
11.30-1.00 p.m	NUTRITION (ASIKO)	FIRST AID & ~~FINANCE~~ Road Safety (ALEX)	RECORDS & Finance ~~ALLERGY~~ (ALEX)	MALARIA & ALLERGY (OMBEGDH)	HIV/AIDS/STD (Group Discussion)
1.00-2.15 p.m	L	U	N	C	H
2.15-4.00 p.m	DEHYDRATION (ASIKO)	MENTAL HEALTH (Group Discussion (RUNNO)	ORAL HEALTH (OPOT)	ANEMIA & SCABIES (ASIKO)	C L O S I N G
4.00-4.30 p.m					

Checking for a BCG scar: Immunization is an important component of the project



Community Health Workers after their training

- They are trained to identify problems and advice accordingly.

Their roles:-

(i) Identify pregnant mothers within their area and advice to prevent most unless during pregnancy.

(ii) Identify high risk group of pregnant mother i.e. Prime gravidas.

(iii) Advice the mothers who are delivering their first baby to go hospital because of unforseen complications.

(iv) They ensure that the expectant mothers are immunized and also when they deliver the new borns are to be immunized at the nearest Health facility. They make up follow ups and checks on immunization cards throughout.

(v) They have a good opportunity to advice the mothers on family planning.

(vi) Conduct deliveries from the 2nd to 5th due to anticipated problems.

(vii) Keep records on delivered children which they take to the Chiefs for notification of birth.

d) Training of Village Health Committees

Village Health Committee (VHC)

Identify the need for health project within the community

Mobilize the community health activities e.g. malaria control, demographic surveys screening etc.

Advise community CHWs and TBAs on specific projects e.g.

Appraisal of all community health projects

Resolve problem related to programme management

Supervise CHWs and TBAs in their work

Stock control in their pharmacies

Send minutes of all VHC meeting to DHMT

Provide feedback to the community on all aspects of the programme needs assessment, survey progress, problem etc.

Identify needy cases to be exempted or given credit facilities

e) Survey through small Christian communities is going on.

- Awareness of self reliance with the help of small Christian communities was going on well. Before leaving, some members had already started their small activities e.g. kitchen gardening, poultry etc. We had few cases seen in the dispensary of measles, scabies and malnutrition. There was a large number of attendance in clinic though they don't come for hospital delivery, the reason was because they had already traditional birth attendants at home.

f) Making Mosquito nets - sold at Kshs. 200 as an income generating project.

g) Digging of wells, rain water catchement by building water tanks, pipe water from rivers - as a source of hygienic water.

h) Health Education through demonstrations - on better agricultural farming methods and management

- Carrying out practical demonstration in the field.

- By field visits we observed good agriculture and learnt from each other.

-They were regular follow-ups, visits by trainers to provide technical assistance as necessary.

i) Digging Pit Latrines, Compost pits - Clean compound and latrines were up to date due to the skills which they were given by the community workers.

j) Diet Care Health Services - They were given seminars on how to prepare a balanced diet.

k) Nutrition - Malnutrition is an important factor contributing to poor health among workers and low work output. It also affects the metabolism of toxic agents and also the tolerance mechanisms. Therefore, provision of a balanced diet or snacks at reasonable costs is important and encouraged.

l) *Communicable Disease Control* – The workplace should provide excellent opportunity for early diagnosis, treatment, prevention and rehabilitation. There is an adequate immunization against preventable communicable diseases, which may be occupational in origin.

m) Environmental sanitation:

(a) Provision of clean and wholesome water which is safe for consumption.

(b) Hygienic food handling

(c) Sufficient latrines and urinals.

(d) Proper garbage and waste disposals.

(e) General plan cleanliness ; the walls, ceiling and floor.

n) Measures women and children - The following measures were always recommendable

(a) Maternity leave

(b) Provision of ante-natal, natal and postnatal care.

(c) Women should not carry heavy weights.

(d) They should not work underground.

(e) No child labour.

o) Health education - This is a basic health need, it is an important health promotional measure. All were informed on matters pertaining to health.

p) Family Planning - This is now recognized as a decisive factor for quality of life and this applies to industrial workers also. The workers were helped to adopt the small family norms.

These activities are varied by one can see them better in Table 4.

Table 4-Time/ Activity Schedule

	Activity	Indicators	Area	Time	Task
1	STD MANAGEMENT				
1.1	Train health care providers in STD case management	Team of 2 Cos, 6 Nurses, 6 PHTs, 2 Records officer trained	Gilgil H/C, Regional Hospital, NYS, Police anti stock theft unit	June 1999	NASC O P
1.2	Conduct a needs assessment for the improvement of examination facilities in the clinical areas with the required diagnostic equipment like speculum, examination light	List of required items made	Gilgil H/C	Sept. 99	H/C i/c NASC O P
1.3	Procure and supply required	Equipment bought	Gilgil H/C	Nov.	NASC

	clinical diagnostic equipment	and distributed as per list		99	O P H/C i/c
1.4	Conduct a needs assessment on lab requirements for effective STD case management	List of required equipment and reagents, Training needs identified	Gilgil Laboratory	Sept. 99	Lab i/c NASC O P
1.5	Procure and supply required lab equipment and consumable	Equipment procured & issued to Lab	Gilgil Laboratory	Oct-Nov 99	NASC O P
1.6	Update Lab incharge on current STD/HIV screening techniques through attachments	Report of experience by Lab Officer	Nairobi	Oct. 99	NASC O P
1.7	Train HCW as facilitators	4 health workers trained in facilitation	AMREF/ Kisumu	Sept. 98 Sept. 99	NASC O P
1.8	Monitor and evaluate Training of HCW and Case management	Records of drugs usage and lab investigations	Gilgil H/C	June 98	NASC O P DHMT
2.	**COLLABORATION WITH COMMERCIAL**	**SEX WORKERS**	**IMPROVED**		
2.1	Map out and register practising commercial sex workers (CSW) voluntarily from all the estates: Land panya, Timber, Syndicate, Married, Township, "88KR", and Skeleton coast	CSW register available	CSW concentration areas	19th-22nd Sept 98	PHTs Core team
2.2	Organise Focus Group Discussions (FGD) for CSW from all the estates	Records of FGDs organised	Gilgil Town	1st Oct. 96 onwards	Core team NASC O P
2.3	Sensitize the CSW for identification of peer group leaders among themselves	1 day sensitization meetings in each estate	CSW concentration areas	June 99	NASC O P, PHTs
2.4	Train CSW Peer Educators in STD/HIV prevention and control activities feasible in their environment	3x1 week workshop for each identified peer educators group conducted Total of 25 trained	Gilgil H/C	1st phase June 99 2nd Phase Aug. 99 last phase Oct.99	NASC O P core team
2.5	Work out training schedules for CSW	1 day weekly training sessions developed	Gilgil town	Jan 98 onwards	Core team peer

					group
2.6	Co-ordinate counseling of CSW by Peer Educators	List of counseled CSW by peer educators	Gilgil town	Jan 98 onwards	Peer group, PHTs
2.7	Promote condom use among CSW and their clients	Condom outlets established	Gilgil town	July 95 onwards	Peer group, PHTs
2.8	Assist CSW form viable organised organizations	Meetings with CSW in each estate	Gilgil town	Nov. 99 onwards	NASCOP, core team Peer group leaders
2.9	Monitor & Evaluate process and impact of peer group training	Competence of peers in disseminating information, Report on peer group activities	Concentration areas for CSW	4 days visits to concentration areas each month	NASCOP
3.	COMMUNITY SENSITIZATION	AND INVOLVEMENT STRENGTHENED			
3.1	sensitize community leaders (Headmasters, Chiefs, D.O.s, C.D.A s Christian leaders, Muslim leaders) and local organised group leaders on std/HIV control activities	2 day w/s conducted for each location	Gilgil town, Sogoni, Karunga	Oct. 1998	NASCOP Core team
3.2	Sensitize the community for maximum involvement in STD/HIV control activities within their areas, starting with Karunga & Gilgil locations	1 day sensitization workshop for each identified group. 1 workshop per week	Gilgil and Karunga locations	From Oct. 98 onwards	Core team
3.3	Identify peer group leaders from within the sensitized organised groups	List of peers identified	Gilgil, Karunga, Kiambogo and Miti Mingi Locations	Oct. 98 onwards	NASCOP Core team
3.5	Monitor and Evaluate the process and impact of training Peer educators within the community	Report on peer educators activities	Karunga and Gilgil	Feb. 97 onwards	
3.6	Organise sensitization workshops for Departmental heads and	1 day x 4 workshop	Gilgil, Karunga, Kiambogo	1st w/s Nov. 96	NASCOP Core

	Opinion leaders		and Miti Mingi Locations	others Feb, 97 onward s	team
4.	**MATERNAL SYPHILIS**	**SCREENING AND OPHTHALMIC**	**NEONATO RUM PROPHYL AXIS**		
4.1	Train HCW on syphilis screening and Ophthalmia Neonatorum (ON) prophylaxis	See 1:1	See 1:1		
4.2	Train TBAs and CHWs in STD case detection, Ophthalmia Neonatorum prophylaxis and syphilis screening in the ante natal mothers	2 days w/s conducted for each organised group	Gilgil, Karunga, Kiambogo and Miti Mingi Locations	Oct. 96	NASC O P Core team
4.3	Sensitize Ante natal mothers on the need for maternal syphilis control and Neonatal eye prophylaxis	Lectures given to Ante natal mothers	Gilgil H/C	Oct. 98 onward s	MCH Staff
4.4	Procure and distribute reagents and equipment for Syphilis screening and TEO for prophylaxis	RPR reagents, Shakers and Centrifuges procured and distributed	Gilgil H/C laboratory	Oct 96	
4.5	Monitor and evaluate maternal syphilis control and neonatal eye prophylaxis programme	Health facility records, Surveillance data	Gilgil H/C	June 97	NASC O P, DHMT
5.	**STD/AIDS**	**CONTROL PROGRAMME MANAGEMENT**			
5.1	Identify project core team	Names of Depts. Represented, Tasks, and Job description of core team staff	Gilgil hospital	Sept 96	NASC O P DHMT
5.2	Identify Multisectoral task force for effective coordination and collaboration	Names of Depts. And organizations represented, Schedule of meetings	Gilgil division	Sept. 96 onward s	DHMT Core team
5.3	Collaboration with Donors, NGOs and private sector organizations in promotion of STD control activities	Meetings with NGO's and private sector staff within project areas	Gilgil division	Oct 96 onward s	DHMT Core team

2.0 The Functions of Gilgil Primary Health Care Unit

The Primary Health Unit:

a) Provides overall co-ordination of primary health care activities in the country.

b) Reviews and evaluates primary health care activities with a view to identifying areas in need of strengthening.

c) Provides technical and financial resources for Primary Health Care at all levels.

d) Promotes inter-sectoral collaboration in Primary Health Care at all levels.

e) Establishes and maintains relevant guidelines for the implementation of Primary Health Care.

f) Liaises with WHO, UNICEF, other International Agencies, such as USAID and World Bank, bi-lateral agencies and NGOs on matters relating to Primary Health Care development.

g) Maintains a data-base on Primary Health Care development and provides quarterly and annual reports on progress.

Criteria for selection of communities include:

a) Whether the project satisfies a felt need of the community.

b) Whether there are ongoing PHC activities, preferably where there are existing VHCs and some CHWs who have been trained.

c) Communities' willingness to pay for the drugs and mosquito nets.

d) Communities' willingness to set up a revolving fund, maintain a bank account and start replenishing drugs at the agreed time.

e) The capacity of the DHMT to supervise and monitor community initiatives.

As much as possible, the locations selected for the Bamako Initiative should fall within areas where other child survival and development activities are going on. Steps for initiatiating the BI have been clearly defined (Annex 1).

Community Control

Primary health care depends very much on the full involvement of communities in planning, implementing and monitoring the health activities. It is therefore essential to review community experiences in health and other programmes and to understand the dynamics of these communities. Links to District Development Committees, district administrations, village development/health committees and other local bodies should be defined and their methods of operation clearly spelled out, including:

a) Commmnity decision-making processes

b) Scheduling of meetings of community development or health committee (or equivalent committees)

c) Defining functions and tasks to be carried out (sanitation, income-generation)

Local Administration (Chief, and Sub-Chief)

Arrange a public meeting and preside over the selection of TBAs and CHWs.

Arrange public meeting for feedback of community survey results.

Mobilize community for development projects.

Mobilize GOK /NGOs interest in supporting development project[5].

[5] Mr. Njoroge Oral interviewed by Mary Munyua, on 12th July, 199. He lives in Gilgil Public Health Centre.

Village Health Committee (VHC)

Roles

Identify the need for health project within the community

Mobilize the community health activities e.g. malaria control, demographic surveys screening etc.

Advise community CHWs and TBAs on specific projects e.g.

Appraisal of all community health projects

Resolve problem related to programme management

Supervise CHWs and TBAs in their work

Stock control in their pharmacies

Send minutes of all VHC meeting to DHMT

Provide feedback to the community on all aspects of the programme needs assessment, survey progress, problem etc.

Identify needy cases to be exempted or given credit facilities

COMMUNITY HEALTH WORKERS (CHWs)

They are the link between health services and the community

Motivate within the community for better health

Provide counseling on all health related topics, especially disease prevention

Provide basic treatment and refer all complicated illnesses

TRAINING OF COMMUNITY HEALTH WORKERS

As I attended their course, community health workers are trained in the following areas,

1. Curative care for malaria, diarrhoea, worms, conjunctivitis, anemia, scabies and fever, dispensing drugs-chloroquine (tablet and syrup), paracetamol, Benzylbenzoatea dn mebendazole-as well as family planning devices and ARS.

2. Home visits to mobilize families towards better health habits, including immunization.

3. Growth monitoring of small children, referring any children showing faltering growth to the nearest health facility.

4. Counseling on home improvements, including proper storage in the home, use of latrines and save disposal of household waste.

5. Promotion of kitchen gardens to provide additional food varieties to the diet, particularly for children

6. Keeping the record of money obtained from the sale of drugs

7. Link between health personnel and the community

8. Motivate the community for better health.

(a) **ACTIVE ACTORS** - are those from within the community who are directly involved in the implementation of activities to promote good health. These include: Clan groups, individuals families traditional Birth Attendants, Community Health Workers ,Village Health Committees, Traditional healers, Local Leaders, Teachers, Pupil ,Youth groups.

(b) **SUPPORTIVE ACTORS** - Refers to those from outside, whose major role is to enable the active actors carry out their activities effectively. In this category there are four main group mainly:-

Ministry of health with it' s relevant sub-branches i.e. CDA, KEPI, and AID Secretariat.

Other health related Government sectors i.e. water, Agriculture, Livestock, Social Services, Education and Public works.

Non-governmental organizations i.e. AMREF, Agakhan foundation Action Aid, Plan International, Kenya Red Cross.

i) Donor Agencies i.e. UNICEF, WHO, IFAD, SIDA DANIDA, USAID, FINIDA

CHAPTER 3

3.0 RESOURCES OF FINANCE

They are both Local and Foreign

Local

- The community is responsible for the building, shelves, payment of watchman and for ensuring a supply of water.

They do this by selling of drugs, mosquito nets and the little money they get from empty containers.

Foreign

- They are organisations like UNICEF, through the Ministry of Health, provides funds for the initial supply of drugs which form the basis of a revolving fund to purchase more drugs.

The government and the Diocese are committed to shifting resources on a gradual basis from purely curative care towards preventive and promotive health care. In summary, the primary health care activity could be either sponsored by NGOs or the government. Originally this money used to train village health committee, community health workers and traditional birth attendants afterwards it was used on a research on demography and mobilization of the community. After the training the community was given a few drugs, mosquito nets and any other supportive equipment. Money generated from the sales of drugs and nets was recycled. Emphasis was also laid on voluntary services. Therefore the active key actors in this case were not paid.

3.1 BUDGET CONTROL

For maintenance of the budget, proper records are kept for all activities, that is, drug flow, patients treated, money received, money spent, money in the bank etc. All this is done through proper monitoring. Community health workers have to write monthly reports on progress to the D.H.M.T through the T.O.T at the division.

STATIONARY

100 Leafs Newsprint @ 5/=	100 x 5	500.00
8 Felt pens @ 65/=	8 x 65	520.00
2 Packets Dustless Chalks @ 40/=	2 x 40	80.00
1 Duster @ 25/=	1 x 25	25.00
2 Masking Tapes @ 42/=	2 x 42	84.00
33 Biro pens @ 8/=	33 x 8	264.00
33 exercise books x32 pg. @4/=	33 x 4	132.00

FACILITATION

Fuel 700/= per day x 10 days	7,000.00
Facilities allowance @ 300/= per day per person (300x7x10)	21,000.00
	28,000.00

FOODS

Charcoal	1 sack @ 100/=each	100.00
Sugar	30kg @ 50/= per kg	1500.00
Tea leaves	500g @ 120 each	100.00
Cocoa	400g @ 20/= each	120.00
Bread	60 loaves @ 20/= each	1200.00
Blue band	3kg @ 120/= per each.	360.00

Meat	40kg @ 100/= per each.	4000.00
Rice	10kg @ 40/= per each.	400.00
Cooking oil	6kg @ 80/= per each	480.00
Salt	500g @ 10/=.	10.00
Carrots	10 packs @ 5/= each	50.00
Tomatoes	10 packs @ 10/= each.	100.00
Milk	7 bottles per day @ 10/= each x 5 days.	350.00
Fruits(orange)	320 oranges @ 5/= each	1600.00
Cooks	3 x 60/= x 5 days	900.00
		11,270.00

DRUGS KIT

Panadols 500mg tabs	3 x 1000 @ 250/=	750.00
Antacid	2 x 1000 @ 130/=	260.00
Chloroquin 250mg tabs	2x 1000 @ 900	1800.00
Chlopheniramine 4mg tabs	5 x 1000 @ 70/=	350.00
Mehendazole 100mg tabs	2 x 1000 @ 450/=	900.00
Septrin 40/80 tabs	2 x 1000 @ 720/=	1440.00
Ampicillia syr. 60ml.	50 x 60ml @ 30/=	1500.00
Septrin syr. 60ml	50 x 60 ml @ 22/=	1100.00
Levanisole syr. 60ml.	5l. @ 200/= per litre	1000.00
Trihistamine cough syrup.	2 x 5l. @ 340/=	680.00
Chroloquin syr.	1 x 5l. @ 1500	1500.00
ORS sachets	100 @ 7/= each	700.00
Tetrasychrine e. oint.	50 @ 10/= each	500.00
Whitefields skin oin.	10@ 98/= each	980.00
Medicine envelopes	1000 @ 350/=	350.00
Medicine cupboard	1 x 2500	2500.00

		16,310.00

Summary	
Stationery	1,605
Facilitation	28,000
Foods	11,270
Drugs Kit	16,310
Total Cash Required (Kshs)	57, 185

3.2 ORGANISATION

The Ministry of Health acts as the supervisory body for all healthcare provision programmes. Non-governmental organizations (NGOs) provide approximately 30% of healthcare in Kenya. Together with the private sector, they contributed to 42% of total expenditure on health in 1988 (both recurrent and development expenditures). NGOs have always charged for their services and in many parts of Kenya their activities are largely self-financing. Nearly all mission hospitals, health centres and dispensaries charge either a consultation fee, a fee for drugs prescribed or a combination of both. Shortages of drugs in such facilities are rare and the quality of health care is considered to be better than in public services.

The two major NGO providers of health care, the Protestant Mission Hospitals and the Catholic Church Hospitals and their subsidiary units, have established an effective joint drug procurement and distribution scheme known as MEDS (Mission for Essential Drugs and Supplies). MEDS buys drugs in bulk, mainly from local manufacturers, and assembles kits for individual units, for which the units pay for them directly.

NGO's, principally the missions and the Aga Khan Foundation have actively promoted community-based health care in Kenya and have developed programmes in many parts of the country. In several of these, CHWs have been trained to supply a limited number of drugs and to establish a revolving fund out of which they receive their allowance. The Aga Khan Health Services Project, operating in 50 villages of Lower Nyakach Division in Kisumu District, for example, has trained 71 CHWs since 1986 to use chloroquine, paracetamol, benzyl benzoate and ORS. Funds from the sale of drugs are kept in a community-operated account. Those who cannot pay benefit from a welfare fund raised by community collections and run by the Deputy Chief of the Division.

A similar project is run by the Diocese of Maseno (Protestant Church) in Maseno and Nyando Divisions in the same district. Community Health Workers, covering 50 villages since 1985, are trained for one week every six months. Funds collected are used mainly for improving water supplies and general sanitation. The poor are exempted from payment.[6]

[6] cf. AMREF, Training Guidelines for Healthcare, (Nairobi:1995) pg. 63.

CHAPTER 4

4.0 STRENGTHS & WEAKNESSES

STRENGTHS

FOLLOW-UP AND MEETINGS

In fulfilling the project objectives, the community Health Workers, Traditional Birth Attendants and Village Health Committees have been meeting regularly for planning, execution and evaluation of the primary health care. Meetings have always been well attended despite financial constraints especially for transport in the case of Community Health Workers from far.

Follow-up involves frequent home visits to the community.

Annual refresher workshop for all the Community Health Workers.

Monthly visits by the training team to meet with the group of a particular area.

Once a year visit by team members to the home of every Community Health Worker and include also visit to women groups, local schools and village elders.

Children who had suffered from scabies were now cured.

Majority of the community had already implemented what they had learned, especially all of them had a latrine, a dish-wash stand, a clean home, and their children were well dressed, well fed and clean.

Kitchen gardens were tried, some succeeded and some failed due to the lack of rain.

The objectives of primary health care as a policy are very excellent.

Tally Sheet used by CHWs

Monthly Record:

- Name of the Community Health Worker .....
- Date .....
- Village .....
- Total Number of houses in the Village (Approximately) .....
- No. of homes visited (must be exact) .....
- New homes visited .....
- Revisits .....
- Improved housing .....
- Latrines built .....
- Ventilation .....
- Rubbish pit built .....
- Chicken house built .....
- Kitchen garden started .....
- Dish rack built .....
- Laundry line put up .....
- Bathroom .....
- Homes now using "leaky tin" .....
- No. of people treated with rehydration fluid .....
- No. of children found with marasmus/kwashiorkor .....
- No. of children found with ringworms .....
- No. of children found with worms .....
- No. of children found with immunized .....
- No. of mothers advised who attend AN/Clinic .....
- How many times have you taught groups .....
- How many times have you taught barazas .....
- How many times have you taught school .....
- How many times have you taught Church .....
- How many times have you assisted deliveries .....

Other things found: Name them .....

Collaboration with Primary Health Trainees, Nutritionist, District Primary Health Nurse and District Water Officers.

4.1 WEAKNESS OF GILGIL PRIMARY HEALTH CARE PROGRAMME

Favoritism in the selection of Community Health Workers and Village Committee Members.

Locating a Community Pharmacy in a site which is not fully approved by the majority of the community members.

Community health workers refusal to allow credit to some community members without adequate explanation.

Misuse of funds by either the village health committee, community health workers or training of trainers (TOT)

Lack of transport to supervise community health workers and community based activities.

The sales of expired drugs.

Lack of enough water especially for kitchen gardens.

SHORT & LONG TERM STRATEGIES

4.2 (a) SHORT-TERM STRATEGIES:

Treatment of minor illnesses at village level. Only major illnesses are referred to health institutions and after a careful evaluation.

Training more local leaders on leadership skills.

Training more community health workers and traditional birth attendants.

Educate the community on nutrition, immunization, sanitation and farming methods.

4.3 (b) LONG-TERM STRATEGIES:

The goal of health for all has two perspectives viewed in long-term context. It simply means the realization of the WHO' S objectives of "attainment of all peoples of the highest possible level of health"[7] .

Health for all means that health is to be brought within the reach of everyone in a given community. It implies the removal of obstacles to health-that is to say, the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing etc.

4.4 RECOMMENDATIONS

Having worked as a volunteer with primary health care programme for two months, I would like to recommend the following, for the continuation of the good work that the programme has initiated.

i) Let the programme continue with the same spirit to more places in order to assist the whole division.

ii) Let the primary health care take care when and if the community health worker who had left the group will be taken back into the group because they can cause disruption of the group.

iii)It is very essential to set clear objectives at the beginning of the programme.

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[7] Jerry Crowley, Community Based Health Care Programme, (Nairobi: Kenya Catholic Secretariat, 1987). pg.28.

iv) It would be very important for all community health workers to introduce pit latrine lids for all the latrines.

v) The sites and distance from the house of cattle sheds to be rectified.

vi) There is need for composite pits for house holds.

vii) There is a need to train more community health workers.

4.6 CONCLUSION

The aim of this programme was to identify Primary Health Care within Gilgil Division and create awareness to the public, particularly to the communities starting from the grass-root. The programme embraced good teamwork from all the ministries involved under the co-ordination of the Public Health Coordinator. In creation of awareness seminars, workshops and meetings were held with various topics covered as mentioned under the programme activities. Indeed, this gave a lot of insight on the primary health care conditions, thus equipping the persons with proper information to disseminate to the community.

Various means were used for publicity being verbally through the chief's baraza and church's. These helped greatly in increasing awareness to already sensitized community. By now, they have learnt that teamwork involves collaborating with other persons/personnel in the division for effective implementation of the programme. This means not only focusing on health but also socio-economic well being of the target group, in order to empower them to be more self-reliant among themselves and thus improvement to their standard of living.

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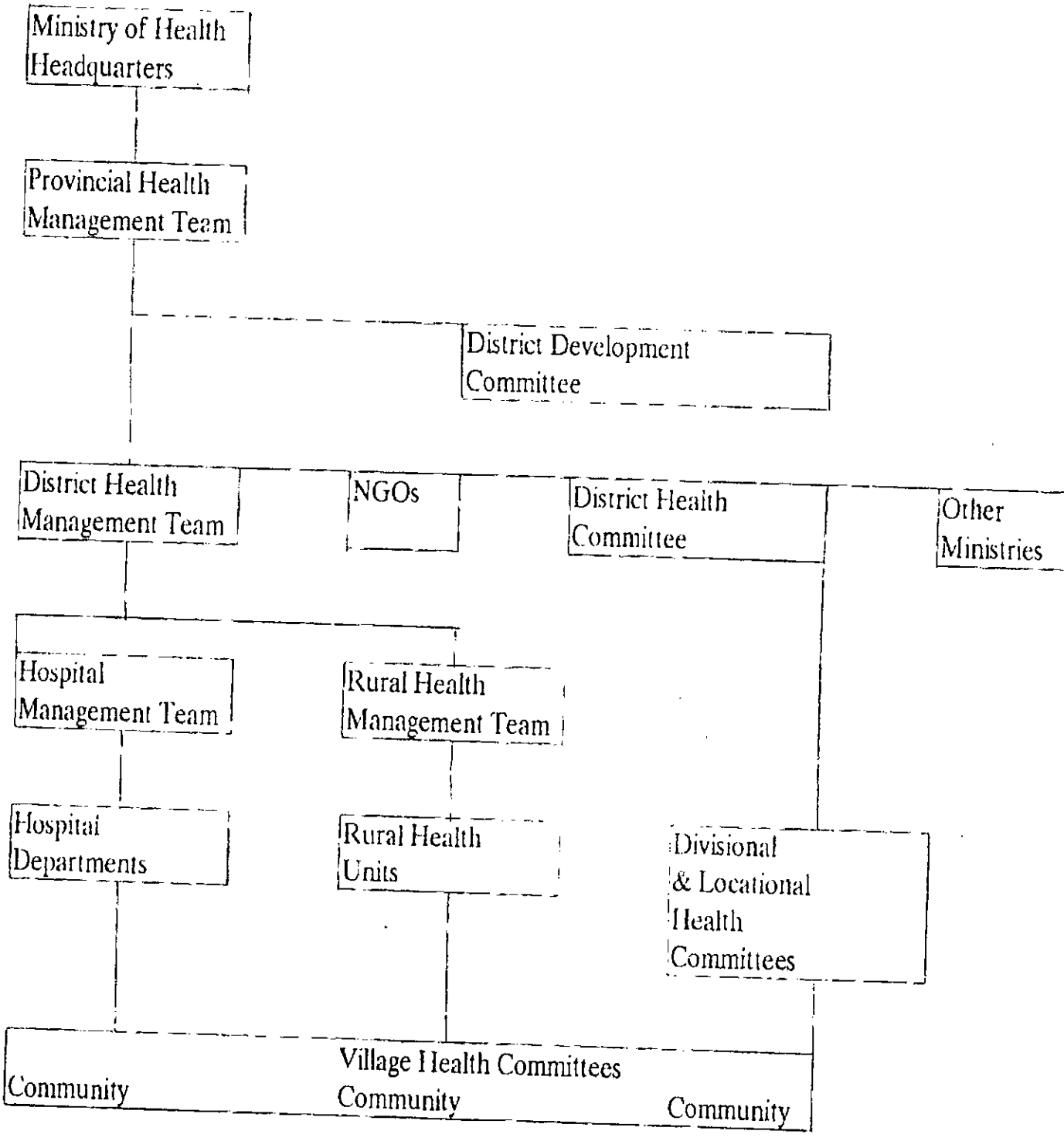
AMREF, Health Education, Nairobi 1995 pg. 1

AMREF, Training Guidelines for Health Care, Nairobi, 1995.

Crowley, Jerry, Community Based Health Care Programme, Nairobi Kenya Catholic Secretariat, 1987.

ANNEX 5

The structure is shown below:

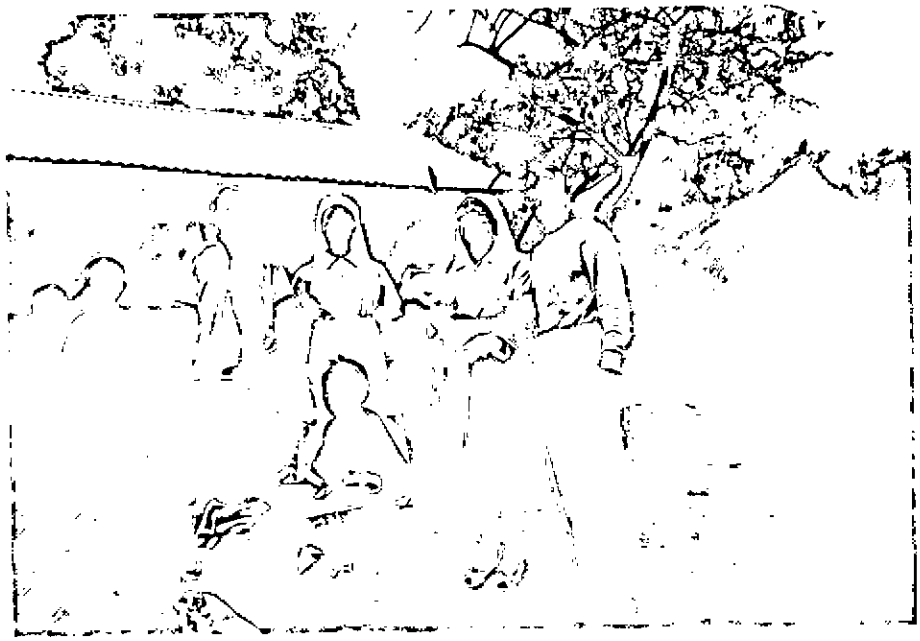


ANNEX 6

Traditional birth attendance in the class listening to the teaching.

A community expressing their problem of water

Home visit in the community health workers



Reaching communities; Gilgil community health workers, Joshua teaches the community health workers importance of kitchen garden.

Empowering women through training

ANNEXS

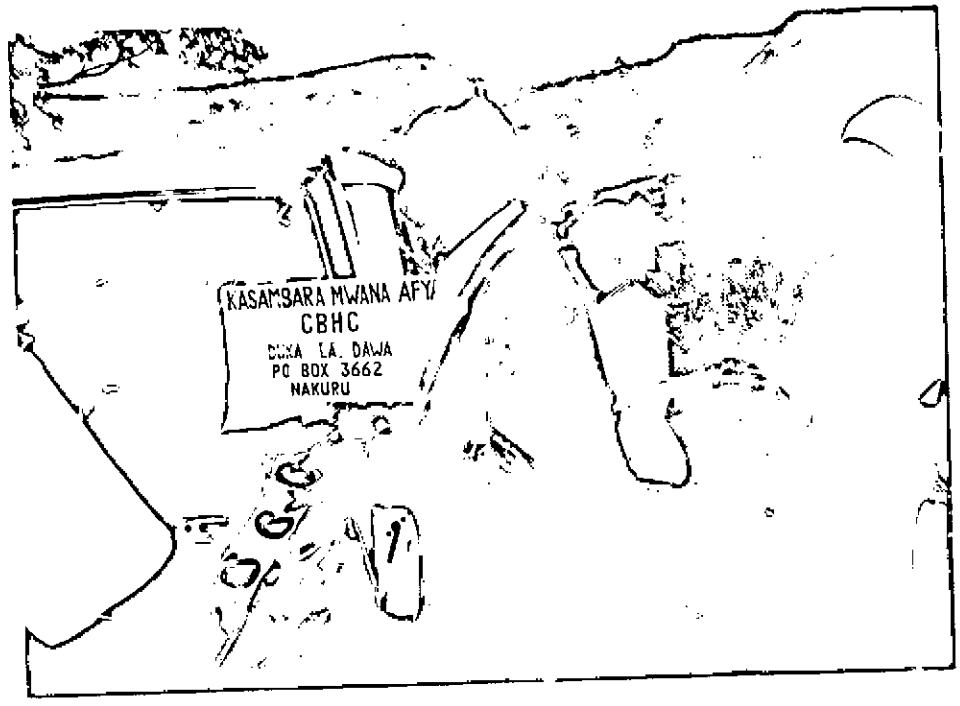
Educational tour

A community health worker explaining the Importance of having a dish ruck in each family

A community health worker explaining the Importance of having a dish ruck in each family

An Agriculture officer in Gilgil accompany Mr. Muriithi to talk to farmers on the best ways to improve fields from their small holding farms

Health talks before starting the work



Community health workers and traditional birth attendance after finishing their work

COMMUNITY INITIATIVES FOR PRIMARY HEALTH CARE IN GILGIL

RIGHT:
The District Public Health Nurse inspects a Community Health Worker's drugs kit.

Traditional Birth Attendants at Sigoti: Safe Motherhood is an integral part of the Bamako Initiative.

RIGHT:
A member of the Sigoti Village Health Committee makes a point at a village meeting.

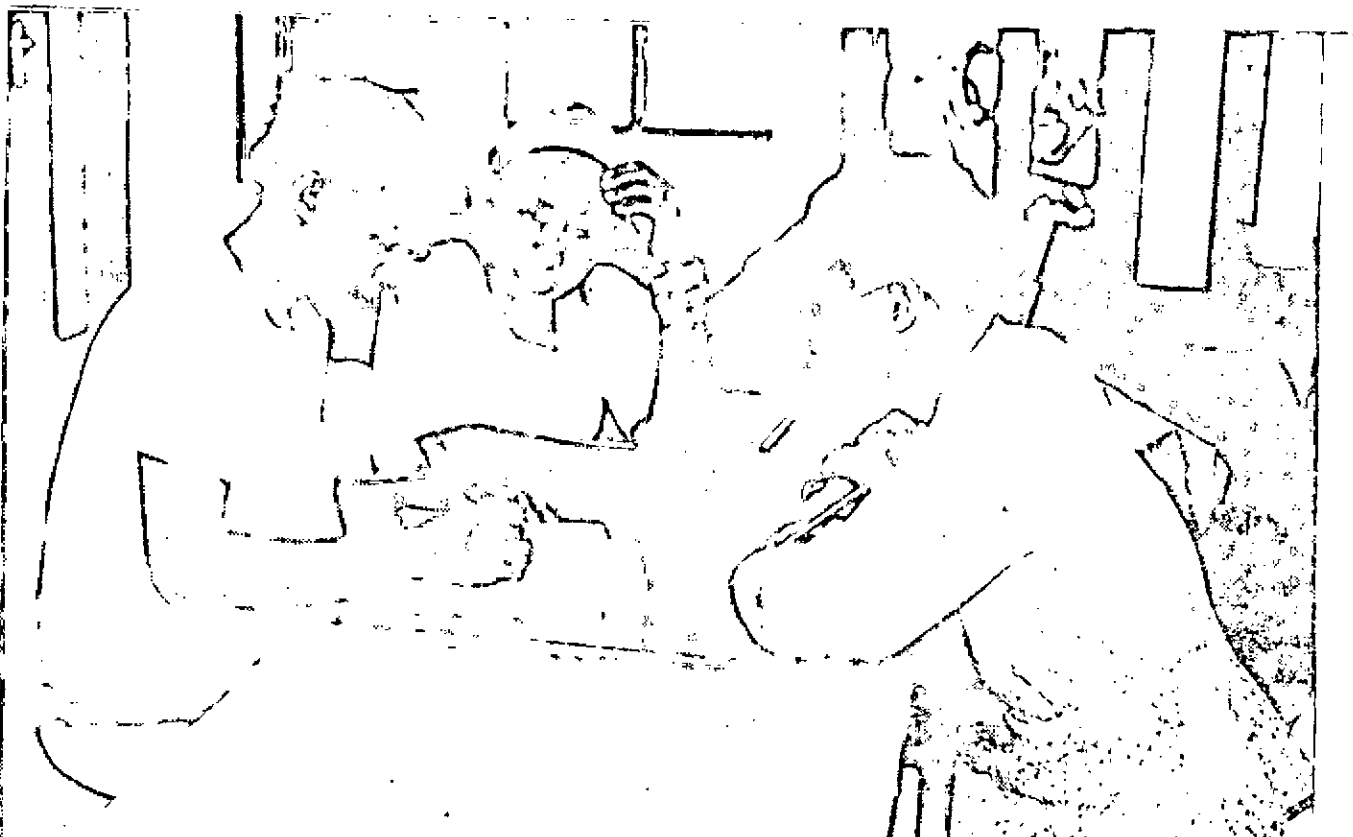
A social minister Mary Munyua planting a tree for rememberance in the home of one of community health workers

Communal tasks such as brick –making for schools organised by the assistant chief [above, standing].

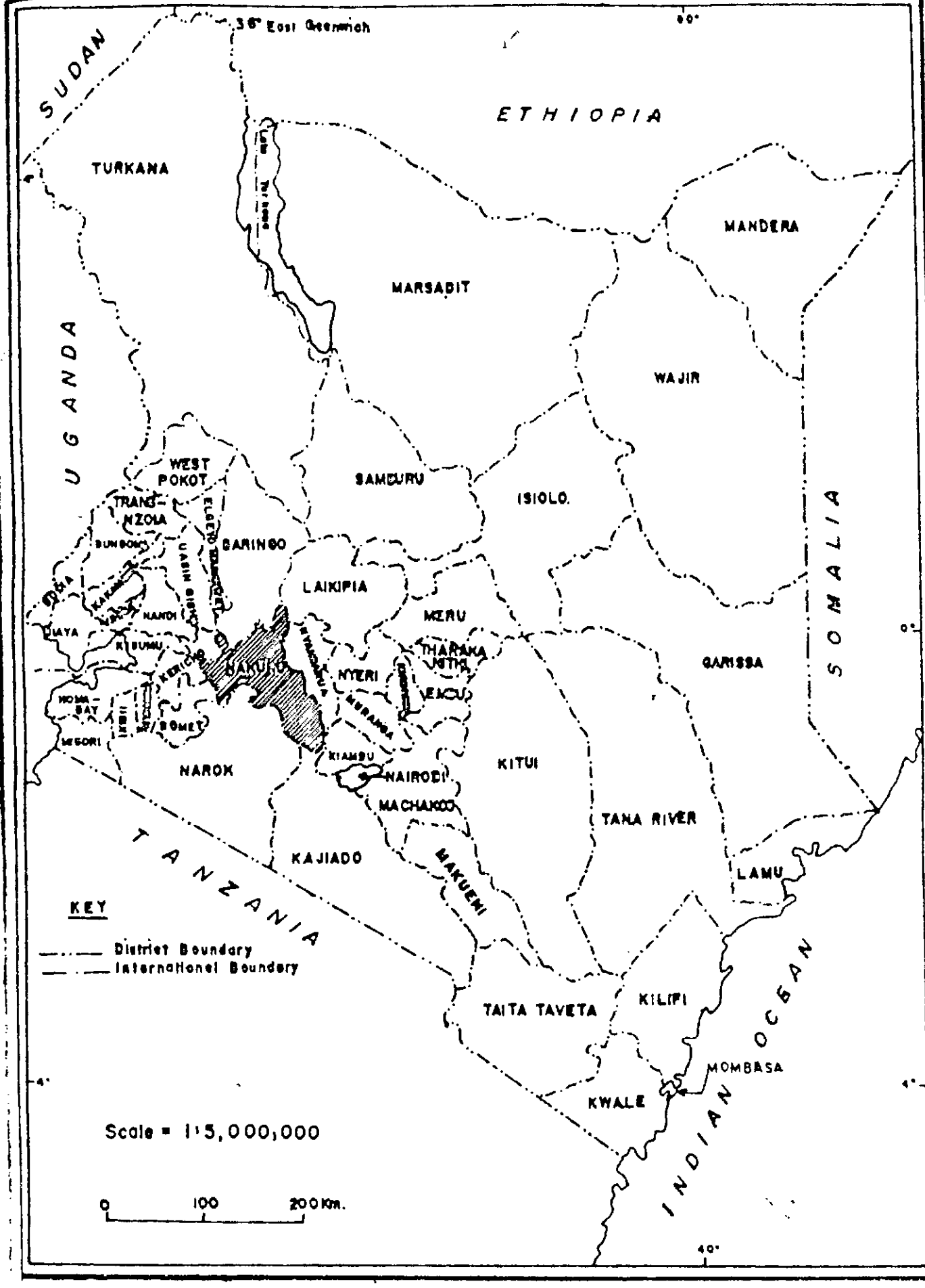
[Below] CHWs create awareness of health issues by use of role plays and other problems --posing codes.

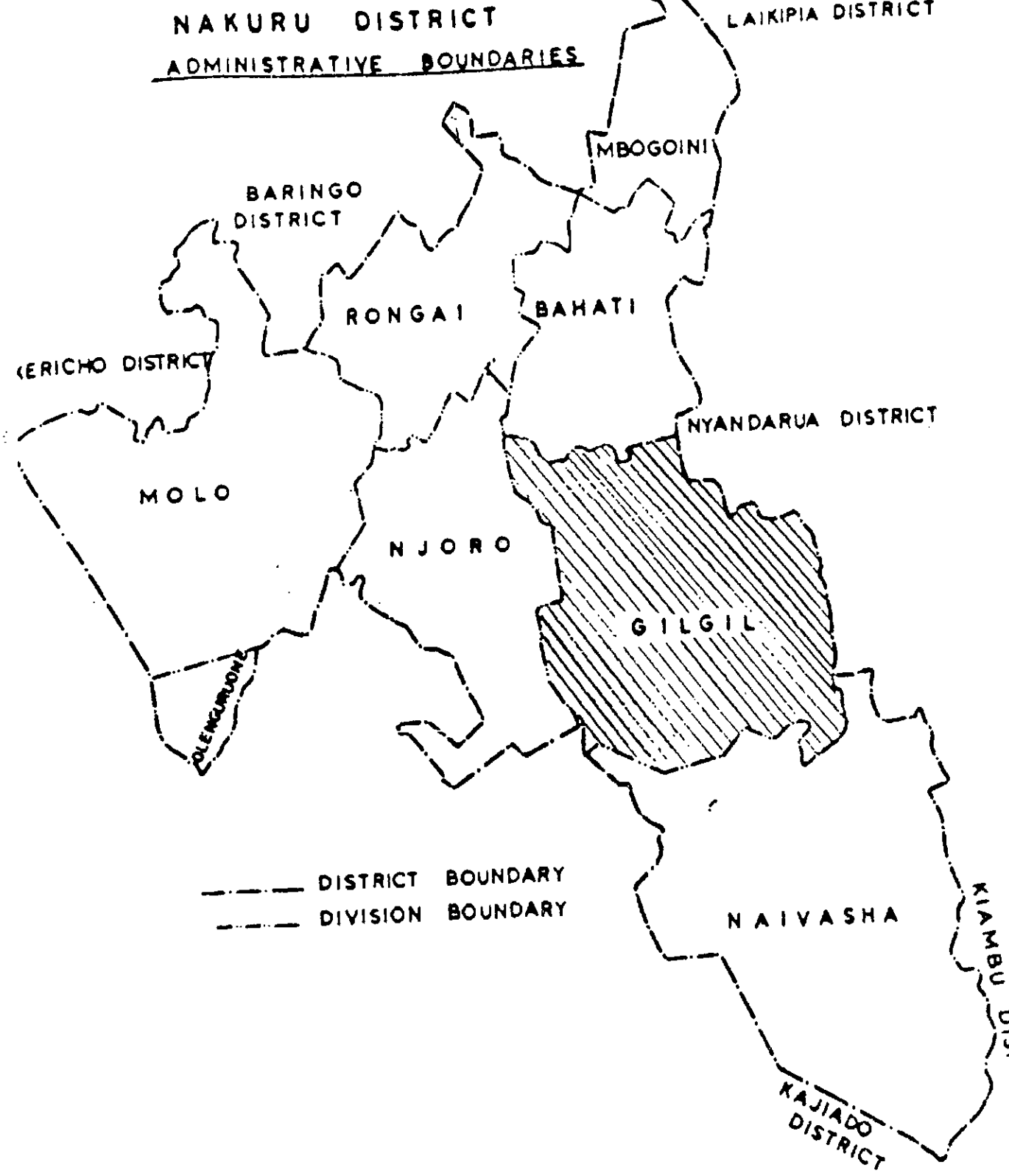
Practical demonstrations in preparing a balanced diet are feature of every community health worker training workershop.

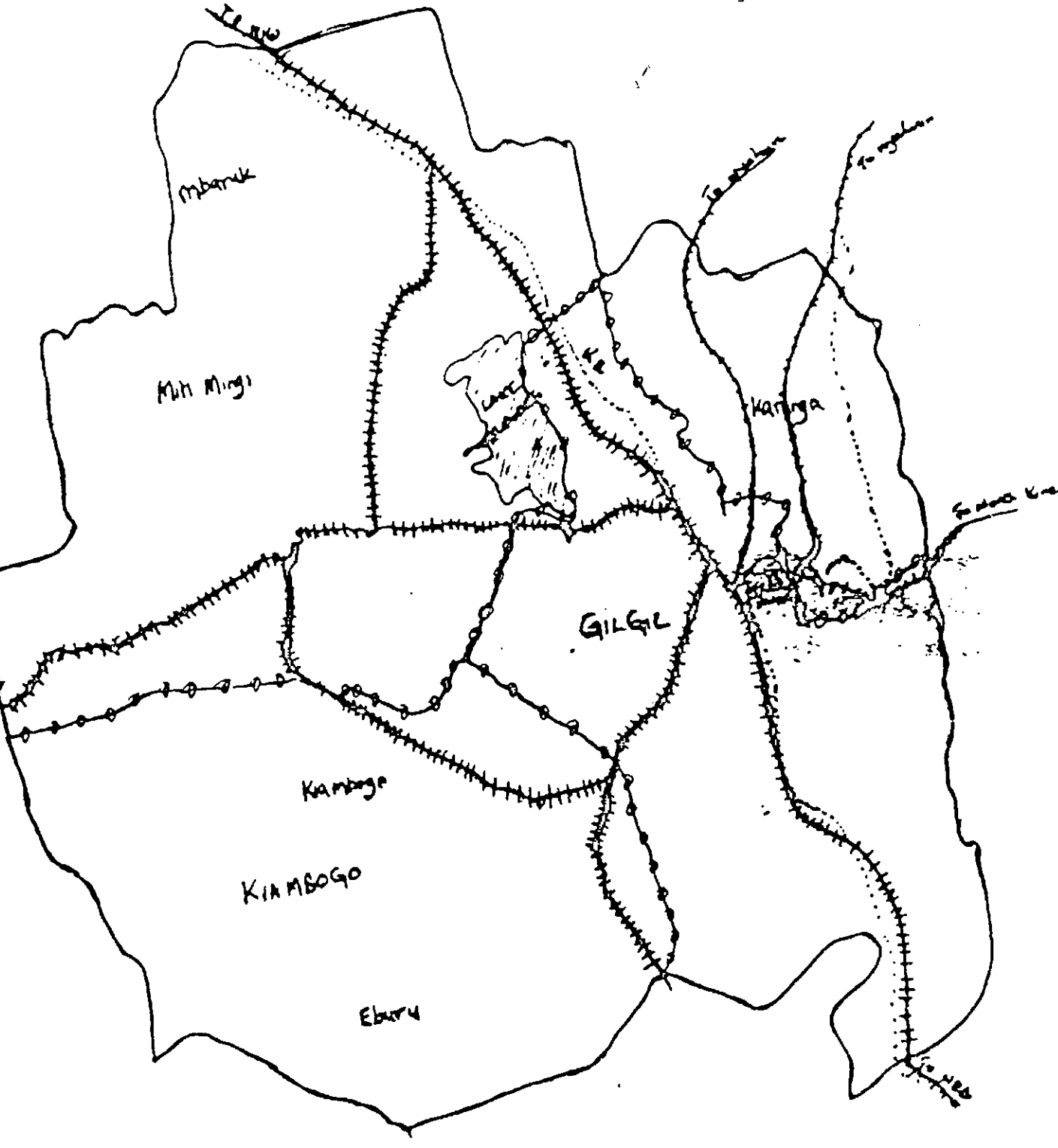
The three area –co-ordinators, discussing their work during a training of trainers workshop.



LOCATION OF THE DISTRICT




NAKURU DISTRICT
ADMINISTRATIVE BOUNDARIES
LAIKIPIA DISTRICT
MBOGOINI
BARINGO DISTRICT
RONGAI
BAHATI
ERICHO DISTRICT
NYANDARUA DISTRICT
MOLO
NJORO
GILGIL
OLENGURUONE
DISTRICT BOUNDARY
DIVISION BOUNDARY
NAIVASHA
KIAMBU
KAJIADO DISTRICT



REFERENCE :

DIVISIONAL BOUNDARY ——————————

LOCATIONAL BOUNDARIES -o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-

ROADS ////////////////////

RAILWAYS .....