INTEGRATED RURAL HEALTH SERVICES PROGRAMME WORKING SEMINAR 25-26.5.1978

RURAL HEALTH DEVELOPMENT PROJECT ADMINISTRATIVE SUPPORT UNIT

MINISTRY OF HEALTH, P.O. BOX 30016, NAIROBI, KENYA

INTEGRATED RURAL HEALTH SERVICES PROGRAMME

WORKING SEMINAR

OUTSPAN HOTEL, NYERI: 25-26 MAY 1978

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1. SYNOPSIS OF OPENING REMARKS

1.1. Professor Mbithi

Professor Mbithi spoke of the thrust for rural development in Kenya. He went on to outline the main objectives of the structure of rural development:

(i) To increase incomes and distribute them more equitably;

(ii) To increase rural employment in order to retain 80% of the rural population in a rural setting;

(iii) To promote national integration through involvement of the local people in planning, implementing and evaluating various programmes.

He then went on to outline the major themes of Kenyan National Development Plans:

(i) 1970-1974: Rural Development;

(ii) 1974-1978: Generation of Employment;

(iii) 1978-1983: The Alleviation of Poverty.

During the current National Development Plan, health services is among the the top three priorities with a commitment towards upgrading and improving the system. In this context, planning should take into consideration the fact that large proportions of the population lead only a subsistence based life which promotes the continuation of a traditional life style. This traditional life style has in the past, and continues to keep people out of the mainstream and isolated from, and ignorant of health services available to them. It is indeed a known fact that some 30%

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of the national populace does not seek health services.

Professor Mbithi concluded by pointing out some socio-political problems facing health service planners, such as: The number of qualified doctors per population group - doctor/population ratios. The question of services will also have to be discussed thoroughly: What is the impact of Harambee projects? What economic resources exist in the rural areas? What impact will the ecological characteristics have on future development? What is the proper size of the dependency populations? i.e. the proportion of women and old men being left in the rural areas while the young migrate to the towns.

1.2. Professor Mutiso

Next, Professor Mutiso spoke of the problem of structures in relation to health services. In this context he raised a number of points for consideration and examination:

(i) The number of rural health units contained within the various divisions;

(ii) The relationship of the Harambee movement as a structural process vis-a-vis the Government establishment in development;

(iii) The use of poorly qualified personnel in the most important task of establishing and maintaining a workable relationship with local populations;

(iv) Can the Ministry of Health afford to field under-qualified personnel, on the local level, when they must interface with highly qualified

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people from other agencies, such as Ministry of Works and Ministry of Agriculture;

(v) How much and what type of resources have been spent on rural health? The Ministry of Health has not committed very many resources, and those that are committed tend to be curative rather than preventive;

(vi) Finally on integration: The problem is not the lack of doctors, but a functional responsibility of the Ministry of Health staff to integrate field personnel, as well as establish and improve intraministerial relationships. The Ministry should train more administrators with this goal in mind.

Some political considerations: The administrators are complaining of political interference - Why not include the politicians in the process?

Since politicians accept the "illegal" movement of people to State land, why doesn't the Ministry of Health administration accept this fact and plan health delivery accordingly?

1.3. Dr. Were

Dr Were concluded the opening remarks by blasting the notion of the doctor as God. " Health is considered holy ground."

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She spoke primarily of her experiences while working with a community based approach toward health services in the Kakamega area.

Local people can carry out certain specific objectives and policies. Local populations can most effectively define their own health problems and needs within their own structural organizations. Through appropriate professional guidance personnel such as the Public Health Nurse, Public Health Technician, Enrolled Nurse, local enumerators are very useful in keeping track of any changes.

She went on to say that the communities' opinion should be respected. The presumption that the poor are stupid is very wrong. One result of the Kakamega project is the increase in the proportion of homesteads having latrines, from 5% to 40%.

The local communities need support from the Ministry of Health - when the distance to the health centre is great, or the Ministry cannot provide a health centre for a particular area, then the Ministry should provide a nuse to work with the community.

. Dr Were concluded her remarks by outlining a structure for community participation on the district level: Community Health Team - can work inside the DMO, supervised by the District Education Office. This team should coordinate its efforts with the District Health Team composed of

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technical people. With this type of structure she is confident that 100% coverage can be obtained.

2. ECOLOGICAL ZONE DISEASE PATTERNS

There are a number of diseases that can generally be described as endemic to Kenya. For example, whooping cough, measles, influenza, respiratory infections, polio, etc. fall into this category. However, there are some diseases which tend to be more prevalent in a given area due, at least in part, to that area's particular ecological characteristics. For example:

- Arid (Semi-desert) Zone

  Brucellosis is probably prevalent and Tetanus is common. A particularly prevalent parasitic disease problem in this zone is Hydatid disease. Nutritional problems are severe and markedly seasonal. Eye diseases affect a substantial proportion of the population.

- Marginal Zone

  Malaria is seasonal, up to two months a year. Schistosomiasis is focal, with both S. Haematobium and S. Mansoni types. KalaAzar occurs in this zone with several epidemics resultant since 1950. Cattle associated diseases are prevalent, notably Brucellosis Anthrax and Tetanus. Anaemia is a substantial problem in addition to other Nutritional problems.

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- Highland Zone

  Amoebiasis is a particular problem throughout the Zone, along with both Dysentary and Liver Abscess. Non- communicable disease problems include Goitre and Carcinoma of the liver.

- Hot/Humid Zone

  Malaria is holo-endemic with transmission occurring throughout the year. The main impact of malaria is on children aged 2 to 4 years. Schistosomiasis is also endemic, S. Mansoni and S. Haematobium being predominant. Soil transmitted helminths are frequent especially Hookworm and Ascaris. Salmonella, including Typhoid, and Shigella infections occur seasonally and Cholera became epidemic in 1975. A number of Arbovirus infections are endemic, especially those involving cattle reservoirs. Leptospirosis is common especially in land development areas. Particular non-communicable disease problems include Carcinoma of the Oesophagus and Burkitt's Lymphona.

3. FOUR GROUP REPORTS

The following group reports are not intended to represent a formal plan of action, but are instead a number of individual points that could, at some future time, be incorporated into a national strategy. Additionally, they should not be judged solely on the basis of current standards but with an eye toward future developments.

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3.1. Arid Zone Group

3.1.1. Population characteristics and settlement

People are generally very conservative leading a life based upon a livestock economy.

It is government policy to settle and "stabilise" the great arid zones in northern and eastern Kenya which is tending to decrease the traditional nomadic movement patterns

From an epidemiological point of view, apart from the diseases mentioned in the accompanying table, it was considered that as the settlement rate increases so will the incidence of alcoholism and S.T.D.s.

The introduction of irrigation schemes into the arid areas is obviously another inducement for the population to settle.

It was noted that even though many of the people were still nomadic they tended to move according to pattern so that nodes could be defined.

It was generally agreed that the delimitation of health unit boundaries and the location of Headquarters should take this changing settlement pattern into account.

3.1.2. Services

The distribution of services must take territoriality rather than just population into account.

The requirements of special population groups, such as old men, women and children (who are often left behind in nomadic societies) should be catered for.

Mobile services are still essential though since they depend upon vehicles, they are inately unreliable and therefore should only be used when there is no alternative.

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Simple buildings that could be used periodically, when people were around, were considered as an intermediate step between mobile and established facilities.

3.1.3. Strategy

It was proposed that a health service strategy based upon four elements be implemented, i.e. the District Hospital, RHU HQ Health Centre, Dispensary, Primary Unit. The interaction between the links in this chain was considered most important in the remote areas. The accompanying diagram shows how this should take place.

The first three elements in the chain are viewed in more or less conventional terms except that for the health centre and dispensary, the buildings and staffing would not need to be as elaborate as they would in densely populated areas. (It was also considered that the role of the Public Health Technician could be widened to include health education, etc.)

The primary health unit on the other hand is a new element. It should comprise a simple 2-room building locally provided (c.f. Harambee school buildings) and would be staffed by a locally recruited primary health worker. A training level for this worker was not defined in detail but it was thought that a three to six month training period would be required. Primary health units would be situated so that no one would be further away from 30 km. from one. Should the need for a particular unit disappear then the place could be locked up and the staff member transferred elsewhere, perhaps to return at some future date. (This would be feasible due to the extremely low capital investment in

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building and equipment, say K.Shs 30,000/-.)

3.1.4. Other aspects (Missions)

Some discussion took place on co-operation between Government and the Missions. It was felt that a special working party should produce an organizational model for implementation. In the meantime it was felt that liaison committees should meet at district level on a monthly basis including representatives of all bodies providing medical services within the district. Such committees should also involve the administration by inviting the DC or DO and the DDO.

3.1.5. Other aspects (Training)

The importance of continuing training through visiting teachers, refresher courses or correspondence course was stressed. The dispensary staff were considered to be most at risk of becoming professionally jaded, therefore trainers should always visit dispensaries.

3.1.6. Other aspects (Supplies and Equipment)

Drugs were considered by far the most important supply item. And it was felt (see diagram) that by combining the collection (or delivery) of drugs to the collection of monthly salaries much of the problem could be solved.

It was stressed that each health unit headquarter should have a 2-way radio so as to keep in contact with the District Hospital. Such a radio would cost about K.Shs 20,000/- and would be useful for:

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- morale purposes;
- reporting shortages;
- epidemics;
- medical advice;
- staff/administrative problems.

It was mentioned that if PHTs were trained to examine sputum (for TB) and stools (for Bilharzia) microscopes would be needed even at dispensary level. Also fridges should be provided at dispensaries so that mass immunization programmes could be followed up.

The maintenance of land-rovers was discussed at length without much progress except to suggest that Cooper Motors should be encouraged to have branches in more of the district headquarters.

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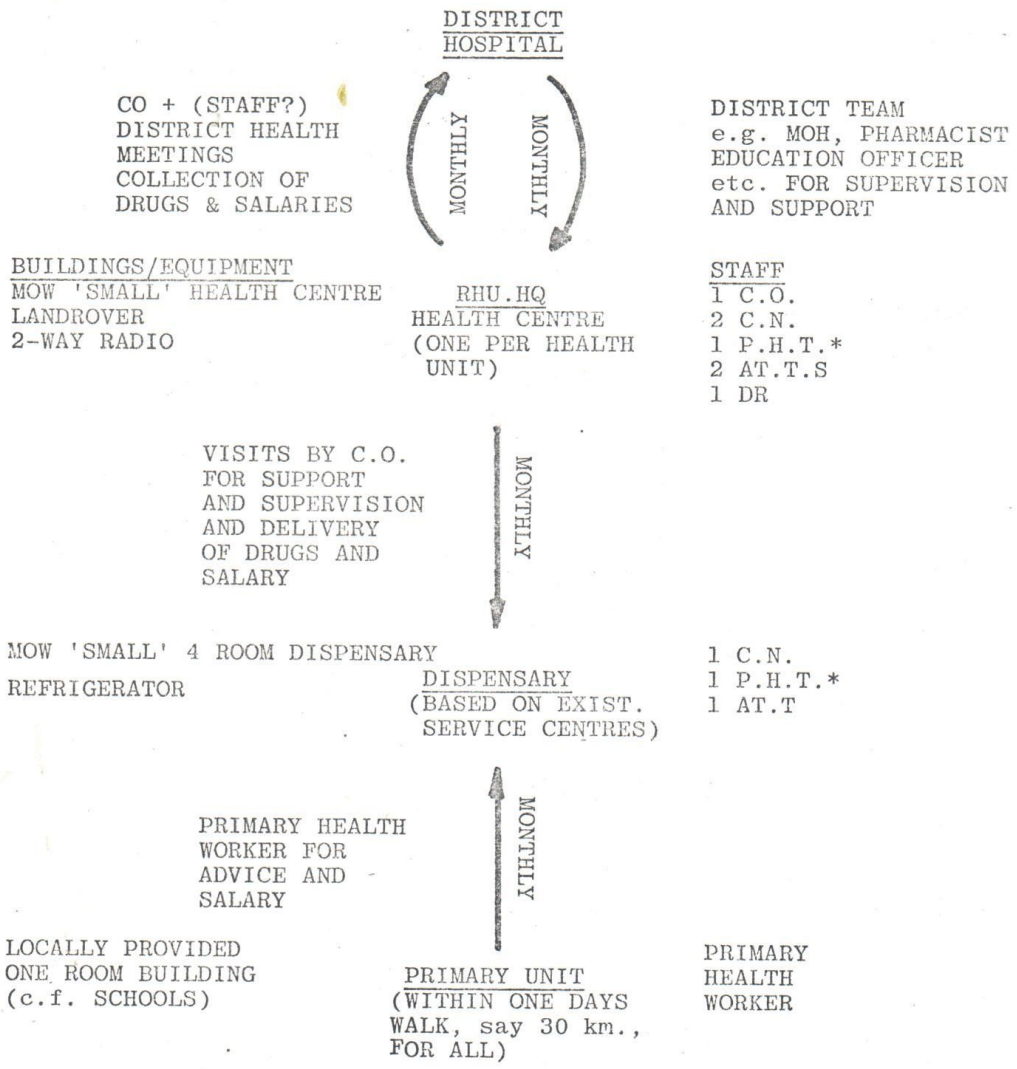
ARID ZONE PHASE II - REPORT

Category	Specific Need	Level of Care	Strategy	Services
Nutrition	Periodic starvation	RHU	Raise basic nutrition Training of E.C.N. Monitor for starvation	Research into local substitutes for milk. DSM ready availability.
Environment	Water-washed diseases Trauma URTI Kala Azar Zoonoses Eye-diseases Schistosomiasis	 PHU PHU Hosp. H.C. or Hosp. PHU Hosp.	PHT liason with M.W.D. Surface-water related Schisto-education Malaria education Faeces education	
C.D.C.	T.B. Schisto Gastroenteritis Malaria Vectorborne Diseases	Hosp. Hosp. PHU PHU Disp.	B.C.G. promotion Sputum Screening and Dispensaries. Short RX manyattas.	Logistics of vaccines re-studied, especially the cold chain and particularly its end link - the fridge in the dispensary. A microscope in every dispensary for P.H.T. to screen Sputa. Research into Brucellosis + Hydatic.
MCH/FP	Rising fertility rate in settled areas - see nutrition	Disp.	Natality matters must defer to (Muslim) cultural moves	
Curative			Medical treatment is of paramount importance	
Interjurisdictional			Involvement of NGO's is a pre-requisite for planning for integration. A joint working party should produce a practical "model" for integration of Government - NGO Services	A national or NGO special team of educationists could be of great help in facilitating and organizing refresher and upgrading courses collaborating with local authorities



*THE ROLE OF THE P.H.T. COULD BE REDEFINED TO INCLUDE FOR E.G. HEALTH EP.

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3.2. Marginal Zone Group

3.2.1. General

The communication network in the RHU is, except for one road, impassable during the rains. This is to some extent characteristic of most RHU's in the marginal zone.

Furthermore, a significant number of RHU's in the marginal zone are of the same size as the case study RHU, which actually implies that distances are long, services are concentrated and new settlements occur in areas where little or no services are available.

The basic principle for providing rural health services should then be one of bringing the services to the people, and not the people coming for the services. (Health service delivery system a reflection of the physical conditions).

3.2.2. Nutrition

Main crops grown are millet and green grams. People also own goats and goatmilk is an important food source.

The poor crops result in vitamin and protein deficiency.

There is also a general deficiency in terms of availability of food in the particular RHU as road connections to adjoining areas (food exporting) are very poor or non-existent.

Potential crops are sunflowers and sesame. Agricultural extension work should be initiated to stimulate these crops which are viable for the specific environment.

3.2.3. Communicable Diseases

The water supply in the RHU is poor and the quality low.

Prevention (immunizations) of specific age groups, particularly under-fives. (Malaria, Kala Azar.)

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3.2.4. MCH/FP

Basic minimum service in terms of immunizations. Antenatal/Postnatal services to be improved due to the low nutrition level.

Spacing of children is important, but complicated due to the specific, traditional family structure. Identification of groups of "high-risk-women" over 35 with more than seven children.

3.2.5. Environmental health

Need for improved and increased water supply.

Need for the promotion and digging of latrines, particularly in areas receiving rural migrants. The programme should be organised by the community.

There are plans for establishing an irrigation scheme in the south-western part of the RHU and consequently a small vector-borne diseases control station should be established.

3.2.6. Curative rural health services

The group noted that the RHU has only one land-rover. Due to the long distances in the RHU there is a definite need for providing more vehicles. The question of using Roho's instead of land-rovers should be looked into.

Common diseases are: infections, burns, respiratory disease, pneumonia, measles, etc.

3.2.7. Strategies

- Macro (ministerial) strategies

Planning should be effectuated under one DDMS who should refer directly to the PS.

Interdivisional co-ordination between departments

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providing rural health services, i.e. rural health, MCH/FP, nutrition, communicable diseases division and public/ environmental health. This can take place in the form of regular meetings between members of the various divisions.

MOH should recognise that medical expertise is in short supply, while at the same time planners are (or can be made) available. This applies to economists, sociologists, regional planners and management experts. In other words, the Ministry of Health should recognise that planning is a multi-disciplinary task.

It was emphasised that overall planning must be above sectorial interests.

The establishment of a central statistical division within the Ministry should be seriously considered as part of the planning division. This will entail introduction and application of more sophisticated data collecting and processing techniques. In this context it is recognised that the Vital Health and Statistics Division is already operating, but the services and capabilities should be expanded.

A pre-requisite for rapid and accurate processing of data is that a monitoring system be developed in order to measure the effect and coverage of the rural health services.

Ways and mean for gathering data at the district level should be found and necessary action should be taken in order to liaise with District Planning Officers . (Treasury.)

The preparation and further work on disease maps should be enhanced, as well as the importance of the MOH co-operating with the Ministry of Agriculture was emphasised

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in respect of MOA's work on nutrition maps.

The final delineation of Rural Health Units should be carefully considered, particularly in respect of catchment areas. It was also felt that existing and future spontaneous settlements should be registered and new facilities should be located where these unserved groups can benefit from rural health services.

The desirability and feasibility of RHU's reflecting constituency boundaries was discussed at length, and it is recommended that if a concept of primary health care is to be successful, the local MP is an important advocate for the particular RHU.

RHU boundaries should respect local community structures.

More flexibility should be exercised when proposals are made for the improvement and upgrading of existing facilities in order to avoid expensive improvements of facilities where the population distribution does not justify the expenditure. In such cases, it should be considered if the population is better served by having a new dispensary or a mobile unit.

It was recommended that arid and marginal RHU's (particularly) should be analysed further in order to identify the effects of a primary health care system. Mobility of the health delivery system is a keyword in this context and detailed maps is an important factor in this analysis.

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It was emphasised that maps be produced for all RHU's showing also the distribution of schools, agricultural service facilities, water holes, roads etc. The maps should also identify where (and which) crops are grown and these maps should form the basis for the nutrition workers efforts.

The group emphasised that parameters should be defined for utilising local resources (staff) more extensively. A guiding principle should be, that at all levels, practical experience should be an important factor in determining the duties and responsibilities of the individual.

The group highlighted the need for interministerial (sectoral) co-ordination with the following ministries:

(a) Agriculture: (nutrition, manpower coordination) in order to make optimum utilisation of nutritionists;

(b) Water Development: (Location of new facilities and improvement of existing);

(c) Ministry of Lands and Settlements: (regional planning, planning for spontaneous settlements);

(d) Ministry of Works (communications and facilities);

(e) Ministry of Finance and Planning: (Rural Planning Unit

The need for, and desirability of, close coordination with non-government organisations was recognised and the group recommends strongly that a machinery for frequent exchange of experience be established. This will facilitate coordinated planning.

- Micro strategies

The group strongly recommends that the basic principle for providing effective rural health services is that the

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system recognises the role played by every member of the health unit team and that everyone should be allowed to feel that he/she is as important as anyone else.

The management principle should not emphasise sophistication, but aim at a decent, simple service level.

Key words to achieve this are: motivation, decentralisation, participation and recognition.

It was stressed that the field health worker (multi-purpose) should be part of the community and recognised by the system.

Emphasis in the training should be laid on primary health education, information, simple disease treatment, nutrition, MCH-service and family planning.

It was strongly recommended that health services be planned and delivered in collaboration with other agencies, as there are already indications, that the rural population is beginning to show-signs of stress as they have to attend nutrition groups on one weekday, family health classes on another, agricultural extension classes on a third, and so on. It is only by coordination at the local level that this can be alleviated. It is also important in this context that the field health worker is multi-purpose in order to avoid stressing the clients. It was also stressed that many nutrition field workers are not familiar with what crops are grown in particular areas, and they tend to recommend use of crops which cannot grow or are unavailable in the particular area.

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Apart from the RHU-team liaising closely with other development agencies in order to stimulate better coordination, it was recommended that Community Health Committees be established in every RHU. One important step in this direction would be that MOH informs local leaders of the RHU-concept.

The integrated rural health services programme should be produced in such a way that it can be used as a communication tool in promoting community participation. "Popular pamphlets" should be worked out (possibly together with Health Education) explaining the concept of RHU's and providing information on RHU in the respective districts.

The group emphasised the importance of job descriptions overlapping functionally in order to stimulate integration of services. This point should be taken up immediately in the Rural Health Project when curricula are reviewed.

It was recommended that some degree of recognition and some formalisation of the role which traditional healers and midwives play be accorded by MOH as well as research into the role of traditional medicine be undertaken. It was realised that this proposal has been made before, but it was felt that linking the research to the actual operation of a number of RHU's could have more impact.

-- Delivery system

The concept of primary health care implies that the delivery system reflects the dynamics of the particular geographic area (both in terms of physical conditions, population characteristics and settlement pattern).

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This means particularly that the type of buildings should reflect the climatic conditions as well as more and less expensive facilities should be provided in the peripheral areas of extensive rural health units.

The extension of health facilities to peripheral areas will also mean some sort of saving factor for the poorer sections of the rural populace who find it difficult to pay for transport to a centrally located health centre.

The concept of a primary health care worker or field health worker will imply that in extensive RHU's (such as arid and marginal) the clinical personnel will do rounds to patients or communities on basis of reports from the field health workers. This requires that arid and marginal RHU's get proportionately more vehicles than hot/humid and highland units.

The criticism levelled against primary health care workers just "dishing out drugs" does not represent a serious problem as far as the group was concerned as it was realised that most health facilities already operate with a limited range of drugs, and this will definitely also be the case for the primary health care worker.

Delivery of health services should be considered along with the delivery of services in other fields, e.g. water, agricultural extension, education, etc.

In order to establish a service level or a proper demand analysis, it is recommended that plans should be worked out for how often a rural family should be visited/visit the health facility. Using time series studies it will then be possible to estimate the manpower requirements. (Experience from Kakamega indicates that it is possible to reach significant

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numbers of families within a three-month period).

It was felt that, if the notion of gathering data at the local level for rapid processing, should stand a chance of success, it is necessary to introduce a simplified record system for use in the field. The communicable diseases division is already using the "credit card system" where patients carry a plastic badge with embossed date. This system should be developed further. Such a simplified record system ties in with previous attempts to reduce the number of registration forms used in the health delivery system.

The group emphasised that when information and guidance is being delivered to the clients, the Baraza system is becoming increasingly difficult to apply. The reasons for this are many. A major one is that there has been (and still is) a tendency for officials to talk down to people or officials not knowing the local conditions.

A basic principle in this context is to specify the target groups more clearly, for instance, a number of households, etc.

Experience from the MCH/FP programme shows that the field workers find it easier and more effective to meet - and get response from - smaller groups.

-- Supply system

The group felt that the provincial level should be eliminated both in terms of delivery and referral. The communication network has been expanded significantly and it is felt that decentralisation should focus on the district level. This is in line with the increasing role being

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played by the district development authorities and by allocation of district grants. Generally, it can be said that the professional competence at the district level is becoming very high indeed.

The introduction of better communications between the district level and headquarters should get immediate attention. There was a feeling in the group that many of the reports being produced by the district authorities are not being used at all at headquarters level. The frequent complaints of lack of drugs, etc., can be directly attributed to the fact that the district level does not hold sufficient stores and district institutions are too dependent on the provincial institutions.

Basing the supply and referral system on the district level will help in alleviating the problems of lack of drugs, lack of maintenance of vehicles etc., all of course under the assumption that authority and stores are being delegated to the district level.

The group recommends that in order to monitor how a decentralised system works, a number of pilot projects be undertaken in order to identify where opportunities exist and where bottlenecks can be eliminated.

3.2.8. Creation of an Integrated Rural Health Services Unit

The group did not have much time for detailing this part according to the check-list provided, but emphasised that the only reasonable and realistic way of proposing an integrated health delivery system is by MOH initiating and undertaking a number of pilot projects.

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The objectives of this undertaking should be to define more clearly - on the basis of the recommendations of the workshop - what an integrated rural health services delivery system is. The group found that by defining four case studies, each with their own specific and characteristic problems, an important step has already been taken. Thus a pilot project should be based on four rural health units located in each of the climatic zones.

The sequence for the work to be carried out under the pilot projects should be:

- Monitoring and analysis of the present rural health service delivery system for: physical structures, communications, equipment, supplies and personnel issues;
- Identification of areas where integration is possible and necessary; areas where integration is impossible and undesirable; and definition of "border line" problems and their future relationship;
- Identification of rural health related areas where coordination at the local level is needed and possible (see section inter-agency coordination);
- The monitoring process is estimated to require a one year period.

The second phase of the pilot project would be the introduction of changes to the present system in line with the overall strategy for the integrated rural health services programme.

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These changes should be monitored carefully and the experience gathered during the second phase (which will probably require a period of one to two years) shall form the basis for universal changes of the health delivery system, which should then be carried out with full support from all parties.

It is stressed that any significant changes require full appreciation and participation at all levels, but the guiding principle again should be that the local people and staff are the main actors in the whole game. Without their support no significant changes are possible.

The group stressed however that one major factor for improving the health delivery system is the problem of staff housing. The MOH should realise that only when staff have got decent living quarters is it possible to require their active and full participation in providing better and integrated services.

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3.3. Highland Zone Group

3.3.1. BASIC HEALTH PROBLEMS AND CAUSES.

Nutrition
- Dependancy ratio
- Nature of occupation
- Unemployment - feeding habits
- Land shortage
- Ignorance
- Drinking (alcoholism)
- Marital problems
- Large families

Gastro-enteritic
- Feeding habits
- Bottle feeding
- Poor hygiene
- Unsafe water/inadequate
- Ingorance

Pneumonia
- Inadequate clothing
- Poor care of children

Tetanus
- Occupation
- Inadequate post-natal care & antenatal care
- Ecology

Tuberculosis
- Overcrowding
- Poor nutrition
- Poor sanitation
- Ignorance
- Social stigma
- Eating habits

Motherhood Problems
- Nutrition
- Lack of ante-natal care
- Inadequate medical care
- Unhygienic deliveries
- Transport
- STD

Population Problem (F/Planning)
- Alcoholism
- Culture

Bilharzia
- Unsafe water
- Poor disposal of human wastes
- Ignorance
- Snails

Intestinal worms
- Poor hygiene
- Eating habits

Amoebiasis
- Poor hygiene
- Eating habits

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11. Accidents
- Neglegence
- Occupation
- Mobility
- Alcoholism

12. Typhoid
- Poor sanitation
- Unsafe water

13. STD
- Prostitution
- Ignorance
- Urbanization
- Social Stigma
- Mobility

14. Eye diseases
- Poor hygiene
- Inadequate water

15. Skin Diseases - Poor personal hygiene

16. Dental problems
- Ignorance
- Food habits
- High fluoride
- Content water
- Commercial advertisment

17. Communicable Diseases

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PHASE II

3.3.2. Strategies

HIGHLANDS

1. Community health committees.
2. Community health teams for health promotions.
   Composition/professionals
3. Encourage home deliveries.
   Training local midwifes - grandmothers
4. Wider distribution of delivery beds.
5. Decrease the number of hospital referrals
   One doctor in the RHU HQ.
6. Streamline suppplies of drugs and equipment.
7. Upgrading and expanding of physical facilities.
8. Have a community health promotor in each marked HC
   with a small supply of basic drugs - "local pharmacist".
9. Intensify health education and training through community
   involvement.
10. Reorienting - retraining of present staff towards changing
    attitudes towards the community.

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3.4. Hot and Humid Zone Group

3.4.1. Contextural background

Nyanginda Rural Health Unit near Ahero.

- Population structure

Age Group	% of Population	
0 - 1 year	4	
1 - 4	17	
5 - 14	32	Under 5yrs= 25%
15 - 49M	18	Under 19yrs= 52%
15 - 49F	20	
15 - 49T	38	
50+	9	
Population density	Average 280 sq.km.	

- Occupational trends

a) Subsistence Agriculture - 60%
b) Off-shore fishermen - 20%
c) Irrigration scheme - 20%

35% - no income = Subsistence
6% - have cattle

- Health facilities

All Government - no non-Governmental organizational facilities. Nyangindà is a Health Centre and there are mobile teams to Musogo from Nyanginda twice a week.

- Health Problem Areas

Utilisation indices - 4% antenatal clinic and hospita
- 11% to health centres a month before their death

0 - 1 Mortality ratio = 200/1000

1 - 4 " = 150/1000

0 - 5 " = 30% mortality overall

Overall mortality rate = 17.5%

Mortality ratio is particularly steep between 3-5 months, due to:

- gastroenteritis
- malaria
- whooping cough
- malnutrition

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- General Morbidity Patterns

1. Malaria - holoendemic, throughout the year parasite rates = maximum of over 80% in children 2 - 4 years. Most impact in children and toddlers.
2. Schistosomiasis - S. mansoni lake shore communities over 80%; S. haematobium focal
3. Hookworm and Ascaris prevalent
4. Waterborne - salmonella (typhoid) and shigella seasonal; cholera epidemic in 1975.
5. CSM - focal outbreaks
6. Arbovirus interbornes endemic - cattle remains.
7. Leptospirus in land development area.
8. Relapsing fever.
9. Non-communicable - carcinoma of the oesophagus and Burkitt's Lymphona; 25% community heterozygous for sickle cell disease; 2% sickle cell disease.

Summary of health problem area: MCH, Environmental Health factors, Nutrition, communicable diseases and non-communicable diseases.

3.4.2. Basic Strategies

A. To develop health facilities for the rural health units that provide basic integrated health services;

B. To structure a community based approach for involving people in their own health care.

Details of strategic developments

1. Nyanginda HC to be developed in to the HQ Health Centre of the Rural Health Unit.

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2. Musogo to be developed into a sub-centre.
3. A dispensary to be developed in the irrigation scheme.

Facilities to be provided

1. Nyanginda
   - Curative services
   - ANC facilities
   - Child Health services
   - Inpatient maternity services
   - Diagnostic laboratory service
   - HE demonstration/lecture area
   - Consultative environmental health services
   - Surveillance services
   - Mobile team

   Operational HQ for community-based approach
2. Musoga - With market and schools and it now a centre for mobile team activities.
   To be developed into health sub-centre.
   Services: similar to Nyaginda except for inpatient maternity services.
3. Irrigation scheme - to have a dispensary in accordance with established facilities experience/activities for laboratory work.
4. Rural Health Centre: Under municipalities - advise municipality to develop it to health sub-centre status.

Personnel for health facilities

1. HQ/HC - Usual staff as per RHDP plus the additional staff/expertise for laboratory surveillance and community based approach.

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2. Health Sub-Centre - Usual staff as per RHDP for sub-centre plus additional staff/expertise for laboratory and surveillance.

3. Dispensary - Usual staff planned for dispensary facilities/period expertise for laboratory work.

4. Mobile Team - This will come directly under the CO in charge of HC to provide specific health functions such as:

   immunization
   child welfare
   nutrition
   health education

3.4.3. Community based approach

1. Rationale: - To recognise community capacity for participating in health care and mobilisation of resources (manpower/ material and physical facilities).
   - To increase community awareness/ participation in health promotion, disease prevention and simple curative activities.
   - To open channels of communication between the community and the established health services.

2. Target Group: - preformed social groups/organisation e.g. maendeleo ya wanawake
   - Church groups

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- Schools
- Community/village/clan units
- Administrative Units - locations and sub-locations
- Co-operatives

3. What is the Community?

For purpose of community mobilisation. The largest functional/manageable unit consists of a geographically identifiable unit made up of 100-400 households.

4. Who should carry out community mobilisation?

There shall be a community-based approach team specifically for community involvement activities. The team shall be made up of:

- Community Nurse - Team Leader
- Public Health Technicians
- Family Health Field Educator
- Community Development Assistant
- Agricultural Extension Workers
- Health Educator

This team will be responsible for HE motivational functions in the current and other target groups. The team will also be responsible for assisting communities to establish community support structures such as:

- Community Health Committees
- The mechanism of selecting and supervising a community resident health worker for continuous motivational and HE functions in the community as well as simple curative functions.

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- The establishment of a Community Fund into which the community as well as Rural Health Project can appropriate funds to assist in the Community Health activities, out of which the community health workers "allowance" comes.

The community-based approach team will have, among other things, a vehicle for moving from place to place as they interact with communities and other target groups, e.g. schools.

This team will also explore the training of teachers at each school for providing basic health services to each school population.

The management and administration function to be seen by the A.S.U. in collaboration with the other sections of the Ministry of Health.

5. Transport for R.H.U. - Three vehicles:
   One for HC
   One for mobile team
   One for community-based team

Note: To Planning Core Group

The time limitation made it impossible to go into communication, equipment and inter-jurisdictional coordination. It is pointed out that these areas are recognised as vital and must be looked into and planned for in the final integrated plan. It is also recommended that in the definite planning, evaluation and monitoring should be built in for purposes of measuring impact and progress in responding to health problems.

ANNEX A

LIST OF PARTICIPANTS

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