**MODULE 3: MANAGING HUMAN RESOURCE FOR HEALTH**

**CONTENT**

**Human Resource Management**

Human resource management (HRM) is a critical area of management that is responsible for an organization’s most important asset, its people. When an organization manages its investment in people wisely, the results is a satisfied and motivated workface that delivers quality health service, an organization that is able to fulfill its mission, meet its health objectives and enhance its competitive advantage (MSH, 2009).

The human resource is the foundation of a health care system. Health services depend critically on the size, skills, and commitment of the health workforce. Human resource for health is therefore at the heart of health service delivery. A well-performing health workforce should have sufficient numbers of trained staff fairly distributed through the country, and supported by appropriate policies and policies and system (health System Approach, 20/20 (2012). The World Report (2006) defines human resources for health (HRH), or the health workforce, as “all people engaged in actions whose primary intent is to enhance health”. According to WHO, this include “those who promote and preserve health as well as those who diagnose and treat disease. Also include are health management and support workers-those help make the health system function but who do not provide health services directly”. Human resources for health therefore includes doctors, nurses, hospital attendants, technologists, inclical assistants and pharmacists who are directly involved in providing outpatient and ward care service. They also include administration, catering, laundry, transport, security, engineering (electrical and civil) and air conditioning maintenance staff involved in supporting the former to provide safe efficient health care delivery.

It is the responsibility of all managers and supervisors at every level in the health system to understand and continually practice the principles of effective HRM. Indeed, it is the collective effort of all manners that will build a human resource for health (HRM) strategy and the HRM infrastructure needed to carry out the strategy. In practice, there is an inherent overlap between the roles of people with HRM responsibilities and health managers/supervisors in the health sector. In many settings, there is no designated HR professional so the management of human resource is primarily left to health managers and supervisors.

Good supervision includes key aspect of human resource management along with other roles. Supervision is also closely relates to effective monitoring and evaluate covered in Module 17. The content of this module is therefore important to anyone with HRM responsibilities in the health sector, be they HR professionals, health managers, supervisors or administrators.

**Definition of Human Resource Management**

According to Armstrong (2010), Human Resource Management (HRM) is the integrated use of policies, systems and management and leadership practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees so that an institution or organization can meet its goals. When HRM functions effectively, staff members’ skills, job satisfaction, and motivation will improve and, over time, lead to high level of performance.

HRM is a strategic and systematic approach to managing people in a way that would maximize their motivation and contribution towards meeting a health system’s objectives at the facility, county and national levels. HRM in health is an organizational function that effectively develops and uses the skills of the people who work in the health care system. It is important because it addresses the system’s need for a competent, stable, and motivated workforce that allows the system to perform optimally i.e. have the right number of service providers with the right skills in the right locations at the right time.

According to the Health system 20/20 a human resource management system comprises of three key elements:

1. Planning the workforce: Accurately estimating HRH needs based on data
2. Developing the workforce: Training, recruiting, selecting and deploying HRH;
3. Managing the workforce: Retaining workers through good performance management (setting performance expectation and appraising), compensation (including benefits), career development, and related activities such as employee relations and labour relation programmes.

A good HRM system provides answer to the following questions which are always at te back an employees’ mind even if they are not verbalized (MSH, 2010):

* Am I being treated fairly?
* What am I supposed to do?
* How well am I doing it?
* Does any work matter to the organization?
* How can I develop myself within the organization?

**Benefits of a strong HRM System (Health System 20/10)**

|  |  |
| --- | --- |
| Benefits to the organization | Benefits to the employee |
| * Increases the organization’s ability to retain staff and achieve its goal. * Increase the level of employee performance * Uses employees’ skills and knowledge * Saves costs through the improved efficiency and productivity of workers * Improves the organization’s ability to manage change | * Provides clarity regarding job responsibility * Helps employees understand how their work relates to the mission and values of the organization * Improves equity between employee compensation and level of responsibility. * Helps motivate employees * Increase employees’ job satisfaction * Encouraged employees to operate as a team. |

**Human Resource Management Functions**

The key HRM functions are HR planning, recruitment, performance management, training, and development and managing employee relations. The level to which the functions are carried out in the health sector largely depends on the extent to which the functions are centralized or decentralized. For instance, recruitment of health workers is largely centralized at the ministry of health and country government.

HR

Planning

Recruiting

Performance management

Training & development

Managing employee relations

**Workforce planning for Health Sector**

An effective health system should comprehensive and coherent human resources for health (HRH) strategic plans. A HRH strategic plan is the overall plan, which includes the workforce plan to improve the effectiveness of health workers and support staff to deliver health care services. Such plans normally include strategies for strengthening performance of staff, improving staff retention and adapting to any major structural changes that may be occurring e.g. devolution and decentralization.

A key component of HRH strategic plan is a workforce plan. Workforce planning is also referred to as manpower or human resource planning. A workforce plan enables those in charge of health services planning and delivery to scan and analyse human resource (HR) data routinely, determine relevant policy questions and institute policies to ensure that adequate numbers of staff with appropriate skills are available where and when they are needed. It is an organized way of estimating how many of what type of additional staff will needed in workplaces over time, both to fill current vacancies and address future losses. The next step is to decide how those jobs will be filled. This usually has significant implications for training and the planning for training institutions. Most work force planning is concerned with trying to increase the number of health workers. However, sometimes, the aim of a workforce plan may be to reduce certain groups of staff, perhaps for financial savings. What is important is that workforce planning support the overall HRH strategic plan within the constraints of available resource (Health Systems Approach 20/20, 2012).

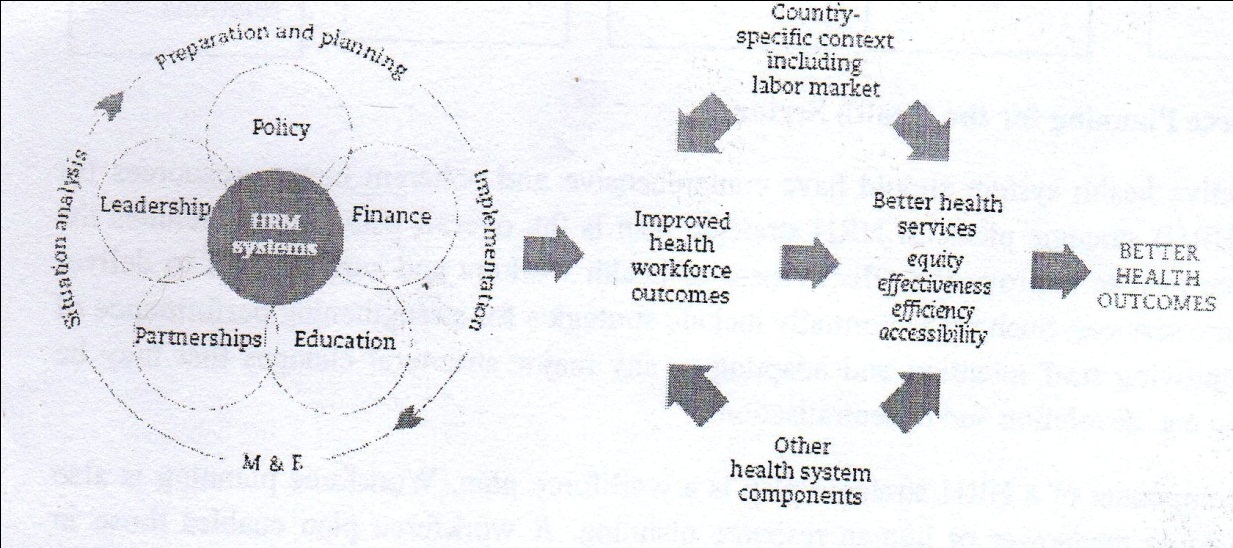
The benefits of developing and implementing a comprehensive HRH plan include an adequate supply of well-trained health staff; high levels of teamwork and staff performance; cost saving because of reduced absenteeism and staff turnover; a more motivated workforce; and a healthier population.

**Human Resource for Health Action Framework**

The HRH Action Framework is an HRM tool designed to assist health managers and governments to develop and implement strategies to achieve an effective and sustainable health workforce. By using a comprehensive approach, the Framework helps in addressing staff shortages, uneven distribution of staff, gaps in skills and competencies, low retention and poor motivation among challenges. The HRH framework can be used as part of developing an HRH strategy to identify constraints in six topic areas, namely policy, finance, education, HR management, partnerships and leadership.

**Figure 3.1. Human Resource for Health Action Framework**

Tools for an effective and sustainable health workforce



**Source: Management Sciences for Health (2010)**

**Identifying Staffing Requirement**

There are various different ways of determining staffing requirements.

**Table 3.2. Different Ways of Determining Staffing Requirement**

|  |  |
| --- | --- |
| **Method** | **Details** |
| Health care demands approach | Based on a forecast of future health service utilization |
| Health needs approach | Staffing requirements assessment based on demographic and epidemiological forecast of the health needs of a population. |
| Personnel to population ratios approach | Staffing based on ratios-or norms – for health personnel to population e.g. one doctor per 10,000 populations. |
| Service targets approach | Staffing based on health service targets. This may be based on expansion of facilities- and staffing per facility – or programmes e.g., staffing required to provide ART services. |

**Developing and HRM plan –A step-by step approach**

A five-step model for developing a HRM plan is recommended. While these steps can apply to any facility, department, directorate or national level, the duration and complexity of each step varies from one level to another depending on the situation. The development of the HRM Plan can be facilitated either by an internal team or outside consultants. In either case, participation of top management and staff representatives is required to ensure the HRM Plan meets the needs of the facility, department, directorate, county or country and is supported by both the management and staff, and can implemented within the local constraints.

**Table 3.3. Five steps in Developing an HRM Plan**

|  |  |
| --- | --- |
| **Step** | **Details** |
| 1. Conduct a strategic analysis | The results of this step are an understanding of the facility/department/country’s vision, mission, values; a strategic review of the situation; and understanding of the challenges being faced. |
| 1. Identify strategic HR issues arising from the strategic analysis | Building on the results of step one, the outcome of this step is an analysis of the strategic HRH issues facing the facility/department/county/country |
| 1. Identify on-going HRH issues | In addition to the strategic HRH issues identified in step two, the ongoing HRH issues impacting the facility/department’s effectiveness must also be identified. |
| 1. Prioritize the strategic and ongoing HR issues and determine action: | Once all the HRH issues have been identified through steps two and three, they should be prioritized and key actions required in respect of each issue identified. |
| 1. Draw up the HRM plan | Once all input into the HRH priority issues is obtained and key action to be taken in step four identified, the HRH Plan and its associated programmes are ready to be formulated |

Step 1- Conduct a departmental strategic analysis

The goal of the HRH Plan is to support and reinforce the facility/department’s objectives and programmes. The first step in developing the plan is to obtain a clear understanding of the facility/department’s objectives, programmes and key challenges. This understanding can be obtained by conducting a strategic analysis.

*How*

* Review key facility/departmental, country and country documents. These include the vision, mission and values, program and other health sector strategic documents. If the vision, mission and values have not yet been formulate, it would be useful to have them worked out at this stage.
* Interview key internal staff and other relevant stakeholders to obtain their views on the direction, critical success factors and challenges.
* Interview relevant stakeholders to obtain their expectations.

**Step 2- Identify strategic HRH issues**

Once a clear understanding of the facility/department/county’s health objectives, direction and key challenges is established, the next step in formulating the HRH plan is to identify the strategic HRH issues. These are key HRH issues that will affect the ability to achieve set strategic. The HRH plan will need to address how to manage these issues.

What to do

* Asses the HRH implications of the findings of the strategic analysis
* Identify the facility/department’s strategic HR issues

|  |
| --- |
| Identify the HR issues Arising from the Strategic Analysis   1. Do people have the competencies to meet the strategic objectives? What new competencies are required? 2. How are superior performers differentiate from average performers? What systems are in place to track their performance? 3. How can below standards performers be guided or developed to upgrade their performance? 4. Are people being developed to meet the challenges of the future? What improvements need to be made? 5. Are people motivated to meet the current and future challenges? What impacts their motivation? 6. Are the right people being attracted and retained to meet the future challenges? If not, what can be done to attract people of the right caliber? 7. Is the current culture aligned with the vision, and values of the facility/department? 8. Where is the misalignment? 9. Is the manpower level sufficient to meet the future health services delivery requirements? |

Step 3- Identify on-going HRH issues

In addition to the strategic HRH issue identified in the previous step, the facility/department’s key on going HRH issues (general HRH issues not linked to specific strategic objectives or issues) must be identified. He HRH plan must address the key ongoing HR issues; otherwise these issues may eventually escalate, impacting the morale and effectiveness of the health workers.

*What to do*

Identify the on-going HRH issues facing the facility/department. On-going HRH issues may relate to manpower planning, recruiting, performance management, training and development and staff relations.

*How*

* Conduct interviews. Interviews are a good way for the team developing the HRH plan to begin to identify the on-going HRH issues facing the facility/department. Topics to be covered in interviews include current HRH issues in the areas of manpower planning, recruiting, performance management, training and development, and staff relations.
* Conduct employee focus groups discussions. Focus groups are a good technique for identifying, probing and priotising HRH issues with different groups of staff.
* Conduct staff opinion surveys. Staff opinion surveys demonstrate commitment to soliciting everyone’s input on the HRH plan, provide an objective way to evaluate staff attitude, and the results can serve as a measurable benchmark for improvement. When considering undertaking a staff opinion survey, keep in mind that it is typically more time-consuming and resource intensive than other feedback mechanism such as interviews and focus groups discussions.

**Step 4- Priotise the HRH issues and determine actions**

Up to this, the strategic and on-going HRH issues facing the facility/department/county have been compiled. Not all the issues will be of equal importance or urgency. They need to be priotised in order to ensure that the HRH plan focuses on the most critical issues.

*What to do*

* Involve the management team in confirming and prioritizing the issues compiled to date. The management team should also give input on the actions that should be taken to address the issues.
* Management involvement in prioritizing HRH issues and identifying actions is critical because it.

1. Reinforce the line management role in human resource management
2. Helps ensure that HRH recommendations are actionable within the constraints.
3. Develops management commitment to and ownership for the HRH Plan implementation.

*How*

* Collate the research findings up to this point. Analyze them critically with a view to articulating the strategic objectives and direction, critical success factors and strategic challenges.
* Compile a preliminary list of the HRH issues identified and group according to logical categories, e.g. training, recruitment e.t.c.
* Conduct a management strategic HRH workshop. The objectives of the workshop are to:

1. Present finding on the strategic challenges and HR issues;
2. prioritize the HRH issues;
3. Develop action to address the current and future HR issues;
4. Prepare the ground work for structuring the HRH Plan.

The key activities in the workshop are to discuss so firm and prioritize the HRH issues (identified from the findings of the strategic analysis and those ongoing HRH issues). The HRH issues should be prioritized according to their:

* Relative importance to the effectiveness of the department:
* Urgency;
* Resources required;
* Brainstorm recommended actions o address the priority issues

Table 3.4. Strategic HRH Workshop Agenda

|  |
| --- |
| Introduction  Workshop objectives  Agenda  Overview of Strategic Direction and Challenges  Presentation of Strategic/On-going HR Issues  Group Discussion  Priotisation of HR Issues  Develop strategic responses to address HR Issues  Develop action plans |

Step 5 Draw up the HRH plan

Once the HRH issues have been prioritized and the management team have given their input into the direction of the HRH plan, the plan is ready to be drawn up. The plan is unique and specific to the facility/department. It represents the management team’s collective view on how the identified HRH issues are to be addressed.

*What to do*

Develop the HRH plan consisting of several key programmes. Each programme should represent one of the key HRH areas that need addressing, e.g. training, performance management, staff relations, e.t.c. each programme within the plan should contain the following information.

* *Strategic of the programme*: Describe the background of the programme, why it is included as one of the programmes within the HRH plan.
* *Programme objectives*: list out the aims of the programme. Be as specific as possible in terms of what the programme will achieve for the facility/department/county.
* *Programme recommendations*: Develop the specific set of actions within the programme that will be carried out. The actions of the programmes, taken together, should be designed to achieve the programme objectives.

*How*

* After obtaining management’s input on how to address the HRH issues, make additional recommendations, if any, to address the identified and priotised HRH issues.
* Group the recommendations into approximately 5-10 programme headings, e.g. training, performance management, staff relations, e.t.c.
* Draw up various HRH programmes which taken together will form the HRH plan.
* Each programme should be approximately 2-3 pages. Each programme should contain an explanation of its strategic importance, objectives, and recommendations.
* Prepare a summary list of HRH programmes covering the programme headings and their key objectives for easy reference
* Circulate the HRH plan to concerned parties for comments.
* Incorporate comments and finalize the HRH Plan.

Upon finalization of the plan, a good practice is to consider identifying a “driver programme” in implementing proposals in the plan. A ‘driver programme’ is one of the HRH programmes that if implemented will have a major impact on helping the department achieve its strategic objectives. The programme may also serve as the platform for implementing and reinforcing the other related HRH programmes, e.g. performance management can ‘drive’ the development of competencies, identification of training and development gaps, career development and succession plans.

**Table 3.5 Sample of a summary List of HRH Programmes**

|  |  |
| --- | --- |
| **Programme** | **Key Objective** |
| Performance management | To increase the effectiveness of the appraisal process, and to strengthen the development aspect of performance management using the competency-based approach to training and career development |
| Career development | To expand career development opportunities, engage supervisors in developing the career of their staff and demonstrate department’s commitment to staff career development. |
| Training and development | To establish management development curriculum based on the competency assessment of the target group, and to provide training and development required to bridge identified competency gaps. |
| Change management | To develop the mindset and necessary skills to manage and deal with change effectively. |
| Staff recognition | To establish systems to recognize staff’s performance and reward their contributions |
| Recruitment | To ensure the county makes hiring decisions that best fit the needs of the Department. |

HRH Statistics

HRH statistics provide quantitative evidence of the HRH situation, e.g. the numbers of health care workers, ratios per population, helps a county/country to judge if they have an adequate number of HRH and if not, the severity of the HRH situation. It also allows quick comparisons to other counties/countries. Disaggregating these statistics allows planners to describe the allocation of specific providers across the various level within the delivery system and the distribution of providers between geographic boundaries (rural/urban). WHO gathers and presents statistics on the number of health care workers per 1,000 populations. This is the recommended practice since it allows easy comparisons between countries in a region, and between areas within a country.

**Table 3.6. HRH Statistics**

|  |  |
| --- | --- |
| Indicator | Definition and interpretation |
| Ration of different health personnel per1,000 | This indicator considers:   * Ration of health cadre per 1,000 people * Total number of physician * Total number of nurses * Total number of midwives * Total number of pharmacists * Total number of health care providers, by cadre, is the raw material upon which all other statistics are based |
| Total number by cadre and sector | This indicator considers:   * Total number of physician by sector * Total number of nurses by sector * Total number of midwives by sector * Total number of pharmacists by sector * Total number of laboratory technicians by sector |
| Ration of health care worker by geographic distribution | This indicator considers:   * Ration of health care workers by cadre and by geographic area * If possible, break out geographic distribution by carde and sector   Use MOH and other HRH data source to examine HRH distribution by: (1) cadre, (2) geopolitical boundaries, (3) urban/rural split and (4) service delivery level, including the number of CHWs (not attached to any level of facility). This reveal inequities in service coverage. |
| Trends for the past five years | This indicator considers:   * Ration of health professionals by population over time * Total numbers by cadre and sector over time. * Ration of health care worker by geographic area overtime   This ratio presents evidence about whether the HRH situation is getting better or worse for as many years as there are data available. |

**Source: Health Systems Approach 20/20 (2012)**

**3.2. Recruitment**

This is also known as hiring and deployment. Recruitment is the process of attracting, screening and selecting qualified person for a defined position. The general principles underpinning recruitment within the public service are that recruitment should:

1. Use procedures which are clearly understood by candidates and which are open to public scrutiny.
2. Be fair, giving candidates who meet the stipulated minimum requirements equal opportunity for selection.
3. Select candidates on the basis of merit and ability.

Figure 3.2 Recruitment Processes

Placement t

Selection

Recruitment

Job Analysis

Job Description

Job Specification

Human

Resource

Planning

Search for Prospective Employees

Identifying Sources of Potential Employees

Evaluating Recruiting Effectiveness

Upgrading in same position

Personnel Research

Transferring to New Job

Planning

Internal Sources

Job Posting

Prompting to higher

Employee

Referrals

External Sources

Evaluating for selection

Advertising

Scouting

Source: Pigors and Myres (1983)

***Job analysis***

Job analysis is a systematic procedure for collecting and analyzing job information. In selecting an applicant for a job, the selectors need to know what the job involves in terms of the key tasks, objectives and responsibilities (job description), the attributes (abilities, experience, personality e.t.c.) required for successful performance (person/job specification).

Not only does this aid in getting the right person for the right job but it also helps individuals to identify with and increase their accountability for their role within the health sector.

***Job Description***

A job description provides information on what a job involves. In other words, exactly what is it that the person has to *do*. Every job should have its own job description explaining exactly what is involved for particular role. A job description is intended to give a candidate a clear feel for what they would be doing should they take up the position.

***Job/person specifications***

A person specification or job specification provides information on what the person needs to do the job. In other words, a statement of the personal attribute required for successful performance in the job. By personal attributes we mean knowledge, skills, aptitudes and experience; everything which is necessary for doing the job. In order to protect against unfair selection and in line with employment legislation, all the attributes listed must be specifically related to the job. The person specification should also specify which requirements are essential and which are desirable.

Essential skills and abilities refer to those things which, without them, the candidate could not do the job. Therefore essential skills/ability must be fully matched by candidates. Desirable skills and abilities refer to those which would offer added value if held by candidates. Public sector job description and person specifications are contained in the respective schemes of service for each cadre.

***Recruitment***

Recruitment forms a step in the process which continues with selection and ceases with the placement of the candidate. It is the next step in the HRH procurement function, the first being the manpower planning. Recruiting makes it possible to acquire the number and types of people necessary to ensure the continued operation of the organization. Recruiting is the discovering of potential applicants for actual or anticipated organizational vacancies.

***Selection***

This involves matching people and their expectations with the job specifications and career path available within the organization.

***Placement***

After an employee has been recruited he is provided with basic background information about the employer, working conditions and the information necessary to perform his job satisfactorily. The new employee’s initial orientation helps him perform better by providing him with employment rues and practices.

According to Pigors and Myers (1983), “placement consists in matching what the supervisor has reason to think the new employee can do with the job demand (job requirements) impose (in strain, working conditions etc) and offers (in the form of pay rate, interest, companionship with other, promotional possibilities e.t.c)”. they further state that it is not easy to match all these factors for a new worker who is still in many ways an unknown entity. For this reason, the first placement usually carries with it a probation period.

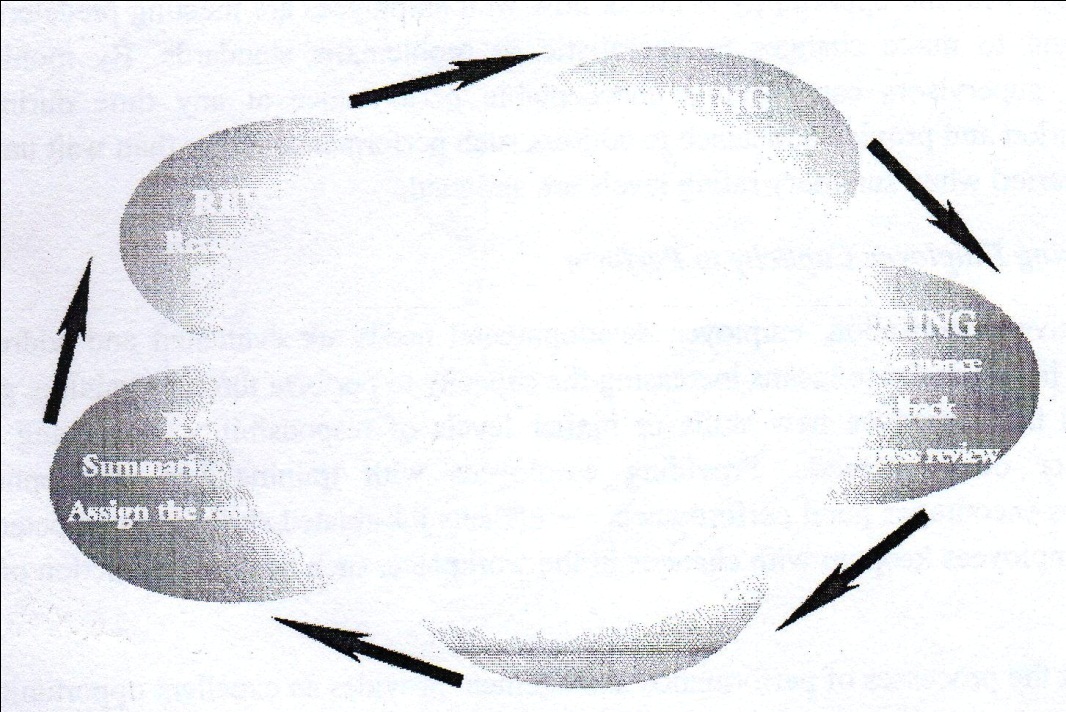
* + 1. *Performance Management*

Performance management is the process of setting quantifiable performance goals and objectives and assessing individual performance against these measures. It is a deliberate human resource management intervention whose sole purpose is to align every employee’s work efforts with the objectives of the organization, manage these efforts on a daily basis, measure employees, reward them according and stimulate individual development to enhance employees contribution to the organizations’ success(Workforce Compensation and performance services, 2011).

According to Armstrong (1008), performance management is the systematic process of:

1. Planning work and setting performance;
2. Continually monitoring performance;
3. Developing employee capacity to perform;
4. Periodically rating performance in a summary fashion;
5. Rewarding good performance

Figure 3.3 Performance Management’s Five Key components



**Source:** United States Office Personnel Management (2001)

1. ***Planning***

Planning means setting performance expectations and goals for group and individuals to channel their efforts towards achieving organizational objectives. Getting employees involved in the planning process will help them understand the goal of the organization, what needs to be done, why it needs to be done, and well it should be done.

Best practice requirements for planning employees’ performance include establishing the elements and standards of their performance appraisal plans. Performance elements and standards should be measurable, understandable, verifiable, equitable and achievable. Through critical elements, employees are held accountable as individual for work assignments or responsibilities. Employee performance plans should be flexible so that they can be adjusted for changing program objectives and work requirements. When used effectively, these plans can be beneficial working documents that are discussed often and not merely paperwork that is filled in a drawer and seen only when ratings of record are required.

Planning work and setting expectations is achieved through work planning at the organizational, department and individual levels.

1. ***Monitoring Performance***

In an effective organization, assignments and projects are monitored continually. Monitoring well means consistently measuring performance and providing on-going feedback to employees and work groups on their goals. Good practices for monitoring performance include conducting progress towards reaching their goals. Practices for monitoring performance include conducting progress reviews with employees where their performance is compared against their elements and standards. On-going monitoring provides the supervisor with the opportunity to check how well employees are meeting predetermined standards and to make changes top unrealistic or problematic standards. By monitoring continually, supervisors can identify unacceptable performance at any time during the appraisal period and provide assistance to address such performance rather than wait until the end of the period when summary rating levels are assigned.

1. ***Developing Employee Capacity to Perform***

In an effective organization, employee developmental needs are evaluated and addressed. Developing in this instance means increasing the capacity to perform through training, giving assignments that introduce new skills or higher levels of responsibility, improving work processes, or other methods. Providing employees with training and developmental opportunities encourages good performance, strengthens job-related skills and competencies, and help employees keep up with changes in the workplace, such as the introduction of new technology.

Carrying out the processes of performance management provides an excellent opportunity for supervisors and employees to identify developmental needs. While planning and monitoring work, deficiencies in performance become evident and should be addressed. Area for improving good performance also stand out and action can be taken to help successful employees improve even further.

1. ***Performance Appraisal (Rating)***

From time to time, organization finds it useful to summarize employee performance. This helps with comparing performance over time or across a set of employees. Organizations need to know who their best performers are. Within the context of formal performance appraisal requirements, rating means evaluating employee or group performance against the elements and standards in an employee’s performance plan and assigning a summary rating of record. The rating of record is assigned according to producers included in the organization’s appraisal programme. It is based on work performed during an entire appraisal period. The rating of record has a bearing on various other HR actions, such as awarding within –grade pay increases and other incentives.

*Performance Plan*

Employees must know what they need to do to perform their jobs successfully. Expectations for employee performance are established in employee performance plans. Employee performance plans are all of the written or otherwise recorded, performance elements that set forth expected performance. A plan must include all critical and non-critical elements and their performance standards.

*Performance Element*

Performance elements tell employees what they have to do and standards tell them how well they have to do. Developing elements and standards that are understandable, measurable, attainable, fair, and challenging is vital to the effectiveness of the performance appraisal process.

Critical Elements

A critical element is an assignment or responsibility of such importance that unacceptable performance in that element would result in a determination that the employee’s overall performance is unacceptable. Good HRM practices require that each employee have at least one critical element in his or her performance plan. Even though no maximum number is placed on the number of critical elements possible, most experts in the field of performance management agree that between three and seven critical elements are appropriate for most work situation. Critical elements are the cornerstone of individual accountability in employee performance management.

*Non – critical Elements*

A non-critical element is a dimension or aspect of individual, team or organizational performance, exclusive of a critical element, that is used in assigning a summary level of performance. Failure on a non-critical element cannot be used as the basis for a performance- based adverse action, such as a demotion or removal. Only critical elements may be used that way. Moreover, if an employee fails on a non-critical element, the employee’s performance cannot be summarized as unacceptable overall based on that failure.

1. ***Rewarding Performance***

In an effective organization, rewards are used often and well. Rewarding means recognizing employees individually and as members of groups for their performance and acknowledging their contributions. A basic principle of effective management is that all behavior is controlled by its consequences. Those consequences can and should be both formal and informal and both positive and negative. Good managers and supervisors do not wait for their organization to solicit nominations for formal awards before recognizing good performance. Recognition is an ongoing nature part of day –to –day experience. A lot of the actions that reward good performance, like saying “thank you”, don’t require a specific regulatory authority. Nonetheless, formal awards regulations provide a broad range of forms that more formal rewards can take, such as bonus, time off and many recognition other items.

Public service employees are required to complete a performance appraisal twice a year and submit the appraisal form to the MoH but the end of the financial year. Certain levels of public service employee work under an annual performance contract which sets out performance plans, performance elements and critical elements.

**3.2.4. Training and Developing the Health Workforce**

To deliver high quality care, health workers must possess a high level of knowledge combined with excellence in practical skills. They must also show kindness and compassion and respect for patients. If any one of these elements is missing, then significant problems in health care may occur. The objective of training and development is to enable employees to acquire the knowledge, skills, abilities and attitude necessary to enable them to improve their performance.

The purpose of training and management development is to improve employee capabilities and organizational capabilities. When the organization invests in improving the knowledge and skills of its employees, the investment is returned in the form of more productive and effective employees. Training and development programmes may be focused on individual performance or team performance.

**Key Terms**

Training Systematic approach to affecting individuals’ knowledge, skills and attitudes in order to improve individual, team, and organizational effectiveness.

Development The systematic efforts affecting individuals’ knowledge or skills for purpose of personal growth or future jobs and/or roles.

Human capital The collective set of performance –relevant knowledge, skills, and attitudes within a workforce at an organizational or societal level.

Training evaluation The systematic investigation of whether a training programme resulted in knowledge, skills or effective changes in students.

**Source:** Goldstein and Ford (2002)

To be effective, training and management development programs need to take into account that employees are adult students (Forrest and Peterson 2006). Knowles’ (1990) theory of adult learning or ‘andragogy’ is based on five ideas, namely:

1. Adults need to know why they are learning something
2. Adults need to be self-directed
3. Adults bring more work-related experience into the learning situation.
4. Adults enter into a learning experience with a problem-centered approach to learning.
5. Adults are motivated to learn by both extrinsic and intrinsic motivators

Having a problem-centered approach means that workers will learn better when they can see how learning will help perform tasks or deal with problems that they confront in their work (Aik and Tway, 2006).

At different stages of their careers, health workers need different kinds of training and different kinds of development experiences. Although a first degree or diploma might prepare students for their first job, they will need to gain knowledge and skills through education and experience as they progress through their career. Forest and Peterson (2006) suggests that there are four stages of management education with different learning outcomes:

1. Functional competence, an understanding of finance, accounting, marketing, strategy, information technology, economics, operations and human resources management;
2. Understanding context and strategy and how organizational processes interrelate, to make sense of health issues, societal changes social values, global issues and technology change;
3. Ability to influence people, based on a broad understanding of people and motivations; and
4. Reflective skills to set priorities for work effort and life goals.

To maximize the effectiveness of training and development, organization must constantly asses their employees’ current training and development needs. They must also identify training and development needs to prepare employees for their next position. This requires that organizations to recognize that different employees have different needs which change overtime as the workers in their careers.

**Training**

Training can be examined from dimensions. Two important dimension are the degree to which there is interaction with others during training (personal versus interpersonal), and the degree of formality of the training. There are four modes of training based on those two dimensions as seen in **table 3.7.**

**Table 3.7. Classification of Training Methods n Organizations**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Degree of formality | |
| Degree of interaction |  | Informal | Formal |
| Personal | Self –training | E-learning |
| Interpersonal | Peer | Instructor-led |

While both individuals and organizations have preferences for particular types of training modalities, many organizations and individuals use several training methods.

***Types of training***

Various types of training are provided in the public. These include but are not limited to:

* **Induction:** to familiarize new recruits with job requirements and procedures, departmental objective and performance standards and d the values and norms of the department
* **Management development:** to equip managers with the knowledge an skills required and to widen their perspective.
* **Management development:** to equip managers with the knowledge an skills required and to widen their perspective.

**Staff Development**

The purpose of career development is to identify and develop the potential within staff, to build existing skill level and to prepare staff to take on greater responsibility during their careers. Career development has to balance the needs and aspirations of the individual with those of the service-where this conflict, the needs of the services should prevail.

There are several methods of facilitating staff development. These include:

1. Posting-Posting for staff should normally take into account the individual’s previous experience and his future needs and potential. Staff can either be developing to have a broad experience across a number of areas. They can focus on a particular area and develop in-depth experience. Determining the most appropriate way to develop staff is a balance between the needs of the organization and the aspirations of the individual. Future posting aspirations should be discussed with staff on the understanding that in the final analysis the needs of the employer are paramount.
2. Acting appointment- There are three kinds of acting appointments:

* Acting “with a view”- whereby staff are posted to the acting rank to assess their suitability for substantive promotion.
* Acting “with a singling out effect”-whereby staff who do not merit immediate promotion or an acting appointment with a view to substantive promotion but who are nevertheless assessed to have better potential than other officers to undertake the more demanding duties in the higher rank, are placed in the higher rank to assess their suitability for substantive promotion.
* Acting for administrative convenience- whereby staff are placed in a higher rank to cover the absence of the normal post holder, e.g. through sickness, long holiday or maternity leave. Staff acting for administrative convenience reverts to their substantive rank when the substantive post holder returns.

Apart from acting for administrative convenience which is more as hoc, the other two types of acting provide opportunities for staff to be exposed to more onerous duties and responsibilities, thereby testing their ability.

1. Secondment- Secondement from department for attachment in other section of the organization are good ways of exposing staff different work environments while the organization is at the same time providing technical support.

|  |
| --- |
| Strategic questions (this may be turns into student activity) |
| 1. Why should an organization be reluctant to invest in training its employees if makes their employees more capable? Isn’t it better to have more capable employees? 2. If an organization offered to send you to a management development programme, with the condition that you agree to work for the organization for 2years to “pay off” the training would you accept the offer? 3. If an organization has a high turnover, should it invest in training programmes? 4. How should an organization measure the outcome of a training or management development programme? 5. How should an organization determine the “break-even” point for management development programe (i.e. where the organization’s investment is paid for by increased productivity)? 6. Should national and county governments fund training programmes to improve the knowledge and skills of health? If organizations are reluctant to invest in training their own employees because those trainees might be working for a competitor one day, should the government be reluctant to fund training programmes? |

**3.2.5. Managing Employee relations**

**The Employment Relationship**

An employee is someone who has agreed to be employed under a contract of service (open ended, fixed contract or casual), to work for some form of payment. This can include wages, salaries or commissions. The rights of full-time employee’s apply equally to part-time employee. These rights also apply to casual employees. However, the way in which annual, sick and bereavement leave are applied may vary for these employees.

1. *Good Faith:* Establishing and maintaining good faith relationship is important for employment relations system for both collective and individual employment arrangement. Good faith involves using practical common sense and treating other in the way you would like to be treated. This means dealing with others honestly, openly and with mutual respect. Acting in good faith reduces the risk of conflict and problems. It is also part of the employment Act.
2. *Employment Agreements*: Good employment relationships begin with a good recruitment process that ensure everyone has clear expectation about the role, working conditions and employment rights. A clearly written employment agreement can help reduce the risks of misunderstanding. Every employee must have a written employment agreement. This can either an individual agreement or a collective agreement. Collective employment agreements are negotiated in good faith between an employer and a registered union on behalf of their members. Employees must not unduly influence employees to join or not join a union.

***Types of Employment Agreements***

The employment Act 2012 sets out most of the rules for forming an employment relationship through employment agreement. The rules differ based on whether there is relevant collective agreement or not. A relevant collective agreement is in place when: an employer and union have negotiated a collective agreement under the employment Act 2012, and Labour Relations Act 2012. The agreement covers the work to be done by the new employee.

If there is no relevant collective agreement the employer and the employee negotiate an individual employment agreement which indicates the terms and conditions of employment. This agreement must neither fall short of legislative requirements nor be inconsistent which the law. The agreement must be in writing.

***Probation Period***

An employer may offer employment with an initial probationary period. This must be writing. A probation period allows a new employee to demonstrate their skills. Such arrangements may be permissible where the duration and tasks are limited and designed to give the employer an opportunity to assess the employee’s skills. Employers must pay for work done during the probation period. A probation period does not limit the legal rights and obligations of the employer or the employee, and both parties must deal with each other in good faith.

***Induction***

A good induction process and training is important in helping employees understand the job and perform well. Both set the tone and expectations for employment relationship.

***Wages and Records***

There are legal requirements governing wages and wage time, holiday and leave records. Legally, wages have to be paid in cash. Other methods need an employee’s written agreement. It is advisable to keep record files upon to date. Employees have the right to know everything recorded in their files and have a right to review them.

***Establishing of Performance Management System***

Performance management involves a lot than simply dealing with problems at the work place. Positive performance management should be embedded into employment relationship. This is important is setting expectations and rewarding success as well as dealing with problems.

**Employment Rights**

By law, two types of employment rights apply to all employees:

1. Minimum pay and emoluments received
2. Treatment at work

Minimum employment rights must be met regardless of whether they are included in agreements. By law, however some provision must be included in employment agreements. The employment law provides framework for the process of negotiating additional entitlement. Employees cannot be asked to less than the minimum rights.

***Health and safety***- employers must provide workplace, with proper training supervision and equipment. This duty includes identifying, assessing and managing hazards and investigating health and safety incidents. Employees must take reasonable care to keep themselves safe and avoid causing harm to others when working,. Employees may refuse work that is likely to cause them serious harm. They also have the right to participate in effort aimed at improving health and safety at work.

Minimum pay- The adult minimum wage must be paid to employees aged 18 years and above.

***Break entitlements***- Employees and employers can agree to the timing of rest meal breaks. If they cannot agree on timing, the rest and meal breaks must be evenly spread through the work period. Employers and employees can agree to more and/or longer breaks.

***Leave and holidays*** –These include:

1. Annual leave-According to the Employment Act 2012, an employee is entitled to a minimum of 21 days paid annual leave at the end of each year. Employers can agree to give employees more than the stipulated leave days.
2. Maternity leave- A female employee shall entitled to three months maternity leave with full pay.
3. Paternity Leave- A male employee is entitled to two weeks paternity leave with full pay.
4. Sick leave- after two consecutive months of service with his employer, an employee shall be entitled to sick leave of not less than seven days with full pay and thereafter to sick leave of seven days with half pay, in each period of twelve consecutive months of service.
5. Public holidays- Employees are entitled to paid day off on a public holiday if it would otherwise be a working day. These public holidays are separated from and additional to annual holidays.

***Equal pay and equal rights-*** Employers cannot pay employees differently based on gender. Employers cannot discriminate in hiring or firing, pay, training or promotion because of race, colour, national or ethnic origin, sex, marital or family status, employment status, age, religious belief, political opinion, disability or participation in certain union activities.

***Union membership rights-*** Employees have the right to decide whether they want to join a union and, if so, which union. It is illegal for an employer or anyone else to put unreasonable pressure on someone to join or to not join a union, or to discriminate against someone because they joined or did not join a union.

**Addressing Employment Relationship problems**

An employment problem includes anything that harms or that may harm an employment relationship. While the most obvious relationship is between an employer and an employee, other examples are relationship among employees, between a union and its members, between a union and an employer and among unions covering grievances requiring specific treatment under the employment Act. A number of staff in the same workplace may share a common view about a problem. If so, it can help to deal with the problems collectively and to look for a solution that works for everyone.

Table 3.8. Examples of Employee Relationship Problems

|  |  |
| --- | --- |
| **Employer’s perspective** | **Employee’s perspective** |
| * Poor performance or unacceptable behavior * Lateness and absenteeism * Long-term illness * Failure to comply with health and safety Procedures * Breaches of organizational policy or the law * Misconduct * Conflict between employees | * Discrimination or harassment * Disagreement whether a warning should be issued * Problems with health and safety * Disagreement about the meaning of a term in an employment agreement * Misunderstood or poorly managed discipline * Dismissals, redundancies or restructuring * Disputes over holidays or pay, including deductions from pay |

Whether a problem involves an individual or group, it is important for everyone to:

1. Deal with the issue as soon as it arises
2. Take the time to get the facts straight;
3. Listen to everyone’s views
4. Seek solutions;
5. Follow laid down dispute settlement procedures and a fair process that everyone understands as provided for in the organizations; policies union agreement or employment law;
6. Record actions and expectation.

***Preventing Employment Relationship Problems***

Problems are least likely to arise when everyone in an employment relationship acts in “good faith”. The following are examples of some simple practices that can help make employment relationship smoother and prevent problems;

1. Employees should be well informed about their employment rights responsibilities
2. Agreements (and changes to agreements) should be recorded in writing. This helps to prevent misunderstanding and resolve problems if they arise later;
3. It should be clear that the terms of employment being offered are only those recorded in the written agreement, and employers should avoid giving assurances that are inconsistent with written agreement or that are not recorded in it;
4. Employees also have a responsibility to prevent and clear up confusion;
5. Before any significant change, the people affected should be consulted. Getting everyone’s ideas and perspectives will often lead to better decisions. People also respond better to change when they have some warning and have been listened to;
6. Rising concerns when they first arise can help stop becoming bigger and harder to resolve. An effective performance management system is a good way of ensuring this.
7. Take time to communicate clearly. Poor communication often causes disputes and misunderstandings.

***Procedures for Resolving Employment Relationship Problems***

1. Problems often occur in workplaces. If a problem arises, it’s important to have a clear idea of the issues. To resolve them, check the facts and make sure that both sides have the time and opportunity to take advice and think through the issues.
2. Every collective and individual employment agreement must clearly explain the steps and processes for resolving employment relationship problems. It should tell employees whet is require of them, their rights and what happens when problem occurs.
3. The sooner an issue is dealt with, and the better a process is followed, the less likely it is that outside assistance will be required in resolving problems. It is important that all partied, in good faith, try to resolve any problems directly. Some parties may be able to settle their differences quickly and cheaply using a mediator as a third party.

The Employment Act and union agreements provides for clear dispute settlement procedures.

**Ending the Employment relationship**

There are several ways in which employment relationship may be terminated. Those include resignation, retirement, dismissal or redundancy. If an employee believes that an employer acted unjustifiably in ending the employment relationship can challenge the employer’s decision.

**MODULE 4: LEADING ORGANISATIONAL CHANGE**

**Organizational Change**

Change is the coping process of moving an unsatisfactory present state to a desired state. Individuals, terms, or organizations that do not adapt to change in timely ways are unlikely to survive. Successful individuals, terms and organizations are those that recognize the inevitability of change, learn to adapt, and to manage it (Hunsaker, 2014).

Organizational change is the movement of an organization from its current state or practices to some future or alternative and hopefully more effective state of processes in order to increase its effectiveness (Lunenburg2010). Organizational change is often stimulated by a major external force. Typically, organizations undertake technical, structural or strategic shifts in the organization to evolve to a different level in their life cycle, for example changing from a highly reactive organization to a more stable proactive results-oriented environment.

Organizational change does not occur spontaneously; it takes place when forces encouraging change become more powerful than those resisting it. Organizational change may be occasioned by external or internal force. Examples of external forces are substantial cuts in funding, change in government policy, technological advancement and increases in demand for services. Sometimes this includes increases in funding for new or expanding areas of health care. Internal drivers of change include issues like declining effectiveness and productivity, internal strife and crisis and can include increased awareness of health managers or health providers related to new and/or more effective ways to deliver services or improve efficiencies.

In response to demands for change, organizations undertake technical, structural or strategic shifts in the organization to evolve to a different level in their life cycle such as changing from a highly reactive organization to a more stable proactive environment.

Change Management.

Change management is a set of processes employed to ensure that significant changes are implemented in a controlled and systematic manner. One of the goals of change management is the alignment of people and culture with strategic shifts in the organization to overcome resistance to change in order to increase engagement and achieve the organization’s goals for effective transformation. Achieving sustainable change begins with a clear understanding of the current state of the organization, followed by the implementation of appropriate and targeted strategies. Change management is a structured approach to shifting/transitioning individuals or teams from a current state to a desire future state. It is an organizational process aimed at helping employees to accept and embrace change in their current work environment. All leader and managers must be prepared for changes by being flexible, positive and proactive in their approach.

Change and Transition.

Bridges (2003) explains there are significant differences between change and transition. Change involves doing things differently while transition is deals with how to move people through the stages to make change work. Change is a shift in the externals of any situation, for example, setting up a new programme, restructuring a hospital, moving to new location, or a promotion. By contract, transition is the mental and emotional transformation that people must undergo to relinquish old arrangements and embrace new ones.

There are other distinctions too. Change is made up of events, while transitions a continuous process that takes place inside people. Change is visible and tangible. Transition is a psychological process that place inside people. Change can happen quickly, but transition, like any organic process, has its own natural pace. Change is about the outcome we are trying to achieve; transition s about how we will get there and how we will manage things while we are en route. Getting people through the transition is essential for change to occur.

It is important to ensure that change management strategies are driven by the changes that need to occur. Nonetheless, do not lose focus on the more personal transition activities needed to ensure the success of the programme.

Change and Transformation.

Transformation occurs as a result of a well-orchestrated and well-led change strategies and transition plan. The result is a metamorphosis to the desired state in which there is a deep seated adoption of the changes and associated values, principles and or processes. This leads to an embedded and marked change in organizational culture and reinforces a journey of continuous improvement.

4.2 Leading and Managing Change

The implementation of any significant change process usually succeeds or fails because of the leadership of that change process. Management as a discipline focuses on processes and systems that keep the operations of an organization running smoothly, while leadership engages the hearts and minds of staff.

Planning for change

Before embarking on an organizational change initiative, it is wise to carefully plan strategies and anticipate potential problems. One useful method of planning for change is Kurt Lewin’s Force-field Analysis (**Figure 4.1**). The term describes a simple analysis that can be used to help plan and manage organizational change. Lewin believed that behavior within an organization was a result of the dynamic balance of two opposing forces. Change would only occur when the balance shifted between these forces. Driving forces are those which positively affect and enhance the desired change. They may be persons, trends, resources, or information. Opposing them are the restraining forces which represent the obstacles to the desired change. As these two sets of force exist within an organization, they create certain equilibrium. That is, if the weights of the driving and restraining forces are relatively equal, then the organization will remain static. As changes occur and affect the weight of either one of the forces, a new balance will occur, and the organization will return to what Lewin called “quasi – stationary equilibrium;.

Force –field analysis assists in planning for change in two major ways:

1. As a way for individuals to scan their organizational context, brainstorming and predicting potential changes in the environment; and
2. As a tool for implementing change.

In (1) force field analysis is used as a method of environmental scanning. The more change can be anticipated, the better individuals and organizations are prepared to deal with the resulting effects. The second use of force-field analysis (in 2) present a way to systematically examine the potential resources that can brought to bear on organizational change and the restraining forces that can be anticipated. This advance planning and analysis assists in developing strategies to implement the desired change.

Figure 4.1 Force Field Analysis

FORCE FIELD ANALYSIS – KURT LEWIN

DRIVING FORCE

RESTRAINING FORCES

(Positive forces for change) (Obstacles to change)

**Present**

**State**

**Or**

**Desired**

**State**

Source Burnes and Cooke (2013).

Strategies for Implementing Change

In order to move the change process from the idea stage implementation, team leaders and health managers must also rally the resources and support of organization. Kanter (1983) describes how the following three sets of”basic commodities “ or “ power tools” or enablers can be acquired by members of an organization to gain power.

* Information – data, technical knowledge, expertise.
* Resources – funds, materials, staffs, time
* Support – endorsement, backing, approval, legitimacy.

The first strategy in implementing a change would be to collect as many of these power tools as possible. As this occurs, you can start seeking support for the planned change. This is particularly important in helping others see the critical need for the planned change. It may be possible to generate support before sponsorship of the change in sought so that the sponsor feels he or she is proactively responding to a critical need.

Another strategy is to” package” the change in a way that makes it less threatening and, therefore, easier to sell. For instance, it is easier to implement change of a product or a project when it is;

1. Conducted on a trial basis;
2. Reversible, if it doesn’t succeed;
3. Done in small steps ;
4. Familiar and consistent with past experience;
5. Fits in the organization’s current direction; or
6. Built on the prior commitments or projects of the organization (Kanter, 1983).

Building coalitions is a strategy that often occurs throughout the entire phase of implementing change. Support must be gathered from all areas which will be affected by the desired change, across different levels of the organization. It is always advisable to get the support of an immediate supervisor early on, although this may not always be possible. In such instances, other support could be gathered across the organization to lobby the supervisor to lend support to the change effort.

Effective change masters use their informal networks and deal with any concerns or questions of supporters individually rather than in formal meeting. “Pre-meetings” can provide a safer environment for airing concerns about implementing change. In such setting, an individual may have the opportunity to “trade” some of the power tools that he or she has acquired in order to generate support.

Additionally, some individuals will support a project or change effort for reasons that are fairly reactive; “if so- supports it, I will, too,” or’ if such – and –such hospital is moving in that direction, then we should, too”. Obviously, the more change masters predict how particular individuals may react, the better able they are to plan for ways to garner support.

**Key Role Actors in change Process**

***Change Sponsor***

A change sponsor is someone who has the authority, seniority, power, enthusiasm and time to lead/carry through/oversee the desire organizational changes. The change sponsor may not get involved with the day-to-day management of the change but should support and monitor progress. Usually, he or she is a senior member of the management team given responsibility for affecting the.

Within the health sector system, a change sponsor may, for instance, be the Director of Medical Service, the chair of the facility management team or a senior medical consultant. The change sponsor must ensure that the necessary resources are available throughout the change process and accept ultimate responsibility for the successful change implementation. He should endorse the change strategy and approach, be an active champion and role model for the desired state and monitor and communicate change progress to interested parties.

***Change Manager***

A change manager is someone with the expertise and credibility to lead the change and can act as a role model for the new reality. One of the top characteristics of successful change leaders is credibility with those making the change. The change manager may be an experienced project or change manager within the organization or possibly, brought in from outside with the specific responsility of managing the change. The change manager is responsible for the day-to-day implementation of the change:

* Designs the change process, strategy and approach and agrees on these with the change team;
* Takes responsibility and strategy and contingency plans for the change;
* Monitors progress;
* Facilitates key events to build commitment for the change;
* Liaises up and down the organizational structure.

***Change Advocate***

A change advocate is an individual or group that wants to achieve change but does not possess legitimization power. Doctors, nurses, clinicians, technologists and technicians are often in the position of change advocates. Although they see the need for change and desire and advocate for the change, they do not have the necessary organizational power to implement it.

***Change Agent***.

Every organizational change, whether large or small, requires one or more change agents. A change agent is anyone who has the skill and power to stimulate facilitate and coordinate the change effort. The individual or group that undertakes the task of initiating and managing change in an organization is known as a *change agent*. Change agents can be internal, such as managers or employees who are appointed to oversee the change process. In many innovative-driven companies, managers and employees alike are today being trained to develop the needed skills to overs change. While change agents can also be external, internal change agents are known to be the most effective.

The success of any change effort depends heavily on the quality and workability of the relationship between the change agent and the key decision-makers within an organization.

**4.3 Change Models**.

Organizational change may be sporadic or on-going continuous improvement initiatives as a result of organizations responding or reacting to external forces for change. Such changes may be a part of improvement initiatives such as Total Quality Management (TQM), Six Sigma, Kaizen or other organizational development initiatives based on various change models.

There are many different models for the change process. These include the balanced scorecard, John Kotter’s Eight steps in leading change, Tuckman’s Four stages of Team Development and Bridges Three Phrases of Transition.

1. **Balance Scorecard**

This is a strategic planning and performance management tool that can be used by team leaders and health managers to keep track of the execution of activities by teams within their control and to monitor the consequences arising from these actions. The Balanced Scorecard presents a mixture of financial and non-financial measures. Each critical indicator is compared to a ‘target’ value. It articulates the links between leading inputs (human and physical), processes, and lagging outcomes and focuses on the importance of managing these components to achieve the organizations strategic priorities. The Balanced Scorecard depicts the organization’s success at aligning organizational improvement efforts to strategies to meet customer needs by focusing on four perspectives as presented in **Table 4.1**.

**Table 4.1 Balanced Score Card Dimensions**.

**Dimension Measure**

Financial Encourages the identification of measures that Answer the

Question.

“How do we optimize expenditures for maximum mission?

Effectiveness”?

Customer Encourages the identification of measures that answer the

Questions.

“How should we appear to our customer to achieve our vision?’

Internal business Encourages the identification of measures that answer the

Processes Questions.

“Which processes must we excel at to satisfy our stakeholders?’

Learning and Encourages the identification of measures that answer the question

growth “How can we continue to improve and create value to achieve our vision

In addition to reviewing past results, the Balanced Scorecard can also utilize as a strategic management system in several ways:

* *Communication –* Cascading the scorecard; driving it down to all levels of the organization – gives employees the opportunity to demonstrate how their day-to-day activities contribute to the organization’s strategies. This creates a line of sight between the front –line employee and top leaders.
* *Strategies resources allocation* - The resources necessary to achieve scorecard targets form the basis for the development of the annual budgeting process, thereby directly trying resources to achieving of the organization’s goals.
* *Continuous improvement* – balanced scorecard results form the basis for reviewing, questioning and refining the strategies and tactics needed to achieve an organization’s goal.

1. **John Kotter’s Eight steps in Leading Change**

According to Kotte’s research, 70% of all major change efforts in organizations fail because organizations often do not take the holistic approach required to see change through. By following Kotter’s Eight step process, organizations can avoid failure and become adept at change. By improving their ability to change, organizations can increase their chances of success, both today and in the future. Without the ability to adapt continuous sly, organizations cannot thrive. Kotte’s eight steps for organizational change are widely viewed as the framework for successful change at all levels of an organization.

**Table 4.2 Kotter’s Eight Steps for Organizational Change**.

|  |  |
| --- | --- |
| 1. Create Urgency | Urgency Kotter suggests for change to be successful, 75% of a company’s Management needs to support the change. So one of the key early tasks is to develop a sense of urgency around the need for Change. This can involve a full SWOT analysis, scenario planning and full deployment of all the strategies planning results of early conclusions should be thoroughly tested with informed third party opinion and a wide cross section of stakeholders. |
| 1. Form a guide   coalition | Managing change is not enough, change must be led. Building the momentum for change requires a strong leadership and visible support from key people within an organization. The coalition will involve a wide representation of the formal and informal power-base within the organization. By working as a team, the coalition helps to create more momentum and build the sense of urgency in relation to the need for change. Kotter recognizes the importance of the emotional dimension and the energy that is generated by a “mastermind” groups all working together. |
| 1. Develop a vision and strategy | A drive for change without a clear focus will rapidly fizzle out unless leaders develop a clear vision of the future that is accompanied by a clear description of how things should look at in the future. The vision must be defined in such a way that it is capable of expression in a short “vision speech” that conveys the heart of the change in less than five minutes. This then needs to be encapsulated in a powerful one or two sentence summary. All members of the coalition must be fluent in both of these vision statements and leaders must, with the coalition, develop strategies. That will deliver the vision. |
| 1. Communicate the vision | Communication is everything, and Kotter maintains change leaders must use very means at their disposal to constantly communicate the new vision and key strategies that support that vision. This goes beyond the “special announcement” meeting and involves frequent and informal face-to-face contact with people by all individual members of the coalition. Email is not an appropriate communication vehicle, except where necessary to support prior face-to-face contact. The leaders must also “walk the talk” visibly. They must be available and accessible to people. They must openly and honestly address staff fear and concerns. |
| 1. Enable action and removal of obstacles | In this stage, the change initiative moves beyond the planning and the talking, and into practical action, as leaders put supportive structures in place and empower and encourage people to take risks in pursuit of the vision. This is where the change leader identifies and removes obstacles and obstructions to change. This may also involve addressing resistant individuals and/or group and helping them to reorient themselves to the requirements of the new realities. |
| 1. Generate short-term wins | Success breeds success. Kotter advises that an early taste of victory in the change process fives people a clear sight of what the realized vision look like. This is important as a counter to critics and negatives influencers who may otherwise impede the process of the initiative. It is also important to recognize and reward all those people who make early gains possible. Change leaders must look for- and create- opportunities for these early wins. |
| 1. Hold the gains and build on change | Kotter argues that many change initiatives fail because victory is declared too early. An early win is not enough. This is the time to increase the activity, change all systems and structures and processes that don’t fit with mostly about continuous improvement. Each success (and failure) is an opportunity to analyses what worked, what did not and what can be improved. |
| 1. Anchor changes in the culture | Kotter says that for any change to be sustained, it needs to become embodded in the new “way we do things around here”, - that is, the culture. A major part of this is for the change leader to articulate the connections between new behaviours and organizational success. This is where the coalition team talks about progress at every opportunity. Tell success stories about the change process, and repeat other success stories. This is successful if change leaders put forth continuous efforts to ensure that the change is seen in every aspect of the organization. |

|  |  |
| --- | --- |
| 1. **Bruce Tuckman’s Four stages of Team Development**.   Change in leadership or programming affects people as individuals and also as a team. As a change model, Tuckman’s Four stages of Team Development illustrate how people interact in team situations. Firstly, it illustrates that it is highlights the need to manage different aspects of team behavior in a crisis or at each stage of development.  **Table 4.3 Bruce Tuckman’s Four stage of Team Development.**   1. **Forming** – In the stages of team occurs. Individual behavior is driven by a desire to be accepted by the others. And avoid controversy or conflict. Serious issues and feelings are avoided, and people focus on being busy with routines such as team organization, roles when to meet, etc. Individuals are also gathering information and impressions about each other, and about the scope of the task and how to approach it. This is a comfortable stage, but the avoidance of conflict and threat means that not much actually gets done.   The team meets and learns about the opportunities and challenges, and then agrees on goals and begins to tackle the tasks. Team members tend to behave quite independently. They may be motivated but are usually relatively uninformed of the issues and objectives of the team. Team members are usually on their best behavior but very focused on themselves. Mature team members begin to model appropriate behavior even at this early phase. Sharing the knowledge of the concept of “team – Forming, storming, Performing” is extremely helpful to the team. Supervisors of the team tend to need to be directive during this phase.  The forming stage of any team is important because it is at this stage that team members get to know one another, exchange some personal information, and make new friends. This is also a good opportunity to see how each member of the team works as an individual and how they respond to pressure.   1. **Storming** – Every will next enter the storming stage in which different ideals compete for consideration. The team addresses issues such as what problems they are really supposed to solve, how they will function independently and together and what leadership model they will accept. Team members open up to each other and confront each other’s ideas and perspectives. In some cases, storming can be resolved quickly. In others, the team never leaves this stage. The maturity of some team members usually determines whether the team will ever move out of this stage. Some team members will focus on the minutiae to evade real issues.   The storming stage is necessary to the growth of the team. It can be contentious, unpleasant and even painful to members of the team who are averse to conflict. Tolerance of each team members and their differences should be emphasized. Without tolerance and patience, the team will fail. This phase can become destructive to the team and will lower motivation if allowed to get out of control. Some teams will never go past this stage.  In this phase, team may be more accessible, but tend to remain directive in their guidance of decision-making and professional behavior. Team members will therefore resolve their differences and members will be able to work with one another more comfortably. The ideal is that they will not feel that they are being judged, and will therefore share their opinions and views.   1. **Norming** – team manages to have one goal. It develops a mutual plan for the team at this stage. Some may have to give up their own ideas and agree with others in order to make the team function. In this stage, all team members take the responsibility and have the ambition to work for the success of the team’s goals. 2. **Performing** - it is possible for some teams to reach the performing stage. High performing teams are able to function as a unit as they w find ways to get the job done smoothly and effectively without inappropriate conflict or the need for external supervision. By this time, they are motivated and knowledgeable. Team members are competent, autonomous and able to handle the decision-making process without supervision. Dissent is expected and allowed as long as it is channeled through means acceptable to the team.   At this stage, team supervisors are almost always participative. The team will make most of the necessary decisions. However, even the most high-performing teams will revert to earlier stages in some circumstances. Many long-standing teams go through these cycles many times as they react to changing circumstances. For example, a change in leadership may cause the team to revert to storming as new people challenge existing team norms and dynamics.   1. ***William Bridges Three Phases of Transition***.   This is an individual change model. According to Bridges’ theory, change is situational. Transition, on the other hand, is a psychological, three-phase process that people go through as they internalize and come to terms with the details of the new situation that change engenders. Situational changes are not as difficult for organizations to make as the psychological transitional of the people impacted by the change. The three – phase process consists of the following:   1. ***Ending losing, letting go*** – This involves helping people deal with their tangible and intangible losses and to mentally move on. Initially, most of the activity in managing the emotional and psychological journey of transition is related to letting go of the past and subsequent investing in and transitioning to the future. Bridges identifies five aspects of the natural ending experience: Disengament, dismantling, dis-identification, disenchantment and disorientation. The process of letting go of the past can bring up feelings of sadness, grief and loss as well as some relief or anticipation about the possible new future. The starting point for dealing with transition is not the outcome, but the ending the person must make to leave the old situation behind. Ending can be managed by treating the past with respect, helping compensate for losses, giving people plenty of the right information, marking the endings, and helping define what is over and what is not. 2. ***The neutral zone***- The neutral zone is that in-between place where one loses the sense of relatedness and purpose. This is because much of the one’s identify is tied up in the old way of life. At this stage, there are no new anchors to give any context or meaning although this can be difficult, confusing and painful. Critical psychological realignments and re patterning takes place. This stage involves helping get people through it, and capitalizing on all of the confusion by encouraging them to be innovators.   The neutral zone is a place of both risk and opportunity.it is risky because people are unsure of the process being created and may become anxious, during which time productivity may fall. Old weaknesses, compensated for in the old arrangements, may rise to the surface. People may get mixed signals between the old regimen and the new. People may become polarized one way or the other, leading to tension and discard. In addition until the new regimen becomes embedded, any new arrangements are vulnerable to internal or external shocks.  For all these reasons, transitions through the neutral zone need to be managed carefully. Bridges provides a number of mechanisms for this, including creating temporary support systems and short –term goals, and redefinition of the activity in the neutral zone in terms of more familiar activity or metaphors. However, the neutral zone is also point of creative opportunity. As people and system “unfreeze” from the old systems, there is tremendous opportunity to identify and realize changes and find new ways of doing things.   1. ***The new begging*** – this involves assisting people develop new identities, experience new energy and discover the new sense of purpose that make the change begin to work. Bridges distinguishes between “starts” and “beginning”. A start occurs when people start doing new things, when they start enacting the changes. However, a beginning occurs only when the personal psychological and behavioural change takes place and people take on new behaviours and identities. Transition managers must identify the “4 Ps” defining the path into the future:  * Purpose of the transition * Picture of vision * Plan * Part for each person to play   In addition, being consistent (avoiding conflicting messages), building momentum with “quick successes,” symbolizing the new entity and celebrating successes can all help with successful transitions. Besides providing a set of tools, Bridges proposes the creation of a Transition Monitoring Team. This is a group composed of individuals from across the organization holding various roles and whose sole purpose is to provide a feedback on the status of the transition across the organization.   * 1. **Managing Reactions to Change.**   People are generally afraid of the unknown. Many think things are fine the way they are and do not understand the need for change. Recognizing the need to change, and acting on it, can be difficult decisions for individuals, leaders and managers to make. However, change, requires the management of people’s anxiety and confusion or conversely their excitement and engagement. These are emotions that most managers find difficult to deal with or address. Managing the change process and transition emotions is fundamental to the success of a change oriented project.  **Individual Resistance to Change**  The primary reason is that people fear change (Bridges 1980). They are not usually eager to forego the familiar, safe, routine ways of conducting their business in favour of unknown and possibly unsafe territory. As humans, we tend to prefer routines and accumulate habits easily; however, fear of change may be attributed to more than a tendency toward regularity. Change represents the unknown. It could mean the possibility of failure, the relinquishing or diminishing of one’s span of control and authority or the possibility of success creating further change. It might be that the planned change has little or no effect on the organization whatsoever. Any one of these possibilities can cause doubt and thus fear, understandably causing resistance to the change efforts.  Additional, the transition between the present state and the changed state is difficult for both individuals and organizations. On an individual level, people must be reminded that every transition or change is going through the process of ending. Ending must be accept and managed before individuals can fully embrace the change. Even if the impending change is desired, a scene of loss will occur. Because our sense of self is defined by our roles, our responsibilities, and our context, change forces us to redefine ourselves and our world. This process is not easy.  Bridges present the following four stages that individuals must pass through in order to move into the transition state and effectively change:   1. **Disengagement** – after individual must make a break with the “old” and with his or her current definition of self. 2. **Disidentification** – after making this break, individuals should loosen their sense of self so that they recognize that they aren’t who were before. 3. **Disenchantment** – in this stage, individuals further clear away the “old,” challenging assumptions and creating a deeper sense of reality for themselves. They perceive that the old way or old state was just a temporary condition, not an immutable fact of life. 4. **Disorientation** – In this final state, individuals feel lost and confused. It’s not a comfortable state, but a necessary one so that they can then move into the transition state and to a new begging.   **Organizational Resistate to Change**.  Organization, regardless of size, are composed of individuals. The extent to which individuals within the organization can appropriately manage change represents the overall organizational capacity for change. However, there are other factors peculiar to the organizational setting that can act as barriers to implementing change. These include:   * ***Inertia*** – one of the most powerful forces that can be affect individuals and organizations is inertia. The day-to-day demands of work diminish the urgency of implementing the change effort until it slowly vanishes within the organization. * ***Lack of clear Communication***- if information concerning the change is not communicated clearly throughout the organization, individuals will have differing perceptions and expectations of the change. * ***Low-Risk Environment*** – In an organization that does not promote change and tends to punish mistakes, individuals develop a resistance to change, preferring instead to continue in safe low risk behaviours. * ***Lack of sufficient Resources*** – If the organization does not have sufficient time, staff, funds or other resources to fully implement the change, the change efforts will be sabotaged.   These factors, combined with others characteristics to the specific organization, can undermine the change effort and create resistance. A wise change agent will spend the necessary time to anticipate and plan for ways to manage resistance.  ***Reasons behind Resistance to Change***  People’s reaction to change depends heavily on their:   * *Perceptions of value*: When we conclude that a proposed change will cause us to lose something of value, we have tended to resist it. The more we expect to gain from change, the more we support it. * *Understanding of change*: We all fear the unknown, so we are less likely to support change if we do not understand it. If we are confused about the implications of change, we usually assume the worst and react accordingly. * *Trust in initiators*: If our trust in management is low, our first reaction is to ask what is really going to happen and how it is this going to affect us. When we do not trust the initiators of change, virtually any change tends to be received negatively. When trust is high, we are likely to support change. * *Agreement with change*: change planners often fail to assess who is likely to agree or disagree with the introduction of a change. It is logical to expect more support from those who think that the change is a good idea than opposed to it. * *Personal feelings*: Our personal characteristics determine whether we support or resist change. For example, if we lack confidence is our skills i.e. skills required by change, we will probably be resistant. Cynicism is another key element in our reaction to change. Cynicism is another key element in our reaction to change.   In addition to the influence of these and other personality attributes (such as dogmatic closed – mindedness and authoritarian personalities), attitude toward change itself can also play an important role in shaping our reactions to any specific change.  *Common phrases in people’s reaction to change*  Habits are normal part of every person’s life although it is often counterproductive when dealing with change. As humans, we are not good at changing. We see change as a negative thing, something that creates instability and insecurity. A normal change management process often involves eight mental phases. (Bridges 1980).  **Table 4.4 Common Phases in People’s Reaction to Change**  Denial Where we fight change and protect the status quo  Frustration When we realize that we cannot avoid change and  Become Insecure because of lack of awareness quo  Negotiation and bargaining Where we try save what we can  Depression we realize that none of the old ways can be  Incorporated into the new.  Acceptance When we accept the change and start to mentally  prepare Ourselves  Experimentation Where we try to find new ways and gradually remove  The old barriers  Discovery and delight When we realize that change will improve our  Future possibilities  Integration When we implement the change. | |
| [- |  |
|  |  |
|  |  |
|  |  |

**MODULE 5: COMMODITY AND SUPPLIES MANAGEMENT**

**5.1 supply chain management**

Reliable and affordable supplies of commodities are critical for the success of health services. They affected the quality the quality of the service, their availability, cost and influence the uptake of health services. An effective commodity management system must be in place to ensure their accessibility and effective use, both at the service delivery level and in referral services.

Supply chain management encompasses the planning and management of all activities involved in sourcing and procurement and all logistics management activities. It also includes coordination and collaboration with partners, which can be suppliers, intermediaries, third party service providers and customers. In essence, supply chain management integrates supply and demand management within and across parties.

Public procurement in all government entities is governed by the public Procurement and Disposal Act and the Regulations; the Act has divided the public entities into three categories as indicated in the table below.

Table 5.1 Public Procurement Act-Categories of Public Entities

**Class Category**

Class A Ministries and State Corporation

Class B City Councils, Universities, Judiciary, Commissions, Colleges, Cooperative Societies, Parliament, Parliament, County Hospitals and SAGAs

Class C Municipalities, County Councils, Urban Councils and Schools and Sub-County Hospitals

The Public Procurement Act was established to achieve the following objectives

1. To maximize the economy and efficiency
2. To promote competition
3. To promote integrity and fairness
4. To increase transparency and accountability
5. To increase of the local industry

The Medical Superintendent or Officer in Change has the obligation to ensure that a health facility complies with provisions of the Act and Regulations.

**5.2. Internal Organization of Health facilities in Supplies management**

All public entities are required to establish the following

**Use Department**

The user department is the end user of the purchase or the department that will benefit from the purchase. The user initiates the purchase request, prepares the technical specifications of the purchase, participates in the evaluation of tenders and ensures that the purchase conforms to the requirements amongst other roles provided in the Procurement Act and Regulations. Some of the users in a health facility include: the Nursing Unit, Pharmacy Unit, Catering Unit and Theatre Unit amongst others.

**Procurement Unit**

The procurement unit should be staffed with procurement professionals. The professionals should have procurement and supplies management qualifications from recognized institutes in purchasing and supplies. This unit is in charge of supplies management in the health facility. Some of the duties of the procurement unit include: maintaining a database of suppliers, preparing tender document, maintaining procurement documentation, coordinating the evaluation of tenders and proposals, preparation of contracts, implementing decisions of the tender and procurement committee amongst others.

**Procurement Committee**

The members of a procurement committee are appointed by the Medical Superintendent or the Officer in Charge. An Accounting Officer will serve as the chairperson of the committee. The secretary of the committee is appointed by the head of the procurement unit and is procurement professional. The other three members are appointed by the Medical Superintendent or the Officer in Charge. The procurement committee evaluate tenders that are over Kshs. 1,000,000 in the County Hospital and over Kshs. 200,000 (or as may be prescribed by the Procurement Act) in sub-County Hospitals (formerly District Hospitals). The procurement committees’ functions include: approval or rejection of submissions made by the procurement unit. In instance where the procurement committee rejects then reasons shall be provided why such reject was made.

**Tender Committee**

A tender committee established in accordance to the Act. The members of a tender committee are appointed by the Medical Superintended or the officer in charge. They should consist of not than five members. The secretary of the Committee should be a Procurement Professional in charge of the Procurement Unit. The tender committee evaluates tenders that are over Kshs. 1,000,000 in the County Hospital and over Kshs. 200,000 (or as may be prescribed by the Procurement Act) in sub-County Hospital (formerly District Hospital). The tender committee reviews the report prepared by the Evaluation Committee to make an award. The tender committee can accept or reject the recommendation made by the evaluation committee by providing relevant explanations to their decision.

Some of the roles of the tender committee includes: approving the selection of successful tenders, awarding procurement contracts, approving the list of tenders, approving the amendments of contracts amongst other roles.

**Evaluation Committee**

The health facility establishes an Evaluation Committee for every procurement within the threshold of the tender committee for the purpose of carrying out the technical and financial evaluation of the tenders or proposals. The report of the evaluation committee is presented to the tender committee for consideration of award.

**Inspection and Acceptance Committee**

The health facility establishes the inspection and acceptance committee, he committee is composed of a chair and at least two members. The members of the inspection and acceptance committee are appointed by the Medical Superintend or the Officer-in-change. The function of the committee include the following ensuring the correct quantities are received, ensuring the service and goods meet the technical, specifications, issuing completion certificates amongst other duties.

**Disposal Committee**

The health facility established the disposal committee. The committee has five members appointed by the Medical Superintendent or the Officer in charge. Their role is to dispose-off unserviceable, obsolete or surplus stores and equipment in the health facility.

**5.3. Procurement Process**

**The procurement process involves**

1. Identification of a need;
2. Procurement planning
3. Preparation and approval of the specifications;
4. publication of the bid
5. Receiving and opening documents
6. Evaluation of the of the bid documents;
7. Notification of award
8. Contracting
9. Contract management and delivery

**Identification of a need**

The user department is responsibility for identifying the needs of their respective department. The needs are then consolidated into a department budget. The budgets are presented to the Medical Superintendent for approval and for presentation to the treasury. The annual budgets are drawn based on the one year government financial year.

**Procurement Planning**

All health facilities are required to prepare a procurement plan. The procurement plan has a breakdown of goods, services and works. It showed a schedule of planned delivery dates, completion dates, the procurement method to be used from each budget line and the source of finance. Procumbent planning includes the pre-qualification of suppliers in every government financial. The health facility invites suppliers to respond to the pre-qualification for various goods and service. The prequalification process identifies suppliers for various categories. The health facility uses the suppliers identified through this process to procure the required goods service. The tender committee pre-qualifies suppliers and generates a list that should be uses in the financial year.

**Preparation and approval of specification**

The various user departments within the health facility are responsible for the preparation of specifications. They prepare specifications based on their needs and submit the specifications to their respective departmental heads. The department heads approve the specifications for procurement and submit them to the procurement unit. The procurement unit will commence the procurement process by initiating the identified procurement method in the procurement plan.

**Publication of the bid**

The procurement unit upon receiving the technical specifications from the user department is expected to prepare bid documents based on the respective procurement methods identified in the procurement plan. The bid templates are prescribed by the Public Procurement Oversight Authority (PPOA). There are specific templates for each procurement method and different timelines (to advertise the bids and evaluate) allocated accordingly.

**Receiving and opening documents**

The bids are received in the health facility in either the tender box or through an address provided in the bid document. The tender documents are to be kept under lock and key until the time indicated for the opening sessions. The tenders can be opened in public where the bidders are expected to be present and observe the opening. This happens when dealing with open tenders. The opening of bids and quotation also takes place in the procurement committees. The procurement committee members open the bids and list them prior to evaluation.

**Evaluation of the bid documents**

Tenders and quotations are evaluated during procurement and evaluation committee meetings. The health facility sets up the tender committees which are used to evaluate tenders. There are two stages in the evaluation stages. Administrative evaluation where the bids are evaluated to confirm compliance to the administrative aspects of the bid contain documentation not considered technical but important to the bid. The bids that are successful for the administrative compliance stage are evaluated for technical compliance.

The procurement committee evaluates and awards while the evaluation committee evaluates and recommends for awards. The report for the evaluation committee is presented to the tender committee. The tender committee evaluates the report of the evaluation committee and awards to the most advantageous bidder or rejects and offers recommendations to the evaluation committee.

**Notification of award**

The health facility is required to notify all bidders of the procurement process whether they are successful or not. In the open tender method, a period of 14 days is to adhered to. The bidders are notified by the facility prior to contracting. Once the contracting period expires; the health facility is supposed to contract the bidders.

**Contracting**

The health facility is supposed to contract the bidder who was awarded by the tender or procurement committee. There are different contractual documents. Local Purchase Order (LPO), Local Service Order (LSO) and Contract. The sample LPO and LSO are appending the Financial and Resource Management Module. The Contract documents are signed by the Medical Superintendent of the hospital or any other signatory as specified in the Act. The contractual documents can be obtained from the PPOA website and are mandatory for use in all government health facilities.

**Contract management**

Contract management is a process of managing the contract milestones, managing the obligations and performance of the contract, managing claims and dispute that may arise and renewing the contract, amending the contract and eventually terminating the contract. It includes ensuring all deliverables are made and that they are in good order. The contract management process commences upon the award of contract by the tender committee. The objectives of contract management; minimize risks related to contracting; increase the efficiency of the process of contracting; reduce the costs; maintain good relationship with suppliers; ensuring the delivery of quality goods, services or work; and ensuring compliance with legal requirements and conditions. The health facility establishes an inspection and acceptance committee. The committee is tasked with the task of reviewing the deliverables and ensuring that the comply with the specifications provided. They issue inspection reports and certificates.

**5.4 Procurement Methods**

1. **open Tender Method**

The open tender method is the default procurement method. It allows all eligible bidders to participate in the tender without discrimination and therefore allows maximum competition. There are no maximum budget ceilings for this procurement method. There are two types of open tender methods; the international Open Tender and the National Open Tender. The International open Tender is for good and services that are obtained outside Kenya while the National Open Tender is for goods and services obtained within Kenya. The International Open Tender is advertised for 30 calendar days while the National Open Tender is advertised for 21 calendar days. A fee of not more than Kshs. 5,000 is charged for bidders obtaining the tender documents. A tender security is charged to the bidder. Such security should not be more than 2% of the contract value.

The technical evaluation for open tenders is performed by the evaluation committee while the award is made by the tender committee. Open tender should be evaluated within 30 days from the date of closure.

1. **Restricted Tendering**

This procurement method is used when the goods, services or work are of complex or specialized nature. This method may be used where the time and cost required to examine and evaluate a large number of tenders would be disproportionate to the value of the goods and where they are only a few known suppliers of the goods, works or services. The bidders are given a period of 14 days to respond to the request for bids.

1. **Request For Proposal (RFP)**

This is also used the services to be procured are of advisory or otherwise of a predominately intellectual nature. The health facility prepares an expression of interests (EOI). The EOI is to be submitted within fourteen days by the tenderers to the health facility. Successful bidders will be requested to write a proposal for further evaluation. The tender committee evaluates the proposal before an award is made. Upon award, the health facility proceeds to negotiate and contract the successful bidder.

1. **Direct Procurement**

The method may be used where there is only one supplier, there is no reasonable alternative or substitute or there is an urgent need and because of urgency, other available methods of procurement are impractical. There must be evidence that the circumstances that give rise to the urgency were not foreseeable. In instance where the health facility uses this method and the procurement is more than Kshs. 500,000 9OR AS MAYBE PRESCRIBED BY THE Procurement Act), the health facility should inform PPOA at least fourteen days after notification of awards of contract. However, direct procurement is not encouraged as it does not offer any competition.

**Request for Quotations**

This method is used where the procurement is for goods or services (quantifiable) that are readily available and for which there is an established market. The quotation should be delivered in sealed envelope. The opening of the quotation should be done jointly by the procurement unit and the use department. In instance where the quotations are higher than the prevailing market proceeds then such quotation should be rejected and the health facility obtain quotation.

1. **Low value procurement**

This method of procurement happens when the value of goods, service or works being procured is less than Kshs. 30,000 (or as may be prescribed by the Procurement Act) this method is used where there is no advantage accrued to the health facility through the request for quotation method. This method should not be used when the health facility is deliberately repetitive or avoiding competition.

5.5. Essential Medicines

Access to medicines is part of the fundamental rights to health. Provision of health service is incomplete without essential medicines. WHO (2002) defines essential medicines as:

*“Those that satisfy health care needs of the population. They are selected with the regard to disease prevalence, evidence on efficacy and safety costs comparative effectiveness. Essential medicines are intended to be available within the context of functioning health system at all times in adequate amount in the appropriate dosage forms with assured quality and at a price the individual and the community can afford”.*

Without the appropriate health commodities, health facilities and health care provides cannot offered population a full range of comprehensive service and products to meet these goals. Ensuring health commodity availability to meet the needs of its clients is the ultimate goals of a health logistics system-to make certain that clients receive the right goods, in the right quantities in the right condition, at the right place, at the right time and the right cost.

Health commodities include public health commodities, pharmaceutical commodities medical supplies, vaccines and non-pharmaceuticals. The objective of commodity and supplies management is to ensure that people have access to essential medicines which are safe, effective, of good quality, and prescribed, dispensed and used properly.

**Essential Medicines List (EML)**

Health care management and therapeutics are highly dynamic fields with new approaches treatment protocols and therapeutics products being developed continuously. Therefore clinic management guidelines and essential; medicines lists are developed to guide and standardize health care delivery. According to the WHO EML, inclusion of medicine on the EML should be considered if the medicine, as far as reasonably possible, meets the following criteria:

1. *Relevance/need*: public health relevance and contributes towards meeting the priority health care needs of the population.
2. *Safety:* Scientifically proven and acceptable safety (side-effects and toxicity) in its expected way of use.
3. *Comparative efficacy:* Proven and reliable efficacy compared with available alternatives based on adequate and scientifically sound data from clinical studies.
4. *Quality:* compliance with internationally acceptance quality standards recognized by the Pharmacy and Poisons Board including stability under expected conditions of storage and use
5. *Performance:* sufficient evidence of acceptable performance in a variety of settings e.g. levels of health care.
6. *Comparative cost-benefit*: a favorable costs-benefit ratio in terms of total treatment costs compared with alternatives
7. *Single ingredient*: unless there is no suitable alternative available, a medicine should have only a single active ingredient.
8. *Local sustainability/appropriateness*: Preference should be given to a medicine which is well known to health professional, suitable for local use e.g. dose-form, staff training support facilities and socio-culturally appropriate e.g. method of use/administration.
9. *Pharmacokinetic profile*: Wherever possible, the medicine should have favorable pharmacokinetic properties-absorption, distribution, metabolism and excretion, drug interaction
10. *Local manufacture*: whenever possible the medicine should have the possibility of being manufacture locally for improved availability, reduce procurement costs.

**5.6. Commodity Management Cycle**

The commodity management framework cycle comprises of all elements required for the establishment and continuity of supplies for health care delivery, including pharmaceutical and non-pharmaceutical commodities. It includes four key stages, namely:

1. Careful choice of medicine according to national or global-World Health Organization (WHO)-guidelines;
2. Procurement of value – for – money commodities of proven good quality.
3. Effective and efficient distribution systems within a facility;
4. Rational prescription and use of medicine/commodities/supplies.

**Figure 5.1. Commodity Management Framework**

**Policy, Law and Regulation**

**Source**: walkowiak, et al (2008)

1. **Selection**

The rationale for selecting a limited number of essential medicines, commodities and supplies is that it may lead to better supply, more national use and lower costs. As the selection has a considerable impact on quality of care and cost of treatment, it is one of the most effective areas for intervention.

1. **Procurement**

This process is described under 5:4 above

***Quality Assurance of Pharmaceutical Products***

Testing medicines for quality is the responsibility of the medicines regulatory authority, the pharmacy and poisons Board (PPB) through the national testing body, the National Quality Control Laboratory (NQCL) and various established procurement entities like the Kenya Medical supplies Agency (KEMSA) and Mission for Essential Drug and Supplies (MEDS). At national level, the procurement of commodities and supplies for the public sector is carried out by KEMSA. The buyer of non-pharmaceuticals is responsible for ensuring that they are of good quality.

1. **Distribution and storage**

Distribution is a complex process that involves the transferring./transporting of health crae commodities from one point to another and the monitoring and follow –up mechanism during and on completion of the distribution process.

The distribution process includes:

* Stock (inventory) control
* Stores management
* Delivery to medicine store and health facilities
* Receipt and management of commodities and supplies by facilities

Distribution of commodities and supplies to public health facilities is mainly carried out by private sector transporters contracted by KEMSA. The distribution cycles are quarterly for dispensaries and health centres and bimonthly for hospitals

**Good Storage Practices**

It is important to correctly receive and carefully check deliveries of commodity consignments in order to confirm that the items are the ones required/ordered. This is also done to identify any problems such as missing or short delivered items, breakages or other damages or short dated/expired items.

**Figure 5.2.Good Storage Practices**

**Storage**

**Good**

**Practices**

**Source:** Management Science for Health (1997)

The aim of good commodity stores management is to ensure that all items are stored systematically safety and securely and that quality is maintained up to the time of issue/use.

This will require:

* Avoiding product contamination or deterioration
* Avoiding damage or disfiguration of item labels
* Maintaining packages integrity
* Preventing/reducing theft
* Preventing infestation by pest
* Store commodities in the designated commodity store only



**Source:** Management Science for health (1997)

**5.7. The Inventory Management Cycle**

The inventory management involves ordering, receiving, storing and issuing of consumable and non-consumable products.

**Ordering and Re-ordering**

Ordering for commodities occurs after qualification is done and whether commodities fall below the re-order levels. When commodities fall below the re-order levels, re-ordering or requesting is done. Official requisition forms include standard forms for requesting supplies e.g. Counter Requisition and Issue Voucher (SII) for MoH, Standards Order Forms for KEMSA, Consumption Report and Request Forms e.g. Facility Consumption Data Report and Request (CDRR) forms.

**Figure 5.3. Inventory Management at Cycle**

Issuing Ordering

Storing Receiving

**Source:** Management Science for Health (2000).

**Delivery and Receipt of Commodities and Supplies (Receiving)**

The necessary action on delivery and receipt of commodities and supplies are:

1. Refer to a copy of the original order
2. Examine the delivery note and compare with copy of the original order. If the two documents list the same type and quantity of supplies, then proceeds to verify quantity delivered.
3. Count the actual, paying attention to the product packaging. Look for physical damage, batch numbers, and expiration dates and products description.
4. When satisfied with the physical condition of the packaging, products description, batch numbers and expiration dates, you may then accept the shipment and sign the delivery.

For medical products, KEMSA prepares specific consignment (facility pack) for every facility based on the order submitted for the three month (rural health facilities) or two month (hospitals) in every supply cycle. This is then delivered directly to the health facility according to a pre-arranged schedule by contracted transporters.

**Stores Management (Storing)**

After receiving items, the next step is to record them in the inventory. This is done by starting a new stock card/bin card/ledger book or updating the old stock/bin card/ledger book. After completing a new stock card or updating existing stock card, the stocks must be stored according to established storage guidelines.

**Issuing**

Issuing is the process of transferring of medicines from a storeroom to other locations (e.g. patient ward). Requisition and issue Vouchers are used to effectively maintain records for the transfer.

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

**MODULE 6: HOSPITAL INFRASTUCTURE AND FACILITIES MANAGEMENT**

**Health system physical facilities, infrastructure and equipment**

The management of physical assets impacts on the quality, efficacy and sustainability of health services at all levels, be it in a dispensary, health Centre, clinic, sub-county or referral hospital. A critical mass of affordable, appropriate, and properly functioning facilities and equipment is required at each level. Physical resource such as physical facilities and equipment and their attendant consumables are often described as health care technology. They are among the principal types of resource inputs in a health system. Physical facilities and equipment is the platform on which the delivery of health care services rests. Their acquisition and utilization require high investment. Related decision must therefore be made carefully to ensure the best match between the supply of physical assets and health system needs, the appropriate balance between capital and recurrent costs and the capacity to manage the asset through its life.

Health system physical assets include building, plant and machinery, furniture and fixtures, communication and information systems, catering and laundry equipment, waste disposal, and vehicle and medical equipment. The term health care technology as used in this module refers to the various equipment and technology found within health facilities.

|  |
| --- |
| **Student Activity** |
| 1. Identify the various types of equipment found health facilities 2. Identify the responsibility for maintenance amongst various cadres of health workers. |

Table 6.1. Below provides a list of categories of requirement and technologies described as ‘health care technology’

**Table 6.1. Category of equipment and technologies**

|  |  |  |
| --- | --- | --- |
| Medical equipment  Communication equipment  Office furniture  Service supply installations  Workshop equipment  Laundry and kitchen equipment | Walking aids  Training equipment  Fixtures built into building  Equipment –specific supplies  Fabric of the building  Waste treatment plant | Health facility furniture  Office equipment  Plant for cooling, heating e.t.c  Fire-fighting equipment  Vehicle  Energy source |

6.2 **Role of information technology**

Health care involve the use and management of an abundance of information that must be collected, managed, reviewed, processed and stored. High – quality patient care relies on careful document of every patient’s medical and family history, health status, current medical conditions and treatment plains. A clinical decision based on information that has been efficiently managed and processed lends itself to quality care outcomes.

Computers are a key component in the category of office equipment. They play an important role in the health care system including communication, records management and storage, billing, accounting, budgeting and supplies management and in conducting research.

Today, there are abundant information technology resources available for health care environments. Multimedia that interacts with the user through text, sight, sound and voice are commonly used. These techniques are to seamlessly integrate technology and information that may be located within a geographical area or even across international boundaries. The use of the internet has provided the health care sector with an avenue to provide care using virtual technology. However, with advancement of technology and integration across boundary, ethical and legal issues with regard to control of information should be well managed.

**Healthcare Informatics, Medical Information And Nursing Informatics.**

Health care informatics is a broad term involving the application of computer and information science in all basic and biomedical sciences (hebda, czar and mascara, 2005). Medical informatics refers to the application of information is the use of information and computer technology to support all aspects of nursing practice. This may include direct delivery of care, education, research, and management. Nursing informatics facilities the integration of data, information, and knowledge to support patients, nursing and other provider involved in the decision – making process.

6.3 **Managing Health Facility Assets**.

Effective and appropriate management of health care facilities and technology contributes to improved efficiency within facilities and the health sector. It leads to improved and increased health outcomes and a more sustainable health service. The object of managing health facilities assets to ensure the quality and safety of health care equipment and facilities and to ensure economical use of all resources – staff, material and funds.

Managing health facility assets also known as health care technology management (HTM) involves the organization and coordination of all of the following activities with the objective of ensuring the successful management of physical pieces of hardware:

* Gathering reliable information about the equipment
* Planning resource needs and allocating sufficient funds for the;
* Purchasing or developing suitable models and installing them effectively
* Providing sufficient resources for their use;
* Operating them effectively and safety
* Maintaining and repair the equipment;
* Decommissioning and, disposing and replacing unsafe and obsolete items;
* Ensuring staff have the right skills to get the best use out of the facilities and equipment.

To manage the resources, the health profession in charge of a facility will require having broad knowledge and skills in the management of a number of areas, including:

* Maintenance-facilities, infrastructures, equipment;
* Finance;
* Procurement and stores management.
* Workshop management;
* Staff development.

The responsibility for the management of physical, facilities, infrastructure and equipment depending on whether the facility has maintenance staff. Systematic and preventive maintenance providers require the permanent presence of maintenance staff. However, private maintenance providers are needed for sophisticated repairs and maintaining sensitive equipment such as X-ray apparatus. External in – house maintenance services complement each other. To ensure good value for money, external services must be monitored by in – house maintenance staff.

**Role of Internal Maintenance Terms.**

In – house maintenance personnel should cover the daily routine cases. In the case of lower level health facilities (health centers and dispensaries) the condition of the buildings and not health care equipment are the predominant tasks such leaking roof and windows, water and cleaning service…

Typical tasks include:

* Inspection and service of simple items
* Simple repair ;
* Managing the maintenance procedure and the workshop;
* Training and advising equipment users.
* Participation in the technical planning and purchasing;
* Reception of new equipment;
* Monitoring of contractors;
* Development of appropriate facilities for solid waste disposal.

Complicated maintenance asks and repair should be contracted out. Motor vehicles baseline maintenance and repair are generally carried out by the driver, which usually means providing them with appropriate training in the place.

**Training for Equipment Users.**

Equipment users must possess adequate technology skills since a significant proportion of all equipment breakdowns are known to be caused by the users themselves. Equipment users should therefore be training of operators include:

* Correct use and handling of equipment;
* Correct use of manuals
* Cleaning;
* Calibration to a certain extent;
* Keeping of records.

**Facilities Without Workshop**

The facility in charge:

* Is the contact point for equipment and maintenance;
* Advices the health management team on asset need issues;
* Supervises private sector artisans when maintenance work is contracted out;
* Support and supervises equipment users;
* Undertakes maintenance and other asset management activities, if they have received the necessary training;
* Liaises with the next higher level for service support e.g. sub – county facility.

**Facilities without Workshop**

Facilities with workshop have a specialized department responsible for management and maintenance. It may be referred to as workshop or biomedical engineering unit or department. The work of the maintenance unit includes:

* Building operation and maintenance;
* Mechanical and electrical maintenance and preventive maintenance;
* Biomedical equipment and electronics maintenance;
* Landscaping and ground maintenance;
* Vehicle operation and maintenance;
* Lift maintenance;
* Plumbing, water supply and sanitary system ;
* Carpentry, painting and signage,
* Solid waste disposal and incineration;
* Fire prevention, fire detection, firefighting method and devices;
* Electrical system including equipment machinery, lighting, emergency generators;
* Equipment and instrumentation evaluation.

The in charge for facility with a workshop is responsible for ensuring that the above responsibilities are carried out efficiently and effectively.

**Responsibility For Facilities And Equipment Maintenance**

Management of facilities and equipment maintenance requires the involvement of staff from many disciplines – technical, clinic, financial administrative atc. It is the responsibility of all health workers who deal with health care technology.

6.2 **Responsibility For Managing Health Facility Assets**.

|  |  |
| --- | --- |
| Government | Provide the regulatory framework for quality service, including facilities and equipment management |
| Health policy-maker, planner | Ensure that physical assets and equipment management is incorporated into the health management system.  Determine the best organizational structure for the maintenance service across the different levels of the health system  Ensure annual goals and plans set and monitored for the use and improvement of health facility assets. |
| Health management teams | Address the practical issues involved with implementing health facility asset management activities.  Ensure annual goals and plans are set monitored for the improvement of health facility assets management activities |
| Finance officer | Allocate sufficient funds for all health facility asset management activities |
| Human resources | Ensure availability of suitably skilled technical staff for the health facility asset management service.  Facilitate in – service training to improve the skills required. |
| Equipment users | Are key successful health facility asset management since they greatly affect the life of equipment and form the first level of service.  Take good care of equipment  Operate equipment properly and safely  Undertake user planned preventive maintenance, and care and cleaning of equipment.  Report faults promptly to their section heads  Educate new user. |

6.**4 Planned Preventive Maintenance (PPM)**

Any pieces of equipment are made up of moving parts. At any time during the life of the equipment, this part can fail due to wear and tear. Thus, it is very important to give regular attention to the equipment through PPM and corrective maintenance (repair). PPM is any variety of scheduled maintenance to an object or item of equipment. It is a scheduled service carried out to ensure that an item of equipment is operating correctly and avoid any breakdown and unscheduled downtime.

Planned maintenance comprises of preventive maintenance, in which the maintenance event is pre-planned and all future maintenance is pre-programmed. A maintenance plan can be based on equipment running hours, date, or, for vehicle, distance travelled. A good example of a planned maintenance programme is car maintenance, where time and distance determine fluid change.

PPM is important because it enable the maintenance department to:

* Catch any problems before they become crises;
* Prevent breakdowns;
* Save money, money, as PPM is cheaper than repair following breakdowns;
* Make sure that equipment is fully operational;
* Guarantee accuracy and reliability;
* Increase the availability of equipment and reduce down – time
* Extended the lifespan of equipment ;
* Reduce equipment running costs;
* Ensure the equipment is safe for patients, users and maintenance staff.

Depending on how well equipment is looked after; the expected life can either be achieved or reduced. Thus maintenance is cruel to the ‘life’ of the equipment. if maintenance is not carried out regularly and on time, equipment will deteriorate to a state where it’s beyond economical repair. In other words, it costs more to repair than to replace it. If maintenance does not occur at all, the equipment will grind to a halt

**The Healthcare Technology Management (HTM) Cycle**

The objective is to ensure the successful management of physical pieces of hardware

**Figure 6.1. The healthcare Technology Management Cycle**

**Source:** Townsend (2005)

**Benefits of effective management of Health facility infrastructure and assists**

These include

1. Health facilities can deliver a full service, unimpeded by non-functioning health technology;
2. Equipment is properly utilized, maintained and safeguarded;
3. Staffs make maximum use of equipment by following written procedure and good practice.
4. Health service providers are given comprehensive, timely and reliable information on;

* The functional status of facilities, infrastructure and equipment;
* The performance of the maintenance service;
* The operational skills and practice of equipment user department;

**MODULE 7: QUALITY ASSURANCE IN HEALTH SERVICES DELIVERY**

**Quality Management Principles And Concepts**

**Quality Management**

Quality management focuses on the means and processes of ensuring that the products or services offered in health facility are consistent and are also referred to as Total Quality Management (TQM).

**Quality Management Principles**

The Key principles of quality management are: Customer focus; leadership; involvement of people; process approach; systems thinking; continuous improvement; informed decision making and establishment of mutually beneficial relationships. These principles are described further below:

***Principle 1: Customer Focus***

A customer focus approach to quality management seeks to ensure that the objectives of the health facility or organizations are linked to customer (patients) needs and expectations at all times. Measures to sustain customer focus include:

* Receiving and understanding customer needs and expectation:
* Communicating customer needs and expectations throughout the organization
* Measuring customer satisfaction and acting on the results of the measurement;
* Systematically managing customer relationship
* Ensuring a balance approach between satisfying customer and other interested parties such as MOH, employees, supplies, financiers, local comminutes and society as a whole.

***Principle 2: Leadership in Quality Management***

Leadership in quality management involves considering the needs of all interested parties including customer, owners, employees, suppliers, financiers, local communities and society as a whole. Below are several aspects of leadership that can be considered:

* Establishing a clear vision of the organization’s future;
* Setting challenging goals and target for the institution;
* Creating and sustaining shared values, fairness and ethical role models at all levels of the organization
* Establishing trust and eliminating fear within the institution;
* Providing people with the required resources, training and freedom to act with responsibility and accountability
* Inspiriting, encouraging and recognizing people’s contribution

***Principles 3: Involvement***

This principle involves motivating the staff at all levels and promotion of and recognition of creativity and innovativeness. This ensures the staff members feel involved and hence makes the process easier to implement and make part of daily tasks.

***Principle 4. Process Approach***

Process approach in quality management involves paying attention to the processes that are supposed to produce the intended results(s). it means looking at ‘How’ things are done, and ho inputs are turned into outputs. Examples of resources inputs/outputs include staff finances and supplies. Services inputs/outputs may include decisions, authorizations, feedback comments, solutions and proposals among others.

***Principle 5. System Approach to Management***

Systems approach to management also referred to as systems thinking. It involves identifying, understanding and managing interrelated processes as system. System thinking ensure that a manager acknowledges that an improvement is one of a system can adversely affect another area of the system. The principles of systems approaches is closely related to the principle of process approaches

***Principle 6: Continuous Improvement***

Continuous improvement is a sustained and on-going effort aimed at improving services products or processes through incremental improvement over time. Within a health care setting, the following can be used as guidance to continuous improvement.

* Health institutions/facilities should make continuous improvement of the overall performance as a permanent objective;
* Inculcate a culture of continuous improvement of all the processes and systems within every individual. The institution should employ organization-wide approach to continuous improvement.
* Provide staff with training in the methods and tools of continuous improvement;
* Recognize and acknowledge improvements

***Principle 7: Informed Decision Making***

At the management level, informed decision making involves using a systematic approach in researching and analyzing available evidence on the policy making process. At the patient care level, it involves having systems that ensure that care provided to patients adheres to best practices.

* This principle ensures that effective decisions are based on the analysis of current and meaningful data and information.
* Evidence based decision making also involves ensuring that data and information is sufficiently accurate and reliable and making sure that this data is available and accessible to those who need them;
* Evidence based decision making is underpinned by analyzing data and information using valid methods and making decision and taking action based on factual analysis, balances with experience and intuition.

***Principle 8: Establishment of Mutually Beneficial Relationships***

This principle acknowledges that an organization and its suppliers are independent and that mutually beneficial relationships enhance the ability of both to create value. Within health care, the largest supplier is the labour workforce. This principle requires a balance between short-term and long-term gains considerations when establishing relationships, there is establishment of joint development and improvement activities and there is continuous encouragement and recognition of improvements and achievements by suppliers.

**7.2. Components of a Total Quality Management (TQM) System**

The following are components of TQM: quality assurance; quality assessment; quality control; quality improvement and quality planning/design.

**Quality Assurance**

Quality assurance is a series of management activities to ensure that processes, items or services are of the type and quality needed by the users and includes all actions taken to establish, project, promote and improve quality. Quality assurance includes setting and communicating standards and identifying indicators for performance monitoring and compliance to standards. These standards can come in different forms e.g. protocols, guidelines and specifications. The two main principles in quality assurance are:

1. Fit for purpose-that the goods or service produced should be or the intended purpose
2. Right first time-mistakes are eliminated

***Quality control (QC)***

Quality control is a procedure or set procedure intended to ensure that a manufactured products or performed service adheres to a defined set of quality criteria or meets the requirements of the client or customer. QC is similar to but not identical with quality assurance (QA)

***Quality improvement (QI)***

Quality improvement is defined as an organized, structure process that involves identification of improvement to achieve enhancements in product or services

***Quality planning/design***

Quality planning or quality design is a systematic process that translates quality policy into measurable objectives and requirements and lays down a sequence of steps for realizing them within a specified timeframe.

**7.3. Quality Assurance and Risk Management in the Health Care Setting**

***Dimensions of Quality***

Quality of care has several dimensions. Quality assurance activities address one or more of these dimensions. These dimensions of quality are a useful framework that assists health teams to define and analyses their problems and to measure the extent to which they are meeting programme standards. The dimension of quality include: technical competence; access to serve; effectiveness; interpersonal relations; efficiency; continuity; safety and amenities. The eight dimensions are explained below with their application in the health care setting provided.

***Technical Competence***

Technical competences include skills, performance and ability of health care workers and support staff to deliver services. Iterates to how well providers execute practice guidelines and standards in terms of dependability, accuracy, reliability and consistency for clinical and non-clinical services. Technical competence also relates to the use of materials and equipment required in delivering health care.

***Access to Service***

This refers to the fact that health services are unhindered by structural, physical, geographic, economic, social, cultural, organizational or linguistic barriers.

***Effectiveness***

Effectiveness deals with two main issues in the health setting. The first issue is whether the kind of treatment given by the health service leads to desired outcomes and the second one is whether the treatment or care provided is appropriate for the setting it is being provided in

***Interpersonal Relations***

The concept of interpersonal relations refers to the nature of interactions between the provider and the clients, the management team and the junior staff, the health system and the community among others.

***Efficiency***

Efficiency deals with the ability of the health care system to provide best returns for the resource provided.

***Continuity***

Continuity means that the client receives the complete range of health service that he or she need without interruption, cessation, or unnecessary repetition of diagnosis or treatment.

***Safety***

Safety means minimizing the risks of injury, infection, harmful side effects, or other dangers related to service both to the provider and to the client. This deals with prevention of injuries to providers, clients or visitors and prevention of hospital acquired infections.

***Amenities***

Amenities relate to the physical appearance of facilities, personnel and materials as well as to comfort, cleanliness, and privacy. Other amenities may include features that make the wait at the service point pleasant such as relaxing music, educational or recreational videos and reading materials.

**7.4. Risks Management in Health Care Settings**

Risk is defined as the possibility of loss or other adverse events that have the potential to interfere with an organization’s ability to fulfill its mandate. Risk management proactively reduces identified risks to an acceptable level by creating a culture founded upon assessment and prevention, rather than reaction and remedy.

Risk management forms an important component of informing and supporting decisions in providing a safe secure environment for staff and patients. It involves identifying and addressing source of risk and loss (Clinical and operational) and continuously evaluating and organization’s processes, functions and facilities so as to identify potential risks. In the health care setting risk management saves lives, protects patients, visitors and staff. In the health care setting risk management saves lives, protects patients, visitors and staff and protects the organizations’ resource and reputation.

**Table 7.1. Examples of Risks factors is a Hospital Set-up**

|  |  |
| --- | --- |
| * Credentialing- checking whether health care practitioners are properly qualified * Informed consent * Fraud and abuse * Billing and medical documentation * Infection control * Readmissions * Security * Fire safety * Slip and falls * Medical errors classification-technical errors, diagnosis errors, failure to prevent injury and misuse or maladministration. | * Visitor’s access to facility * Complaints * Medical staffing * Employees * Patient deaths * Safety assessment for medical applications of radiation * Treatment errors-treatment misadministration’s treatment incidents, treatment accidents * Occupational hazard to staff: musculoskeletal loads, chemical substance, radiation hazard, violence from patients and members of public. |

**7.5. Methods and Tools of measuring Quality**

**A) The PDCA (Plan-Do-Check-Act) cycle**

The PDCA is a four-step model assessing problems and enacting solutions with the goal of improving quality. The PDCA is also referred to as plant-do-study-act (PDSA). Deming’s cycle or Deming’s wheel. The PDCA is considered a continuous improvement process represented by a circular graphic and emphasis on processes that incorporate continuous feedback loops to identify source of error on an on-going basis and provide the data needed to make the necessary changes and improvements.

PDCA follows the concept of the scientific methods of first establishing a hypothesis, developing and executing a plan to test the hypothesis, analysis the results and then making modifications to the hypothesis. The cycle is then repeated to continue to assess and improve the quality process. PDCA provides a blueprint for quality assurance managers to properly identify the goals accurate metrics for measuring the goals, evaluate the outcome and then implement the solutions.

The four stapes of PDCA include:

1. ***Plan-***This is an analysis that establishes the objectives or the expected results and creates a plan of action. By starting from the end result and working backwards, each step of the process can be included in the analysis and in the solution. The plan is a critical step in the process of achieving quality outcomes. This stage deconstructs the entire process and allows for the identification of problems and the acknowledgment of what works. Once problems are identified, specific steps can be outlined to address them. The process is repeated with gradual improvement made in each of the interactions. Incremental changes made with each cycle, instead of a one-time approach to attaining perfection, avoid analysis-paralysis that can ensure when trying to attain perfection on the first pass.
2. ***DO***-Implementation of the plan
3. ***Check***: (Study) Measurement of the objectives to see how closely they meet expectations. This is an important step as it allows for the adjustment of the plan where necessary.
4. ***Act*** – Implementation of changes in the CHECK phase

The DO and CHECK phase should provide data that shows trends and patients that can be used to devise a list of solutions that will be carried out in the ACT phase. All change ideas should be tested in a small way first before they can be rolled out. This ensures that there is minimal disruption to the system if the ideas do not work. If the initial small set works then there is confidence it into the whole system.

Figure 7.1 The Plan-Do-Check-Act (PDCA)

**B) Data collection tools**

1. ***Cause and effect diagrams***

Cause-and –effect analysis is sometimes referred to as the Ishikawa, or fishbone diagram. In a cause-and-effect diagram, the problem (effect) is stated in a box on the right side of the chart, and likely causes are listed around major headings (bones) that lead to the effect. They can assist in organizing the contributing causes to a complex problem Cause- and-effect diagrams do not have a statistical basis but are excellent aids for problem solving and trouble-shooting. They reveal important relationship among various variables and possible causes and provide additional insight into process behavior.

**Figure 7.1Fishbone Diagram**

Environment Personnel

Pregnant women anticipating delivery are not motivated to decide if their partner or family member should accompany them during delivery

Inadequate Does not speak

Infrastructure with clients

No delivery Lack of

Room information

Inputs Clients

**Source:** USAID 2012

1. ***Check sheets***

These are structured forms designed for collection and analysis of data. A check sheet can be modified for various situations.

*How to use a check sheet*

* Decide what event or problem will be observed and develop operational definitions:
* Decide when data will be collecting and for how long;
* Design the form. Set it up so that data can be recorded simply by making check marks of Xs or similar symbols and so that data do not have to be recopied for analysis.
* Label all spaces on the from;
* Test the check sheet for a short trial period to be sure it collects the appropriate data and is easy to use;
* Each time the targeted even or problem occurs, record data on the check sheet.

**Table 7.2. Sample Check Sheet: Hospital Infections Occurrences Checklist**

|  |
| --- |
| **Infection by unit Mon Tue Wed Thu Fri Sat Sun Total**  **Delivery** III I III IIII IIII I I 20  **Intensive Care** II III 6  **Coronary Care** I II IIII IIII IIII 18  **Respiratory Care** IIII 5  **Surgical** IIII IIII 10  **Total** 11 6 14 5 10 6 6 59 |

1. ***Pareto diagrams***

A Pareto chart is display of the frequency of occurrences that helps to show the “Vital few” contribution’s to problem so that management can concentrate resources on correcting these major contributors (Amrica Society for Quality, 2000). The Parento Principle states that: “Not all of the causes of a particular phenomenon occur with the same frequency or with the same impact”. Such characteristics can be highlighted using Pareto Charts. Pareto charts show the most frequently occurring factors.

Analysis of Pareto charts help to make best of limited resource by targeting the most important problems to tackle. Concentrate on reducing defects A, B and C (salaries, equipment and transport) since they make up 75% of all defects.

**Figure 7.2 Parento Chart**

**Parento Chart**

Percent

100

80

Dollars

500

400

300

200

100

0

Salaries Equipment Transport Phone/Fax Supplies

Charges, First Quarter

**Source:**USAID (2012)

1. ***Control charts***

Run-chart-Run charts are plots of data, arranged chronologically, that can be used to determine the presence of some types of signals of special cause variation in processes. A centre line (usually the median) is plotted along with the data to test for shifts in the process being studied.

Control chart- A control chart consists of chronological data along upper and lower control limits of common cause variation. It is used to monitor and analyse variation from a process to determine if that process is stable and predictable (comes from common cause variation) or unstable and not predictable (shown signals of specific cause variation).

**Figure 7.3. Sample Control Cart**

**Quality characteristics**

11.0

UCL = 10.860

\_ \_\_ \_\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_

Centre line = 10.058

10.0

LCL=9.256

9.0

Sample

3 6 9 12 15

**Source:** USAID (2012)

Quality Assessment is a component of continuous quality improvement. It is a systematic, ongoing cycle of collecting and analyzing evidence of a programme’s effectiveness. The information collected is used to evaluate how well the programme’s goal is being achieved and decided what may be done to better achieve the goal. The main purpose of quality assessment is to improve health care quality. Quality assessment should be conducted routinely as part of integral provision of health services.

Types of quality assessment

* Internal-carried by individual working in an organization. The individual has better understanding of the system but may be biased.
* External-should be thoroughly oriented concerning the realities of the system

**7.6. Standards in Quality Management**

**Definition**

Standards are a means of describing the level of quality that health care organization are expected to meet or to aspire to. The performance of organizations can be assessed against this level of quality.

**Setting Standards**

Standards are set for comparison of indicators. For example, at least 80% of all pregnant women attending the antenatal clinic should have their height, blood pressure, HIV status and urine tested.

**Characteristics of Standards**

1. Should have a scientific basic i.e. their application should ensure application of a certain level of efficiency in health care
2. Standards should be relevant for specific region that they are applied to be realistic to implement and measure
3. Should be dynamic-changed when it is necessary
4. Should be measurable

**Level of standardization**

When formulating standards, a critical decision that must be made is the level at that the standards should be set-minimal, optimal and achievable. Minimal standards specify when level must be met for quality to be considered acceptable. The implication is that if care does not meet a minimal standard, remedial action is called for. For example, minimum standards of quality specified in terms of nurse staffing levels, a structural measure of quality. In the case, hospital that does meet minimum staffing level by definition cannot deliver care of acceptable quality (“safe care”). Optimal denote the level of quality that can be reached under the best conditions, typically conditions similar to those under which efficacy is determined. Achievable standards represents similar to those which efficacy is determined. Achievable standards represent the level of performance that should be reached by everyone to whom the standards are being applied.

**Domains of Standards**

The following are domains of standards: Safety, Clinical and cost effectiveness, governance patient focus, accessible and responsive care; care environment and amenities and public health.

***Domain 1: safety for patient, staff and visitors***

This domain includes measures aimed at reducing adverse drug reaction, reduction of hospital acquired infections, and prevention of Methicillin Resistant *Staphylococcus Aurous* (AMSA) infections, prevention of needle pricks, waste disposal and fail in the facility among others. There are standards for hospital safety which should be continuously and systematically reviewed and effort should be applied to adhere to the standards.

***Domain 2: Clinical and cost effectiveness***

This domain includes within the laid down or agreed clinical guidelines and best practices. This domain also includes ensuring that health workers have up-to-date information on their specialties through regular audit, supervision and continuous education.

***Domain 3: Governance***

This domain deals with the management style and organization culture so that quality improvement quality assurance and patient safety are promoted within the health care institution. On the management style, this includes ensuring that there is accountability.

***Domain 4: Patient focus***

This domain focuses on ensuring that health care is delivered in partnership with patients, their relatives and also ensuring that their needs are accommodated during care.

***Domain 5: Accessible and responsive care***

This domain focuses on provision of care promptly and prevention of unnecessary delay e.g. waiting, registration, ambulance, payment procedures, unnecessary screaming and tests). It also deals with creating mechanisms for ensuring that all members of the population can access health care.

***Domain 6: Care of environment and amenities***

This domain involves provision and maintenance of environments designed to offer comfort and privacy for the patients and cafe working environment for health workers.

***Domain 7: Public health***

This domain includes efforts and collaborations that promote and improve health of populations but also help bridge inequalities among different populations by preventing disease i.e. the promotion of good sanitation, environmental management/cleanliness health seeking behaviors as well as responding to outbreak swiftly –overlap with infection control.

**International Standardization**

The International Standards Organization (ISO) 9000 facility of standards is related to quality management systems and designed to help organizations ensure that they meet the needs of customers and other stakeholders. The ISO 9001 is the internationally recognized standards for quality management and deals with the requirements that organizations wishing to meet the standards have to fulfill. It specifies requirements for a quality management system that can be used for internal application by organization or for certification or for contractual purpose. It focuses on the effectiveness of the quality management system in meeting customer requirements and looks at:

* Processes that creates and control products and services within the organization
* Prescribes certain requirements to ensure that client’s needs are met

ISO 9001: 2008 is the key internationally agreed standard for quality management systems. It has four requirements:

1. *Management responsibility*: This element ensure that the top management has commitment to quality systems and develops the business objectives to meet customers’ quality requirements
2. *Resource Management*: This element that the human resource, work environment and infrastructure need to implement quality are in place.
3. *Product realization*: This element ensures that the organization delivers goods and services that the customers want.
4. *Measurement, analysis and improvement*: This element considers that the institution has in place mechanisms to measure customer satisfaction and effectiveness of the whole systems.

**7.7. The Kenya Quality Model for Health**

The Kenya Quality Model for Health envisions improving overall livelihoods of Kenyans through provision of efficient and high quality health care systems. Its development was spearheaded by the Department of Standards and Regulatory services of the Ministry of Health in 2001 as the Kenya Quality Model. The Kenya quality Model was later reviewed and renamed KQMH. KQMH integrates evidence-based medicine (EBM) with total quality management and patient partnership.

Principals of KQMH

The principles of KQMH are similar to principles of quality management. These are: Leadership: customer orientation; involvement of people and stakeholders; systems approach to management; continuous quality improvement (CQI); and evidence-based decision-making.

Integration of KQMH Principles into the Kenyan Health System

Successful implementation is based on the Plan-Do-Check-Act (PDCA) methodology. The following steps are applied:

* Health managers use KQMH checklists to assess performance of the health system against KQMH standards and opportunity for improvement are identified.
* The science of improvement is used to ensure realization of KQMH standards

**Dimensions of the Kenya Health Systems**

KQMH is anchored on twelve (12) dimensions which are the resources, processes and outcomes that are vital to ensuring that quality services is delivered. The KQMH dimensions are based on the Donabedian Model of structure process and outcome listed above.

**Structure**

In the KQMH structure, dimensions are; Leadership, human resource, policy standards and guidelines, facilities. Equipment, transportation, referral system, hospital records and health management information systems (HMIS) and financial management.

**Process**

Process dimension is divided into four other sub-dimensions namely: the client-provider interaction, continuous quality improvement, programmes management for reproductive health, extended programme for immunizations, HIV/AIDS, tuberculosis and IMCI (integrated management of childhood illness) and management of none communicable disease.

Outcome (results)

Outcome dimension is also divided into four other sub-dimensions namely user-client satisfaction, performance of facility and primary health care, staff satisfaction and societal satisfaction.

**Implementation of KQMH**

KQMH has five implementation phases

Phase1: preparation

Phase 2: Introduction

Phase 3: Implementation

Phase 4: Expanding

Phase 5: Sustaining/Maintenance

Elements of KQMH included:

1. ***Work environment improvement (WEI)***

This is a structural progamme that seeks to achieve cleanliness, organization and standardization at the wrok place. WEI uses the 5S approach which is a Japanese model and includes: Seiri-Sorting, Seitomn-Set, Seiso-Shining Seiketsu-Standarising and Shitsuke-Sustaining

1. ***Setting p of quality improvement teams (QIT)***

QITs are teams formed in a health facility to take the lead in implementing quality improvement activities. The QIT includes members of the health facility management team and individuals from middle management. The QIT is responsible for the following

* Training health facility staff on KQMH tools and methods
* Conducting situation analysis
* Implementation of KQMH
* Conducting periods monitoring of improvement activities
* Feeding back to the work improvement team (WIT)
* Documentation of KQMH activities
* Reviewing of progress and action plan;
* Provision of quarterly reports to the hospital management team.

1. Work improvement teams (WIT)

These are composed of small groups of first-line facility employees who continually control and improve quality of their networks, products and services. The following are the main roles of WIT:

* Promote improvement activities in the health facility;
* Identify analyze and solve work improvement problems;
* Train others on quality management
* Monitor the process of quality improvement.

1. ***Tools for implementation of continuous quality improvement in KQMH***

The following tools/processes are used in KQMH either alone or in combination for promotion of quality improvement:

* *Alignment*: Hospital equipment, tools, files e.t.c are arranged in an orderly manner
* *Numbering/alphabetical coding*: Files and equipment are indexed for easy retrieval.
* *Sorting*: all the items in a facility are grouped into three categories namely necessary, may be necessary items. Unnecessary items are often discarded.
* *Safety signs:* sighs are installed in all the areas to warn workers or visitors about hazardous materials, International or national safety standardized sign are used. Signage is also recommended for identifying different places in a facility.
* *Colour coding* is used to distinguish hazardous from non-hazardous waste. Waste is also segregated into separate bins.
* Use of labeling and symbols.
* *Zoning*: this is whereby positions for storing items are marked so as to easily identify when items are missing or out of place.

**7.8. Measuring Client Satisfaction**

Client satisfaction is a measure of the production of customer whose reports experience with the goods or service provided by an organization exceeds a pre-specified approval rating. Client satisfaction assessment in a hospital setting is conducted through patient surveys. They are important in assessing hospital outcomes and for assessing the human/interpersonal aspect of health care quality. Simply put, client satisfaction surveys measures the gap between expected service and the experience of the service.

**Advantages of Clients Satisfaction Assessment**

* They can provide information on the effectiveness of the service process or other processes;
* They can give a measure of the facility’s performance in the past and a guide to changes for the future;
* They can be used as a marketing toll by making clients aware f the range of services available.
* They have the potential to reduce the chance of complaints;
* They are part of the service process itself, i.e. they establish or reinforce contact.

**Ways of Conducting client Surveys**

* Interview existing patients
* Conduct interviews on patients who have been discharged from hospital before they leave
* Observation of activities. We often see good and bad actions such as clients being left waiting in the reception. Take note of the details. Use them as examples, adopting a remedial preventive style with colleague and fee earners rather than a punitive approach;
* Interview occasional clients if and when opportunities arise;
* Reflect carefully on complaints whether good or bad. Repeat them to your colleagues and consider the implications.

**Factors that Influences Clients Expectations of a service**

* Past experience-previous encounter with the hospital;
* External influences –such as the media;
* Personal needs-some clients might have special needs such as religious dietary requirements which are beyond the standards requirements;
* Word of mouth-experiences, especially negative ones, are easily shared amongst communities. This might influence the expectations of clients.

**Factors that Influence Patients Experience of Service**

* Tangibles – the quality of equipment and of the physical surroundings;
* Reliability-the ability to accurately perform the service offered;
* Responsiveness-willingness to assist clients;
* Assurance-ability of the service provider to be knowledgeable and to inspire confidence and trust;
* Empathy-ability to care and display compassion towards clients;
* Access- the cost and time for patients to use a service as well as hospital hours.

**MODULE 8 : FINANCIAL MANAGEMENT AND RESOURCES MOBILISATION**

**8.1 Financial Management**

Financial management entails planning, organizing controlling and monitoring the financial resources of the organization to achieve. Financial management in the public sector is governed by

* The public financial management Act is to ensure that public financial are managed both at the national level and the county level in accordance with the constitution of Kenya
* Government financial regulations and procedure. This contains financial regulations and procedure that govern government financial.

**Principle of Financial Management**

It is useful to identify a series of good practice principles which can be used as a standard in developing proper financial management systems. These principles provide a high – level guide for staff for members.

**Consistency**

The financial policies and systems must be consistent over time. This promotes efficient operations and transparency especially in financial reporting. This does not mean that systems may not be refined to cope with a changing organization. Inconsistent approaches to financial management could be a sign that the financial situation is being manipulated.

**Accountability**

The organization must explain how it has used its resources and what has achieved as a result to all stakeholders, including beneficiaries. All stakeholders have the right to know how their funds and authority have been used. Organizations have an operational, moral and legal duty to explain their decisions and actions, and submit their financial report to scrutiny. Accountability is the moral or legal duty placed on an individual group or organization to explain how funds, equipment or authority given by a third has been used.

**Transparency**

The organization must be open about its work, making information about its activities and plans available to relevant to relevant stakeholders. This includes preparing accurate, complete and timely financial report and making them accessible to stakeholders, including beneficiaries. If an organization is not transparent, them it may give the impression of having something to hide.

**Viability**

To be financially viable, a health facility’s expenditure must be kept in balance with incoming funds, both at the operation and the strategic levels. Viability is a measure of financial continuity and security. The HMT and HMC should prepare a financing strategy to show how the organization will meet all of its financial obligations and deliver its strategic plan.

**Integrity**

On a personal level, individuals must operate with honesty and propriety. For example, member of the HMT and HMC members are expected to lead by example in following policy and procedures and declare any personal interests that might conflict with their official duties. The integrity of financial records and report is dependent on accuracy and completeness of financial records.

**Stewardship**

The HMC is expected to take good care of the financial resources it is entrusted with and make sure that they are used for purpose intended, this is known as financial stewardship. The HMC has overall responsibility for this. In practice financial stewardship is achieved through careful strategic planning, assessing financial risk and setting up appropriate systems and controls.

**Accounting Terminology**

1. **Break – Even Analysis**

Break – even analysis is a technique widely used by production management and management accountants. It is based on categorizing production costs between those which are ‘variable’ (costs that change when the production output changes) and those that are ‘fixed’ (costs not directly related to the volume of production). Total variable and fixed costs are compared with sales revenue in order to determine the level of sales volume, sales value or production at which the business makes neither a profit nor a loss (the ‘break – even point).

1. **Differential analysis**

Differential analysis involves analyzing the different costs and benefits arising from alternative solution to the situation. Relevant costs and revenues are those that differ between alternatives. Differential cost is the amount by which relevant cost differ between two alternatives. Differential revenue is the amount by which relevant revenue differ between two alternatives. The alternative resulting in the greatest positive difference between future revenue and future expenses (cocts ) should be selected when using differential analysis.

1. **Capital investment decisions**

The objective of making capital investment decisions is to maximize wealth. To do we need to invest in those projects that will give the correct rate of return for the risk involved. The process of making an investment decision entails the following: identifying suitable investment opportunities, deciding on the best selection method, identifying the cash flows that will be generated by those investments, discounting them at the correct cost of capital and choosing the one or ones from those available.

Discount the cash flows at the appropriate market determines opportunity cost of capital. There are various methods for evaluating project, accounting rare of returns (ARR), internal rate of return (IRR) and the net present value (NPV). The NPV is the best method among all of them. The NPV is the net difference between the present value of the investment’s net cash inflows and the investment’s cost (cash outflows) discounted at the company’s required rate return (hurdle) rate. The investment must or exceed the hurdle rate to be acceptable.

i.v. Financial Control

A system of controls, checks and balances is collectively referred to as internal controls. It is put in place to safeguard an organization’s assets and manage internal risk. Its purpose is to deter opportunistic or fraud and to detect errors and omissions in the accounting records. An effective internal control system also protects staff involved in financial tasks.

**8.2. The Government Accountant General and Treasury**

The Accountant General (AG) is a department which facilitates planning, developing and implementing government accounting policies, systems and procedures. It monitors revenue collection in liaison with the economic Affairs Department (EAD) and expenditure as approved by parliament. The two departments are based at treasury. Is in charge of establishing procedure and systems of effective management of government money to ensure that it is properly accounted for, prepare and submit accounts for each financial year under the public Audit Act 2003 for audit by the controller and Auditor – General and the accounts are prepared, treasury issues circulars to the ministry, Departments and Agencies on the powers to access to all books, records, returns, reports and other government documents require any government officer to provide explanations information and assistance.

**Medium Term Expenditure Framework (MTEF)**

The government prepares an annual budget and submits it to parliament. The budget includes government revenue and expenditure and is prepared under the Medium Term Expenditure framework (MTEF). MTEF is a tree- year rolling budget framework. It is transparent planning and budget formulation process that attempts to improve the decision making process so as to link with government policy, priorities and requirements within limited resources.

The government introduced MTEF in order to:

* Provide a comprehensive and realistic framework for planning and management of public resources
* Increases predictability of resources through structure budget planning process that provides realistic estimates of revenues and expenditure over a three year period;
* Link resources allocation to government policy and programme priorities; improve the basic of budget by moving away from incremental budgeting;
* Timely preparation of audit reports by the National Audit Office.

**MTEF Budgeting cycle**

There five clear stages of the MTEF budget cycle as indicated below:

1. Policy development

* National development plans
* Economic Recovery Strategy
* Poverty Reduction Strategy
* Medium Term Plan of Vision 2030

1. MTEF Budget process

* Macro – economic forecasts
* Fiscal and budgeting framework
* Development of sector proposals
* Allocation between sectors and Ministry, Department and Agency (MDA)
* Budget document
* Budget approval and County Governments

1. Budget Implementation

* Collection of revenue
* Cash management rules
* Cash allocation and release of funds
* Management of service, human resources
* Procurement

1. Accounting and monitoring

* Capturing expenses in the accounting system
* Recording and use of management information on outputs
* Internal audit

1. Evaluation and audit

Oversight and audit by national and county assemblies

Measurement of achievement of objectives

Evaluation and adjustment of policies

**The Budget Preparation Process**

The following depicts summary the budget preparation process

* Preparation of national and county development plans i.e. the macro economic framework for projection of revenues and expenditure over three years. This is done by the ministry of finance and the Ministry of Devolution and planning. These policies are contained in various government documents and party manifestos. The policies set the platform on which the budget are made. The documents used to ensure that the budget links to policy include the Vision 2030 and the Medium Term Plan (MTP). The MTP covers a period of three years. It forces on the attainment of the Millennium Development Goals (MDGs).
* Undertaking sector review to provide the basic for the allocation of resources. The government also uses the Sector Working Groups (SWGs). These helps in developing the ministerial ceiling in line with the various classifications. The SWGs are used to ensure that the sector priorities are consistent with the national development agenda. They are supposed to ensure that expenditure is adequate on the high priority areas to meet the desired goals of the Kenya Vision 2030.
* The state corporation’s semi – autonomous agencies and government entities prepare annual budget proposals and submit those to their respective parent ministries. The ministries are supposed to consolidate the budget proposals and submit them to treasury.
* The state corporation’s semi – autonomous agencies and government entities prepare annual budget proposals and submit those to their respective parent ministries. The ministries are supposed to consolidate the budget proposals and submit them to treasury.
* Treasury is supposed to involve the public in the budget preparation process through consultations with stakeholder at county levels. The consultation is supposed to cover all the forty – seven (47) counties. Each county is expected to provide a report on county sector issues and priorities.
* The public sector hearings then deliberate and validate the national budget prepared by the SWGs and county governments. The public sector hearings stakeholders are drawn from both national and county levels. The output of the public sector hearings from the budget proposals used to inform the MTEF budget.
* The ministry of finance reviews the estimates based on priorities and cost established in their sector review and consisted with the allocation of the sectorial ceilings. The budgets are thereafter presented in parliament for approval. Once approved, MDAs can proceed to implement the budget.
* The MDAs can request for additional above their printed estimates through the supplementary budgets. The supplementary request must be approved by respective accounting officers. The supplementary estimates are approved by parliament.

**Budget Controls**

This involves implementation of programmes project control as approved by the national and county assemblies and collection of revenues. Once the budget has been approved, the MDAs are supposed to open a vote book and record each of the budgetary line items against which all allocations are entered and commitments plus subsequent payments made from. All expenditure should be in line with the approved budget. The accounting officer should ensure availability of funds within the budget before approval or disbursement of payment request.

All commitment and payments are records in the vote book to allow comparison of the budget and the actual expenditures. Regular analysis of actual and expenditure should be carried out and any variances highlighted and explained. Deviations from the budget are reported on a timely basic and prior approvals obtained for any budget reviews / reallocations.

There is a budget monitoring unit in the ministry of finance. This is required to prepared quarterly budget reviews which monitor and report on implementation of budget through a budget policy matrix. The budget monitoring Unit also monitors reporting and tracks adherence to government priorities. There is an Efficiency monitoring unit (EMU) which is also mandated to undertake systems and management audit of government MDAs.

**Government Revenue and Income**

All government revenue is paid into the consolidated fund in the exchequer account. The exchequer account is maintained by the central bank of Kenya and cannot be overdrawn at any time. There are various sources of government funds, namely:

* Income tax
* Import duty
* Excise duty
* Value added tax ( VAT)
* Investment income
* Donations, grants and loans
* Government charges

Any revenues generated in MDAs should be collected and remitted to the exchequer in the consolidated fund. MDAs who receive any revenue from the source identified should issues receipts and record the receipts in their respective vote books. MDAs collect revenue in form of taxes, fines, other charges or receive donor. Funds for direct financing of a project. MDAs can request to spend this money instead of waiting for disbursements from the exchequer. When this happens, the amount is deducted from the approved budget. The amount allowed to be spent is referred to as Appropriations – in – Aid (A –I –A).

8.**4 County Financial Management**

The following legal framework governs the county financial management:

* County government Act 2012;
* Public financial management Act 2012;
* Government financial management Act 2004
* County government public finance management transition Act 2013
* Appropriation Act 2010.
* Constitution of Kenya

**County Budgeting Process**

The county government will prepare its own budget based on their county integrated Development plan (CIDP). County governments have established the county budget and Economic forum (CBEF). The CBEF is mandated by the public finance management (PFM) Act to create forum to provide a means for consultation by the county government on:

* Preparation of county plans, the county fiscal strategy paper and the budget review and outlook paper for the county
* Matters relating to budgeting, the economy and financial management at the county level

County governments prepare budget estimates and appropriation bills. They then make public pronouncements on revenue raising measures in the county. The approval of the finance bill is done within the county structures.

**Treasury Management and Budget Executions**

County governments’ operationalse the county revenue fund. The have a single account. They open a county emergency fund and provide for the establishment of other county public funds. They are obligated to prepare a cash flow plan and forecast and provide a process of budget allocations supplementary estimates. They should establish an internal audit function. There should be revenue collectors within counties.

**Accounting, Reporting and Audit**

Counties prepare consolidate annual and quarterly finance statements of accounts for the county. They are required to prepare an annual of revenue received and collected. They are also supposed to report on waivers, variations in taxes fees and charges.

**The Role** of **County Treasuries**

The county treasuries have the following

* Facilities standard financial management including budget, accounting and reporting;
* Coordinate county planning activities;
* Coordinate the implementation of the budget
* Mobilize resources for funding;
* Act as a custodian of all county government assets.
* Ensure compliance with county accounting standards
* Maintain proper accounts and for the county revenue fund and county emergency;
* Issue circulars on financial matters;
* Advice the county executive committee on county assemblies.
* Prepare reports for submission to parliament county assemblies

**8.5 Government Accounting Documents**

There are many accounting document that are used in the accounting department. They include:

1. **S 11 form** – requisition and issue voucher. This is a stores request for items from the stores department. They are normally filled in by the requester of the item. The S11 is in triplicate and is issued as follows: the original is kept by the store man issuing out the goods in a safe file, the duplicate is kept by the user receiving the goods in a safe file too and the triplicate is retained in the pad. See the form in Appendix 1.
2. **S 12 form** - issue and receipt voucher. This form is used to issue items from the store. It is filled in by the stores personal see form in appendix
3. **S 13 form** – once an item has been purchased, the item is presented to the stores department for commissioning as a government asset. Upon receipt of the item, the stores department issues form S13. See form Appendix 3.
4. **S 20 forms –** Local purchase order (LPO). This is a contracting document raised in case of goods being procured. See form in Appendix 4.
5. **S 21 forms –** Local service order (LSO). This is a contracting document raised in case of service being procured. See form in Appendix 5.
6. **Vote book –** This is a record of all financial transaction of a ministry, department or agency detailing the balance available for each of the budget lines. Each page in the vote book represents an item in the printed estimates. See form in Appendix 6.
7. **Impress request form –** This is a form used by staff members to request for imp rest. It should be filled by the staff members and relevant document attached to the form. It is then approved by the authority to incur expenditure (AIF) holder or authorized representatives. The imprest should be surrendered within 48 after completion of the purpose of the imp rest. See form in appendix 7. A copy of the imp rest surrender form is in Appendix 8.

**8.6 Expenditure**

Government expenditure is divided into:

1. Recurrent expenditure

Recurrent expenditure is on – going expenditure incurred every financial year e.g. personnel costs. There are also known as mandatory expenses which must be paid from the consolidated fund.

1. Development expenditure

Development expenditure are provisions made for the creation of new assets. These include expenses such as construction of roads, rehabilitation and construction of water installations and the transfers from government to other agencies for capital expenditure.

**Authorization of Expenditure**

The AIE holders fill responsibility for the approval of all expenditure incurred under their respective expenditure heads. The AIE holders should also have delegated officers who act in their absence. In cases where there is an emergency expenditure and both the AIE holder and delegate are absent, then such expenditure should be brought to the attention of the AIE holder for information and endorsement within two days of his / her return. The absence of both the AIE holder and his / her alternate should be brought to the attention of the Accounting officer in writing before the signing of the document. Any persons signing such documents. Without such notice will be held personally accountable for any loss or problem arising from the transaction.

The procurement department always makes available all copies of committed and duly signed LPOs, LSOs filling and safe keeping in the finance department pending the delivery of goods / services before payment. The invoice received in the finance department should be subsequently booked in the invoice register before being released for payment. All the indicate the date of receipt of the invoice or claim for monitoring purposes.

The mode of payment shall include: cash, cheque, telegraphic transfer / electronic transfer appropriately authorized. Expenditure must be fully supported by genuine or authentic supporting document from the supplier and from the MDA. The finance department should confirm availability of fund under the respective budget lines before LPOs and LSOs are issued by the procurement department. If the funds are available then the commitment shall be entered in the vote book and the order endorsed ‘funds available’ and signed by the accountant in charge of the vote book. Payments shall be approved by the Accounting officer or his or her authorized representative.

A pre – numbered payment voucher is raised for all payment related to invoice goods and service and any advance payments. The payments voucher should indicate the date, the payee’s name and address, the description of goods and service, amount inward’s and figures budget line code against which the purchase should should be charged, signature of preparing and authorizing officers, signature of payee (for cash payment

The cashier draws a cheque for all dully approved vouchers. The cheques are signed by authorized personnel. There should be an officer assigned to release all cheque to respective payees. Individual collecting cheques should only do so upon presentation of proper identification documentation. A cheque dispatch register should be maintained in the cash office to register the cheques as they are collected. Payment vouchers and supporting documents should be used to record or post the transactions in the cash book.

**Impresst**

Imprest is a form of cash advance or a ‘float’ which the accounting officer may authorize to be issuedto an officer (s) who , in the course of their duty, are required to make payments which cannot be conveniently be made through the normal payment process. Some of the rules applicable in imrest accounting include:

* AIE holders will scrutinize and approve all task – based budgets upon which impress are requested;
* Stationery transportation fuel and airtime should not be include in imprest budgets. They should be procured through the procurement department;
* No officer with outstanding imprest will be granted another imprest without retiring the first one,
* The amount of contingencies should not exceed 10%of the total imprest requested;
* Application of imprest should be made in advance;
* the respective AIE holders immediately upon return to the office or upon copletation of the task which the imprest was approved for. The assistant accountant general will return / reject any surrender that does not comply with laid doen requirements application of of imprest is done through an imprest requisition form (Apendikc 7)

There are several types of imprest

1. ***Travel imprest*** – there is local travel and internal travel impre. Local travelel imprest is for travel expensenses within the country. Support documentation for local travel imprest is bus ticket or a work where official means is provided. International travels support document include copies of the officerd; passport, boarding passages and and air tickes.
2. ***Pettycash impresst \_***this is a cash flot held by the patty cash cashier. Petty cash is used to pay for mirror or incidental expenditure petty cash imprest should not be co-authngled wiyh general operation receipts. All pay made from the petty cash should be cash reimbursement form to enable him reimburse exenpenses include.

***Payments to suppliers.***

The following documents are required for processing supplier payments:

* Original invoice ;
* Goods receive volcher )GRC) where applicable
* Certificate of completion or confirmation of receipt of survice or goods
* Approved lease agreements for rent payments
* Dully fill and approved purchese requision form.
* Acontract for service dully executed.

Payment instruction are issued based on available cash good and service rendered. Payments should be make based on the integrated financial management information system system (IFMIS)

The accountant determined that the payments are in order by confirming the GRV attached agrees with the LSO or LPO. He /she also confirms that the invoice agrees with the price on the LPO, or contract. The accountant shall also confirm that the invoice is correct. A certificate true invoice shall be used in case th original ivoice is not available based on a clear letter from the supperlir. The finance tepartment hould confirm the availability of funds from the vote book prio to signing of the cheque.

**Salaries**

Once the pyroll is approved , the period is closed. Jounals for any drawn to updaterespective ledgers. Salaries are processed through a system a system known as the integrated personal payroll database (IPPD). The system generated payroll reports include payslips, files for bank payments payroll control summaries, statutory and other deduction reports. Payslips are printed and distributed to respective officer. The following are some of the deductions made on salaries

* Statutory deductions;
* Registered savings and credit cooperative societies;
* Recognized tenant purchase housing schemes or staff mortagage scheme;
* Life insurance
* Loan repayments e.g. car loans and personal bank loans.

No salary deducted can be effected without valid and properly authorized from the office the payment deadlines for payroll deductions are shown in table 8.1 below

**Table 8.1 submission date for statutory deductions**

|  |  |
| --- | --- |
| Deduction | 9th subsequent month |
| Pay as you | 9th of the subsequent |
| National social security fund (NSSF) | 9th of the subsequent month |
| National Hospital insurance fund (NHIF) | 9of the subsequent month |

Musterol confirming the number of the days worked. A payment certificate should be prepared to support cash payments made for casual wages. Casual workers who are paid over the taxable threshold of ksh.10,164 are supposed to be deducted payee. All casual should also pay NHIF based on their tax brackets as indicated in the muster payroll. A casual worker employed for and should therefore accrue the benefits an employee. See a sample must roll in appendix 11

**Allowances**

Allowances are regulated by government in accordance with job Groups Bands. They stipulated the rate applicable for each job group and the location one is visiting. There are several types of allowances as see below:

***Accommodation allowance-*** this shows the amount of allowance payable for a night – out of the perm ant duty station. These a mounts are presented in Kenya shillings.

ii. metal allowances – paid to officers travelling within the country but who will not be required to spend a night way from the permanent duty station there are two allowances under the metal allowances and the metal allowances these amounts are presented in Kenya shillings

iii. subsistence allowances for overseas travel – these are rates payable to public officers who travel outside the country and capture various countries and the amount payable in each country these amount are presented in united state dollars the rate are daily rate

iv. leave allowances – this is an allowances payable once a year for qualifying employees

v. sitting allowances – these are allowances paid to various officers for sitting in meetings

**8.7 facility improvement fund**

The basic goal of fif is to generate money improving the quality of care at facilities this can be done by improving physical facility by doing the following: painting the buildings providing functional equipment’s making adequate supplies and maintaining a friendly attitude towards patient when patient are asked to pay for the service they expect better services and higher quality of care the patient contributes to the ff through daily inpatient fees outpatient treatment fees and laboratory fees as part of implementing fif officer in charge of health centers should prepare a plan of action for improving quality care some of the steps to do this include

* Holding regular meetings to create awareness of patient care issues
* Cleaning toilets and washrooms and ensuring they are cleaned and checked regularly
* Improving the confidentiality and privacy of patient at all times
* Reducing back door or corridor consultation
* Keeping patients informed at all times on matters requiring their attention

**8.8 financial statements**

Counties and ministries are required to operate one bank account for recurrent and development expenditure under their ministries the summary should shows bank branch account number and treasury authority reference ministry should directly request for a bank statement from the bank

**Cash books and bank accounts**

The cashbook is one of the major books of original entry since it captures all the payments and receipts a cashbook is maintained for each and every bank account the entries in the cashbook originated from the following sources

* Cheques and electronic transfer payments
* All receipts
* Direct bank credits
* Direct bank debits e.g. bank charges
* Any cashbook adjustments e.g. cheque cancellation

The debits and credit of the cashbook should be added and balances daily and bank reconciliations should be done on a regular basis and at least once monthly monthly a simple cash and book can be seen in appendix 12

**Summary of expenditure report**

District accountants are required to submit through the district department head or AIE holder a summary of expenditure which includes all payments for its respective ministry as captured in the vote book management system. The report should be accompanied by a reconciliation of the actual cash receive and the actual expenditure. The return should be signed by the district accountant. The district internal auditor is required to audit and certify that the statement is correct any unspent balance from the district offices the office should be surrendered to the exchequer. A sample of a summary expenditure report can be seen in appendix 13

**Revenue / appropriate in aid returns**

District accountant are required to maintain a record of all revenue and collected any discrepancies between the ledger and the district return should be reconciled

**Bank reconciliations**

Account units are supposed to carry out bank reconciliation on a daily basis the reconciliation should be completed and submitted to central bank according to set timelines a simple bank reconciliation statement can be seen in appendix 14

**Ledgers and trial balances**

Ministry and departments are responsible for the production of their own ledgers from the IFMIS systems. The heads of accounting units are required to submit copies of the ledgers statements to the respective district accountants to obtain confirmation of their correctness a sample of ledger can be seen in appendix 15 and a sample of a trial balance can be seen in appendix 16

**Appropriate accounts**

The appropriation accounts are prepared on a basis by the mdas they show the service for the appropriated money was spent the actual amount spent on each service the status of each vote compared with the appropriation for the vote a statement explaining any variation between the actual expenditure and the sum voted and any other information specified by treasury these accounts are then transmitted to treasury the appropriation accounts are attached in appendix 17

**Cash flow statement**

A cash flow statement provides information on liquidity it indicates the amount timing and probity of future cash flow every county government is required to prepare an annual cash flow project for the county for the each financial year and submit the cash flow projection to the controller of budget and a copy the intergovernmental budget and economic council and treasury.

For each item of income and expenditure on the budget you need to predict and plot on the forecast sheet when cash will come in and out this is dependent on when activities are planned to take place however some activity is more predictable than other e.g. monthly such as salaries or annual such as insurance other transaction are unpredictable e.g. repair a sample of a cash flow statement can be seen in appendix 18

**Fund accounts**

Some grants are given for a specific purpose these are known as restricted funds because they may only be used for particular activity rather than for general purpose such funds must be accounted for separately so that the organization can demonstrate to the donor how the funds have been utilized this is known as funds must be accounting and requires care when setting up accounts system to identify and separate the necessary information in such circumstances it may be appropriate to identify activities by cost center or budget cost center are typically applied to projects functions or department which have their own budget and funding sources a sample fund account statement can be seen in appendix 19

**Income and expenditure statements**

This is a statement that shows the income and expenditure for a given period of time compared with the budget such statements are prepared on a monthly or quarterly basis and are very important for decision making they also present any variances to budget which are explained by the accounting department a sample income and expenditure statement can be seen in appendix 20

**Balance sheet (statement of assets and liabilities**

The balance sheet is a list of all the assets and liabilities on one particular date. This provides a snapshot of the organization financial position the balance sheet is in two parts.one part records all balance on assets account the other record all balances on liability accounts plus the income and expenditure account balance. The balance sheet will either be presented with the assets listed on the left and the liabilities presented on the right of the page or more commonly nowadays listed down the page with asset presented first then liabilities deducted from them

* Fixed assets

These are the tangible long-term assets such as buildings equipment and vehicle having a value lasting more than year fixed assets are shown on the balance sheet after an allowances for wear tear or depreciation has been made

* Current assets

These are more liquid assets such as cash bank payment made in advance and stocks these in theory at least can be converted into cash within 12 months

* Liabilities

Liabilities are also divided into current liabilities and long-term liability there are current or short term liabilities including outstanding payments and short-term borrowing to be paid within 12 months it also includes long-term liabilities such as loans that need to be paid after 12 months

See a sample balance sheet in appendix 21

**8.9 health care financing**

This regulation may be cited as the government financial management regulation 2009

**Health care financing sources**

The act specifically mention the establishment of a hospital management service fund to consist of health care source of funds as follows

1. Government of Kenya budgetary allocation – in the financial year 2010/11 allocation was Kshs 41.5 billion which was approximately 6.5% of the total government budget these allocations were made the two ministries
2. Appropriation in aid – this includes grants and loans from development partners the main development partners in health care in Kenya include the German federal government Arab bank for economic development and the African development bank among others aid also includes user charges collection made in the various public health centers in the country
3. National health insurance fund – this is a fund for formally employed individuals and those in the informal sector employees contribution are deducted and remitted to the fund by their employers for members under the voluntary category they pay Kshs 160 per month for those in formal employment contribution are made as per their income this also include income generated from the proceeds of the services
4. Private insurance – this is a fund contributed by corporate and individual for various insurance products to the health sector

**Health care financing principles and regulations**

The following are some of the most importance financing principles regulation:

* The expenditure incurred by a medical facility on the service shall be on the basis of and limited to the annual allocation or grants and authority to incur expenditure
* The receipts earning accruals and the balance of the services at the close of each financing year shall not be paid into the consolidated fund but shall be retained by the respective hospitals or medical facility for the purpose for which the service is established

The objectives and purpose of the hospital management service fund

* Provide financial resources for medical supplies rehabilitation and equipment of hospital in the country
* Support capacity buildings in management of hospitals
* Give more power to hospital and medical facilities to plan and manage the resources under them
* Improve the quality of health care services in the hospitals

**Health facilities management committees**

These committees are established at provincial district and sub district hospital management committees.

**Provincial management committees**

The total membership of the committee is seven although they can have up to nine members the composition of the committee is a caiman nominated by members of the committee from among themselves and appointed by the minister the area county commissioner or his representatives duly nominated by him/ her in writing the area county director of medical services or his representatives duly nominated by him/ her in writing the person in charge of a provincial hospital who shall be the secretary the person in charge of a local authority provincial hospital or its equivalent and the following person who shall be resident of the area of jurisdiction appointed by the minister

* One person who shall have knowledge and experience in finance and administration matters
* One person nominated by women groups
* One person nominated by faith based organization and
* Not more than two person nominated by recognized community based development organization of whom one shall be a woman

The committee is supposed to meet four times a year and is expected to maintain records of its deliberations the following are their functions

* Supervising and controlling the administration of the funds allocated to a provincial hospital
* Opening and operating a bank account at a bank to be approved by the minister of finance
* Preparing work plans on estimated expenditure
* Ensuring that the basic books of accounts and records of accounts of the income expenditure assets and liabilities of a provincial hospital are maintained as prescribed by the officer administering the funds
* Preparing and submitting certified periodic financial and performance reports
* Ensuring that permanent record of all its deliberation are maintained

**District or sub – District hospital management committee**

The total membership of the committee is at least seven and not more than nine members the committee consists of a chairman nominated by the committee from among themselves and appointed by the minister the area district commissioner or his representative duly nominated by him in writing the person in charge of a district or sub district hospital or its equivalent and the following person who shall be resident of the area of jurisdiction appointed by the minister

* One person who shall knowledge and experience in finance and administration matter
* One person nominated by women groups
* One person by faith based organization
* Not more than two person nominated may recognized community based development organization of whom one shall be woman

The committee meets at least four times a year and is expected to maintain records of its deliberations the function of committee are:

* Supervising and controlling the administration of the funds allocation to a district sub – district hospital
* Opening and operating a bank account at a bank approved by the minister for the time being responsible for finance
* Prepare work plans based on estimating expenditure
* Ensuring that basic books of accounts and records of accounts of the income expenditure asseets and liabilities of a district or sub district hospital are maintained as prescribed by the officer administerin the fund
* Preparing and submitting certified periodic financial information
* Preparing performance report as prescribed
* Ensuring that permanent record of all its deliberations are maintained

**National hospital service committee**

The national hospital service committee consists of a chairman (not public officer) appointed by the minister the permanent secretary of the ministry for the time being responsible for matters relating to medical service or his representatives duly nominated by him in writing te permanent secretary of the ministry for the time being responsible for finance or his representative duly nominated him in writing the director of medical servicewho is the secretary and three person of whom two shall be women appointed by the ministerand of whom:

* One who shall be appointed by virtue of his knowledge or experience in financial ,management
* One who shall be appointed by virtue of his experience in medical care delivery management and
* One who shall be appointed by virtue of his expertise and experiences as a medical practitioner
* One person nominated by a health non – governmental organization network in Kenya appointed by minister

The function of national committee include

* Approving the work plans prepared by the facilities
* Ensuring equitable distribution of resource to the medical facilities and
* Reviewing and approving annual expenditure statement

**Administration of the hospital management fund**

The officer administering the fund has the following roles:

* Preparing signing and transmitting to the controller and auditor – general in respect of each financial year and within three months the end therefore a statement of account relating to the fund specifying all contributions to the fund and the expenditure incurred from the fund and such details as the treasury may from time to time direct in accordance with the provision of the public audit act
* Furnishing any additional information as he may be required that is proper and sufficient for the purpose of examination and audit by the controller and auditor general in accordance with the provision of the public audit act
* Developing criteria for the allocation of funds for approval by the national committee
* Preparing annual distribution of resources by hospital
* In consultation with the national committee impose condition on the use of expenditure authorized by him or on his behalf and may impose any reasonable prohibition restriction or other requirement such use of expenditure
* Instituting prudent measure for the proper utilization for monies deposition in the fund using suitable internal control and appropriate mechanism for accountability including audit of account by internal auditor of the ministry responsible for matters relating to finance
* Ensuring that proper books of account and record relating to all receipts payment assets liabilities of the fund and to any other activities and undertaking financed by the fund are maintained

**8.9 resources mobilization**

A resource is a source or supply from which a benefit is reduced the resources applied in a hospital setting include finance human resources and material resources mobilization in the health sector is the act of seeking for seeking for resource to meet health provision needs

**Process of resources mobilization**

There are basic steps in undertaking resource mobilization including:

* Defining the situation by undertaking a needs assessment and swot analysis
* Determining the inputs
* Condition the appraisal of resource situation in term of adequacy and sustainability
* Evaluating the resource appraisal
* Developing resource mobilization plan
* Implementing the action plans

**Key sources of organization resource**

Health facilities have various sources that they could mobilize from including the following

* Financial institution like banks and cooperative societies
* Security exchange
* Foundation and trust
* Multilateral funds
* Bilateral donors
* NGOS and project
* Government
* Corporate donors
* Consultancy and training

**Resources mobilization strategies**

Health facilities seek funds to improve their service in order to mobilize resource health facilities need to be strategic in order to generate more funds the following are some of the strategies that can be adopted to generate funding

1. Bidding as a consortium

This involves different health care organization forming consortia to be more competitive when seeking funds. This methods can be used to respond to government contract or donor request for proposal health care organization can form consortia with training or research institution they present their uniqueness and complementarity with each other hence making them more desirable to the funding agencies this is even more important for large programme that are funded by donor bids submitted by a consortium of organization this applies to cases where consortium members play a complementarity role

1. Developing a reputation for excellence

Health care organization should invest in developing a reputation of excellence through several ways. This includes maintaining powerful profiles promoting their activities through periodic publication that promote their activities good management of health facilities through proper care of patient amongst others the profile of these organization should focus on their operation for example a health care facility with a research center that conducts different research activities can attract funding it will demonstrate its capacity to design and execute successful different initiative that impact positively on the lives of the people that it work with. The good reputation will help attract funding for example the Kenya red cross receives unsolicited funds from corporate and individuals because they have a repentant of excellence in what they undertake

1. In – kind donations

This is where care organization receives donation from individuals and companies this includes volunteer work or secondment of expert staff. Such donation are a measure of people confidence in the health facility the facility should record these in kind donation and quantity them in monetary terms

IV income generating activities

There are many and varied income generating activities a health care facility can identify areas through which they can generate extra income over above their daily activities for examples a health care facility can hold quarterly sessions to train the public on various topics on health care these activities based on their experience and expertise should be offered at a fee

**Resources mobilization action plan**

A health care facility should develop an action plan on their intention to achieve the goal of resources mobilization the following determines the success of the planning process

* A dedicated resources mobilization team within the health facility and ideally in the finance section who work in other areas including resources mobilization
* A responsible staff member in the finance section in charge of resources mobilization
* Periodic resources mobilization work plans to ensure that activities are prepared and monitored on a regular basis
* Establishment of a support environment e.g. funding for proposal writing meeting cost
* A monitoring system for the resources mobilization plans and actions

**Handout and notes**

**Problem scenario 1: definition of financial management**

How do you mange vehicle to ensure that it is remains as good as new? If will not run in a good fuel and oil and regularly service it its function suffers it will not run efficiently if neglected the vehicle will eventually break down and fail to reach its intended destination in practice financial management is about taking action to look after the financial health of an organization and not leaving things to chance

**Problem scenario 2: payment documentation required**

A supplier of medical equipment has to been paid for six months since he supplied some medical equipment in madodo hospital. He has been asking the accounts to settle his payment since the contract indicates that he shall be paid 30 days upon supply of the of the equipment and presentation of a valid invoice. The accountant has informed the supplier that he cannot effect the payment since he has not been issued with certificate of confirmation of receipt of goods and other documents the supplier has presented a delivery one and claims that the equipment is already been used in the hospital what document could be missing to enable this supplier receives payment?

**Problem scenario 3: facility improvement fund**

Madodo hospital in located in madodo county the county has a population of 5000 people it is the only hospital in the entire county, the hospital does not have running water for six months due to unpaid water bills the toilets used by the patient are very dirty and unusable the building are unkempt and very dirty. The paints are peeling off having been painted almost 15 years ago. The hospital also lacks drugs rescrubbed by doctor and patient have to buy the drugs from another county hospital. The nurses do not provide all the necessary information to the patient since they are very few and a lot of patient conflict

**Article 1 – to use in MTEF – critical thinking piece**

The lecture is supposed to use this piece to explain the mtef process the student should read and brainstorm before introduction of the mtef topic

**Uhuru to present Kenya’s biggest budget ever** – the standard Thursday, 2 june 2011 by David Ochami and Steve mkawale

Finance minister Uhuru Kenyattta will present to the country a sh. 1.1 trillion budget the largest in the history of the country the minister submitted to parliament revenue and expenditure estimates for the 2011/2012 financial year but maintained he had not branched the constitution ;

“I am proud to report that with the support of my hard working teams we have already delivered “said Uhuru. uhuru lamented that he had been compelled to obey a section of the law he believes should not apply under the current parliament alleging that his critics are unconcerned by Kenya obligation to the east Africa community and the impacts this early publication of estimates will have on overall macro – economic stability

“one aspect of the EAC treaty was to agree on a common budget date which is June 8 said uhuru he submitted the estimated Tuesday evening to the budget committee of parliament to beat the deadline it set of May 3 the committee had accused uhuru of breaking the constitution uhuru said it is now up to parliament to allow him read the budget speech before it on Wednesday

“ I stand guided by parliament “ he told journalist at a press conference in this treasury office Thursday in an apparent climb down and gesture to hostile MPs who accused him of breaking article221 of the new constitution by not submitting the estimate in April .

“Whether it si read or not the budget is already here what normally happening parliament is a tradition and is actually the last stage of the lengthy budget making process” uhuru said

Noting that chapter 2221 of the constitution was one of the proposed ot the treasury to the committee of experts uhuru said the ministry has public and parliamentary participation in the preparation of the national budget cycle is a process that took between 10 – 11 months and reminded Kenyans that the budget cycle under the old constitution and the promulgation of the new one have met each other halfway

‘given the length of time takes to formulate the budget there probably should have been transitional clauses due to the fact that the budget date had been moved forward by two months said uhuru who was accompanied by the permanent secretary joseph kinyua and other senior official in the ministry he said under the spirit of the new constitution ministry of finance official fast tracked the budget process and recorded some achievements the ministry prepared budget proposal based on ten sector these proposal ere shared with the public during public sector hearing which were held on January 12- 14 at kick “ said the minister

**Article 2 – o be used as an examples for the impress topic**

**The standard Wednesday 19 may 2010 by David Ochami page 4**

Ministry assistant minister and senior staff have not paid back shs 348 million taken from government coffers as impress for the 2006/2007 and 2007/2008 financial years finance permanent secretary joseph kinyua ha consequently threatened to surcharge other ministers PSS and accounting officer in such minister to compel them to become proactive when kinyua testified to parliament public accounts committee in Nairobi Tuesday it was not clear which minister and assistant minister had defaulted

But it was apparent bonny khalwale urged the EPS to seek parliament assistance to recover debts from minister who are also legislators Dr. khalwale said salaries of defaulting minister and assistant could be attached to recover the unpaid impress “am concerned that accounting officer have not been able to account for his money “says kinyua

Returning from trips he said offer returning from trips and duties for which they requested an impress were required to repay and account for it within 48 hours after the mission. Kinyua said he issued instruction to accounting officer in ministries including the surcharge threat he said the threat to surcharge accounting officer would compel them to pursue money lent to the defaulting minister and senor staff. According to the auditor and controller general sh. 200 million has not been accounted for the year 200/2007 and shs. 148 million is missing for the next financial year kinyua said missing money has impacted negatively on government programmes. Khalwale said*Parliament had introduced new strict rules defeat non-payment of such debts where no one can secure money before replying an old imprest*

***Hand –out on different cost analysis***

*Differential cost analysis*

Differential cost is the difference in the total cost that arises from the selection of one alternative instead of another. The alternate choice may arise on account of change in the method of production, sales volume product mix, price, selection of an additional sales channel, make or buy decisions e.t.c. characteristics of differential costing.

* In order to ascertain the differential costs, only total cost is needed and not cost per unit;
* Existing level is taken to be the base for comparison with some future of forecasted level;
* Differential cost is the economist’s concept of marginal cost;
* It may be referred to as incremental cost when the difference in cost is due to increase in level of production and decremental costs when difference in cost is due to decrease in the level of production;
* It does not form part of the accounting records, but may be incorporated in budgets;
* It is not necessary to adopt marginal cost technique for differential costs analysis because it can be worked out on the method of absorption costing or standing costing;
* What is said of the differential cost above, applies to differential revenue alo.

Uses of differential costing in policy decision like:

* The introduction of a new plant;
* Make or buy decisions;
* Lease or buy decisions
* Discounting a product, suspending or closing down a segment of the business
* The profitability of a charge in product mix;
* Acceptance of an offer at a lower selling price;
* Change in the methods of production;
* The determination of the most profitable levels of production and price;
* Submitting tenders
* The determination of price at which raw materials can be purchased;
* Equipment replacement decisions;
* The profitability or otherwise of further processing;
* The opening of a new sales area or territory.

**Example: Make or Buy Decision**

Suppose a manufacturing company incurs the following costs with respect to producing a product ‘A’(5,000 units)

|  |  |
| --- | --- |
| **Item** | **Cost (Kshs)** |
| Materials | 500,000 |
| Labour | 250,000 |
| Overheads | 200,000 |
| Indirect expenses | 150,000 |
| **Total Expenses** | **1,100.00** |

Suppose the same product ‘A’ is available from an outsider at Kshs. 200 per unit. The company will decide to buy rather than make because buying will cost the company Kshs. 1,000,000, which is lower than the cost of production.

**Module 9: communication in health services delivery**

**Nature of communication**

Communication can be defined as the act of conveying thoughts or information. It can also be defied as the exchange of information between people. Being able to communicate well is essential to effective health service delivery. Good communication skills are vital for health professional because they help them to:

Develop positive relationships with people using health services and their families and friends, so they can understand and meet their needs

Develop positive relationships with work colleagues and other professionals;

Share information with people using their services by providing and receiving information

Report on the work they do.

**Communication Context**

Context refers to the circumstances in which an event occurs, a setting

**One-to-one person communication**

One-to-one means one person communicating with another person with no other people joining in. it is important to create the right atmosphere by being friendly and showing interest in and report for the other person. The conversation needs a start e.g. ‘Good morning’, a middle when you both discuss what you need to talk about and an ending e.g. – see you on your next appointment.’

**Group communication**

Group communication is difficult because it only works properly if everyone gets involved. In most groups, there are people who speak a lot and others who rarely speak. If at all, because they feel uncomfortable speaking in front of a group of people or they are just not interested. Groups work best if there is a team leader who encourages everyone to have a say in turn, rather than everyone trying to speak at once.

**Formal and Information communication**

Formal communication tends to start with a greeting such as ‘Good afternoon. How are you feeling today?’ it can be used to show respect for others. Formal conversation is often used when a professional person, such as health worker, speaks to someone using a service. It is clear, correct and avoids misunderstanding. Communication with a supervisor is usually formal. A supervisor is usually more distant from those they manage so that if they need to, for example, issue a formal warning to someone, it is less awkward for both parties than if they are friends.

Informal communication is often used between people who know each other well, like friends and family is more likely to start with ‘Hi, how are you?’ and allows for more variety according to the area someone lives in or culture. For example, in some places, it is common for people to call other people ‘brother or sister’ even if thye have only just met. People usually communicate more informally with friends, including those they work closely with on a day-to-day basis.

**Figure 9.1. Communication Skills Needed by People Working in a Health Environment**

Being able to organize a conversation

Using listening skills to check understanding

Using skills for keeping a conversation going

Using non-verbal messages to communicate

Understanding non- verbal messages

Understanding cultural differences

Understanding the communication cycle

**Communication skills**

Knowing how to ask questions effectively

**Source:** Person Education (014).

**Forms of communication**

There are three main forms of communication namely: verbal, non-verbal and written. We can also use technology to communicate

***Verbal communication***

Verbal communication uses words to present ideas, thoughts and feelings. Good verbal communication is the ability to both explain and present your ideas clearly through the spoken word and to listen carefully to other people. This involves using a variety of approaches and style appropriate to the audience you are addressing.

***Non-verbal communication***

This refers to the message we send out to express ideas and opinion without talking. This might be through the use of body language, facial expressions, gestures, tone of voice, touch or contact, sig, symbols, pictures, objects and other visual aids. It is very important to be able to recognize what a person’s body language is saying, especially when as a health worker, you are dealing with someone who is in pain, worried or upset. You must also be able to understand the message you send with your own body when working with other people.

**Figure 9. The Main Elements Involved in Non-Verbal Communication**

Touch

Proximity

Eye contact

Signs, symbols, pictures

**Non-verbal communication**

Facial expression

Appearance

Head movement

Hand movement

**Source:** Person Education (2014).

*Body language*- The way we sit or stand, which is called posture, can send message. Slouching on a chair can show a lack of interest in what is going on. Folded arms can suggest that you are feeling negative or defensive about a person or situation. Even the way we move can give out messages. For example, shaking your head while someone else is talking might indicate that you disagree with them or waving your arms around can indicate you are excited.

*Facial expression*- We can often tell that someone is feeling by looking at their eyes. Our eyes become wider when we are excited or happy, attracted to, or interested in someone. A smile shows we are happy and a frown shows we are annoyed.

*Touch or contact*- Touching another person can send message of care, affection, power or sexual interest. It is important to think about the setting you are in and what you are trying to convey before touching a person in a health environment. An arm around a child who is upset about something in hospital or a nursery can go a long way to making them feel better. On the other hand, however, a teenager might feel intimidated by such contact from an older person.

*Signs, symbols and pictures*- There are certain common signs or gestures that most people automatically recognize. For example, a wave of the hand can mean hello or goodbye. Thumbs up can mean that all is well. Picture of all forms and objects also communicate message. An X-ray and model of a knee joint can more easily communicate to someone needing a knee replacement exactly what is involved.

**Witten Communication**

This is central to the work of any person providing a service in a health environment. This is important for records and writing reports. Different types of communication need different style of writing but all require literacy skills. A more for a=mal style of writing is needed when recording information about a patient. It would be unacceptable to text message abbreviation.

***Technology Aids***

Technology is moving so quickly now that we have many electronic aids help us communicate. For example, mobile phones can be used to make calls. We can also use them to send text messages and emails. We have computers on which we can record, store and communicate health information very quickly and efficiently over long distances. Though video link, health professional can participate in, or guide an operation taking place in a different physical location.

**Communication Cycle**

Communication is a process. In order to effectively communicate, the parties involved must go through a communication process.

**Figure 9.3 The Communication Cycle.**

**Source:** Peron Education (2014)

|  |
| --- |
| Ideas occurs Communication starts with an idea. You think of something you want  to communicate. Communication always has a purpose. It might be  used to pass on information or an idea, persuade someone to do  something or to entertain or inspire |
| Message coded You think about how you are going to say what you are thinking and  decide in what form the communication will be. For example, spoken  word or sign language, email letter. You put it into this form in your  head. |
| Message sent You send the message. For example, speak or sign, or write what you  want to communicate. |
| Message received The other person senses that you have sent message by, for example  hearing your words, seeing your sign or receiving your written  communication. |
| Message decode The other person has to interpret what you have communicated. This is  known as decoding |
| Message if you have communicated clearly and the other person has  Understood concentrated, and there are no barriers to communication, the other  Person understands your ideas. They show this by giving you feedback,  i.e. by sending you a message back. |

The communication cycle happens very quickly and subconsciously because we think three times faster than we speak. In reality, the stages of the communication cycle do not happen in sequence. The communication process is repeated backwards and forwards as long as the conversation goes on. The sender of the message becomes the receiver of a message sent back; the receiver becomes the sender and so on. Each person continues the conversation because they have to check that they have understood what the other person meant. They do this by listening to what the person says and asking questions about it or putting it in their own words and repeating them back, so reflecting what has been said. A conversation can therefore also be called an interaction.

**9.2. Communication Barriers**

Some things stop communication from being effective. People who work in a health environment need to understand the barrier so they can overcome them. It is very important to be able to communicate effectively in a health or social care setting. A service user will not be able to take part in a discussion about their care or planning their future if they do not understand what is being said. Equally, the person providing the service cannot help if they cannot find a way to understand what the service user is trying to ask for. There are many factors that affect communication as illustrated in the table below.

**Table 9.1. Barriers to Effective Communication**

|  |
| --- |
| Sensory deprivation This occurs when someone cannot receive or pass on information  because they have impairment to one or more of their senses, most  commonly a visual or a hearing disability. |
| Language barrier When someone speaks a different language or uses sign language,  They may not be able to make any sense of information they are  being given by someone trying to help them if that person does not  speak their language. |
| Jargon When a service provider uses technical language, the service user  may not understand. For example the doctor may say that a patient  needs bloods and an MRI scan. That can sound very frightening to  someone who has been rushed to hospital. It is better if the doctor  explains that they need to take some blood to do some simple tests  and then explain what a MRI scan is. Understanding the facts can  make something less scary. |
| Slang when a service uses language that not everyone uses, such as saying  they have a problem with their waterworks. This can mean their  plumbing system but also having a problem going to the toilet. It may  be appropriate to use slang with peers. However, in normal working  with colleagues or service users, you should avoid using any language  that can be misunderstood or misinterpreted or that which cause  offence. |
| Dialect or When people use different words or pronunciation for everyday  Pronunciation object or feelings depending on the part of the country they come  from. Some communities pronounce certain letters of the alphabet  differently. It may cause confusion if someone did not listen keenly. |
| Acronyms When words are shortened to initials. There are lots of acronyms in  health and the can be very confusing. Sometimes people do not realize  that not everyone knows what they mean and mistakes can be made or  people can feel left out if they are not familiar with the terms. A health  care professional might say, “you will need to take these |
| Cultural differences When the same thing means different thing in two cultures,  communication can be difficult. For example, it is seen as polite and  respectful to make eye contact when speaking to someone in some  cultures but not in others where this may be taken as being rude and  defiant. There are also cultural barriers based on age differences  between a service seeker and service provided where an order person  cannot expose their private parts for examination by a younger person. |
| Distress When someone is distressed, they might find it difficult to  communicate. They may not listen properly and so misinterpret or not  understand what is being said. They might also be tearful or have  difficulty speaking. |
| Health issues When you are feeling ill, you may not be able to communicate as  effectively as when you are well. This can affect your colleagues and  service users. Similarly, people who are being cared for in hospital  because of an illness may not communicate normally. Some long-term  (chronic) illness such as Parkinson’s disease or Multiple sclerosis also  affect an individual’s ability to communicate. You need to be aware of  this if you are working with such people. |
| Environmental When communication is affected by the environment that people find  problems: themselves in. for example, someone who does not see very well will  struggle to read written information in a dimly lit room. A person who is  in a wheelchair may find it impossible to communicate with the  receptionist of the dentist’s if the desk is too high and above the  wheelchair user’s head. |
| Misinterpretation When someone reads a person’s body language wrongly. For example  of Message someone with their arms folded and tapping their feet might be  impatiently waiting for someone who is late. However you might assume  they are angry with you. This may stop you from asking for help. |

**Study Activity**

Four other factors that affect communication are differing humor, sarcasm, inappropriate behavior and aggression. Think of an example where each of these may lead to a breakthrough in communication.

**More barriers to communication and ways to overcome them**

***Aggression***

Aggression is behavior that is unpleasant, frightening or intimidating. It takes a variety of forms and can be physical, mental or verbal. It can cause physical pain or emotional harm to those it is direct at. It is caused by a range of factors such as substance abuse, mental health, a personality problem, fear or an attempt to dominate someone else. People who are aggressive towards other people are often bullies.

Aggression is a form of communication. It communicates a person’s states of mind, such as annoyance. It is also barrier to communication. Aggression is often emotion that is out of control. It can be destructive. When someone shouts at someone else, the other person can be afraid and will either shout back or shut the aggressive person out.

If someone working in a health environment is annoyed, frustrated or irritated (breathes quickly, shouts has clenched jaw and/ or rigid body language) the person they are attending to may feel dominated, threatened and unable to respond. This may lead to poorer service due to a breakdown in communication.

**Assertion**

Assertion is the skill of being calm and firm but not aggressive in the way you communicate with others. It helps you to communicate your needs, feelings and thoughts in a clear and confident way while taking into account the feeling of others and respecting their right to an opinion as well.

How to be assertive

* Plan what you are going to say. Be polite, state the nature of the problem, how it affects you, how feel about it and what you want to happen. Make it clear that you see the other person’s point of view and be prepared to compromise if it leads to what you want.
* Control your emotion such as anger or tearfulness and be calm and authoritative in your interactions with others. You need to be clear and prepared to defend your position and be able to say no. this will not cause offence if it is said firmly and calmly.
* Use questions such as, ‘How can we solve this problem?’ Use the ‘broken record’ technique where you just keep repeating your statement softly, calmly and persistently. at the same time, use body language that shows you are relaxed, e.g. make firm, direct eye contact with relaxed facial features and use open hand gestures.

**Using Verbal Skills to Overcome Barriers**

When you use your verbal skills effectively, you can help overcome barriers that many hinder communication. Some of the skills health service providers need when communication verbally and assertively when need be, with service users are shown in the diagram below. They are useful tools in checking the understanding part of the communication cycle.

Figure 9.4: Oral Communication Skills

Listening

**Verbal**

**Skills**

Summarizing

Clarifying

Paraphrasing

Closed questions

Open questions

**Source:** Person Education (2014)

***Paraphrasing*** means repeating something a person has said in a different way to make sure you have understood the message. For example, someone may say, ‘I have been sick since Sunday’ and you respond by saying, ‘You have been feeling this way for 4 days no?’

Closed questions are question that can be answered with either a single word or short phrase. For example, ‘DO you like cabbage?’ could be answered, ‘No’ or ‘No, I can’t stand them’. Closed questions give facts, are easy and quick to answer and keep control of the conversation. They are useful as an opening question, such as ‘are you feeling better today?; for testing understanding, such as, ‘ so you want to go on the pill?; and for bringing a conversation to an end, such as, ‘SO that’s you final decision?’

***Open questions*** may require a longer answer. For example, ‘why don’t you like cabbages?’ might be answered by, “ I haven’t liked the taste or smell of them since I was made to eat them all the times when I was a child…….’, Open questions give control of the conservation to the person you are speaking to. They ask the person to think and reflect, give opinion and feelings. They are useful as a follow-up to a closed question. To find out more, to help someone realize or face their problems and to show concern.

***Clarification*** means to make something clear and understandable

***Summarizing***means to sum up what has been said in a short, clear way

**Overcoming Barriers to Communication**

Communication difficulties can isolate a person, making them feel cut off. So it is particularly important in a health environment to overcome these difficulties. Barriers to communication can be minimized in several ways.

1. ***Adapting the environment***

This can be done in number of ways, such as improving lighting for those with sight impairment and reducing background noise for those with hearing impairments. Lifts can be installed with a voice giving information such as when the doors are opening and closing which floor the lift on for those who cannot see. Ramps can be added, reception desks lowered and signs put lower on walls so that people with physical disabilities can access people and information

1. ***Understanding language needs and preferences***

Service provider need to understand language needs and preferences of the people they are serving. They may have to re-word messages so that they are in short , clear sentences. They should avoid slang, jargon and dialect as much as possible. They should explain to people who cannot see and encourage them to touch things such as their face.

They should not shout at those who cannot hear well. They should use normal, clear speech and make sure their face is visible. They should employ a communicator or interpreter for spoken or signed language and show pictures or write messages, depending on what is best for the service.

1. ***Using individual preferred language***

Most leaflets produces by public bodies such as the Ministry of Health are now Witten in the two official languages in Kenya-English and Kiswahili-so that people who do not speak one language can still access the information. If there is a member of staff who speaks the preferred language of service user they will help translate. However, it is always important to ask a service user what their preferred language is for written and verbal communication.

1. ***Timing***

It is important to pick the right to communicate important information to a service user E.g. if, a doctor has just told a patient that they have a life threatening illness the patient needs time to absorb the information. If the doctor tells them all about the treatment straight away, chances are the patient may not really hear much of what is said because they are in shock. It may be better to see that patient once they have processed the information and are receptive to hearing additional information.

1. ***Electronic devices***

There are many electronic devices that help overcome barriers to communication. These include:

* *Mobile phone*- These are generally devices that affordable and available to the population at large, making them more accessible than computers. They have may uses in health care. For example, they enable emergency response teams to coordinate their efforts, aloe a medical team to contact someone awaiting an operation, coordinate a support group, gather and send information e.t.c.
* *Telephone amplifiers*- These are devices that amplify, or make louder, the ring tone of a phone so that people who are hard of hearing and those who use a hearing aid can hear the phone more clearly. They also amplify the volume of the person speaking on the other end by up to 100%.
* *Other devices on telephones*-include flashing lights for those who are hard of hearing to see that the phone is ringing.
* Hearing loops- a hearing loop system helps deaf people who use a hearing aid or loop listener hear sounds more clearly because it reduces or cuts out background noise. at home, for example, one can use a loop to listen to what is on television. You can also set up a loop with a microphone to help you hear conversations in noisy places like public transport vehicle. A hearing impaired student can wear a loop and the teacher a microphone to help the student listen to the teacher.

|  |
| --- |
| **Case Study** |

Juma has not been in the city for long. He gets a job as a patient attendant in the county hospital but because his Kiswahili is not very good he does not always understand what the other staff or patients have asked him to do. This has caused one or two arguments and almost seen him sacked.

1. Suggest what juma employer can do to resolve this so that Juma can remain a patient attendant.
2. What can Juma do to help himself?
3. How do you think i) the patients (ii) staff (iii) Juma feels when communication fails like this?

|  |
| --- |
| **Study Activity** |

1. List three different ways of adapting the environment to help overcome barriers to communication.
2. Ways is timing important when giving someone information?
3. Describe how an electronic device such as a mobile phone can help overcome barriers to communication.

**9.3. Alternative Forms of Communication**

Sometimes it is not possible to overcome a barrier to communication so an alternative form of communication must be found.

**Sign language**

Sign language uses visual sign. These are made up of the shapes, positions and movement of the hands, arms or bod and facial expressions to a speaker’s thoughts. Sign language is commonly used in communities which include the friends of deaf people well as people who are deaf or hard of hearing themselves.

Kenyan Sign language (KSL) is a visual language comprising specific gestures (signs), hand-shapes and facial expressions. The sign follow grammatical rules. It is official language of the Deaf community in Kenya.

**Figure 9.5. Some Examples of Sign Language**

***Lip Reading***

People with normal subconsciously use information from the lips and face to help understand what is being said. Many people misunderstand deafness, thinking that if someone cannot hear very well, they are being rude or stupid. This can leave a deaf person feeling isolated, excluded from everyday activity and conversations, frustrated and lacking in confidence. Lip reading is a technique of interpreting the movement of a person’s lips, face and tongue, along with information provide by an important that you look directly at someone who is lip reading and stand learning difficulties.

***Makaton***

Makaton is a method of communication using signs and symbols and is often used as communication process for those with learing difficulties. It was first developed in the UK in 1970s. Unlike sign language, Makaton uses speech as well as actions and symols. It uses picture cads and ties in facil expressions with the word easily recognizable by those with learning difficulties.

***Braille***

The braille system is a method which wisely used by blind people to read and write. Braille was devised in 1821 by Louis Braille, a Frenchman. Each Braille character is made up of six dot position, arranged in a rectangle. A dot may be raised at any of the six positions to form sixty-four possible combinations and these raised dots are read by touch.

***Technological aids***

These have already been mentioned earlier as a way of overcoming barriers to communication. They are also alternative forms of communication.

***Human aids***

Human aids are people who help people communicate with each other. Examples are:

* *Interpreters*- people who communicate a conversation whether it be spoken or signed, to someone in a different language they will understand. This is not easy because they not only have to interpret the words or signs but also have to find a way of expressing the meaning of the words clearly.
* *Translator*- People who change recorded information, such as the written word, into another language. Again, they have to convey the meaning as well as the words.
* *Signers*- People who can communicate using a sign language

|  |
| --- |
| **Student Activity: Signs and symbols** |
| * Do some research to find out the sign for (i) poison (ii) no entry (ii) no smoking (iv) fire exit (v) wet floor * Find at least five more common sign/symbols that most people will recognize which are used in a health environment of your choice. |

**9.4. Skills for Effective Communication**

This topic introduces students to more skills for effective communities. These include active listening, body language, facial expressions and eye contact. Some of these have already been covered at the beginning of this unit.

**Active Listening and Body Language**

Listening to people involves more than just hearing what they say. To listen well, you need to hear the words being spoken; thinking about what they mean and then thinking what to say back to the person. You can also show that you are listening and what you think about what is being said by your language, facial expressions and eye contact. By yawning or looking at your notes when someone is taking, you give the impression of being bored by what is being said. By shaking your head and frowning, you are showing that you disagree with or approve of what they are saying.

The process of active listening involves:

* Allowing the person taking time to explain and not interrupting
* Giving encouragement by smiling, nodding and making encouraging remarks such as ‘that’s interesting’ and, really?;
* Asking questions for clarification, such as, ‘can you explain that again please?;
* Showing empathy by making comments such as, ‘that must be making life really hard for you;
* Looking interested by maintaining eye contact and not looking at your watch;
* Not being distracted by anything else, such as an interruption on your mobile-switch it off or say you will ring back;
* Summarizing to check that you have understood the other person. You can do this by saying, ‘so what you mean is……..?;
* Use of appropriate language

***Ask students***

*How would you feel if your supervisor suddenly stated using swear words while they were addressing you? Why would you feel that way?*

We adjust how we speak depending on who we are with and who is listening to us. Things that are said with a group of friends or at a family gathering might not be understood by others because we use different types of language in different situation. People, even unconsciously, change their tone or use of dialect depending on whom they are speaking to. A person’s accent or dialect may become more pronounced when they are speaking to someone from their family or from they are they grew up in.

***Tone of voice***

If you talk to someone in a loud with a fixed tone, the person you are speaking to will think you are angry with them. On the other hand, if you speak calmly and quietly with a varying tone, the other person will think you are being friendly and kind. So it is important to remember that it Is not just what you say, but also the way you say it that matters.

***Pace***

If you speak really quickly and excitedly, the person listening to you will not be able to hear everything you say. If you keep hesitating or saying ‘um’ or ‘er’ It makes it harder for people to concentrate on what you are saying. If you speak at a steady pace, however, you will be able to deliver your message more clearly and the other person will be able to hear every word you say.

***Proximity***

The space around a person is called their personal space. In a formal situation, such as a doctor talking to a patient, the doctor does not sit close to the patient to invade their personal space. In an informal situation, people who are friends or intimate with each other will often sit closer to each other. People usually sit so they are eye-to-eye if they are in a formal or aggressive situation. Sitting at an angle to each other creates a more relaxed, friendly and less formal feeling.

***Written communication***

Health workers need to be able to communicate well with the written word. This could be by writing something themselves, such as a letter to refer a client to a different service, a record of a person’s condition and treatment or a prescription. This means they need to be able to use different ways of presenting information, such as letters, memos, emails, reports or forms. They need to make their meaning absolutely clear and structure the information well and in an appropriate manner so those mistakes do not happen. It is also necessary to use grammar, spelling and punctuation correctly. Handwriting should also be legible so that the person the information is intended for can actually read it. It is also important that the language used is appropriate. Health professionals should not use a lot of technical words, acronyms or jargon if they are writing to someone who will not understand it. They should read information provided by other health workers thoroughly. They need to be able to identify the main points and be able to find other information from a wide variety of source. They also need ICT skills to update and access information.

**Knowing the Barriers of Communication**

Effective communication, including active listening, can be hard work, people who work in health care environments tend to enjoy learning about other people and their lives. Things can go wrong, however, if:

* The context is wrong e.. the surrounding are unsuitable due to lack of privacy;
* The service provider and service user are mismatched. Sometimes communication breaks down because of factors such as age, education level, gender and ethnic background.
* A person withholds information because they fear being judges, example e.g. because they have taken illegal drugs or procured an abortion;
* A person fears that confidentially will be broken even through this should never happen, e.g. about their sexual orientation.
* The service user thinks that the advice given is too vague and has not asked for clarification.
* The subject matter is embarrassing such as talking about sex or intimate body parts.
* A person fears they are going to hear bad news so avoids going to a service provider until it is too late to help.

If health workers do not develop good communication skills, the effectiveness fo their work will be affected and things can go wrong. This will not help service users feel good about themselves, leading to negative consequences. Remember, it is important to overcome problems such as those listed above, communicate effectively, including checking understanding, so that you get the best out of your interactions with colleagues and service users.

**MODULE 10: HEALTH SECTOR POLICY AND REFORM**

**10.1 Aim of Health Policy and Reforms**.

Health Policy refers t decisions, and actions that are undertaken to achieve specific health care goals within a society. The purpose of a broad public health policy is to protect the health of populations. According to the World Health Organization (1978), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. WHO has further proclaimed that “the health of all the people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states” and the enjoyment of highest attainable standards of health” is one of the fundamental rights of every human being.

On attaining independence, the government committed itself to providing free-health services as part of its development strategy to alleviate poverty and improve the welfare and productivity of the nation. The aim of the health sector policy and reforms is to develop and expand health services and facilities in terms of spatial coverage, training of personnel and tertiary health care delivery services.

**10.2 Health Indicators**

The health status of the population can be assessed by a number of indicators including infant, child and maternal mortality and morbidity rates, crude death rate, life expectancy at birth, and the number of medical staff and facilities available per unit of population. These are the basic indicators of a country’s health, socio-economic situation and quality of life.

***Infant Mortality Rate***

Infant mortality rate is the probability of dying between birth and exactly one year of age, expressed per 1,000 live births. Under-five mortality rate is the probability of dying between birth and exactly five years of age, expressed per 1,000 live births.

***Life Expectancy***

Life expectancy at birth is the number of years a new born infant would live if prevailing factors of mortality at the time of birth were to stay the same throughout the child’s life.

**Crude Birth and Death*Rates***

Crude birth rate is the number of births per 1,000. Crude death rate is defined as the numbers of deaths per 1,000 and is calculated as follows:

Crude death rate = Number of death x 1000

Estimated midyear population

Both crude birth and death rates are important determinants of population size. An increase in crude birth rate may lead to an increase in population size if the crude death rate remains constant.

***Fertility Rates***

Total fertility rate is the number of children a woman would have by the end of her childbearing years if she were to pass through those bearing children. Analysis of fertility rates plays an important role in determining population growth rate, which in turn help in planning for social provisioning.

***Nutritional Status***

The nutritional well-being of young children reflects household, community and national investments in family health and contributes in both direct and indirect ways to the country’s development. The nutritional status of children is summarized using anthropometric indices (height and weight) which reflect past deprivation.

Malnutrition is a major source of ill health and premature death. Undernourished people are those whose food intake is insufficient to meet their minimum energy requirements. Stunting (insufficient height for age) is an indication of cumulative deficient growth linked to long term deprivation of both food and no-food requirements. Wasting (insufficient weight for height) associates with short-term deprivations charges rapidly and is sensitive to acute food deprivation and morbidity. Low weight for age indicates chronic and acute under nutrition.

**10.3Structure of the Health Care System**

The level of a nation’s development depends upon the economic and social conditions and the extent and quality of health service provided to the population. Therefore, the health care we have today is a result of policies made some years ago. The development of health care system in Kenya goes back to the pre-colonial era.

In 1901, a medical department was created as one of the evil departments of the central administration. This was the first step toward establishment of colonial medical organizations supported and controlled by the state. In 1903, medical administrators were request, first, to preserve the health of the European Community, second, to keep the African and Asiatic labour force in good working condition and third, to prevent the spread of tropical disease.

Medical education in Kenya started in 1967 when the University Of East Africa establish a faculty of medicine at University College, Nairobi, which in 1970 became the university of Nairobi. After independence, Kenya inherited a three-tier health system in which the central government provided service at district, provincial and national levels; missionaries provided health services at sub-district levels; and local government provided services in urban areas. This system operated until 1970 when the government established a system of comprehensive rural health services in which health centers become the focal points for comprehensive provision of preventive, promotive and curative services.

Today, alongside government services, non-profit and FBOs organizations and NGOs provide health services at delivery points that range from dispensaries to hospitals. The government’s health care delivery system is pyramidal, with the national referral facilities at Kenyatta National Hospital (Nairobi) and Moi Teaching and Referral Hospital (Eldoret) forming the peak, followed by provincial, district and sub-district hospitals, with health centres and dispensaries forming the base.

**10.4 Health Policies and Objectives**

The main mandate of health system is to ensure that the people enjoy long lives that are relatively free from the burden of disease and ill Health. Health policies and strategies are aimed at reducing incidence of diseases and improving the health status of Kenyans. Health policy in Kenya revolves around two critical issues, namely: how to deliver a basic package of quality health services to a growing workforce and their dependents and how to finance and manage those services in a way that guarantees their availability, accessibility and affordability to those in most need. The overall goal of the government is to promote and improve the health status of all Kenyans by making all health services more effective, accessible and affordable.

In all its development and sectoral plans, the government’s main objectives for development of health services since independence have been:

* Strengthening and carrying out measures for eradication, prevention and control of disease. Such measures include protection of the environment against health hazards, vector disease control, immunization against disease, early detection and treatment of diseases and health education.
* Provision for adequate and effective diagnostic, therapeutic and rehabilitative services for the whole population at hospitals, health centres, dispensaries and mobile units;
* Promotion and development of biomedical and health services’ research as a means of identifying improved and cost effectives methods for the protection of the health of the people.

The main health policies in Kenya include:

* Increasing coverage and accessibility of health services in rural areas;
* Further consolidating urban and rural curative and preventive and promotive services;
* Increasing emphasis on maternal and child health and family planning services in order to reduce morbidity, mortality and fertility.
* Strengthening Ministry of Health management capacities with emphasis at the county level;
* Increasing inter-ministerial coordination of health service delivery ; and
* Increasing alternative financial mechanisms.

The Ministry of Health is the main provider of health services in the county. It has the following functions:

* Formulating and implementation of a national health policy;
* Preparing and implementation of national health development;
* Organization and administration of central health services;
* Development of health and regulations;
* Training of health acts and allies personnel;
* Promotion of medical science and maintenance of medical and health standards;
* Liaison and coordination with other government departments and NGO agencies; and
* Internal health regulations.

**10.5 Health policy and the Constitution of Kenya 2010**

The constitution of Kenya 2010 provides an overarching conducive legal framework for ensuring a comprehensive and people-driven health service delivery. It provides for a right base approach to health whereby every person has the right to the highest attainable standards of health. It further indicates that a person shall not be denied emergency medical treatment and that the state shall provide appropriate social security to persons who are unable to support themselves and their dependents.

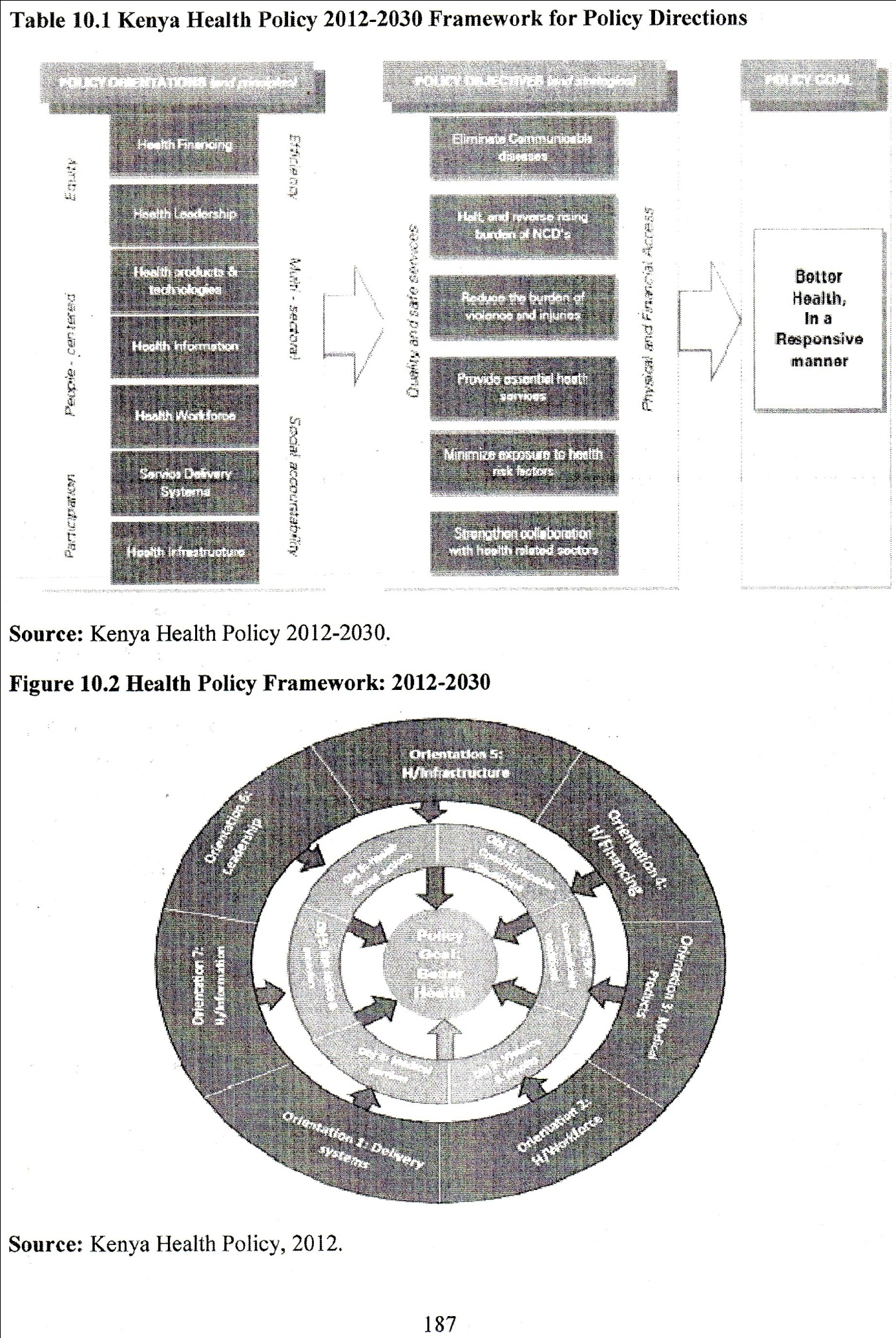
The constitution single out health care for specific group such as children and persons living with disabilities. In addition, the underlying determinants of the right to health such as adequate housing, food, clean safe water, social security and education are also guaranteed in the constitution. The current Health Policy therefore seeks to make the realization of the right to health by all Kenyans a reality.

**10.6 Kenya Health policy Framework 2012-2030**

This Kenyan Health policy 2012-2030 represents the government’s commitment towards improving the health of the people of Kenya by significantly reducing ill health. The policy defines the health goal, objectives including strategies, guiding principles and orientations aimed at achieving the health agenda in Kenya.

The Kenya Health Policy 2012-20130 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government’s health goals. The policy is aligned to Kenya’s vision 2030 (Kenya’s national development agenda), the constitution of Kenya and global health commitments and uses a three-pronged framework (comprehensive balanced and coherent) to define policy direction as shown in **Figure 10.2**.

The goal of Kenya Health Policy 2012 – 2030 is ‘*attaining the highest possible standard of health in a manner responsive to the needs of the population*’. The policy focuses on six objectives and seven orientations to attain the overall government’s health goals. The implementation of the policy will be done through five –year medium-term strategic plans.



.

Policy Objectives

1. Eliminate communicable conditions
2. Halt and reverse the rising burden of non-communicable conditions
3. Reduce the burden of violence and injuries
4. Province essential health care
5. Minimize exposure to health risk factors
6. Strengthen collaboration with other sectors that have an impact on health.

Policy orientations

Policy orientations define ‘how’ the health sector will organize itself to facilitate attainment of the health objectives. The orientations are organized around the following Health system Building Blocks:

1. Service delivery systems: How health service delivery will be organized;
2. Leadership and governance : How health service delivery will be managed;
3. Health workforce : The human resources required for the provision of health services;
4. Health financing : The systems needed to ensure adequate resources for service provision;
5. Health products and technologies: The essential medicines, medical supplies, vaccines, health technologies and public health commodities required in provision of survives;
6. Health information: systems for generations, analysis, dissemination, and utilization of health related information;
7. Health infrastructure: The physical

**MODULE 11: LAW AND ETHICS IN HEALTH CARE**

**Health Professionals Legal Responsibilities**

Patients have the right to receive considerate and respectful health care. It is the health care provider’s legal and ethical responsibility to know and respect the patient’s rights. Professionally health care workers have specific legal responsibilities that regulate their particular professions. Adhering to legal regulations is vital for the health care worker’s own protection, the protection of employer and more importantly, the safety and well-being of the patient. Failure to observe legal and ethical obligations leads to negligence or malpractice.

**Medical Negligence**

Medical negligence, according to Mosby’s Medical Dictionary (8th edition), can be defined as the commission of an act that a prudent person would have done or the omission of duty a prudent person would not have done or the omission of a duty that a prudent person would have fulfilled, resulting in injury or harm to a patient.

**Medical Malpractice**

Medical malpractice means bad, wrong or injudicious treatment of a patient professionally which results in injury, unnecessary suffering or death. Malpractice and negligence may occur through omission of necessary act as well as commission of an unwise or negligent act. This may be in the form of misdiagnosis, wrong decisions and treatment, prescription errors and medical or surgical complications, all of which may result in suffering, permanent injury or death.

**Regulation**

In Kenya, medical, nursing and midwifery practices are regulated by statutory authorities, including the Medical Practitioners and Dentists Board, the Nursing Council of Kenya, the Clinical Officers Council and the Pharmacy and Poisons Board. These bodies are obliged to protect members of the public by ensuring that medical practitioners including dentists, nurses and midwives, clinical officers and pharmacists are properly qualified that they perform their services to patients with skills and diligence and observe at all times high moral and ethical standards. Health care professional are expected to know and follow the laws regulating their profession, license or registration.

**Applicable laws**

Legal responsibilities in the health sector are interpreted through civil or criminal law Civil law deals with legal relationships between people and protection of a person’s rights. Criminal law deals with wrong against a person, property or society, practicing without the required license, theft and murder among others. Many of the wrong doing in health care are civil wrongs. However, they can lead to legal action.

**Compliance**

The following are basic guidelines on how to comply with appropriate laws and procedure:

* Protect the patient from exposure (heat or cold);
* Knock and pause before entering a room;
* Draw curtains or close door when providing care;
* Leave while visitors are with the patient;
* Do not listen when patients make phone calls;
* Abide by the rules of confidentiality;
* Do not discuss the patient’s condition with anyone outside of work;
* Be aware of your surrounding and not discuss a patient within areas others could overhear (lifts, cafeteria, corridors, parking lot, etc.

**Privileged Communication**

All information given to health personnel by a patient is considered privileged communication, and by law must be kept confidential. However, certain information is exempt by law and must be reported. This includes:

**Births and deaths**

* Injuries caused by violence requiring police intervention (assault and battery, abuse, stabbings):
* Drug abuse
* Chronic diseases

**Health Care Records**

* Belongs to the health care provider;
* Patient has right to obtain copy of any information in record;
* Can be a legal record in court of law;
* Must be properly maintained, kept confidential and maintained for amount of time required by state.
* When destroyed after permits, must be burned or shredded to maintain confidentiality.

**Patient Instructions**

***Advance directives***

These are a patient’s instructions, usually relating to end-of-life issues regarding what measures should or should not be used to prolong life if their condition is terminal e.g. CPR, ventilator, feeding tube etc. advance directives frequently results in a ‘ do not resuscitate” (DNR) order. Advance directives are legally binding documents. They must be signed when the individual is competent and witnessed by two adults who will not benefit from the death.

There are two main types of advance directives:

1. **Durable Power of Attorney (POA) for health care**

This is a document permitting an individual (principal) to appoint another person (agent) to make any decision regarding health care if the principal is unable to make those decisions. Usually POAs are given to spouses or adult children or another adult. The POA must be signed by the principal, agent and two adult witnesses.

1. **Living will**

This is a document allowing individuals to sate what measures should or should not be used to prolong life if their condition is terminal e.g. CPR, ventilator, feeding tube e.t.c.

This frequently results in a “do not resuscitate” (DNR) order

**Professional Standards and Code of Contact**

Professional standards help meet legal responsibilities, ethics and patients’ rights. By following certain standards at all times, the times, the health care worker can protect themselves, their employer and the patient. Some of the basic standards are:

1. Perform only hose procedures for which you have been trained and are legally permitted to do (scope of practice);
2. If asked to perform procedure for which you are not qualified, decline;
3. Use approved, correct methods while performing any procedure;
4. Follow procedure manual;
5. Obtain correct authorization before performing any procedure;
6. Identify patient and obtain consent before performing any procedure;
7. Check wrist band if available: State patient’s name clearly and repeat if necessary ask patient their name and birth date;
8. If patient refuses, do not perform procedure;
9. Obtain written consent where needed;
10. Observe all safety precautions;
11. Keep all information confidential;
12. Think before you speak and watch everything you say;
13. Treat all patient equally;
14. Accept no tips or bribes for care;
15. If error occurs or you make a mistake, report it immediately to your supervisor;
16. Behave professionally in dress, language, manners and actions.

Table 11.1. Forms of Civil Wrong in Health Service Provision

* Ordering side rails left down and patient falls from bed
* Using or not reporting defective equipment that injures patient
* Patient develop infection from poor sterile
* Patient burned from bath water that was too hot

**Description**

Negligence

**Type**

Assault and battery

* Assault – threatening to injury
* Battery – unlawful touch of another without their consent

Undertaking procedures without obtaining written or verbal consent- giving an injection, taking a blood pressure, drawing blood for a lab test, starting an IV, performing physical exam; surgery, invasive diagnostic tests, treatment of minors

Failure to obtain informed consent

Unnecessary exposure of an individual or revealing personal information about an individual without consent.

Examples: Exposing a patient while transporting them to x-ray; sending information to a medical insurance company without patient’s permission; informing third parties of patient’s condition without permission

Invasion of privacy

Restraining a patient or restricting their freedom

Examples: Applying side rails without a doctor’s order and a patient’s permission; placing patient in restraints without order or permission; keeping a patient hospitalized against their will.

False imprisonment

Any care that’s results in physical harm, pain or mental anguish. Types:

* Physical-hitting, forcing persons against their will, restraining movement, depriving food or water
* Verbal –speaking harshly, swearing or shouting, writing threats or abusive statements
* Psychological-threatening harm, denying right, belittling, intimidating
* Sexual- any unwanted sexual touching or act, sexual gestures or suggested sexual behaviour

Abuse

False statements which may damage a person’s reputation. Two types:

* Slander – information is spoken. Example: Starting a person has a drug problem when another medical problem exists.
* Libel – information is written

Example: Sending inaccurate lab results for a commission of inquiry

Defamation

**Students Activity**

Identify the type of civil wrong committed under each of the following fictions scenarios. Denial of information, action without action consent, malpractice, medical negligence.

Table 11.2. Civil Wrongs

|  |
| --- |
| **Activity Action** |
| Denial of Failure to explain the nature of illness or injury and the modality of  information treatment and its consequences. In particular, there was inadequate  Information given to the patients before and after surgery |
| Sterilization a mother of three was admitted with abruption placenta at a Mission  without consent Hospital where she was letter taken to theatre for Caesarean Section  (CS) and, unknown to her, bilateral tubal ligation was carried out.  She had not consented and was not informed of the latter |
| Doctor attended to A woman was admitted at a public District Hospital in early labour  Patient while drunk She had previously delivered by CS and so was asked to sign consent  for repeat CS which she did. However a doctor who was drunk saw  her in the Labour Ward and asked her to begin pushing the baby,  without any success. He then tried unsuccessfully to apply forceps.  By the time she eventually was taken to the operating thetre her  uterus had already ruptured, the baby had died, and she  subsequently developed difficulty in controlling urine (vesico  Vaginal Fistula). She had not conceived since then and she could as  well have had a hystereconony done. |
| **Activity Action** |
| Forgotten foreign A relative told of the case of a woman who had CS performed by a  Bodies after doctor during which an abdominal pack was (accidentally) forgot  Surgery |
| Failure to apply Another case was that of a single mother of two delivered normally  standard at a health centre (level 3). An episiotomy had been performed and a  proceduresa swab left in the vagina which should have been removed after a  few hours. However, the patient was not informed about it and the  swab was left in for two weeks. By that time infection had set in and  she had also developed faecal incontinence (RVF). She is now  ashamed of her condition and has not mentioned it to anyone except  her mother. It is possible that she suffered rectal injury when the  episiotomy incision was made. |
| Doctors refused to A mother of three was admitted to a public district hospital in labour  come to the labour where she remained for 48 hours without delivery mainly  hospital when because the only doctor who could do a CS refused to come. When  summoned eventually the doctor came she was taken to thetre, delivery of a very  depressed child who breathed after prolonged resuscitation, nut the  mother died on the table. The child is now intellectually handicapped. |
| Failure to provide An HIV + woman was admitted at a public district hospital with  prescribed medical rapturemembranes. Her husband, also HIV positive, told the staff  care that they have been advised by another doctor that the delivery  should be by Cs, but this was declined. Besides, she was not given  ARV therapy as instructed in the PMTCT guidelines. Instead, she was  allowed to have a prolonged labour, delivering a fresh stillborn child. |
| Failure to give an A primigravida at term was admitted in a private hospital where she  Essential had made several antenatal visits. Her labour was uneventful,  Prophylaxis delivery a healthy male child. However, although she had been  informed at the same hospital that she was Rhesus Negative she was  not offered a standard vaccine, anti-D gamma globulin to protect  against Rhesus iso-immunisation. In addition, she was not advised  what to do in case of a subsequent pregnancy. |
| Hysterectomy A woman with dwarfism (possible achondroplasi) was diagnosed  performed without with uterine fibroids at a provincial hospital and advised she needed  consent on a an operation to remove the fibroids. She was taken to theatre but  disabled personafterwards was not told what had been done. When three weeks later  she realized that a hysterectomy had been performed she sought  explanation from the doctor wondered aloud if in her condition she  rally expected to get a baby! |
| **Activity Action** |
| Hysterectomy A married woman of four girls had hope that a boy would come  performed in a someday. She was seen at a provincial hospital complaining of  woman diagnosed abdominal pain, where an ovarian cyst was diagnosed and confirmed  with an ovarian by an ultrasound scan. She was advised to undergo an operation in  cyst order to remove the cyct; at no time was possibility of hysterectomy  mentioned. She discovered this on her own when she read the  discharge summary which stated that the uterus had a fibroid and a  hysterectomy was performed. |
| Hysterectomy A woman in her first pregnancy was under care of a private  performed possibly obstetrician who was her several times during pregnancy. When she  because of went two weeks past the due date, he admitted her at a private  intractable post- hospital for induction of labour, but for three days labour did not set  partum in. However, when labour started on the fourth day her doctor was  haemorrhage nowhere to be found. It was not until the next day that he appeared in  the middle of the night and attempted to deliver her by vacuum  extraction, but this was abandoned because there was a lot of bleeding.  She was then taken to theatre and CS was performed. She gave birth to  a baby boy weight 4kg. when she was returned to the ward, the  bleeding continued and had to be returned to theater again, but was  not told what was done there. Details of operations done on her were  only made known to her husband when he went to clear the bills. And  then it was not until three months later that her husband actually  informed her of the loss of her uterus. After some years, her husband  left her for another woman to have more children. |

**Policies and Procedures**

Health care workers must be familiar with their employer’s policies and procedures. Policies and procedures are the guidelines that provide information about employment terms, work place procedure, quality control e.t.c. technical procedures tell you how to complete tasks the way your employer then done. There may be procedures for the following:

* How to take a temperature
* How to give an enema;
* How to fill out forms;
* How to package and wrap trays
* Standard operating procedures;
* Treatment protocols

These guidelines assure that the health care worker performs their jobs correctly. It is important to always follow a health facility’s policies and procedures. Doing this protect your patients, co-workers, employer and yourself.

**11.2 Ethics Issue and Theories in Modern Health Care**

Ethics is a set of moral principles and a code for behaviour governing an individual’s action with other individual and within society. Ethics is a critical reflection about morality- what is believed to beright and good. Medicine and technology are rapidly changing and offering choices to healthprofessionals. Although challenging and even exciting, the choices can be difficult. For example, should medications known to be effective be withheld from a patient because it is thought they are incompetent or do not have the means to store or manage the medication properly?

In modern health care and research, value conflicts arise where there often appears to be no clear consensus as to the “right thing to do”. These conflicts present problems requiring moral decisions that necessitates a choice between two or more alternative,

Examples:

* Should a parent have a right to refuse immunizations for his or her child?
* Does public safety supersede an individual’s right?
* Should children with serious birth defects be kept alive?
* Should a woman be allowed an abortion for any reason?

**Ethical dilemmas and theories**

***Ethical dilemma***

This is a value conflict with no clear consensus as to the “right” thing to do. It is conflict between moral obligations that are difficult to reconcile and require moral reasoning. Situations necessitating a choice between two equal (usually undesirable) alternatives. Modern health care technology has created many ethical dilemmas. For example:

* Assisted suicide- is it justified in certain patients?
* Stem cell research-should abortion fetuses be used?
* Should a patient be permitted to smoke marijuana if it eases pain or effects of chemotherapy?

***Deontology/Non-consequentialism Theory***

This is derived from the Greek word “Deon”, meaning duty. Under this theory, some acts are right or wrong independent of their consequences. The theory is used based on the concept of duty. It is premised on one’s obligation and on that basis seeks to determine what is ethical by answering the question. What should I do any and why should I do it?

|  |
| --- |
| **Illustration: Deontology: A duty** |
| Anita, a practitioner, believes she has a duty to give cardiac clients detailed information on the pathology involved in their condition even though the client has indicated that the are not ready or may be terrified to hear the information causing the client distress. |
| **Consequentialism Theory** |
| Also called Teleogical theory. Actions are determined and justified by the consequence of the act. Consequentialists consider all the consequences of what they are about to do prior to deciding a right action. This is also answers the question. What should I do and why should I do it? |
| **Illustration: Consequentialism: Action** |
| Had Anita respected the wishes of her clients, she would have given them only the information which would have been a benefit to them and not caused them undue stress. She would have been motivated by her desire to do good (beneficence), rather than her sense of duty. This would amount to deontological betrayal. |

**Utilitarian Theory**

Considers the greatest good for the largest number of people. Also answers the question: what should I do why should I do it? The problem with employing Utilitarian theory is determining who decides the definition of “greatest” and “good”.

**Intuitionism Theory**

Resolves ethical dilemmas by appealing to one’s intuition, a moral faculty of a person which intuitionism is in deciding whose moral position is more valid.

**Rights Based Theory**

This theory resolves ethical dilemmas by first determining what rights or moral claims are involved and take precedence. Consider the abortion debate, personal-mom vs., fetus/child, and societal-women’s choice vs. potential life of the unborn).

**Virtue Ethics Theory**

Contrary to other ethical theories, virtue ethics tells us kind of person one ought to be, rather than what they do. The focus is to character (goodness) of the person.

**11.3 Basic Rules of Medical Ethics**

* Put saving of life and promotion of health above all else;
* Make every effort to keep patient as comfortable as possible and to preserve life when possible;
* Respect patient’s choice to die peacefully and with dignity ( advanced directive);
* Treat all patients equally, avoid bias, prejudice and discrimination;
* Provide care for all persons to the best of your ability;
* Maintain competent level of skill consistent with occupation;
* Maintain confidentiality;
* Gossiping about patients is ethically wrong;
* Avoid immoral, unethical or illegal practice;
* Show loyalty to patients, co-workers and employer;
* Be sincere, honest and caring.

**Suggested Student Activities**

|  |
| --- |
| **Legal Responsibilities** |

1. As a future health care professional, how can you avoid a lawsuit?
2. Can you restrain a person against his or her will if it is for his or her own good?
3. Can you be used if you unintentionally leave a patient’s record open and visitor sees that the patient has a equally transmitted disease?
4. What should you do if you see another health care worker make a serious error?
5. What is meant by the statement; ‘it is easier to prevent negligence than it is to defend it?
6. Why malpractice is also called ‘professional negligence’? Who can and cannot be guilty of malpractice?
7. Could a dental assistant ever be guilty of negligence? Give example
8. What is the difference between assaults and battery?
9. In your own words, describe invasion of privacy.
10. What type of abuse do you think is the most difficult to provide in court? Why?
11. A teacher who was hospitalized sues a student’s nurse for defamation. What do you think might have happened?

**Medical legal puzzle**

**Across**

1. When false statement damage a person’s reputation

4. For example, a physical therapist treats a child without parental consent

1. For example, when a dentist writes a letter to a newspaper editor claiming that a patient is a big baby and never pays his bills.

7. False \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can be charged if a patient is restrained without proper authorization.

12. A wrongful act that does not involve a contract.

14. Informed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is permission granted voluntarily by a person who is of sound mind.

15. Malpractice is often described as bad \_\_\_\_\_\_\_\_\_\_\_\_\_\_ or professional negligence.

16. An example of abuse when a health care worker swears and shouts at patient.

17. For example, when a nurse tells the press something about a celebrity patient that is insulting and untrue.

**Down**

1. Any care resulting in physical harm, pain, or mental anguish.
2. Unnecessarily exposing an individual
3. For example, a doctor cuts into the bladder when removing the uterus.

8. A threat or attempt to injure

9. For example, nursing assistant used hot bath water and burned patient.

10. Invasion of privacy can be caused by revealing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_information about a patient

11. Type of informed consent required for major surgery

13. Negligence occurs when that is \_\_\_\_\_\_\_ expected is not given.

|  |
| --- |
| **Legal and Ethical Questions** |

1. What is a threat or attempt to injure? **Assault**
2. If a nurse assistant forgets to raise the side rails on the bed and the patient’s falls of individual’s profession, the physician could be guilty of: **Negligence**.
3. If a physician fails to use the degree of skill and learning commonly expected in that individual’s profession, the physician could be guilty of: **Malpractice.**
4. A person who is under the influence of drugs does not have the legal capacity to form a contract because he/she has a: **Legal disability**.
5. If a laboratory technician sends e-mails to co-workers saying that a particular physician is careless and killed a patient, the lab tech might be guilty of **Libel**.
6. What term describes the fact that information about a patient must remain private? **Confidentiality**.
7. Before you perform any procedure on a patient, you must have proper: **Authorization**.
8. What should you do as a health care worker does if you make a mistake? **Report it immediately to your superviso**r.
9. When can a health care worker accept a tip or a bribe? **Never**
10. What term describes a standard code of conduct for health professionals? **Ethics or Code of Ethics**
11. A nurse is helping a patient walk and jerks the patient by the arm, causing a bruise. The nurse may be guilty of: **Battery**.
12. What is permission granted voluntarily by a person who is of sound mind after the procedure has been explained in terms the person can understand? **Informed consent**.
13. If a health care worker makes false statements about a patient that cause the patient to be damaged or ridiculed, the health care worker may be guilty of: **Defamation (or slander)**.
14. Speaking harshly, swearing or shouting and using inappropriate words to describe a person’s tribe or nationality are all examples of what kind of abuse? **Verbal.**
15. What kind of contact exist when a nurse is holding a thermometer and says “put this under your tongue” and the patients puts the thermometer under his or her tongue? **Implied contract**.
16. If I have the legal capacity to sign a consent form, I must be: 18 years-old and mentally competent. **(Free of legal Rights).**
17. What patient’s right document applies to persons in long-term care facilities? **Resident’s Bill of Rights**.
18. A document that a person signs to indicate he/she does not want to be resuscitated when he/she stops breathing is a: **Living will**.
19. Health care records are examples of: **Priviledge communications**.
20. What is an example of physical abuse? Hitting, forcing people against their will, e.t.c.
21. Keeping someone in the hospital against their will could be an example of: **Forced imprisonment.**
22. Jane’s father signs a document saying that Jane will make decisions for him once he is unable to make decisions. The document is a:**Durable Power Attorney**.
23. According to professional standards, before a health care worker performs any procedure on a patient, the health care worker should: Identify the patient and/ or obtain the patient’s consent.

|  |
| --- |
| **Patient’s Right and Duties** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Circle the correct answer** | |
| 1 | Patients have the right to know whether medical treatment is experimental | True | False |
| 2 | Patient have the right to smoke in the hospital | True | False |
| 3 | Patient duties imply that they should give a physical all information that may be pertinent to their case, even if this information is strictly personal | True | False |
| 4 | Patients are entitled to receive explanations for medical treatment in order to give informed consent | True | False |
| 5 | Patients have the right to ignore? Or have the duty to follow physician orders | True | False |
| 6 | All patients have the right to confidentiality | True | False |
| 7 | Patients may examine their bills, but cannot expect to have them explained due to the many extraneous charges that are accrued | True | False |
| 8 | Patients have a duty to considerate and respectful to health providers? | True | False |
| 9 | Patients who are hospitalized cannot expect consideration of privacy due to the intimate nature of many exams and producers. | True | False |

Answers

1. True 2. False 3. True 4. False 5. False 6. True 7. False 8. False 9.

**MODULE 12: HEALTH INFORMATION SYSTEMS**.

***12.1 Health Information System (HIS)***

Health Information systems refers to any system that captures, stores, manages and transmits information related to the health of individuals or the activities of organizations that work within the health sector. This definition incorporates national, county, sub-county and health facility level routine information systems, disease surveillance systems and also includes laboratory information systems, hospital patient administration systems (PAS) and human resources management information systems (HRMIS).

Sound and reliable information is the foundation of decision-making across all health system building blocks. It is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, services delivery and financing. The health information system provides the underpinnings for decision-making and has four key functions.

* Data generation;
* Compilation;
* Analysis and synthesis; and
* Communication and use.

The health information system collects data from health and other relevant sectors, analyses the date and ensures their overall quality, relevance and timeliness and converts the data into information for health-related decision –making.

**12.2 Objectives of HIS**

An efficient health information system seeks to ensure that users of health information have access to reliable, authoritative, usage, understandable and comparative data. The key users of health information policy-makers, planners, managers, health-care providers, communities and individuals.

The broad objectives of HIS are to:

* Provide data for monitoring and evaluation;
* Provide an alert and early warning capacity;
* Support patient and health facility management;
* Enable planning;
* Provide a basis for research;
* Facilitate health situation and trends analyses;
* Facilitate reporting, and reinforce communication of health challenges to diverse users.

**Student Activity.**

1. Identify the various types of health information.
2. What are the correct sources the information you have identified in (1) above?
3. How can the information be collected and by who?

***12.3 The need for Strong Health Information Systems***

Sound and reliable health information;

* Is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, services and financing.
* Gives a clear picture of health and sickness at all level of society-individual, household, community, county, country, regional and global.
* Leads to better decisions and better spending.
* Makes it easier to track and confront threats to health at all levels.

***12.4 Health Sector Information Needs***

Health professionals and health workers that deal with health issues everyday need to have essential information that can be used for day-to-day management or long-term planning.

The different kinds of information need include:

1. ***Health determinants*** – socioeconomic, environmental, behavioural and genetic factors) and the contextual environments within which the health system operates;
2. ***Inputs to the health system and related processes*** – policy and organization, health infrastructure, facilities and equipment, costs, human and financial resources and health information system;
3. ***The performance or outputs of the health system*** – availability, accessibility, quality and use of health information and services, responsiveness of the system to user needs, and financial risk protection;
4. ***Health outcomes –*** mortality, morbidity, disease outbreaks, health status, disability and wellbeing; and
5. Health inequities – determinants, coverage of use of services, and health outcomes, and including key stratifies such as sex, socioeconomic status, ethnic group and geographical location.

**12.5 Components of a Health Information System**

A country’s HIS is made up of all the data and records about the population’s health. The source of data include civil and vital registration (recording births, deaths and causes of death) censuses and surveys, individual medical records, service records and financial and resources tracking information.

A health system comprises of three components: inputs, processes and outputs.

**Inputs**

Inputs or resources are the physical and structural prerequisites of an effective HIS. They include the ability of those responsible to lead and co-ordinate the process; the existence of necessary laws and policies; financial resources and people with the necessary skills to do the work and the infrastructure- everything from office space and desks to filling systems and computer networks.

**Processes**

The processes used by an HIS include:

* Indicators – a set of measures that show changes in health profile;
* Data sources – an integrated HIS brings together data from a variety of sources;
* Data management needs enable easy access to relevant information for those who need it, while protecting the privacy of individual patients;

**Outputs**

The information produced – the HIS outputs – should be relevant, accessible, and useful; evidence for decision making.

* Information products are collated from a range of sources, and synthesized into usable statistics that can be analyzed and compared;
* Dissemination and use. Through widespread dissemination and use of information products, the HIS provides directs benefit to all those who participate in it, providing an ongoing incentive for users to continue to strengthen the system.

**Figure 12.1: Components of a Health Information System**

* **HI**S **resources**

1. There are several physical structural requirements that need to be put in place

Legislative regulatory & planning frame work.

- Personnel, financing, logistic support, it and communication systems

Resources include everything the system needs form office suppliers to computer system, the staff and their capabilities, and the policies that allow the system to operate.

- Each country’s HIS needs to be designed to make use of the resources that are available and to best meet the country’s needs

WHO has produced a compendium of standard definitions and measurement issues for 40 key core indicators- World Health Statistics 2009. This is a good reference for developing indicators.

1. **Indicators**

To monitor the system’s effectiveness, it needs measurable sets of data that reflect change over time

Indicatorsmeasure determinants of health, health system and health status.

- Indicators need to be valid, reliable, specific, sensitive and feasible to measure.

Population – based sources

- Population survey, civil registration, census.

-Institution-based sources individual records, resources record

1. **Data sources**

A combination of source, both periodic and continual, provides the best quality information most efficiently.

An integrated HIS pulls together data from a range of source, and integrates them into meaningful information products that can be readily accessed and used.

A’minimum dataset’ simplifies collection and improves the quality of data.

An ‘integrated data repository’ combines data from different sources and both collects and manages information, and enable wide distribution of data.

Once data has been collected and stored. It needs to be processed and compiled in such a way that the data can easily be compared and collated with information draw from other sources, so that data is not duplicated, mistakes are identified and corrected, and accuracy and confidence levels can be measured.

**4. Data Management**

- to get best collection, storage, quality –assurance, processing, compilation and analysis

**5. Information products**

- data transformed into information that can be used to by decision makers to improve health care

A cycle of value adding through compilation, analysis, interpretation, presentation influence and implementation results in a strengthened His and a more effective health system.

User dashboards, reports, queries, and alerts give ready access to the results of the value –added information resulting from the analysis of the data.

Country information can be made a core part of day –to-day management of health systems.

This can be achieved by placing a greater value on information collection, management and use

**6. Dissemination and use**

- The value of information is enhanced by being accessible to decision makers and by providing incentives for information use.

By connecting data production with its use, the HMN framework empowers all those who contribute to strengthening the system.

**Source : Health Metrics Network (2008).**

**12.6 Structure of Health Information System in Kenya**

The Kenya National Health Information system (NHIS) is comprehensive and integrated structure that collects, collates, analyses, evaluates, stones, disseminates health and health related data and information for use by all. The NHIS seeks to address such issues as partnership in data collection sharing, guidelines on data processing and data warehousing as well as instituting standardized mandatory reporting by all care providers (public and private) and quality in data management in the health sector.

The NHIS is composed of producers of health statistics including Ministry of Health, Kenya National Bureau of Statistics (KNBS), vital registration, private health institutions, research institutions and FBO’s amongst others.

Figure 12.2: Structure and Responsibilities in the National Health Information System

|  |
| --- |
| **NHIS**  The NHISCC is made up of representatives from senior level officers in the Ministry of Health, statistical constituencies and development partners. The role if the NHISCC is to provide technical advisory role for health and social welfare data management in close collaboration with other strategic partners including KNBS and Vital Registration. The committee ensures unified and timely data collection, collation, processing and dissemination.  **Committee**  **(NHISCC**) |
| The public should ensure that any vital events or other significant health occurrences in the community are reported to the responsible authorities. On the other hand the public is entitled to information on the Ministry’s performance through relevant publications or on specific special requests.  **General Public** |
| All health service providers in the private sector have a mandatory responsibility to submit their health data regularly including data on all diseases under surveillance.  **Private Sector**  **Non- governmental**  **organizations** |
| Non-governmental organizations are responsible for ensuring that all health facilities under their respective umbrellas adhere to the NHIS. In collaboration with the Ministry of Health and other partners, NGOs are expected to mobilize resources for NHIS and ensure efficient data and information management in all its satellite facilities.  **Ministry of Health – Roles by level** |
| **Communtiy level**  Every Community Unit (CU) should maintain and update its CHIS that shall be shared regularly with household members in a forum as stated in the health sector community strategy. The community health workers maintain registers recording daily activities and reporting regularly to supervising health facility. |
| **Health facility**  Sub-county has an oversight responsibility to manage all health and health related data from all service provides within their area of jurisdiction.   * It provides technical, materials and financial support to all service providers in HIS. * Creates and maintains a data repository. * Collaborates and work in partnership with other statistical constituencies at the sub-county level to build one HIS. * It should collate, analyse, disseminate, use health and health related data from all health facilities/providers and give feedback to all health care providers in addition to submitting the same to MoH.   Health facilities Unit (UN) update HIS data which include records, filing system(s) and registry for primary data collection tools such as registers, cards, file folders, summary forms such as reporting forms, CDs, electronic backups safeguarded from any risks e.g. fire, floods, access by unauthorized person, etc.  Every health facility summaries health and health related data from the community and health facility, analyse, disseminate and use the information for decision-making, provide feedback then transmit summaries to the next level.  **Level**  **Sub-county level** |
| The MoH have oversight responsibility to manage all health related data from all service provides.   * Provides technical, materials and financial support to all counties and service providers in HIS. * Develops guidelines and formulates policies. * Coordinates development of minimum data sets and requirements of health sector. * Collates, analyse, disseminate and use health and health related data from all counties and services providers and provide feedback to all. * Creates and maintains a national data repository. * Collaborates and works in partnership with other statistical constituencies at the national to build one HIS.   **MoH** |

**12.7 Sources of Health Information**.

A reliable country/county health information system provides the best source of relevant timely and credible health information.

**Table 12.1 Sources of Health Information**

**Type of Information Source.**

Population based

Census, household survey, specials studies, civil/vita registration systems.

In information

Outline service statistics, national health accounts, and electronic medical records service

Health service

Information

Financial information system, human resource information system, logistics and supplies information system, service statistics system, electronic medical records system, pharmaceutical procurement.

Health management

Information

Special health information

Academic, research institutions and international organizations for research and survey findings.

MODULE 13:

13.1 **PROJECT MANAGEMENT**

Project management is a methodical approach to achieve agreed upon results within a specified timeframe with available resources. It involves applying knowledge, skills, tools, and techniques to a wide range of actives in order to meet the requirements of a project. The focus of project management is to meet the expectation of a project in order to fulfill the needs that have been identified by the people. Project management is accomplished through managerial process of planning , organizing , controlling , lead and motivating human resources to identify resources requirements , establishing clear and achievable objectives , balancing the competing demands for quality , scope ,time and scope and adapting the specifications , plans , and approach to the different concern and expectation of the various stakeholders to generate outputs (deliverables) . Project management is often an importance role for health managers / supervisors. The concept, method and tools describe in this module are an important part of a supervisor’s repertoire.

13.2**. Principles and concept of projects Management**

**Clearly Define Goals**

A goal is an end point to be achieved by caring out a project. Every project should have a clear end point expressed in writing as part of the contents of projects documents. The project goal is during the design stage.

**Consistency**

For any project to succeed, one should keep focused to an end goal. It is important to use various tools to ensure success of the project. This includes schedules, tasks list and budgets to keep the project on track. This ensures adherence to the phase of the project cycle (13.4). This principle stipulates adherences to the phases of project cycle and a well- informed decision – making process.

**Effective Stakeholder Management**

Stakeholder involvement in project management involves the use of participatory planning workshops at key phase of the project cycle and the formulation of the project purpose in terms of sustainable benefit to be delivered to beneficiaries. Stakeholders can contribute their expert knowledge; offer their political endorsement which is essential to the success of the project, provide access (to power, influential people and or resources).

**Effective planning, Design and control**

**P**rojects are delivered under constraints of time, cost, scope and quality of uncertain environment. Therefore, projects must be designed with the end (or goal) in mind and involvement stakeholders so that control is possible. This will ensure sustainable benefits.

**Effective Change Management**

In a project, set up change is unavoidable. A fixed approach needs to be maintained to absorb any change that may rise but also not divert completely from the initial plan and intended project objectives. Change management is an approach to shifting or transitioning individual’s team and organization from a current state to a desired future state. It is an organizational process aimed at helping stakeholders to accept and embrace change in their environment. In some projects management contexts, change management refers to a process wherein change to a project are formally introduced and approved. Change management uses basic structure and tools to control any organizational change effort. The goal is to maximize benefits and minimize the change impacts on workers and avoid distractions.

**Sustainability**

**T**here should be aspects incorporated for sustainability of the project within the plan at the project stage. Sustainable development is developed that meets the needs of the present without compromising the ability of future generation to meet their own needs. In other words, it ensures that today’s growth does not jeopardize the growth possibilities of future generation.

The lecturer should ask the student some of the questions that one should ask in the design phase to ensure that the project is sustainable.

13.3 **Project planning and design**

Project planning is the process of developing and maintaining or adapting a project plan that provides support details to the project definition in terms of resources, time, cost, scope and quality plan and schedules. It is about construction a statement that indicates why, what, who, when, where, how much, what standards and so that. The major inputs to project planning process are the scope statement, environment factor analysis, which includes political, economic, technical, social culture and technological factors and a good understanding of the resource requirement for the proposed activities the main output for project planning is the project management plan. The planning phase involves scheduling of time, costing and budgeting and risks management. This is a very critical stage of any project

**Importance of project planning and design**

**Cost – effectiveness**

Project management provides a roadmap for the journey of success. It is the greatest resource that allows the manager to understand available resource s and their use. Thus with a plan in hand, it is easy to utilize the resource in in the best possible way. Project planning, prior to launching a project, identifies irrelevant costs, reduces wastage of wastage of resources and thus ensures cost – effectiveness in the longer run.

**Better productivity**

Project management keeps the quality of products and service in constant check thus ensuring better productivity in terms of quality and quantity. This not only helps the organization in earning goodwill for a lifetime but also promises customer satisfaction. Trustworthy quality of products and service is intended to retain existing clientele and attracting new ones.

**Minimization of risks**

Every organization face risks of loss for various reasons. However, identify risks and solution is easier with a strategy. This maintains stability in the work. By planning and analyzing a project manager can mitigate risks and be a part of fair competition. Project management helps in identifications of loopholes and be potential threats. Once these are singled out the management can then take decision to change strategies to minimize risks that can negatively affect productivity.

An organization can prepare a risks management plan detailing how to deal with the various risks that they may encounter during project implementation. For example during the implementation of the project one of the common risks is that there may be lack of technical capacity of implementing organization to manage project resources efficiently and effectively. Therefore during the planning phase standard and regulation should be formulated. These standards and regulation should focus on capacities of the organization the requirement and actions necessary where such requirements and capacities are not met-

**Accomplishing predetermined goals**

Every viable organization has goals and objectives which allow the organization institution to fulfill its mission. Project management is the key tool for achieving predetermined targets in a structured way. It decides the strategy that will be used to reach the quickly. It is a structured way of getting to your objectives

13.4 **Project Cycle Management**

The project cycle is a way of viewing the main elements that projects have in common and how they relate to each other in sequence. The precise formulation of the cycle and its phases varies from organization to organization. There is no standard cycle although the basic comments are discussed below.

Project cycle management is the systematic process of programming, project identification, project appraisal, financing implementing, monitoring and evaluation. It is used to guide management activities and decision making procedures during the life – cycle of a project from start to end. It involves regulating and supervising various activities undertaken at each phase of the project cycle.

**Figure 13.1The project cycle**

**Programming / Project concept**

**T**his is the establishment of the general intervention strategy. This is the stage where the media regarding the required intervention in a specific area is identified i.e. the problem tube addressed is identified. The idea may be identified through several interaction including focus group discussion, brainstorming and problem inventory analysis, among others.

In the public identification phase, ideas for project and other development action are identified and screened for further study. This involves consultation with the intended beneficiaries of each action, an analysis of the problems they face (give the aspiration) and the identification of option to address these problems. Decision should be made on the relevance of each project idea both to the intended beneficiaries and to the programming framework and which ideas should be further studied during the formulation phase.

At the formulation stage, the relevant project ideas are developed into operational project plans. Beneficiaries and other stakeholder participate in the detailed specification of the project idea that is then assessed for its for its feasibility(whether it is likely to succeed) and sustainability (whether it is likely to generate long – term for the beneficiaries).on the basis of this assessment a decision is made on whether to draw up a formal project proposal and seek funding for the project .A monitor plan should be prepared during this phase to ensure that the project is implemented against proposed resources and timelines

At this phase baseline data is collected and needs assessment carried out. The idea is expressed in a proposal. This includes documentation, validated, ranking and approving various projects by the project staff or professional consultants.

**Project appraisal**

**T**his is the analysis of a proposed operation to determine its merit and acceptability in accordance with established criteria in the request for proposal (RFP).This is the final step before an operation is agreed for financing. It checks that the operation is feasible against the situation on the ground that the objectives set remain appropriate and that costs are reasonable. The proposal is appraised based on the submitted documents – operation proposal and funding request describing the context the needs and problem analysis, the expected results and impacts as well as implementation and resource schedule. During this phase negotiation are carried out and a final proposal submitted for financing. The negotiation are carried out with funding organization who could be the Government of Kenya and / development partner.

**Financing**

During the financing phase, project proposals are examined by the government or funding agencies and a decision taken on whether or not to fund the project. The government and /or development partner agree on the modalities of implementation and formalize these in a legal document which sets out the arrangement by which the project will be founded and implemented. The document could be in form of the following documents: budget sector plans for government of Kenya funded activities and or financing agreements from partner country. These are signed between two countries. Further information is in module 8: financial management and resources mobilization the award is made during this phase and relevant contractual documentation signed between the organization and the funding agency.

**Implementation**

During the implementation phase the project is mobilized and executed. This may require the tendering and award of contract for technical assistance or works and supplies. During implementation and in consultation with beneficiaries and stakeholders project management assesses actual progress against planned progress to determine whether the projects on track towards achieving its objectives. If necessary the project is re – oriented to bring it back on track or to modify some of its object gives in the light of any significant change that may have occurred since its formulation.

**Mentoring**

Monitoring is a continuous assessment of implementation in relation to agreed schedule ad use of inputs based on planned expectation. This phase takes during the implementation. A monitoring plan is used to monitor project implementation. It ensures ensures that input deliveries, work schedule, targeted outputs and other required action are proceeding according to plan. Monitoring provides the manager and other key stakeholder with continuous feedback on implementation i: e identifies actual or potential success and problems as early as possible to facilitate timely intervention or adjustment to the operation.

Monitoring is a management activity that follows a continuous adaptation of the intervention if problem arise or if change in the context have an influence on the performance of the operation. During the monitoring operation manager compare at different moment the actual implementation with that was planned. If activities cannot be implemented as foreseen for some reasons a reflection has to be lead to an adaptation of that activity so that the success of the remains guaranteed.

Continues communication with different stakeholder is important. Through periodic reports usually stipulated in the deliverables they keep the contracting agency whether government or development partner informed about the progress, results, challenges, lessons learnt and planned activities for the next period .The internal monitoring report, made by project staffs complete the monitoring procedures. The activity and resources form schedule form the basis for a monitoring system

**Evaluation**

Evaluation is a process of determining the relevance, efficiency, effectiveness and impact of activities in light of their objectives. It decision maker by providing information about any needed adjustments of objectives, policies, implementation strategies and other project element. It examines whether the assumption made during project formulation or appraisal stag are still valid or if changes are required to ensure overall project objectives are achieved. Refer to Module 17 for more detailed information on this area.

There are several ways of categorizing project evaluation where: the summative evaluation is also known as end term evaluation and formative evaluation also known as midterm evaluation. Summative evaluations are carried out when the project is over and the aim is to assess its effectiveness and impact. Formative evaluation are usually undertaken early to gain understanding of what is being achieved in order to introduce improvements.

Summative evaluation judge merit and the work; the extent to which the desired goals have been attained; whether measure outcome can be attributed to observe intervention and the condition under which goal were attained. Formative evaluation help programmes get ready for summative evaluation by improving programme process are more and providing feedback about strength and weakness that appears to a

And qualitative effect goal attainment.

* Quantitative and qualitative evaluation - quantitative evaluation focus on measurable inputs provided and change that result from the direct implementation of project activities. Qualitative evaluation are more process oriented and focus on assessment of change of hard – to – measure factor such as attitude behaviour skills and level of knowledge.
* Self – evaluation - this is an evaluation conduct by people direct involved in the implementation of the project.
* Internal evaluation - A evaluation conducted by those who are from part of the staff of the organization of the project.
* External evaluation - An evaluation conducted by those who are external to funding organization and project.

During the phase the government and or development partner assess the projects accomplished and identified lessons that have been learned the final evaluation finding are used to improve the design projects or programmes.

13.5 Planning methods and tools are linear and logical . Other may be more intuitive and creative hence creating a mental picture.

**TYPES OF TOOLS**.

1. **The logical frame work matrix**

The logical frame sets out the intervention logic of the project i.e. if activities are undertaken results will e achieved and thus project purpose. It describes the important assumptions and risks that underlie this logic. This provides the basic for checking the feasibility of the project. It defines the tasks to be undertaken the resources require and the management responsibilities. It provides a framework against which progress will e monitored and evaluated.

**Table 13.1 Logical Frame work Matrix Structure**

|  |  |  |  |
| --- | --- | --- | --- |
| Project description | Performance indicators | Means of verification | Assumption |
| **Goal**: The broader development impact to which the project contributes to at a national or sectorial level | Measure of the extent to which a sustainable contribution to the goal has been made. Used during evaluation | Source of information and methods used to collect and report it. |  |
| **Purpose**: The development outcome expected at the end of the project .all components will contribute to this. | Condition at the end of the project indicating that the purpose has been achieved and benefits are sustainable. Use for project completion and evaluation | Source of information methods used to collect and report it. | Assumptions concerning the purpose/ goal linkage |
| **Component objective**: The expected outcome of each component | Measure of the extent to which components and objectives have been achieved and lead to sustainable benefits. Used during review and evaluation | Sources of information and methods used to collect report it | Assumption concerning the component, objective/purpose linkage |
| **Outputs**: The direct measurable results(goods or service s) of the project which are largely under project management control | Measure of the quantity and quality of output and the timing of their delivery. Used during monitoring and review. | Sources of information and used to collect and report it. | Assumptions concerning the output/component objectives/ purpose linkage |
| **Activities:** The tasks carried out to implement the project ad deliver the identified output | Implementation/work programmed targets. Used during monitoring | Sources of information and methods of collect and report it | Assumption concerning the activity /output linkage |

**Source**: Gitonga (2010)

The logical framework is used in the design monitoring and evaluating of project. It is used during the entire project implementation cycle. It ensures that the fundamental questions are asked and weakness analyses in order to provide decision makers with better and more relevant information. The tool guides systematic and logical analysis of the inter – related key element improves planning by highlight linkages between project elements and external factors provides a better basis for systematic monitoring and analysis of the effects of project facilities common understanding and better communication between decision markers managers and other parties involve in the project and ensures systematic monitoring of the project.

The logic frame work is considered rigid as the objectives and external factors specific at the onset are over emphasized. The tool is a fairly complex to obtain full benefits the implementers should have through understanding of the same

1. **Gantt Charts**

A Gantt chart is an important project management tool.it is used to keep track for each activity. A Gantt chart breaks the work down into smaller steps, indicates dependencies and define milestone. It assigns human resource to work on task. They are excellent model for scheduling, budgeting, reporting, presenting and communicating project plans and progress easily and quickly. A Gantt chart can be constructed using MS Excel or similar spreadsheet.

**Figure 13.2 Gantt chart**

Project name………………………..kick polio out of Kenya………….

Project description…………polio immunization………….

Project start…10 days

date…………………..01/07/13……………….end date………17/07/13

The Gantt charts crate a picture of complexity of the project and assist to set realistic timeframe. Gantts chats can however, become extra ordinarily complex. The length of the bar does not indicate the amount of work input at every stage. The Gantt chart requires Constance update to provide adequate information o\to the management.

1. **Brainstorming**

Brainstorming is usually the first crucial creative stage of the project management and project planning process. The brainstorming process is ideally a free – thinking and random technique. Consequently this stage of the project planning process can benefit from being facilitated by a team member able to manage such a session specially to help organize people to think randomly and creatively. The advantages of using brainstorming are that new ideas are generated and problems are better defined. It also helps reduce conflict. However the brainstorming sessions can generate unworkable ideas.

**IV. Fishbone diagram**

The fishbone diagram identifies possible cause for an effect or problem. Fishbone diagram are good at identifying hidden factors which can be significant in enabling larger activities, resources areas or parts of a process. Fishbone diagram are not good for scheduling showing interdependent time critical factor. Fishbone diagram are also called “Cause and effect diagrams “and Ishikawa diagram after Kaoru Ishikawa (1915 – 89), a Japanese professor specializing in industrial quality management and engineering who devised the technique in the 1960s.

A fishbone diagram has a central spine running left to right around which is built a map of factors which contribute to the final results (or problem). For each project the main categories of factors are identified and shown as the main “bone” leading to the spine.Ishikawa’s diagram became known as a fishbone diagram obviously because it looks like a fishbone:

**Figure 13.3 Fishbone Diagram**

A critical path analyses is normally shown as fallows diagram whose format is linear (organize in a line and specially a time line. CPA is also called Critical Path Method (CPM).A commonly used tool within CPA is PERT (programme/ project evaluation and review technique) which is a specialized for identifying related and interdependent activities and events especially where a big project may contain hundreds or thousands of connected element. PERT is not normally relevant in simple projects but any project of crucial can benefits from the detailed analysis enabled by PERT methods.

CPA flow diagrams are very good for showing interdependent factors whose timing overlaps or coincide. They also enable a plan to be scheduled according to a time scale. Critical path analysis flow diagrams also enabling costing and budgeting and help planners to identified causal elements

**Figure 13.4 Critical Analysis Flow Diagrams**

The project above takes 126 minutes to complete. It has a total of 8 stages from start to end. It moves from one stage to another as follows

**Table 13.2 Activity Scheduling Using Critical Path Analysis**

|  |  |  |  |
| --- | --- | --- | --- |
| Stage | Activities | No. of minutes | Cumulative |
| **1.** | A – registration of patient | 1 | 1 |
| **2.** | B – patient pays | 3 | 4 |
| **3.** | C – patient | 60 | 64 |
| **4.** | D – patient gets laboratory tests | 1 | 65 |
| **5.** | E – Patient gets X – rays | 10 | 75 |
| **6.** | F – patient goes back to the drugs | 2 | 77 |
| **7.** | G – Patient pays for the drugs | 15 | 92 |
| **8.** | H – patient collects drugs | 45 | 45 |
| Total |  |  | **137** |

The total cumulative time is 137 minutes. However from the diagram the time taken is 126 minutes since laboratory and X – ray’s tests are done concurrently. Often the patient does one as he is waiting for the results of the other procedure thereby saving on the time. This method therefore helps identify such activities and schedule to minimize the time of the project hence saving on project resource.

**TYPES OF PLANS**

There are several types of plan in organizations. These plans relate to one another. The diagram below shows how each plan informs others. These plans are discussed in the section that follows

**Figure 13.5 Types of Organization Plans**

1. **Strategic Plans**

**S**trategic planning is part of organizations activities. It is used to set priorities, focus energy and resources, strengthen operations ensure that employee and stakeholders are working towards common goals establish agreement around intended outcome / results and assess and adjust the organization direction in response to a changing environment. This is done through establishing priorities making of strategic choice, pulling the entire organization together and providing an outline on the application of strategic plan focuses on the following:

* Where we are now? This is based on a comprehensive assessment of the internal and external environment.
* Where do we want to be? This is a picture (real or mental) of the desired future X number of years from now.
* What keeps us or might keep us from moving to where we want to be (obstacles)?
* How can we address these obstacles or hindering? This is the thrust of the strategic.
* How do we monitor our progress? This set parameters on how to measure gains to be made.

1. **Annual operational Plans**

An operational planning is a sub – set strategic work planning. It describes short term ways of achieving milestone and explains how or what portion of strategic plan will be put into operation during a given operational period in the case of commercial application, a fiscal year or another given budgetary term. An annual operational plan is the basis for and would need five operational plans funded by five operating budgets

An annual operational plan describes the activities and required budget for each part of the organization for the next 1-3 years. They link the strategic plan with the activities the organization will deliver and the resources required to deliver them annual plans can be tweaked and should especially as circumstances change compile to the strategic plan.

Annual operational plans draw directly from the strategic plans, programme mission and goals objectives. The annual operational plan is both the first and the last step in preparing an operating budget request. As the first step the annual operational plan provides a plan for resource allocation. As the last step the annual operation plan may be modified to reflect policy decision or financial change made during the budget development process.

Annual operation plan should be prepared by the people who will be involved in project implementation. There is often a need for significant cross – departmental dialogue as plans created by one part of the organization inevitable have implication for other parts. Annual operation plans have the following section:

* Objectives – sometimes dived among key organizational strategies;
* Activities to be implemented
* Quality standard
* Describes outcomes measurable indicators deliverable
* Staffing and resource requirement
* Implementation timetable
* A process for monitoring progress9or monitoring and evaluation plan)

1. **Departmental plans**

A department plan defines the goals and activities a department will undertake for a specified time period and maybe included as a section in the organization overall plan. The department plan is linked to the operation plan. It shows clear deliverables and output for the department. Because different department have different responsibilities the particular data needed for and useful in department business plans varies widely. The department plan may have the following sections:

* Mission and vision of the department;
* The results of the situational analysis that is relevant to the mission of the department
* The goals of the department that derives from the mission, vision and analysis.
* Objectives for each strategic direction
* Key performance indicators for the department;
* The budget to support the plan;
* The long term outcome

1. **Individuals Plans**

The individual plan has two component parts: the performance plan and a (professional) development plan. The individual plan, sometimes called a performance agreement from periodic conversation between the supervisor and employee for a particular performance management cycle. Once agree it is signed off by the functional head (or supervisor)to ensure that resource implications are taken into account (and provided) .the individual plan link back to the departmental plan, and ultimately the organization or agency strategic plan, with all plans adding up to create progress towards the vision within the confines of the mission. The individual development plan includes the following:

* Key results areas;
* Key performance indicators and targets;
* Individual action plans;
* Professional development (continuing education) plans.

**`MODULE 14: GOVERNANCE IN HEALTH SYSTEM**

**14.1. Definition of a Health System**

A “system” is an arrangement of part which are connected together for a purpose. A health system is concerned with people’s health. A health system has many parts that include patients, families and communities, Ministry of Health, health providers, health services organizations, pharmaceutical companies’ professional societies and health financing bodies, and other organization. The interconnections of the health system can be viewed as the functions and roles played by these parts.

The World Health Organization (WHO) defines health systems as all organizations, institutions and resources that are devoted to producing health actions. This definition includes the full range of players engaged in the provision and financing of health services including the public, private sector, NGO, FBO as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health foundations, and voluntary organizations involved in funding or implementing health activities.

**14.2. Health System Governance**

Governance in health refers to the actions and means adopted by a county to organize, promote and protect the health of its population. The governance frame work and its functioning can be formal e.g. Public Health Act, International Health Regulations or informal e.g. Hippocratic Oath to prescribe and proscribe behaviour. The health governance frame work in Kenya is a devolved system. Good governance is also closely linked with effective leadership and efficient management which are covered in Module One.

**Objective**

The objective of health governance is to promote and protect the health of a population at the individual, community, county and national level. An effective health governance system is therefore one which competently directs health system resources, performance, and stakeholders participation towards the goal of reducing illness, saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people.

**Characteristics of an Effective health System**

1. Well defined rules, roles and responsibilities of each of the actors in the health system and the relationships, structure, and procedures that connect them.
2. Accountable to citizens, health service users, stakeholders and the wider community within which health care providers work, take decisions and lead their people to achieve their objectives;
3. An enhancing environment through which policy makers, county health management teams and hospital management teams and other sectors and actors are able to direct, monitor and supervise the conduct and operation of the health system and its management in a manner that ensures appropriate levels of authority, accountability, stewardship, leadership, direction and control;
4. A responsible leadership which portrays, efficiency, probity, transparency and accountability.

**14.3. Policy Framework**

The Kenya health sector operates in the context of a number of policy frame works and within a policy environment that is subject to both internal and external influences. The MDGs, and other global initiatives, and Vision 2020 Sector Plan for Health comprise the major external influences on the Kenyan health sector system. The health sector strategic plan and the community health strategy are some of the factors within the institutional and organizational context which shape the internal environment.

**Health in the Millennium Development Goals**

The MDGs provide a common set of priorities for addressing poverty. Health is represented in three of the eight goals as shown on table 14.1.

**Table 14.1 Health Related Millennium Developed Goals**

|  |
| --- |
| **Goals Health Indicator** |
| * Under-five mortality rate * Infant mortality rate * Proportion of one-year children immunized against measles   **Goal 4: Reduce child mortality**  Target: Reduce by two-thirds, between 1900 and 2015, the under- five mortality rate |
| * Maternal mortality ratio * Proportion of births attended by skilled health personnel experience at each level   **Goal 5: Improve maternal health**  Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio |
| * HIV prevalence among pregnant women aged 15-24 years. * Condom use rate of the contraceptive prevalence rate * Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years. * Prevalence and death rates associated with malaria * Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures. * Proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short-source)   **Goal 6: Combat HIV/AIDS, malaria and other diseases**  Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.  Have halted by 2015 and begun to reverse the incidence of malaria and other major disease |

*Implications of MDG’s on health system governance*

From a health perspective, the MDGs are important because:

1. They provide a common set of priorities for addressing poverty.
2. Health is at the heart of the MDGs. This recognition signifies that health is central to the global agenda of reducing poverty as well as an important measure of human well-being:
3. They set quantifiable and ambitious targets against which to measure progress. These provide an indication of whether efforts are on track, and a means of holding decision maker to account;
4. It is possible to calculate what it would cost to achieve the MDGs. This draw attention to the funding gap between available and needed resources, thus providing support to health sector call for increased funding.
5. MDGs have helped to crystallize the challenges health. If health. If a country looks seriously at what it would take to achieve the health MDGs, the bottlenecks to progress become clearer.

The challenges to health brought out in the MDGs are the need to strengthen health systems, ensure that health is prioritized within overall development and economic policies develop health strategies that respond to the diverse and evolving needs to the population, mobilize more resources for health at the national and county level, and improve the quality of health data.

|  |
| --- |
| ***Student activity***  MDGs provide an overarching framework for development efforts, and benchmarks against which to judge success.   1. *Identity and discuss the health elements in MDGs 1,2,3,7 and 8* |

***Health sector and the Vision 2030***

The aim of the Kenya Vision 2030 is to create “a globally competitive and prosperous country with a high quality of life by 2030” through transforming the country from a third world country into an industrialized, middle income country. To improve the overall efficiency, integrated and high affordable health care. The health sector reform strategy lays particular emphasis on; geographical and financial access to health care services; regional and gender disparities; efficiency; financing; health care policy; and public private partnerships.

Table 14.2 Vision 2030: Key Focus in the Health Sector

|  |
| --- |
| **Areas of Focus Issues Indicators**   * Affordability * Availability * Accessibility-distance to facility * Geographical access * Financial access * Socio-cultural barriers |
| **Access**   * Regional disparities * Socio-economic factors * Gender and vulnerable groups * Physically challenged |
| **Equity**   * Appropriateness * Level of delivery * Service range * Quality and quantity of Human Resource * Continuity * Effectiveness * efficiency * Access by gender * Access indicators across regions * Specific information on the vulnerable and physically challenged. |
| **Quality**   * Service delivery system * Health care inputs * Partnerships * Health care financing * Research * Procedure safety * Capacity development –health care personnel * Resources * Health system-curative vs. preventive * Utilization of health care systems * Equitable allocation of resources * Service delivery * Research * Efficiency |
| **Capacity**   * Health care policy * Level and type of autonomy/integration * Incentive structure * Stakeholder involvement/collaboration |
| **Institutional**   * Level and type of integration * Stakeholder involvement in policy formulation.   **framework** |

Figure 14.1 Vision 2030 Goals and Strategies for Health Care

**Goals for 2012**

**Vision for 2030**

**Equitable and affordable healthcare system of the highest possible quality**

Strategic trust

Health structure: Provide a functional, efficient and sustainable health infrastructure network

Health service delivery: Improve the quality of healthcare delivery to international standards

Develop equitable health financing mechanism

**Focus**Preventive-primitive healthcare service for all Kenyans

**Overall**Reduce health inequalities and reverse the downwards trend in the health-related impact outcome indicators

* All health facilities rehabilitated and well equipped.
* Fully functional health facilities in every urban centre
* 80% of Kenyan reached thro’ comprehensive community services
* Health Management information System developed

**Specific**

* Make Kenya a regional health services hub.
* World class medical centres established
* Reduce the shortage of HRH by 60%
* Professional managers in all hospitals
* PPP’s institutionalized
* Reduce the out-of-pocket expenditure to 25%
* Social health insurance scheme (p=Purchase provider system) in place

**Strategies**

**Cross cutting**

**issues**

* Health Sector reforms to promote preventive health care services, management and regulation across all levels
* Improved literacy rates and change of retrogressive cultures and attitudes.
* De mographic issues
* Develop a social health insurance scheme
* Establish a health service commission
* Scale up Output Based Approach (OBA) system.
* Market and promote Kenya as regional health service hub
* Promote medical tourism
* Increase the number and cadre of health personnel ad improve working environment.
* Establish quality standard norms
* Strengthen regulatory framework
* Build capacity of health service facilities on procurement requirements.
* Establish and operationalize district health boards and DHSFs
* Separate service provision from regulation
* Establish a course on hospital Management.
* Increase access to physical infrastructure
* Support improved availability of quality health services.
* Strengthen KEMSA to be the strategic procurement unit for health sector.
* Provide defined health services of the community level
* Strengthen health facility community linkage
* Enhance the promotion of individual health & lifestyle.
* Strengthen the capacity of community

**Source:** Kenya Vision 2030

**14.4 The Legal Framework of the Health Sector**

The legal framework of the health sector in Kenya is governed primarily by Kenya’s Health Policy Framework (KHPF) of 1994. The document in its agenda for reform identified the strengthening of the central public policy role of the Ministry of Health in all matters pertaining to health as a key priority. In terms of regulation and enforcement, the government has over the years asserted its commitment to continue regulating the health sector by enforcing the following Acts of Parliament pertaining to the health sector.

1. Public Health Cap 242
2. Radiation protection act cap 243
3. Pharmacy and poisons Act cap 244
4. Dangerous Drug Act cap 245
5. Malaria Prevention Act cap 246
6. Mental health Act cap 248
7. Medical Practioners and Dentist Act cap 253
8. Nurses Act cap 257
9. Clinical Officers (Training, Registration and Licensing) Act cap 260
10. National Hospital Issuance Fund Act cap 255
11. Food, Drugs and Chemical Substances Act cap 254
12. Animal Disease Act cap 364

The health sector is also impacted upon by other legislation. The following are some of the other statutes that impact on their health sector.

1. The medical Laboratory technicians and Technology Act (1999).
2. The Science and Technology Act cap 250
3. The Local Government Act cap 265
4. HIV and AIDS Prevention and Control Act, Act no 14 of 2006
5. The Anatomy Act cap 249
6. The Public Procurement and Disposal Act 2005 Act n0 3 of 2005 and the Regulations made therein.
7. The Finance Act (enacted every financial year)
8. Education Act cap 211
9. Kenya Medical Training College Act cap 261
10. Various public universities’ acts.
11. The Constitution of Kenya 2010 (especially Chapters creating the Public Service Commission and the County Public Service Commission.
12. The Penal Code (1960)
13. The Sexual Offences Act 2006.

All these statutes have an impact on the health sector. For instance, the Finance Act directly affects the budgetary allocation to the ministry of Health. The Public Procurement and Disposal Act affects the manner in which of health acquires its supplies. The Education Act and various legislation governing public universities affect the quality of training given to health workers in those institutions. The Public Service Commission and staff affect the Ministry of Health’s organizational structure, appointments, promotions and staff discipline. The Penal Code provides for criminal liability for health workers who facilitate abortions. The National Commission of Gender and Development is mandated to promote gender equity in health. The Public Health Act, sector 3(1) establishes a Central Board of Health whose function is to advise the minister on all matters affecting public health. The Constitution of Kenya 2010 provides for equality and freedom from discrimination (Art 27) and he right ot health and reproductive health (Art 43).

In the current legal framework, there are over twenty statutes dealing with the health sector in the country. The legal framework of the health sector is not under a single institution but spread within a number of ministries and department of the government. Within the Ministry of health, there are division, department and specialized agencies responsible for different aspect of health regulations. In the devolved system of government, this scenario is replicated at the county level.

The health sector policy focus is guided by Vision 2030. The strategic focus is well defined and elaborated in the Kenya Health Policy with clear goals on the long-term policy directions the country intends to achieve in pursuit of the imperatives of the Vision 2030, and the 2010 Constitution.

Governance of the health sector is anchored on current key policy, legal and legislative framework. The Kenyan Health policy 2012-2030, Health Act 2012 and Kenya Health Sector Strategic and Investment Plan 2012-2017 are the key instruments which align the sector with the Constitution of Kenya 2010 and the social pillar of vision 203. These and other policy documents guide the two of Governments (national and County) and the health sector as a whole.

**Vision:** A health and globally competitive nation

**Mission:** To deliberately build progressive, responsive and sustainable technology

driven, evidence-based and client-centered health system for accelerated

attained of highest standard of health to all Kenyans.

**Goal:**  Better health in a responsive manner

To fulfill the vision and mission of the health sector, those with management and leadership responsibilities are expected to formulate health policies and strategic direction, set standards and ensure provision of health services through public facilities and regulations of all actors/services.

**Health Policy Objectives**

The following six policy objectives provide guidance towards the realization of the health sector vision and goal.

**Table 14.3 Kenya Health Policy Objectives and Activities**

|  |
| --- |
| **Objective Activity** |
| Eliminate communicable Reduction of the burden of communicable disease, till they  Conditions are not of major public health concern. |
| Halt and reverse the rising Ensuring clear strategies for implementation to address all the  Burden of non- identified non communicable conditions in the country.  Communicable conditions |
| Reduce the burden of Collaboration with stakeholders in other sectors that equitable,  Violence and injuries each of the causes of injuries and violence at the time. |
| Provide essential health care provision of medical services that are affordable, equitable,  accessible and responsive to client needs |
| Minimize exposure to health Strengthen health promoting interventions, which address  risks factors risk factors to health, plus facilitating use of products and  services that lead to healthy behaviour in the population. |
| Strengthen collaboration Building partnerships and other integrative approaches which  with other sectors ensure the health sector interacts with influence s design  implementation and monitoring processes in all health related sector actions. |

**International Commitments and Obligations**

The county has ratified many global commitments meant to support the health sector implement the various global commitments it has entered signed. These include:

1. Implementation of the International Health Regulations-to guide the country on key action needed to assure adherence to international health regulations;
2. Implementation of the Global Framework Convention for Tobacco Control-to guides the country on tobacco control activities.
3. Ouagadougou declaration on Primary Health Care and Health System – to guide the overall strategic focus for the health sector.
4. Millennium Development Declaration (MDGs)-to guide the country in developing national targets towards international development initiatives.
5. International Health Partnership (IHP+) on aid Effectiveness;
6. UN secretary Generals’ Global Strategy ‘ Every women every child;
7. Abuja Declaration –to support the improvement of health systems in the county by domesticating the provision through national legislation, the country committed in the Abuja Declaration to allocate 15% of government expenditure budgets to health;
8. International Human Right agreements including International Declaration for Human Rights, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), child Rights Convection (CRC), the International Conference on Population and Development programme of action (ICPD), and the Beijing Declaration and Platform of Action (BPFA).

**14.5 Governance Responsibilities in the Health System**

Various forms of governance functions and responsibilities exist at each at each level of the health system structures discussed in Module 1.

|  |
| --- |
| * Delivery of efficient, cost effective and equitable health services * Devolution of health service delivery, administration and management to community level * Stakeholder participation and accountability in health service delivery, administration and management. * Operational autonomy * Efficient and cost-effective monitoring, evaluation, reviewing and reporting system. * Smooth transition from current to proposed development arrangement * Complementarily of efforts and interventions. |

**The Role of the State Department Responsible for Health**

The primary role of the National Department of Health is to support counties in delivering health care services as well as to help to lead, shape and support the national health care system. The KHSSP 2013-2017 outlines the mandate, structure, roles and responsibilities of the state department responsible for health as discussed below.

The principal mandate of the National State Department as stipulated in the Constitution of Kenya 2010 and National Health Policy 2012-2030 is:-

1. Establishing a national health policy and legislation, standard setting, national reporting:
2. Sector coordination and resource mobilization.
3. Offering technical support with emphasis on planning, development and monitoring of Health services and delivery standards throughout the country;
4. Monitoring quality and standards of performance of the county governments in the provision of health services:
5. Providing national health referral services;
6. Conducting studies required for administrative or management purposes.

**Figure 14.2 Structure of the State Department for Health**

Cabinet Secretary

Principle Secretary

Director General

Heads of semi Autonomy Government Agency (SAGAs)

Directorate of Prevention and Promotive services

Directorate of Administration

Directorate of Policy, Strategy and International Health

Directorate of Standards and Quality Assurance

Directorate of Curative and Rehabilitative Services

**Table 14.4 Roles and responsibilities in the State Department of Health**

|  |  |  |
| --- | --- | --- |
| **Office** | **Role** | **Responsibilities** |
| Cabinet  Secretary for  Health | Overall responsibility for addressing the health agenda in the Country | * Guide the organs of the state on the strategic direction of addressing the Health agenda in the Country. * Act as a liaison between the National Government and the county Executive Committee on health matters. * Coordinate mobilization of resources for implementing the health policy agenda by National and county Governments * Chair the joint Inter Agency Coordinating Committee bringing together heads of all signatories of the Sector Code of Conduct * Represents the health sector internationally at the highest level. |
| Principal  secretary for  Health | Principal accounting officer for the Department of Health both Public and non-public resources | * Coordinating actions of SAGAs in the health sector * Cary out regular expenditure reviews on useof Government, and external resources including efficiency and value reviews. * Coordination of financial management systems at the national level, and between national and County Governments. * Carry out regular value-for-money audits, sector-wide efficiency assessment and regular updating of costing data of funds supporting health activities in the sector. * Guide the Cabinet Secretary on technical issues in Health, for communication within Government, parliament, and other state organs and internationally. |
| Director General  for health | Technical officer for the department for both public and Non Public | * Guide the Principal Secretary on technical issues in Health, for communication within Government, parliament, and other state organs and internationally. * Provide the sector with technical direction in all matters relating to the strategic direction of the Health Sector. * Act as a liaison between the National Government and County Directors of health to coordinate attainment of Health goals. |

**Table 14.5 Responsibilities and Key Policy Areas of Directorates in the State Department of Health**

|  |  |  |  |
| --- | --- | --- | --- |
| **Directorate** | **Responsibility** | **Key policy areas** |  |
| **Curative & rehabilitative services** | Oversee policy formulation and implementation review in curative and rehabilitative service | * Blood transfusion & tissue transplantation * Rehabilitation * Surgical services * Clinical services * Pharmacy * Child and Adolescent Health * Dental services * Emergency Medical Services | * Referral services * Complementary and traditional medicine * Radiological * Medical engineering * Diagnostic and Forensic * Mental Health * Reproductive health |
| **Preventive and Promotive Services** | Oversee the preventive and promotive strategic issue including policy formulation | * Mental health and substance abuse * Non-Communicable disease * Reproductive Health * Child and Adolescent health * Community Health * Vaccines and immunization * Nutrition and deities * National health programmes * Disease surveillance * Infection prevention and control * Oral health * Ophthalmic health | * Pollution control * Water safety * Sanitation * Occupational Health and Safety * Disaster and risk reduction * Port Health * Refuse (waste) Management * Food safety * Health Promotion * International health regulation * International health. |
| **Standards and Quality Assurance** | Oversee the formulation and implementation of standards and norms & quality in the health sector. | * Health service delivery * Healthcare infrastructure * Clinical Guidelines * Medical products devices and technology * Health workforce * Regulatory services | * Health Research & development * Quality Assurance and Management * Health Inspection * Continuous Professional Development (CPD) |
| **Policy, Planning and Health Relations** | Coordinate policy and strategic development for the ministry of Health | * Policy and Strategic planning * Health financing * Annual Operation Plans * Medium Term Expenditure Framework, including budgeting * Monitoring and Evaluation * Performance contracting/MMU | * Operational and other Health Research and development * E-Health * Health Information System * Partnership coordination * Health reform * Intergovernmental Relations * International Health Regulations and Relations. |
| **Administration & Support Services** | Oversee the support services to complement the health technical activities. | * Human Resource Management * Human Resource Development * Health infrastructure, equipment including ICT maintenance. * Gender mainstreaming * Disability mainstreaming * Logistic management | * Finance and accounts * Procurement * Internal audit * Legal Unit * Public relations |

**Semi-Autonomous Government Agencies (SAGAs)**

There are six SAGs under department responsible for health. SAGAs are governed by a board of management (BOM) comprising 8-15 senior officer members representing the public sector (state department responsible for health and other ministries), and private sector and other stakeholder. A chief executive officer (CEO) is responsible for the daily management and implementation of the institutions’ strategic plans which are guided by the sector strategic plan. Each SAGA operates under a performance contract signed with the Principal Secretary in the state department responsible for health. They are partly financed through GOK (state department of fiancé).

**Table 14.6 SAGAs and their Key Mandates**

|  |  |  |  |
| --- | --- | --- | --- |
| **SAGA** | **Founded** | **Corporation status date** | **Key Mandate** |
| Kenyatta national Hospital (KNH) | 1901 | Legal notice no. 109 (April 1987) | Provide specialized care training and research. |
| Moi Teaching and Referral Hospital (MTRH) | 1917 | Legal notice no. 78 (June 1998) | Provide specialized care training and research |
| Kenya Medical Training College (KMTC) | 1827  1990 | Legal notice no 14 (1994) KMTC Act cap 61. | Train middle level health professionals |
| Kenya Medical Research Institution (KEMRI) | 1979 | Science and technology act no. 79 (April 1979) | Conduct multi sector health research |
| Kenya Medical Supplies Agency (KEMSA) | 2001 | Act of parliament cap 446 (2000), Legal notice no. 17 | Procure, warehouse and distribute health commodities in Kenya |
| National Hospital Insurance fund (NHIF). | 1966 | Act 9 (1998) | Provide quality social health insurance |

**The Role and Structure of the County Department for Health**

***County Health Management Structure***

According to the Constitution of Kenya 2010, county governments are responsible for:

1. County health facilities and pharmacies;
2. Ambulance services;
3. Promotion of primary health care;
4. Licensing and control of undertaking the sell food to the public;
5. Veterinary services excluding regulation of the profession.
6. Cemeteries, funeral parlors and crematories; and
7. Refuse removal, refuse dumps and solid waste disposal

***Structure of County Department Responsible for Health***

County health services are managed by a chief officer for Health who reports to the County Executive (CEC) member responsible for health

**Table 14.7 Structure for County Department responsible for Health**

Chief Officer of Health

County Hospitals

Primary Health Facilities

Clinical Service

County Health Planning and Monitoring Unit

Preventive and promotive Health Service

County Director of Health

**Source:** Adapted from Kenya Health Sector Strategic and Investment Plan-KHSSP July 2012-June 2017.

**Governance Responsibilities at the County Level**

***Chief Officer for Health***

The chief officer for Health responsible for technical coordination and management of County Health Services, focusing on:

1. Overall management and oversight of public health facilities in the county;
2. Guiding implementation of health related issues from the county executive committee:
3. Interpreting and integrating national government health policy;
4. Coordinating development implementation of county health strategies and priorities;
5. Coordinating disaster preparedness and response in the county;
6. Management of referral health services, in county, across countries, and with the national government;
7. Act as the accounting officer of the department responsible for health

***County Director of Health***

The county Director of Health is the technical advisor for all health matters in the county.

Their role shall be:

1. The technical advisor to the County Executive Commissioner and the Governor;
2. To supervise all health services within the County;
3. To promote the public health and the prevention, limitation or suppression of infections, communicable or preventable diseases within the County;
4. To prepare and publish reports and statistical or other information relative to the public health within the County.
5. To report periodically to the Chief Officer for health on all public health occurrences including disease outbreaks, disaster and any other health matters;
6. To perform any other duties as may be assigned by the appointing authority and any other written law.

The County Director of health is the technical advisor for all health matters in the county.

Their role shall be:

1. The technical advisor to the County Executive Commissioner and the Governor;
2. To supervise all health services within the County;
3. To promote the public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within the County;
4. To prepare and publish report and statistical or other information relative to the public health within the County;
5. To report periodically to the Director-General for health on all public health occurrences including disease outbreaks, disease outbreaks, disaster and any other health matters.
6. To perform any other duties as may be assigned by the appointing authority and any other within law.

Table 14.8 Other Structural Units at the County Level

|  |  |  |  |
| --- | --- | --- | --- |
| **Units** | **Policy implementation responsibilities** | **Constitutional functions** | **Constitutional Sub-units** |
| **Preventive and Promotive Service** | * Eliminate Communicable Conditions * Minimize exposure to health risk factors | * Promotion of primary health care * License & control undertakings that sell food to the public * Refuse removal; refuse dumps and solid waste disposal | * Child Health * HIV, TB and Malaria * Health Promotion * Neglected Disease management * Hygiene control * Community services |
| **Clinical services** | * Halt and reverse the rising burden of Non-communicable conditions. * Provision of essential health services. * Reducing the burden of violence and injuries | * Ambulance services * Management of health facilities and pharmacies * Cemeteries: funeral parlors and crematoria | * Maternal Health * Blood safety * Laboratory services * Pharmaceutical services * Nursing services |
| **Planning and monitoring** | * Organization & management of health service delivery strengthening collaboration with health related sector. |  | * Health planning * Sector coordination * Health information |

**Source**: Adapted from Kenya Health Sector Strategic and Investment Plan –KHSSP July 2012 –June 2017

**Stewardship Responsibilities at the Different Level of the Health Sector**

The Constitution reserves the responsibility for health policy to the national government. The state department of health is responsible for shaping policy direction for health in the country, and for facilitating the implementation of a sector-wide approach. The principal mandate of the state department of health is as stipulated in the Constitution and the Health Policy and is further detailed in the table below.

**Table 14.9 Stewardship Responsibilities at the Different Levels of Health Sector**

|  |  |  |
| --- | --- | --- |
|  | **National Government Policy Role** | **Corresponding County Government Role** |
| 1) | Establishing a National Health Policy and Legislation, health regulation and standard setting national reporting sector coordination & resource mobilization | County level prioritization of health investments, setting and reporting on relevant targets and coordination of actors in the county health system. |
| 2) | Offering technical support with emphasis on planning, development and monitoring of Health services and delivery standards through the county. | Planning, development and monitoring of County Health Services and facilitating compliance with national health standards. |
| 3) | Monitoring quality and standards of performance of the County Government and community organizations in the provision of Health service. |  |
| 4) | Provide guidelines on tariffs chargeable for the provision of Health service and the distribution of health benefits through various financing mechanisms. | Provide guidance to health facilities within the county in implementing health service tariffs and benefits. |
| 5) | Provide National health referral service | Development and management of referral services within the county health system |
| 6) | Conduct national studies required for administrative or management purposes. | Conduct county studies required for administrative or management purposes. |
| 7) | Develop national guidelines on the role of non-state actors in health and regulate their service | Facilitate the role of non-state actors in the county health system; and ensure their compliance with national policy and regulatory requirements. |

**Source:** Adapted from Kenya Health Sector Strategic and Investment Plan – KHSSP July 2012-June 2017.

**Table 14.10 Governance Responsibilities in the Health Sector**

**Levels Responsibilities/functions**

|  |
| --- |
| **Senior management at National level (Directorates**)   * Formulating policy, developing strategic plans, setting priorities * Budgeting allocating resources * Regulating setting standards, formulating guidelines * Monitoring performance and adhered to the planning cycle * Mobilizing resource * Coordinating with all (Internal and external) partners * Provision of Technical support to the county level * Capacity building of county level * National health referrals services * Training health staff (both pre and in service), ensuring curricula and training institutions are in place. |
| * Delivering services in all health facilities (levels 1-3) * Developing and implementing facility health plans (FHPs) * Supervising and controlling the implementation of FHP (M&E) * Coordinating and collaborating through county Health stakeholder Forums (PBOs, NGOs, CSOs, development partner) * Training and developing capacity (in-service) * Maintaining quality control and adhered to guidelines. * Provide leadership and stewardship for overall health management in the County, * Provide Strategic and operational planning, monitoring and Evaluation of Health service delivery in the county * Provide a linkage with the national State department responsible for health * Collaborate with state and non-state stakeholders at the County and between countries in health services. * Mobilize resource for county health service * Establish mechanisms for the referral function within and between the countries and between the different levels of the health system in line with sector referral strategy. * Coordinating and collaborating through county health stakeholder forum (CHHMB, FBOs, NGOs, CSOs, development partners) * Supervise county health services.   **County health management teams (CHMT)** |
| **County health facility management teams (CFMT)** |

Source: Adapted from Kenya Health Sector Strategic and Investment Plan-KHSSP July 2012-June 2017

**Stakeholder Involvement**

The right to health cannot be achieved without the active involvement of other stakeholders. Health sector stakeholder includes:

***Clients:*** The individuals, households and communities whose health is the focus of this strategic plan.

***State actors***- The public sector (MOH-National and County, SAGAs, other ministries and the state department responsible for devolution), constitutional Commissions, regulatory bodies (boards and councils) and professional bodies/associations whose mandate is drawn from that of the state, and an effect on health;

Non-state actors- The Private sector NGOs, Civil Society Organizations (CSOs), FBOs traditional practitioners, media and all other persons whose actions have an impact on health but not draw from the state;

**Health Sector Intergovernmental Relations and Coordination Framework**

Effective governance is achieved through active engagement, consultation cooperation and mutual accountability between the national department responsible for health and the county department of health as well engagement among the county department of health. The figure presents an illustration of how the health sector partnership, governance and stewardship process work together to provide overall leadership in addressing the health agenda in the country.

Table 14.11 health Sector Partnership, Governance and stewardship process

**PARTNERSHIP GOVERNANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STEWARDSHIP**

NATIONAL MINISTRY FOR HEALTH

PARLIAMNETARY COMMITTEE ON HEALTH

JOINT INTER AGENCY COORDINATING COMMITTEE

HEALTH SECTOR COORDINATING COMMITTEE

Primary care facility management facility

COMMUNITY HEALTH COMMITTEE

Primary Care facility management economic

Sub County Health Management

County Hospital Management Team

COUNTY HEALTH COMMITTEE

Country Hospital Board

SUB COUNTY HEALTH STAKEHOLDERS FORUM

COUNTY HEALTH STAKEHOLDERS FORUM

**Technical working groups & their ICC’S**

COMMUNITY UNIT

COUNTY HEALTH MANAGEMENT TEAM

**Source:** Adapted from Kenya Health Sector Strategic and Investment Plan- KHSSP July 2012-2017

**Student Activity**

|  |
| --- |
| **Suggestion Group/Class Discussions**   1. Identify and discuss the role by the various actors in the system 2. What ethical principles should guide government practice in the health sector? 3. In preparation for your practicum, prepare a checklist of indicators of good governance could guide you in assessing government at a health facility level county government and national government level. |

**MODULE 15: ENTREPRENEURSHIP FOR HEALTH PROFESSIONALS**

**15.1 Entrepreneurship**

**Definition and characteristics**

The word entrepreneur is derived from the French “enterprendre” which means to undertake. The Merriam – Webster dictionary an defines an entrepreneur as who organizes manage and assumes the risks of a business enterprise. An entrepreneur is a person who recognizes opportunities where others don’t or where others see chaos or confusion and undertake to organize manage and assume the risks in a resulting business enterprise.

An entrepreneur is an innovator who recognizes an opportunity converts those opportunities into workable / marketable ideas adds value to them through time effort money or skills and assumes the risks of the competitive marketable to implement these ideas.

**Entrepreneurship Involves**

1. Initiative taking – the creation process creating something new of value
2. The organizing and reorganizing of social economic mechanisms to turn resources and situations to business opportunities. This requires devotion of the necessary time and effort;
3. The acceptance of risks or failure – entrepreneur are widely accepted as risk takers and the risks they take could be in various form, depending on the field of effort of the entrepreneur;
4. Reward seeking – entrepreneurs seek for rewards which are in the form of independence, personal satisfaction and monetary reward profit.

**Traits of Successful Entrepreneurs**

The personality traits of successful entrepreneur have been analyzed by many experts. But as many of them are quick to point out the problem with any formula for success as an entrepreneur is that success relies on a ability to see “new” patterns so you should be careful about evaluating the entrepreneurial ability based on general established patterns.

The traits that are most often thought to be common in successful entrepreneurs are:

1. A degree of tough – mindedness – this enables entrepreneur to make and stick by decisions that are based on a combination of intuition and logic. Tough – minded entrepreneur are not frightened by the unknown. They lead the way for the rest to follow.
2. A willingness to work a little harder and a little longer – successful entrepreneur work not only for rewards but also for the pleasure of creating the enterprise.
3. A degree of self – confidence – This lets entrepreneur make firm decision and keeps them from worrying afterwards. Self – confidence entrepreneur feel that the decision is probably right – but if not adjustment can make it work
4. A willingness to take “reasonable” risks – entrepreneur feel that results are controllable not strictly up to chance.
5. A high degree of flexibility – This enables entrepreneur to meet changing goals pressures technology and competition. Entrepreneur feel that their own flexibility will allow a chance to change things if decision turn out badly.
6. A finely tuned sense of the needs of the marketplace, along with a curious mind – successful entrepreneur are quick to spot market needs and to supply products to meet those needs in new profitable ways
7. A sense of long – term goals – Entrepreneur see needs possibilities and solutions where others see only problems.
8. Good problems – solving ability – this uses problems as a roadmap. Each problem solved helps entrepreneur chart a course for future success
9. A desire for profit – Entrepreneur use profit to measure their success. Because of the profit motive entrepreneur will tend to find an efficient use of resources.
10. An underlying enthusiasm – Enthusiasm keeps up entrepreneur spirit. Enthusiasm helps successful entrepreneur maintain the level of creative thinking and focused activity necessary to carry out the success venture.

**15.2 Types Of Business Venture**

There are three types of business venture, mainly classified according to their constitution and the formation process:

i) Sole proprietorship;

ii) Partnerships

Iii) Corporative

**Sole Proprietorships**

Sole proprietorships are by far the most common business form. The businesses are owned by one person and there is no legal distinction between the owner and the business. They are easy to create, operate and terminate since few formalities are involved. Most sole proprietorships are ready for business as soon as they set up operations.

The business is usually small in size and requires minimal capital to start and operate. Their sponsors are essentially individuals who go into business for themselves. It is the only form where the sponsor is truly independent and his own boss.

**Advantages**

i) The proprietor of a sole proprietorship is independent and is his or her own boss. There can be no arguments about policy and decisions. More and more women are becoming entrepreneurs

ii) Sole proprietorship requires relatively low start – up and working capital

iii) There are minimal legal formalities and requirements to start and operate. They are easy to establish and dissolve. Once the owner obtains the start – up funds and necessary licenses and permits or she can start the business. Termination is equally easy.

iv) There is limited government regulation in Kenya. Although all business is subject to some government controls sole proprietorships have freedom than other form of business;

1. There is greater self – interest and satisfaction due to the sense of ownership associated with this form of business.
2. Decision – making and implementation are fast since the owner is not required to consult others in doing so
3. Sole proprietorship can respond quickly to change in the external business environment conditions since the proprietor has direct and total control of decision the making process
4. The proprietor is in close contact with all stakeholders including employees customers suppliers and distributors the proprietor can easily get essential feedback and address individual needs
5. The proprietor gets all the after tax profit of the business which serves as an incentive to work hard and be efficient the harder and more efficient one is the higher the profit business
6. Sole proprietorships that start out small – scale are an ideal way of testing ones business idea. Failure does not result in heavy losses as would be the case with large business

**Disadvantages**

1. In sole proprietorships the sponsor has unlimited liability hence they bear all the risks, liabilities and obligations of the business. In law the proprietor and the businesses are identical. The owner is therefore personally responsible for all the debts and other obligations of the business even when they are more than the business even when they are more than the business is worthy. The owner may have to sell personal property such as cars houses or furniture to satisfy claims against the business.
2. Sole proprietorship may not afford to employ experts or professionals these businesses also have difficulties finding and keeping good employees since professional prefer employment in business where liabilities are limited. Furthermore small businesses often cannot offer employee the same fringe benefits and opportunity for advancement as large companies.
3. They have difficulties in raising additional capital since their sources of financial resources are more limited. Business lenders view the owner’s liability as a high risk since business assets are not protected from claims of personal creditors. Owners must use personal funds to finance the business.
4. The inability of sole proprietorships to raise additional funds may curtail the business expansion plans
5. They may not take advantage of offer’s and discount that may arise due to inability to buy in bulk.
6. Sole proprietorship often has limited managerial expertise. Their success depends entirely on the owner’s skills and talents. The owner is fully responsible for all business an investor who creates a new product may not be a good marketer production manager human resource manager or accountant. Such an investor would have limited range of ideas required for decision – making
7. Decision can be hasty due to lack of moderating voices.
8. Running a sole proprietorship requires a huge time commitment and often dominates the owner’s life. The owner must be willing to make sacrifices often working 18 or more hours a day six or seven days a week with little time for leisure.
9. There is no one to fill in the proprietor is absent due to illness family or social function and holidays
10. Sole proprietorship lacks continuity of existence these businesses have uncertain life if the owner loses interest retires dies is disabling or become a lunatic the business will cease to exist unless the owner the owner finds a buyer. sale of the business may results in loss of goodwill

**Partnerships**

A partnership is owned by between 2 and 20 people or 50 in the case of professional partnership. There is no legal separation between ordinary partners. Some partner may have limited liability if it is a limited partnership. Ordinary partnerships are like sole proprietorship easy to create operate and terminate since few formalities are involved. Most of them are ready for business as soon as they set up operations. If one partner makes a business mistake without the knowledge or consent of others, all the other partners too must shoulder the consequence personal assets could be taken to pay the creditors even though the mistake was no fault of these other partners.

If your partner goes bankrupt in his or her personal capacity, for whatever reason, his or her creditors can seize his or her shares in the partnership. Even death may not release a partner from partnership obligations and in some circumstance’s the partner’s estate can remain liable however limited partners would lose their right to manage the business moreover at least one of the partner must remain an ordinary partner with unlimited liability.

Partnerships are prone to disputes and disagreements hence it would be well advised to negotiate a written agreement or deed that state the terms and conditions for their partnership. Such written contract can avoid confusion dispute and litigation later. The deed would normally specify issues such as arrangements between the partners such as their financial contributor’s management how profits and losses will be shared method of taking into business future additional partners and issues of dissolution

The partner’s contribution to the firm may come in various forms: service s skills property or cash and since partners are co – owners the law presumes that they would share profit and losses equally unless they specify in the deed otherwise.

**Advantages**

1. Partnerships are easy to form like sole proprietorship partnership can be established quickly and cheaply and with few legal formalities the partners agree to do business together and a develop a partnership agreement
2. Most partnerships require relatively low start – up capital. Like sole proprietorship they are relatively expensive to form once the owner obtained the start – up funds and necessary licenses and permits, he she can start the business
3. They provide additional source of investment capital because two or more people contribute financial resources partnerships can raise funds more easily for starting operating and business expansion the partner’s combined financial strength also increase the firm’s ability to raise fund from outside source.
4. Synergy partners can share the responsibility for managing and operating the business .the cost of running the business is cheaper for individual partners due to pooling of resources
5. There can be diversity of skills and expertise ideal partnerships bring together people with complementary background rather than those similar experiences combining partner skills to set goals and objectives manage the overall direction of firm and solve problems increase the likelihood of the partnerships success. Finding the right partners entails looking at your own strength and weaknesses and examining what you are looking for in a partner
6. Discussion are possible whereby new and more ideas as a result
7. Personal contact with customers employees suppliers and other people associated with the business is still possible as in sole proprietorship
8. There is flexibility since some partners can have limited liability
9. General partners take active role in managing their firms ventures and can respond relatively quickly to change in the external business environment
10. Business continuity absence due to illness family and social functions and holidays can be covered for by other partners
11. Business losses liabilities and other obligation are shared by the partner and are not shouldered by one individual
12. There is limited government regulation except for local by – laws rules for licensing and permits the government has little control over partnership activities.

**Disadvantages**

1. Some partners have unlimited liability in fact any one partner can held personally liable for all partnership debts and legal judgments like malpractice regardless of who caused them. As in sole proprietorships business failure can lead to loss of the general partner’s personal assets. To overcome this disadvantage there is provision for the formation of limited partnership which allows some partners to have limited liability
2. There are relatively limited sources of capital for expansion hence difficulty in raising large amount of additional capital;
3. It is hard to find suitable partner
4. There is potential for conflict between partners. Partners may have different ideas, both business and personal about such matters as how and expand the business, which employees to hire or fire and how to allocate responsibilities. Such differences of opinion may lead to disharmony and possible business disruption
5. There can be delay in decision making due to the need for consensus or further consultation
6. Decision of one partner are binding to all other partners unless otherwise stated in the partnership deed
7. Death retirement disability or lunacy of one partner may lead to the dissolution of the business
8. There may be problems getting a buyer who is acceptable to all partners.
9. There is usually little or no reward for partners who work harder than others
10. Partners have to share profit dividing profit is relatively easy. If all partners contribute about the same amount of time, expertise and capital. However if one partner provides more money and the other put more time. It is more difficult to arrive at a fair profit sharing formula

**Limited companies (corporative venture)**

A limited company is owned by between 2 and 50 people. The business has a legal identity of its own separate from the people who own it. It can own assets sue and be sued. Creditors and other claim are to the asset of the business hence a shareholder liability is limited to the amount you have contributed by way of share capital. The business has perpetual life. There is a legal requirement that a character or certified accountant audit the business account.

**Advantages**

1. All shareholders have limited liability. A stockholders liability for debt of the firm is limited to the amount of shares owned this means that if the corporation goes bankrupt, creditors can look only to the asset of the corporation for payment
2. The corporate is a legal entity separate from its owner’s .It can own property disposed of the property be sued and sue.
3. It has unlimited or perpetual life .change in director and shareholders do not affect the life of the business. Death bankruptcy, disability and lunacy would not lead to dissolution
4. They can employ specialists or professionals to manage the business
5. Corporations have ability to attract financing. They can raise money by selling new shares of stock. They can also raise funds through corporate bonds and debentures. The large size and stability of corporation further helps them get bank loans. These financial resource allow the corporation to invest in facility and human resource and grow much large than sole proprietorships and partnerships
6. Shareholder of limited companies can transfer their shares in accordance with their article of association
7. The business can expand obtain economie of scale due to stronger capital base
8. Money raised from issue of shares remain permanently in the business shareholders can only transfer their shares

**Disadvantage**

1. They require high cost and are complex to form forming a corporation takes several steps each of which requires some expenditure
2. They involve greater legal formalities in their creation and dissolution
3. They are subject to greater government regulation and reporting requirements before selling stock corporation must register with the capital markets authority the firm must prepare financial reports on a regular basis and file return with the Kenya revenue authority
4. There are reduced self-interest and satisfaction since managers are usually not the shareholders but professional employees. Shareholders lose direct to manage the business and are usually involved during annual general meetings
5. Profit are share between the shareholders with each getting only a small portion of the earning for the period
6. There are usually delay in decision making and implementation due to increased bureaucracy in the management this makes them be less innovative
7. There is lack of personal contact with stakeholders. Stakeholders may not even know who the shareholders are;
8. There can be possible development of conflict between shareholders and executives those in management may fail to appreciate the interests of shareholders.

**15.3 business plans**

A business plan is a management tool used well run companies of all size at all stages of growth to set down down business objective and goals and the details as to how these can be achieved.

**The 4m’s of a Business Plan**

1. Management – who is going to do it?
2. Marketing – what is the opportunity and how will it be seized?
3. Money – how much money will it take and who will finance it?
4. Money machine – how will the business operate as a money machine?

**The Business Plan Content**

1. Executive summary – the executive summary is the first part of the business plan to be read by potential lender and investors. This section describes the business and its strategic direction describes the company market and marketing plan briefly discusses the background of management and state the company revenue and profit expectation
2. Describe of proposed business this section of the business plan provides very detailed explanation about the proposed business. The goods or service that the entrepreneur intends to produce or provide to the entrepreneur foresees.
3. Industry analysis - this provides an analysis of the industry that the entrepreneur is venturing into. It defines the customs that are there in the industry, the competitor and the pricing strategy that the entrepreneur intends to utilize to become successful in their trade
4. Mission vision and core values – this provides the mission statement of the business the vision where the business is projected to be in the future and the core value that the entrepreneur and or the partnership limited company stand for.
5. Management plan – this indicates the organization structure and the management team. The management team is composed of the senior team members their roles and responsibility in the business.
6. Products and service and the process of business - this indicates how the product and or service will flow from production to the market. It shows the stage involved in the process and the resource the entrepreneur will use in the entire chain of the business. It provides clarity to the entrepreneur and any funders interested in investing in the business.
7. Operations –s this indicates how the operation of the business shall be performed. the organization of the daily activities and tasks are detailed here
8. Marketing – This indicates the overall industry or markets the competition and the sales forecasts among others.
9. Global issue – this present global details of the issue and trends of the specific industry
10. Risks factors and mitigating factor – this indicates the risks foreseen the business and and the strategies to mitigate those risks
11. Financial plan – this shows the operational cost estimates indicative income statement indicates balance sheet project cash flow statement and the break even analysis
12. Appendices – these include promotional items like fliers and the posters photographs of products or service product flow charts financial information like the project cash flow and the indicative balance sheet amongst others.

**15.4 managing business Finance**

Every business deals with money to pay for expenses buy equipment and stock receipts from sales and so on. These transactions are either in cash or credit (promise to pay or be paid later). Financial management would therefore involve recording of business activities that are of financial nature (book keeping) organizing and summarizing this data and presenting it in report for use by stakeholders the first and most important user of this information is the owner of the business

**The importance of Financial Management**

The purpose of financial management is to help in decision making on matters of profitability investment cash management pricing and other aspect of business performance. The cost making wrong decision is high and in many cases leads to business failure. Financial management helps reduce mistakes in decision making enhance management effectiveness (making the right decision)

**15.5 Principle of Business Management**

Principles of business management consist resources and combining and coordinating them effectively to help meet the goal of the business. To be able to do this the manager performs the function of planning organization leading staffing and controlling.

**Planning Activities**

Planning is a process of preparing a plan of action to achieve a set target for business activities. this may involve forecasting event scheduling and re – schedule of activities and tasks that affect the attainment of a target or goal planning is thinking ahead of time planning affects all the activities that the business undertaking. The entrepreneur and his or her team should plan for everything in the business include and not limited to finance, marketing buying of stock and the people he she employees in the business

Planning for the business involves the following:

1. Setting goals objectives and targets this involves:

* Making a decision on what and target to achieve after a certain period of time
* Developing long term and short term plans for the business

1. Deciding on the activities that will be under taken to help achieve the goals objectives and targets.
2. Developing ways of finding out whether the business is achieving its desired targets

**Organization**

This is the process of identifying activities and tasks which will be carried out in the business and deciding the order in which the activities will be implemented and the people responsible for the activities. There are many activities that could be involved in a particular business such as purchasing of medical equipment’s or laboratory material and banking**.** The complexity andintensity of these will depend on the size of the enterprise**.**

The entrepreneur needs to employ workers to help in carrying out some routine activities they should identified the tasks and allocate duties and responsibilities to others.

The following are the main function in the organizing

1. Listing down all the activities that must be carried out in the business such as accounting record keeping and purchasing
2. Grouping all the activities that are related together for example for accounting include record keeping banking and planning finances(budgeting)
3. Deciding which activities must be done by the business owner and those by others tusk allowing the business owner to focus on the core business activity of patient treatment or product development etc. depending on the nature of the business delegating i.e. allocating duties and responsibility to others. When delegating the entrepreneur should make sure that others know their full responsibilities

**Leadership**

This is the function of providing strategic direction in the business in a business there may be people working for or assisting the owner in one way or another .but it is the owner who knows the direction he or she wants to take the business vision may be written or not to have a success cover leader ship and management in more detail

**Resources Mobilization**

Resources mobilization involves looking for required resources to implement the activities identified in the business plan. These resources could be people money raw material equipment and so no .it is the responsibility of the business owner to look for these resources further details on resources mobilization can be obtained from the module on financing management and resources mobilization.

**Controlling**

Controlling is one of the most important roles for any entrepreneur. Control involves knowing whether what has been planned or invested in the business is going according to plan and schedule. The business owner should take pro – active measure to prevent damages to the business. The following are some of the main control activities:

1. Controlling the budget involves ensuring that spending does not exceed what was budgeted;
2. Controlling cash movement and the way it is spent (used) involves making sure that there is enough cash to meet daily business activities;
3. Controlling credit sales involves reducing the number of debtors;
4. Controlling stock held so that the business does not have too much or too little ;
5. Controlling performance of workers so that they are able to meet the targets and that they sticks to the work that has been planned;

**15.6 Raising Business Capital**

One the most difficult things when starting a business is raising the start – up or capital. The entrepreneur might have a great and clear idea of how to run a successful business. However if sufficient finance cannot be raised it is unlikely that the business will get off the ground. Raising finance for start – up require planning. The entrepreneur needs to decide.

* How much finance is required?
* When and how long the finance is needed for?
* What security (if any) can be provided?
* Whether the entrepreneur is prepared to give up some control (ownership) of the start – up in return for investment?

The finance needs of a start – up should take account of these key areas

1. Set – up the cost that are incurred before the business starts to trade
2. Starting investment n capacity – the fixed asset that the business needs before it can begin to trade
3. Working capital the stock needed by the business e.g. raw material and allowances for amount that will be owned by customers once sales begin
4. Growth and development – e.g. extra investment in capacity

**Debt financing (borrowing)**

This is a financing method which involves an interest bearing loan being advanced to the business. The loan repayment is usually scheduled to be funded directly from the sales and profit of the venture. The financing may be short – term or long – term borrowing. Regular (monthly) interest payments are required to repay the loan and these could be difficult to service in case of poor performance of the business. Interest costs can escalate if loan interest rate is revised upwards by the lender.

The following are some sources of debt financing

1. Loans from commercial bank - Although some banks will make unsecured short term loans most banks are secured by receivables inventories or other assets. The bank requires collateral for them to them to issue a loan and the collateral value will depend on the amount of loan that an entrepreneur is applying for. The loan is payable at an interest that i asset by bank issuing the loan
2. Bank overdraft this more short term kind of finance which is also widely used by startup and small business. An overdraft is really a loan facility the bank lets the business “owe it money” when the bank balance goes below zero, in return for charging a high rate of interest .as a result an overdraft is a flexible source of finance in the sense that it is only used when needed . bank over drafts are excellent for helping a business handle seasonal fluctuation in cash flow or when the business runs into short term cash flow problem (e.g. major customer fails to pay on time)
3. Trade credit – this is credit given by suppliers who sell goods on account this credit is reflected on the entrepreneur’s balance sheet as account payable and in most cases must be paid in 30 to 90 days.
4. Account received factoring – this is short term financing that involves either the pledge of receivables as collateral for a loan or a future sale where a customer’s order can be produced as proof of the intended sale.
5. Finance companies – these are assets based lender that lend money against assets such as receivables inventory and equipment
6. Leasing companies – there are companies that can lease out office space or equipment usually for regular rental payments over a special period of time
7. Loan association – like corporative societies members clubs self – help group and investment clubs among others

**Equity Financing**

This is where a venture reaches out to equity partners with no legal obligation for entrepreneur to repay the principal amount or pay interest on it. However it requires sharing ownership and profit with the equity partners. This profit is mostly in forming of normally paid after tax. It can be raised through two major sources public stock offering and private placement

**Public stock offerings**

Going public term used to refer a business raising capital markets. In Kenya initial public offering and right issues are some of the common practices of companies going or seeking to grow term capital base. The company invets the public or existing shareholder to buy shares and invest in its future. Selling security is one of the fastest ways to raise large sums of capital in short period of time. Despite the positive that raise there are expenses involved in going public like accounting and legal fees among others. Detailed disclosures of the company affairs must be made public. There are also numerous requirements imposed by the regulating bodies such as capital markets authority and the Kenya revenue authority.

**Private equity**

This is another method of raising capital that small ventures often use. The entrepreneur would approach or be approached by potential partners who provides the required financing for specific growth or business needs. Private equity is easier however business owners sometimes have to give up controlling interest of their business in order to benefit from private equity.

**Internal Sources**

The main internal sources of fiancé for a start – up include:

1. Personal saving – these are the most important sources of financing for a star – up business most start – up makes use of the personal financial arrangement of the accumulated. It can be personal debt facilities which are made available to the business. Investing personal saving maximize the control the entrepreneur keeps over the business it is also a strong signal of commitment to outside investors providers of finance.
2. Retained profit – this is another important source of finance for any business large or small. Is the cash that is generated by the business when it trades profitable? Retained profit can generate cash the moment trading has begun if the entrepreneur is willing to plough back the profit of early transaction into the business to finance other transaction
3. Borrowing from friends and family - this is also a common way of raising financing where friends and family who are supportive of the business idea provided money either directly to the entrepreneur or to the business. This can be quicker and cheaper to arrange compare with a standard bank loan and the interest and repayment terms may be more flexible than a bank loan. However borrowing in this way can add to the stress faced by an entrepreneur particularly if the business gets into difficulties.
4. Credit cards - this is a surprisingly popular way of financing a small start – up .many entrepreneur who have access to credit card facilities use his as a means of financing small business opportunities /contracts and regular expenses the entrepreneur pays for various business related expenses on a credit card and receives a statement balance within the credit – free period the effect is that the business gets access to a free credit period of around 30 – 45 days

**Leasing**

Many businesses today are faced with the challenge of financing their fixed assets either through outright purchase or leasing of the asset. Current trends mainly driven by cash flow pressure in the short term are opting for flexible payment for the use of an asset as opposed to outright purchase which will make set aside cash upfront for purchase of the asset

Leasing verses Buying

As opposed to an outright purchase a leasing arrangement offers the opportunity to only pay a portion of the asset every month – he portion which you use – up during the time you are using the asset this arrangement is made to provide for return to the owner at the end of the lease period.

Some lease arrangement also prefer to monitoring the use of the asset to minimize misuse and ensure that maintenance is carried out as required essentially they are the true owners of the asset and it is in their interest to keep track of the assets use. In the case of vehicle some cap the number of kilometer that the vehicle should travel per month. They also keep track of the asset to ensure that the lessee is not misusing the asset at the end of the lease you may return the asset or purchase it for its depreciated resale value

**Handout # 1**

**Advantages and disadvantages of using leasing for financing business assets**

**Advantages**

* Reducing initial cash outlay – you do not need all the cash up front you just need the first months installment for a start.
* Easier credit terms – it is easier to get someone to lease you an asset than sell to you on credit furthermore you may negotiate a longer for period for use of the asset. The owner has the title to the asset and therefore his risk is reduced.
* Avoidance of financial restriction – leasing your balance sheet to be able to borrow for other purpose
* Flexibility in addressing obsolesce – leasing is flexible enough to enable you keep pace with technology you do not tie yourself to obsolete technology. You simply let go of the asset and take a fresh lease on the new one.
* Flexibility in addressing need and suitability – if you are not sure of the suitability of the asset you can use the lease period to make the assessment without being bounded by owning the asset p front
* Maintenance support - under some leases the lesser may agree to be responsible for maintaining and repairing the leased equipment at their cost
* Current deductibility of rent - your lease or rental payment are fully deductible for tax purpose if you use the leased asset in your business
* Balance sheet appearance – leasing improves certain financial indicators such as your debt – to – equity and gives you a financial outlook

**Disadvantages**

* Overall cost – your cost over the life of the asset are generally going to be higher than if you purchase the asset. This is because your rental payment must compensate the lesser not only for acquisition and financing costs but also for the risks of not being in possession of his assets
* No ownership interest – your lease payment do not establish any ownership in your leased equipment .at the end of the lease you will not have a tangible asset to show for your payment.
* Lost tax benefits – you lose the tax benefit of depreciation that come with ownership
* Commitment property – once you sign a lease agreement you are generally committed to making payments for the entire lease period even if you stop using the property

**Advantages of buying upfront purchase of business assets**

* You retain control - there are restriction that come with a leased asset that deny you the freedom to make decision without referring to the lesser
* You can consider the long term cost – there are benefits of purchase that accrue in the long run especially if the equipment can continue being productive for many years
* You want to stay at the same location – in case of the business premises you stand to benefit from strategic location if you buy upfront since leasing can cause you to lose premises when you are not ready.
* A purchase may bring you tax saving – there are tax saving that accrue especially with depreciation allowances on asset that you get to enjoy if you own the asset the saving can be significant if the value of the asset is significant

**Disadvantages of buying / upfront purchase of business assets**

* Heavy initial outlay – this could be a challenge especially in hard economic times. Most business especially small ones may find it hard to afford the initial outlay required
* Associated cost – for a business that may not afford initial cash upfront loan financing may be another option of purchase upfront. This raises the related cost of interest and the risk interest can be adjust upward without notice in hard economic times
* The owner bears the risks - any risks such as damage obsolesce depreciation or breakdown are solely borne by the owner
* Inflexible disposal – it may proof difficult to economically dispose the asset especially if it is used for a while. Some business owner end up getting stuck with old equipment that litter the factories because they cannot identify a possible buyer

**Handout # 2**

**Major Pitfalls of Entrepreneur**

There are many pitfalls that face an entrepreneur during start up and during the course of running an entrepreneurial venture. These increase risks level and exposure to the entrepreneur there are of the factors entrepreneur needs to be aware of beforehand

Below are some of them

* Lack of enough cash for startup and operation
* Failing to collect debt on time
* Impatience – shortcuts to success or quitting too soon
* Failure to formalize transaction with contracts
* Failure to implement system and keep proper records
* Taking on a wrong partner
* Hiring cheap incompetent employees
* Thinking the business idea will make the company – failure to value employees
* Competing on price alone
* Thinking too small
* Focus on only one area of the business and ignoring the rest – financing / marketing/ operation
* Trying to cut cost your way to success
* Failure to defines banking boundaries – mixing personal cash with business cash
* Failure to comply with tax laws

**MODULE 16: DISASTER MANAGEMENT**

**16.1 Concepts terminologies and types of disasters**

There is no country that is immune from disaster or hazards though vulnerability varies .disaster cannot be predicted when they happen they create an emergency situation and impact on the health care system through increased demand for essential service such as the provision of health care or destruction

For this purpose health care professional should understand be prepared for and participate in preparing for responding to and recovering from the impact of disaster

**Definitions and concepts of disaster management**

**Crisis**

An event or series of events representing a critical threat to the health safety security or wellbeing of a community usually over a wide area. Armed conflict epidemics famine natural disaster environmental emergencies and other major harmful events may involve or lead to a humanitarian crisis

**Emergency**

This is a situation generated by the real or imminent occurrence of an event that requires immediate attention. Paying immediate attention to an event or situation is important as the event / situation can generate negative consequences and escalate into an emergency the purpose of emergency planning is to minimize those consequences

**Emergency preparedness**

A programme of long-term activities whose goals are to strengthen the overall capacity and capability of a country or a community to manage defiantly all types of emergencies and bring about an orderly transition from relief through and back to normalcy. It requires that emergency plans are in place personnel at all levels and in all sectors be trained and community at risks be educated and that these measure be monitored and evaluated regularly

**Hazard**

This is the potential for a natural or human - caused event to occur with negative consequence. A hazard can become an emergency when the emergency moves beyond the control of the population it becomes a disaster.

1. Natural hazard

Natural process or phenomenon that may cause loss of life injury or other health impact property damage loss of livelihood and service social and economic disruption or environmental damage.

ii) Geologic hazard

Geological process or phenomenon that that may cause loss of life injury or other health impacts property damage loss of livelihood and services social and economic disruption or environmental damage

iii) Technological hazard

a hazard originating from technologic or industries condition including accident dangerous procedures infrastructure failure or specific human activities that may cause loss of life injury illness or other health impacts property damage loss of livelihood and service social and economic disruption or environmental damage

**Disaster**

This is a natural or human caused event which causes intensive negative impact on people goods service and /or the environment exceeding the affected community capability to respond

1. Disaster risks

The potential disaster losses in lives health status livelihoods assets and services which could occur to a particular community or a society over some specified future time period.

1. Disaster risk management

The systematic process of using administrative directive organization and operational skills and capacities to implement strategies policies and improving coping capacities in order to lessen the adverse impact of hazards and the possibility of disaster.

1. Disaster risk reduction

The concept and practice of reducing risks through systematic efforts to analyze and manage the causal factors of disaster including through reducing exposure to hazard lessened vulnerability of people and property wise management of land the environmental and preparedness for adverse events

**Risk**

This is the probability that loss will occur as the result of an adverse event the hazard and the vulnerability risk can be determined as a product of hazard (H) and vulnerability

(V) i.e. R = H x V

The probability of harmful consequences or expected losses such as death injuries property disrupted livelihood and economic activity or environmental damage resulting from interaction between natural or human – induced hazards and vulnerability

1. Risk assessment

A methodology to determine the nature and extent of risk by analyzing potential hazards and evaluating existing conditions of vulnerability that together could potentially harm exposed people property service livelihood and the environment on which they depend

1. Risk management

Consist of identifying threats determining their probability of occurrences estimating what the impact of the threat might be to the communities at risks determining measure that can reduce the risk and taking action to reduce the threat.

Iii0 taking measures to either prevent hazard from creating risks or to lessen the distribution intensity or severity hazard. These measure include awareness raising and improving public health security

**Vulnerability**

The degree to which a population or an individual is unable to anticipate cope with resist and recover from the impact of disaster

**Distinguish between an emergency and a disaster situation**

An emergency and a disaster are two different situations;

* An emergency is a situation in which the community is capable of coping it is a situation generated by the real or imminent occurrence of an event that requires immediate attention of emergency resource
* A disaster is a situation in which the community is incapable of coping it is a natural or human caused event which cause intense negative impact on people goods service and or the environment exceeding the affected community capability to respond therefore the community seeks the assistance of government and international agencies

**Types of Disaster and hazards**

There are 4 main types of disaster

1. **Natural Disasters** - these include drought floods hurricanes earthquake and volcano eruptions that can have immediate impact on human health as secondary impacts causing further death and suffering from floods causing landslide earthquake resulting in fires tsunamis causing widespread flooding and typhoons sinking ferries
2. **Environmental emergencies** - these include technology or industrial accidents usually involving hazardous material and occur where these materials are produced used or transported forest fires are generally include in this definition because they tend to be caused to be caused by humans
3. **Complex emergencies –** this emergency involves a break – down of authority looting and attacks on strategic installation complex emergencies include conflict situations and war.
4. **Epidemic and pandemic** – these emergencies involve a sudden onset of a disease that raise well beyond the expected numbers that the health system can handle an epidemic is specific to one city region or country while a pandemic covers a much wider geographical area and goes much further than national borders often world wide a pandemic also infected many more people than an epidemic these affect and disrupt health service service and business leading to economic and social cost

**Human Inducted Disaster**

Some disasters are caused by human factors these include;

**Transport related accidents**

The increasing numbers of accident that take place during road air and water and railway transportation are occasional fatal and hazardous. Currently road accidents are more frequent because road transportation is used more often than air railways and water transport in addition motorcycle accidents have become notoriously rampart and fatal occasionally there

Are reported incident of boats that capsize on some occasion crocodile attack people who use small canoes

**Fires**

Fire hazards include the planned and massive burning which may cause destruction of equipment settlements property and life. Among the many factors fire hazard are poor electric wiring power outage poor construction standards accidents arson and congested human settlements road transportation of oil gas and petroleum resources which are highly inflammable increase the risk of fire in the event of road accident followed by people trying to illegally siphon the products

**Terrorism**

Terrorism is coordinated crime and brutal aggression against government and civilian establishment the first major terrorist attack occurred in 1998 targeting the American embassy since then the country has been under a constant threat of terrorism

**Impact of Disasters on the Health system**

All forms of disaster and hazard affect human life. The impact on and can at time compromise public health infrastructure and systems what way first result in direct injuries and death may rapidly change to excess indirect illness and subsequent death as essential public health resources are destroyed deteriorated or are systematically denied to vulnerable population.

The public health consequences include;

Death loss of clean water

Injuries loss of shelter

Public concern for safety loss of sanitation

Panic loss of routine hygiene

Increased pests vectors damage to health care system

Worsening of chronic illnesses toxic / hazardous exposure

**Student activity**

1. Define the following
2. Disaster management
3. Hazard
4. Emergency
5. Disaster
6. Vulnerability
7. Risk
8. What is the difference between an emergency and a disaster situation
9. Identify and describes 3 nature disaster which you are familiar with
10. Identify and describe 3 man-made disaster you have learnt about

**Disaster management Cycle**

Disaster management is a cyclical process. The end of one phase is the beginning of another although one phase of the cycle does not necessarily have to be completed in order for the next to take place often several phases take place concurrently. Timely decision making during each phase results in greater preparedness better warning reduced vulnerability and or the prevention of future disasters.

A complete disaster management cycle includes the shaping of public policies and plans that either addresses the cause of disaster or mitigates their effects on people property and infrastructure

**Mitigation -** measures put how to minimize the results from a disaster e.g. building codes and zoning vulnerability analyses and public education

**Preparedness** – planning how to respond e.g. preparedness plans emergency exercises / training and early warning systems

**Response** – initial actions taken as the event takes place it involves effort to minimize the hazards created by a disaster e.g. evacuation search and rescue and emergency relief

**Recovery -** returning the community to normal ideally the affected area should be put in a condition equal to or better than it was before the disaster took place e.g. temporary housing financial support and medical care

**Disaster Risk management**

Disaster management is an enormous task that is not confide to any particular location, neither do they disappear as quickly as they appear. Therefore it is imperative that there is proper management to optimize efficiency of planning and respond due to limited resources collaboration requires a coordinated and organized multi – sectorial effort to militate against, prepare for respond to and recover from emergencies and their effects in the shortest time possible. The health system has a responsibility to protect the health of affected persons or communities in the event of a disaster or hazard this function is fulfilled through effective disaster risk management

Disaster risk management is a proactive and systematic process based on the key management principles of planning organizing leading coordinating and controlling its aim is to reduce the negative impact or consequences of adverse events. Disaster cannot always be prevent but the adverse effects can be minimized as a system disaster risk management has components

**Objectives of disaster management**

1. Reduce damage and deaths

Effective disaster management reduces or avoids morbidity mortality and economic and physical damage from a hazard. The methods used to achieve this include hazard and vulnerability analysis preparedness mitigation and prevention measure and the use of predictive and warning system

1. Reduce personal suffering

Disaster management reduces personal suffering such as morbidity and emotional stress following a hazard. The methods used to prevent suffering include hazard and vulnerability analysis preparedness and mitigation and prevention measures. Examples of effort to reduce personal suffering include providing safe food supplies and drinking water when water supplies become contaminated

1. Speed recovery

The methods to accomplish this objective include effective response mechanism and the institution of recovery programmes and assistance. Examples of effort to speed recovery include providing paperwork assistance for insurance claims and grant or loan application

1. Protective victims

Disaster management provides protection to victims and or displace person facilities utilize preparedness response mechanism recovery programme and assistance to address shelter needs and provide protective service

**Disaster risk management plan**

An effective disaster risk management plan includes:

1. Prevention

Prevention includes activities designed to provide permanent protection from disaster. Disaster prevention plans are designed to provide permanent protection from disasters not all disasters particularly natural disaster can be prevented but the risk of loss of life and injury cab be mitigated with good evacuation plans environmental planning and design standards

1. Preparedness

These are activities designed to minimize loss of life and damage e.g. by removing people and property from a threatened location and by facilitating timely and effective rescue relief and rehabilitation preparedness and management should be a high priority in health system management appropriate preparedness result in persons knowing what to do and how to respond after disaster has occurred

1. Mitigation

This is a coordinated multi – sectorial response to reduce the impact of a disaster and its long – term results relief activities include rescue relocation providing food and water preventing disease and disability repairing vital service such as telecommunication and transport providing temporary shelter and emergency health care`

1. Recovery

Once emergency needs have been met and the initial crisis is over the people affected and the communities that support them are still vulnerable recovery activities include rebuilding infrastructure health care and rehabilitation these should blend with development activities such as building human resources for health and developing policies and practices to avoid similar situation in future

**Disaster associated health issues**

When a disaster occurs the general population expects the government and other agencies to rapidly mobilize the need service with urgency preservation of life and health are of paramount importance to casualties immediately a disaster occurs medical professional first ad and emergency medicine should be made available as a consequence of disaster it is also important to identify risk factor communicable disease and determine ways of minimizing these risks.

**Emergency health service in disasters**

During the first few hours /days following a disaster the priority is usually to treat causalities and the sick or injured disaster like earthquake and collapse building often involve the management of mass causalities which normally require the following activities search rescue and first aid transport of health facilities and treatment triage tagging and redistribution of patient between when necessary.

The demand for curative care is highest during the acute emergency stage when the affect population is not vulnerable in their new environment and before basic public health measure e.g. water sanitation and shelter have been provided thereafter the priority should shift towards preventive measure. Any prolonged interruption in routine immunization and other disease control measure may result in serious outbreak of disease like measles cholera etc.

Disaster call for a coordinated response between curative and preventive health service including food supply water and sanitation etc. in order to minimize mortality and morbidity it is also necessary to organize the response according to three levels of preventive health measures namely primary secondary and tertiary prevention

**Infrastructure and procedures in accessing emergency situation**

**Managing a mass casualty incident (MCI)**

A MCI is any event producing a large number of victims such that the normal capacity of local health service is disrupted. Common cause of an MCI include road accidents floods fire explosion industrial accidents or conflict situation

The response may be delayed after a MCI due to poor communication inadequate transportation may be decrease the survival of victims in critical condition normally the following groups of patient reach the health facility first:

* Those nearest to the arriving ambulances
* Those who are to be rescued and
* Those who are the most gravely injured

If there is only one first referral health facility it may quickly become overwhelmed limited resources are used to care for victim arriving first even though most of the may have minor injuries as a result they tie up the personnel examining rooms etc. increasing the risk of death for the critically ill victims whose survival depends on receiving prompt medical attention

**Triaging**

Triage is defined simply as and prioritizing patient for medical attention according to the degree of injury or illness and expectations for survival. Triage is carried out to reduce the burden on health facilities and is normally done by the most experience health worker assisted by content staff on the triage team

Triage is a continues process that begins when patient arrive at the medical post and continues as their condition evolves until they are evacuated to hospital. By providing care to victims with minor or location injuries health facilities are freed to attend to more critical tasks triage is necessary where health facilities cannot meet the needs of all victims immediately particularly following an MCI

The goal of managing a mci is to minimize the loss of life or disability of disaster victims by first meeting the needs of those most likely to benefit from service. This goal can be achieved by setting the following priorities for triage

* priority for transportation to the hospital is based upon referrals of priority needs of patients
* priorities for care in the field are often identified by visible colour– coded tags that categorize patient needs

However it is important to note that different jurisdiction use varying systems and the use of colour – code tags may cause some confusion

Management of mci begins with being prepared to mobilize resources and follow standard procedures in the field and at the hospital. Hospital with a limited number of emergency workers may find it difficult to hold regular training session on mci management. Health facilities with limited resource should focus on the following:

* improving routine emergency service for sudden impact small scale incidents e.g. car accidents or accident in the home to avoid confusion the same procedures that are necessary to save lives during an mci should be performed as routine emergency service

Coordinating activities that involve more than an emergency medical unit e.g. police fire fighters ambulance hospital etc. and ensuring a quick from routine emergency service to mass casualty management establishing standard procedure for managing all incidents (small or large scale) such as search and rescue first aid triage transfer to hospital and hospital care

**Transportation of Casualties**

Evacuation of causalities may be organized when they are at a first aid post a dispensary or any facility of the casualty – care chain in which case they would have already been triaged and a priority category for evacuation has been assigned to each

1. evacuation is contemplated when means are available and reliable routes and time frames are known and security has been ensured prior to the moving of casualties it is imperative that personnel at destination have been informed and are ready to receive the casualty or causalities
2. Evacuation vehicle assigned for medical purpose must be used exclusively for the latter. Their availability and hygiene should be respected other vehicle should preferable be used to transport the dead bodies if at all possible. In case priority should be given to the living causalities
3. Proper lifting techniques are used to ensure comfort of the causality and personnel responsible for lifting should be in good physical condition
4. All departure of evacuation vehicles should be reported to supervisors in charge of managing evacuation providing the following information :departure time, number and condition of casualties ,destination estimated travel and route and number of first aiders a board
5. The means of transport should ideally be such that emergency and stabilization measure can continue and should be safe as possible as it is important that the trip is not traumatic for the causalities
6. It should also be such that causality can be accommodated in different lying or sitting position depending on their condition furthermore it should be able to accommodate for a provider of care or a first aider to accompany the casualty
7. The means of transport should provide adequate protection against the elements e.g. extreme temperature sun rain wind
8. Driving needs to be smooth and safe. Once a casualty has been stabilized it is unnecessary to drive at high speed and risk a road traffic accident extra care should be taken especially if the roads are bumpy or have pothole as hitting into them causes more pain to the casualty may increase bleeding and displace traumatized limbs hence causing more complication
9. Casualties found on the roadside should be taken on board only if there is adequate space and no other alternatives
10. On arrival at the hospital every injury person should be reassessed stabilized and give definitive care. The colour coded tags are strictly for field triage and field use they should not be used for documented health health care in the hospital
11. Hospital should also regularly advise the incident commander about their health care capability and capacity so that the transfer of mci victims is well organized if the hospital capacity or capability is low patient and victims may have to wait a long time for treatment in surgical or intensive care unit

**Communicable diseases common in disaster situation**

The main communicable diseases are:

1. Diseases transmitted by contact – a cute respiratory infection which are common among people after a disaster especially among the children these are spread through personal contact or being around people who are infected already these include the common cold influenza bronchitis diphtheria and pneumonia
2. Vector transmitted disease – these include malaria yellow fever dengue and leptospirosis these infection become prominent when the balance of nature is disturbed as is the case in disaster
3. Disease can also be transmitted through faucal matter ingested orally as a result of drinking contaminated water or eating food and fruits that are contaminated these disease include cholera typhoid fever diarrhoe disease and leptospirosis they can be transmitted through poor personal hygiene or from a contaminated environment
4. Diseases transmitted through breath contaminated air or from germs that are airborne can be problematic after a disaster. These diseases include tuberculosis measles meningococcal meningitis and whooping cough.
5. Sexually transmitted disease are on the rise in peaceful time let alone being in disaster mode these disease are transmitted through sexual contact with infected people such as
6. HIV and aids ,gonorrhea syphilis chlamydia and trichomonas

**STUDENT ACTIVITY**

DESCRIBE ALL COMPONENTS INVOLVED IN EMERGENCY MEDICINE AND WRITE SMALL NOTES ON EACH GIVING EXAMPLES WHERE POSSIBLE

**16.2 Policy frame work in disaster management**

Disaster preparedness is an ongoing multi sectorial activity it requires coordination and organization by different departments of the government to facilitate assessment of a country disaster risk adoption of standard and regulation and action to ensure that resources can be mobilized rapidly in disaster situation

The health objectives of disaster preparedness are to:

1. Prevent morbidity and mortality
2. Provide care for casualties
3. Manage adverse climatic and environmental condition
4. Ensure restoration of normal health
5. Re – establish health service
6. Protect staff and
7. Protect public health and medical asset

The preparedness process include policy development vulnerability assessments disaster planning training and education and monitoring and evaluation

**Policy development**

National government must designate a branch of the ministry or organization with the responsibility to develop organize and manage an emergency preparedness programme for the country this must work with central government, county provincial and community organization and ngos whether local or international to develop a set of policies agreed upon by all this process is vital for a well-coordinated response and a sustainable policy the policies endpoint must allow quick decision making ensure the action are legal and free liability and ensure that appropriate pre-defined action are taken during a state of emergency

**Disaster preparedness process**

1. Vulnerability assessment

Potential hazards at all levels of society are identified and priorities in a vulnerability assessment the community capacity can be determined by the availability of resources of the community and how the community is able to utilize these resources

1. Disaster planning

Planning is only one component of preparedness a disaster output plan should provide

* Provide an understanding of organizational responsibility in response and recovery
* Provide stronger emergency management network
* Improve society awareness and participation
* Effective response and recovery strategies and
* Be documented

1. Training and education

An important component of preparedness is to train and educate public health official and other stakeholders about the disaster plan. Training at all levels should ensure adequate distribution of important skills and knowledge needed for an effective disaster response

The county director of health is the technical advisor for all health matter in the county their role shall be:

1. The technical advisor to the county executive commissioner and them governor
2. To supervise all health service within the country
3. To promote the public health and the prevention limitation or suppression of infectious communicable or preventive disease within the county
4. To prepare and publish report and statistical or other information relative to the public health within the county
5. To report periodically to the director general for health on all public health occurrences including disease outbreak disaster and any other health matter
6. To perform any other duties as may be assigned by the appointing authority and any other written law

The objective in monitoring and evaluating is to measure how well the disaster preparedness plan and programme is being implemented and if it achieving its health objectives as discussed

Who recommends that an effective risk reduction and emergency preparedness strategy be based on an all hazard /whole health concept

* All hazard entails developing and implementing emergency management strategies for the full range of likely risks and emergencies natural biological technological and societal different hazard and emergencies can be caused similar problem in a intrasectoral coordination evaluation health service and community recovery should be implemented along the same model regardless of cause
* A whole health approach should be in place in a county there should not be parallel planning and coordination system for each category of health risks while technical leadership may vary emergency planning process overall coordination procedure surge and operational platform should be unified under one emergency preparedness and response unit. Plan of the health sector can then be effectively coordination with other sector as well as the designed national multi – sectorial emergency management agency

In addition to disaster preparedness plans must should include common coordination information tools and support services such as environmental health ,management of chronic disease , maternal newborn and child health , communicable disease control , nutrition , pharmaceuticals and biological and health care delivery service other specialized service may be include for preparedness and management of specific risks

**16.3 National policies for disaster management in Kenya**

Under policy objective 4 and 5 the Kenya health policy commits to provide and ensure free access to trauma care critical care emergency care and disaster care service and an adequate response to health effects of disaster and emergency and including putting in place appropriate financing mechanism for emergency health service risk reduction and emergency preparedness are the responsibility of all sectors and stakeholders at all levels of society at the level the ministry of health is the lead of agency of the health sector

The national policy for disaster management in Kenya (2010) has for key objective

1. To establish a policy and institutional framework for management of disaster including promotion of disaster awareness and for building the capacity for disaster risk reduction at all levels
2. To ensure that institutional and activities for disaster risk management are coordinated focused to foster participatory partnership between the government and other stakeholders at all level including international regional sub –regional national and sub –national bodies
3. To promote linkage between disaster risk management and sustainable development for reduction of vulnerable to hazard and disasters
4. To mobilize resource including establishing of specific funds for disaster risk reduction strategies and programmes

**16**.**4 handling emergencies at the health facility level**

An emergency occurs when health facility does not have enough resource to cope with an abrupt demand for services in such situation normal procedure should be abandoned and resource to increase to expand capacity. When a hospital receives an overwhelming number of emergency cases it must plan a simplified treatment address prevention of loss of life complication deformities infections and delay treatment

All health facilities within the structure of national health system should have an emergency action plan that take into consideration the rank of the hospital within the system based on its size location and disaster vulnerable

**Handling disaster occurring inside the facility**

Disaster may occur rendering the facility non function prior planning is therefore required to ensure the continuity of service during such occurrences all facility should have internal disaster plan for fire and other common disaster within the areas should be developed with input from the department

The plan should cover operational matter as:

* Allocation duties and responsibility
* Instruction on the use of alarm and other security system
* Instruction on firefighting methods
* Location of firefighting equipment
* System for notifying trained personnel
* Specification of evaluation procedures

All staff should be acquainted with the plan fire drills and internal emergency exercises should be carried out at least once a year to ensure staff is trained to carry out assigned duties and assess the efficacy of the plan

**MODULE 17: HEALTH SERVICES MONITORING AND EVALUATION**

**17.1 Purpose of Monitoring and Evaluation (M & E) in health System**

Monitoring is a systematic process covering routine collecting, analysis, and use of information about how well a project or programme is performing. It involves contentious review of the performance of all the components in the project to ensure that input deliveries work schedules, targeted outputs, and other required action are proceeding as per the work plans (MOMS & MPHS, 2011).

Evaluations is the periodic assessment of a project or programme to determine the achievements against clearly set performance targets. The purpose of conducting an evaluation is to assess whether the project is making progress towards achieving its overall goals and objectives, and providing opportunities for mid-course corrections to project implementation, if necessary (MOMS & MPHHS, 2011).

Monitoring and evaluation (M&E) are fundamental components of any programme that aims at continuously improving and providing better health outputs and outcome. Although there are differences between monitoring and evaluation, the two processes work together and lead to same end a result, which is to produce information that can be used to continuously improve the performance of a given facility, department or programme and learn about what is working and what is not working.

**17.2. Goal and Objectives of Kenyan National M & E System**

The goal of the National M & E is to provide timely and reliable information that will enable tracking of progress and to enhance informed decision -making at all levels in the implementation of interventions under the health sector mandate in the country. The specific objectives are to:

1. Establish a reliable M & E system at National and County level.
2. Strengthen the M & E capacity of MoHS and health facilities to collect, analyze and use data for decision making and health system improvement.
3. Promote importance of M&E, the need for systematic data collection and use of results and lessons learned in the further planning of health interventions by the government and its partners.
4. Increase understanding of trends and explaining the changes in disease incidences or prevalence overtime as well as morbidity and mortality rates and ratios;
5. To ensure accountability, transparency, transparency and the quality of information to achieve the desired results.

**17.3. Monitoring and Evaluation Framework**

Effective M&E is based on a clear logical pathway of results in which results at one level are expected to lead to results at the next, leading to the achievement of the overall goal. Consequently, if there are gaps in the logic, the pathways will not lead to the required results.

Major levels for M&E framework are: Inputs, process, outputs, outcomes and impacts.

* *Inputs*- The people equipment, materials and resources that are put into a project in order to implement the project.
* *Process*es- The activities performed/involved in delivery the project such as training, meetings, treatment and distribution among others. Processes associated with service delivery are very important and involve quality, unit costs, access and coverage.
* *Outputs*- The first level of results associated with the project e.g. the numbers of people trained or services delivered in order to achieve outcomes. These are short-term results.
* *Outcomes*-The second level results associated with the project mid-term results e.g. the changes in health status, behaviour or skills. These must be related to the project goals.
* *Impacts*-The third level results with long-term consequences of a project e.g. decrease mortality and morbidity changes overtime and usually long-term.

**17.4 M &E Indicators**

An indicator is defined as a set of values used to measure against, it is like a sign post that is used to measure against. Valid and measureable indicators are very crucial in an M&E system. Each of the M&E levels-inputs, outputs, outcomes, impacts-has an indicator to very whether the desired objectives or activities re implemented achieved or not.

A minimal set of indicators is advisable in any M&E system. The following three golden rules of M&E provide a good basis:

1. Define indicators that can be measured;
2. Collect data that is useful for decision-making or from which lessons be learned, and;
3. It is better to approximate an answer for a few important questions than to have an exact answer for many unimportant questions.

Table 17.1 Types and Sources of Information Required for Monitoring in the Health Sector

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Category of information** | **What monitor & Evaluate** | **What records to keep** | **Who collects data** | **Who uses data** | **How to use information** | **What decisions can be made** |
| **Work plan activities** | Timing of activities | Monthly/quarterly/ annual work plans | Health facility | Project implementation team | Ensure staff and other resources are available | Reschedule activities and deployed of resources as needed |
| Availability of personnel, resources | Work schedules | HDO | HMT, HDO |
| **Costs and expenditure** | Utilization of resource | * Project budget * Accounting records * Receipts * Cash and bank transaction * Report MOH/   donor | Accountant | * HMT * HMC * Auditor * MoH Headquarters * Donor partners | * Ensure funds are available to implement activities. * ensure compliance with GoK and funding regulations | * authorize expenditure * make budget and project revisions * determine need for other funding sources |
| Resources mobilized |
| Expenditure |
| **Staff supervision** | Knowledge attitudes and skills of and staff | * performance reviews * job descriptions | * HoD * HRM * Quality Teams | * HMC * HRM | * Staff motivation staff * Staff development * Resolve work place problems | * Task allocation * Training needs * Recruitment * Disciplinary action * Promotion |
| Experience/commitment/education of and staff |
| Salaries and benefits or other forms of compensation |
| Job performance |
| **Category of information** | **What monitor & Evaluate** | **What records to keep** | **Who collects data** | **Who uses data** | **How to use information** | **What decisions can be made** |
| **Management of facility assets and other physical materials** | Equipment e.g. computer, motor vehicle stock | * Assets and stock registers * Assets and stock movement logs/registers * Invoices * Inspection/service/ audit reports | HoD | * Hod * Supplies & Logistics * Maintenance | * Ensure availability of required physical resources. * Ensure good condition of physical resources | * Authorized on for utilization * Minimum quality to be kept * When to order * Amount to keep in reserve for emergency. |
| Procurement regulations |
| Performance results | Outputs, outcomes, impact | * Minutes of project review meetings * Minutes of Departmental meetings * Attendance registers | * HMC * HOD * Project implementation team | * HMC * HOD * Project implementation team * Donor agency | * Ensure objectives are realistic * Assess quality of services provided * Assess appropriateness of interventions | * Revise objectives * Retrain staff * Revise project strategy and approach. |

**17.5 Types of Evaluation**

***Baseline/formative***

The evaluation is conducted before implementation of the plan to assess needs and potentials. It can also determine feasibility of the plan.

***Midterm Evaluation***

Conducted during the implementation period to identify areas that require change or modification and in the process deficiencies and ensure immediate redesign of intervention strategies to forestall failed implementation.

***Summative/End of Project Evaluation***

This is conducted at the end of the project to assess outcomes achieved as an effect of project activity implementation.

***Post Project Evaluation***

Evaluation conducted to measure programme sustainability after its successful implementation and closure.

***Impact Evaluation***

Evaluation to assess long term effects association with a successful project implementation.

17.6. Monitoring Process

The monitoring process will take the logical steps below depending on whether one is looking at the process from accountability perspective, manager perceptive or evaluator’s perceptive. This involves:

1. Recording data on key indicators as a result of activities carried out;
2. Analysis and processing data for consumption
3. Storing and retrieving information for use by different stakeholders;
4. Reporting activity results based on activity timeframe;
5. Providing feedback to appropriate managers and stakeholders internally and externally.

**17.7. Evaluation Process**

The evaluation process will entail:

1. Designing evaluation strategy;
2. Participatory planning meeting;
3. Developing evaluation plan;
4. Impalement evaluation plan
5. Analyze evaluation results;
6. Participatory reflection on results;
7. Implementation of improvements.

**17.8 M&E Conceptual Framework**

The M&E conceptual framework demonstrates the theory of the sequences of cause and effect that ultimately lead to particular ultimate result. In the health sector, the ultimate result is positive health impact on clients in any of the health areas.

**Impact**

* Incidences
* Prevalence rates

**Outcome**

* Knowledge
* Improved services

**Output**

* Services
* trainees

**Process**

* activities

e.g. training, Distribution.

**Input**

* Resources
* Staff
* Supplies

**Source:** MSH (2013).

The conceptual framework demonstrates the process of monitoring and evaluation.

What you need to do at each level

* *Inputs level*- Monitor whether resources, staff, supplies e.t.c being provided
* *Process level*: Monitor whether activities are happening.
* *Outputs level*: Monitor whether required outputs are generated by activities carried out according to palled schedule.
* *Outcome level*: Evaluate whether there is gain in the expected areas
* *Impact level*; evaluate or conduct demographic health survey to show impact..

**179.9 Evaluation Terms of Reference (TOR)**

**What is TOR?**

TOR refers to the definition and structured description of the scope of work and the schedule that must be carried out by the person, company or evaluation team undertaking an evaluation.

**Characteristicsof TORs**

The terms of reference recall the background and specific the scope of the evaluation, process, products, technical aspects and states the main motivates for anevaluation and the questions asked. It sums up available knowledge and outlines an evaluation methodology describing the distribution of work, schedule and the responsibilities among the people participating in an evaluation process. It is also specifies the qualifications required from candidates teams or individuals as well as the criteria to be used to select an evaluation team.

TOR serves as ‘contact’ between project/institution and evaluators, outlining key elements and should reflect strategic choices on what to focus on. The optimal type of TOR is one that satisfies the interests of all stakeholders concerned. This is not always possible. However given the range of motivations for undertaking an evaluation, it requires the TOR to retain enough flexibility for the evaluation team to determine the best approach for collecting and analysis data.

Components of TOR

At a minimum, it is expected that ToRs for all evaluations will address the following sections.

1. *Title*
2. *Backgrounding and context*

Overview and historical context of project under evaluation, project justification and implementation experiences/challenges, project documents and revisions thereof, project objectives and expected outcomes.

1. *Purpose of the evaluation (objectives)*

Who commissioned the evaluation? Why at this point? What is it expected to accomplish? What decisions might evaluation guide in? Who will use the evaluation results and how do you involve them?

1. Scope of work for the evaluation

There is need to determine the unit of analysis to be covered –project cluster of projects, programme, a process within a project, time period, geographical coverage.

1. *Evaluation criteria and key evaluation questions*

Identify the key evaluation questions to be answered by the evaluation on along with their related evaluation criteria-project relevance, efficiency, effectiveness, impact, and sustainability.

1. *Evaluation methodology*

The methods used to collect and analyses data on which the quality of the evaluation is dependent on i.e. desk reviews, questionnaires, survey, structured interviews, discussions, workshops, field visit, observations, retrospective baseline construction e.t.c, data sources, and possible references to an evaluation.

1. *Expected deliverable/outputs*

Planed field missions and expected deliverables and respective timeframes including:

* Inception report –containing a refined work plan, methodology and evaluation tools.
* Draft evaluation report in line with institution evaluation policy and guidelines.
* Final evaluation report, including annex with management response.
* Presentation of evaluation findings, lessons and recommendations to project and stakeholders.

1. *Timeframe*

Evaluation inception to presentation of results

1. *Evaluation team composition*

Qualified independent and impartial evaluators not involved in project design or implementation, gender balanced, balance geographical representation.

1. *Management of evaluation process*

Roles and responsibilities matrix of all the evaluation stakeholders-evaluators, managers, technical unit, field staff, implementers.

1. *Budget*
2. *Annexes*

**17.10 Monitoring and Evaluation Tools**

Basic monitoring tools are used to collect input, process and output indicators. The tools and formats should focus on results and progress towards outcomes. These include:

**Work plan**

The work plan is a planning tool that serves as a guide for implementation of action states (activities) to achieve the stated overall goal and particularly specific objectives of a project. It provide the framework for evaluating progress towards objectives and is the primary document used to monitor on-going progress, to adjust activities as needed and to evaluate outcomes. The work plan is ‘living’ document and, as such, it may change over the duration of implementation to reflect a more realistic implementation process.

**Monitoring Plan**

A monitoring plan is a set of requirements for monitoring and verification of objectives achieved by a project during implementation. These may be;

* Monthly services statistics summary registers
* Financial reports;
* Monthly/quarterly institutional reports;
* Checklists;
* Questionnaires
* Interview guides;
* Focus group discussion guides
* Observation guides
* Internet (secondary data)

**Evaluation tools**

Evaluation tools are used for assessing effective indicators (outcome and impact indicators). They focus on assessing program outcomes and impact. These include.

1. *Performance monitoring plan*

A performance monitoring plan (PMP) serves as a roadmap for monitoring and evaluating programme performance through its lifespan. It is a detailed plan for managing indicators in order to monitor project performance, outcomes and impact. The PMP contain the performance indicators and their definition, data source method of data collection or calculation, when data is collected, responsibility, why the data is important, who will use the data and for what purpose.

1. *Evaluation plan*

An evaluation plan is a written document that states the objective of the evaluation questions, information to be collected and timeframe of the evaluation. The plan should constitute sections describing the key questions to be addressed related to areas of expected learning from the evaluation as a part of the evaluation framework, programme implementation objectives, outcome objectives and performance measure and procedures for managing and monitoring the evaluation.

**17.11. Work Plans**

**Definition**

A work plan is an annual or multi-year summary of tasks, timeframes and responsibilities that is used to support the implementation and evaluation of programmes implementation. It is a valuable tool with a detailed account of how employees propose to accomplish, their goals during project implementation-what sections need to happen, who will do them, when they will be completed and what production of outputs and progress towards outcomes and impact is timely and reflects project goals.

**Key elements of a work plan**

1. Clearly defined goals, outputs and outcomes;
2. Activities –tasks to achieve outputs, outcomes;
3. Costs(budget) indication of the activity’s costs;
4. Monitoring and evaluation-ensures that measures to monitor and assess the effectiveness of an activity are included such as recording achievements, collecting data, and assessments.

**Developing a work plan**

The overall process of work planning is a comprehensive tool that helps programme staff to translate project/programmes goals into operational terms on an annual basis. Monitoring and evaluation are integral parts of a work and will provide a basis for tracking achievements and revising strategies on how to best achieve project goals.

Work plans set out a project will achieve its clearly defined foals by converting project goals into smaller, manageable outcomes and tasks that will ensure that the skills, experience and resource available are used efficiently and sustainably. A work plan will also help a supervisor know what project and activities supervisees will be working on over the next several moths.

A work plan generally includes a brief introduction or overview of a project and a breakdown of how individual project related tasks will be accomplished through activities. The detailed breakdown is usually tabulated with columns capturing specific activity descriptions, outputs/outcomes, a timeline for completion, cost projections for implementation and staff responsible (Table 17.2). it is mandatory to include monitoring and evaluation activities in the work plan.

Table 17.2. Work Plan Template

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective** | **Activity Deception** | **Output/**  **outcomes deliverables** | **Responsibility** | **Budget assumptions** | **Budget (Ksh)** | **Progress remarks** | **June** | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **apr** | **May** |
| **1.1 Provide essential drugs for adults and elderly with common health conditions to increase their survival rate by 10%** | a)Conduct HIV?AIDS testing for adults and elderly facility clients | 10 clients receiving ART every month | Jone Salama | 100 units testing kits | 200,000 |  | x | x | x | x | x | x | x | x | x | x |  |  |
| b)Conduct outreaches quarterly | 1 outreach every quarter | Cyril Mwema | Transport, Tent hire, brochures | 45,000 |  | x |  |  | x |  |  | x |  |  |  |  |  |

**Implanting Work Plans**

Implementation is the process of taking a work plan and its concepts and putting it into action. The work plan will serve as a guide for what needs to be accomplished, by whom and in what specific timeframe. However, surprises do come up and changes in the work plan may be necessary. It is critically important that staffs involves in work plan implementation are made aware of such changes and how the changes may effected their role in the implementation process.

Throughout the implementation process, data related to the measures identified should be collected. These data will be important in the monitoring and evaluation process to determine whether or not the programme had the intended outcome.

**Monitoring and Evaluation Work Plans**

Monitoring the wok plan will be done by assessing whether activities were implemented as initially planned. This is usually done through monthly/quarterly activity implementation reviews. Enhanced process evaluation will entail an examination of whether activities are belonging carried out correctly, on time and within budget. Results of the evaluation should be used to enhance or review implementation.

**17.12 Evaluation Reports**

According to the Business Dictionary a report is a document containing information organized in a narrative, graphic, or tabular form, prepared on ad hoc, periodic, recurring, regular, or on as required basis.

In program management, a report is;

1. A compilation of description information;
2. A communication tool to present M&E results by presenting raw data and information as knowledge;
3. An opportunity for project implementers to inform themselves and others (stakeholders, partners, donor’s e.t.c) on the progress, problems, and difficulties encountered successes and lessons learned during implementation of programs and activities.

Reports may refer to specific periods, events, occurrences, or subjects, and may be communicated or presented in oral or written from. Some questions to answer before writing to report are:

* Have you considered the needs/characteristics of the readers? i.e. executive, technical team, staff, donor, general public).
* If it is a public health report, does it make health care performance information clear meaningful, and usable by consumers?

*Why report?*

* Reporting enables the assessment of progress and achievements and helps focus audiences on the results of activities, enabling the improvement of subsequent work plans.
* Reporting helps form the basic for decision –making and learning at the programme level.
* Reporting communicates show effectively and efficiency a programme is meeting its objectives.

*Elements of a good report*

* Self –explanatory statement of facts relating o a specific subject(s).
* Systematic and logical presentations of relevant ascertained facts, figures, conclusions and recommendations.
* Time bound for timely decision making
* Concise and objective.
* Appropriate grammar, language and tone for the consumers (avoid technical jargon).
* Complete and compact document.

**Monitoring and evaluation reports**

*Types of reports*

* Progress report-usually quarterly, semi-annual or annual
* Evaluation report-mid-term, end –term evaluation
* End of project report.

Guidelines for writing M&E reports

* Provide a 1 page brief summary (executive summary) and ensure it accurately captures the content and recommendations in the report.
* Be as concise as possible given the information that needs to be conveyed.
* Focus on relevant results being achieved compared with the expected results as defined in the log frame/performance monitoring plan and check that the expected results are realistic.
* Specify actions to overcome problems and accelerate performance where necessary. (The basic of this narrative is what you had planned and how you are responding. For example, why something that was planned did not take place and what you plan to do about it).
* If findings are included in the report, make sure they are objectively verifiable.
* Be clear on your audience (directors, government, donor, technical persons, staff) and ensure that the information is meaningful and useful to the intended reader.
* Ensure timely submission of progress reports.
* Be consistent in your use of terminology, definitions and define any technical terms or acronyms.
* Present data with the help of figures, summary table, maps, photographs and graphs.
* Include references for source and authorities (if any) and a table of contents.

*Progress report format*

**Cover page**

* Name of institution
* Reporting period;
* Name of person responsible for reporting/contact person;
* Table of contents
* Acronyms
* Executive summary;
* This section should have one introductory paragraph and major highlight of findings and key lessons learned ( to 2pages);
* Report body

This section should consist of a table of the hierarchical objectives with a short paragraph describing significant outcome results, why your targets were met/not met and what steps totake; lessons learned (If any) and highlights of activities for the next period. Tables, maps, photographs and graphs may be used where appropriate to enhance clarity and results interpretation.

**Figure 17.2 Sample Project Achievements Table**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Objective** | **Output/Outcome/**  **Deliverable** | |  |  |
| **Planned** | **Achieved** | **Remarks on achievement** | **Next period activities** |
|  |  |  |  |

Indicator achievement (include when these are achieved)

* Achievements on outcome indicators;
* Achievements on milestones
* Achievements on impact indicators;
* Focus on relevant results being achieved compared with the expected results as defined in the long frame/performance monitoring plan and that the expected results are realistic.
* Specify actions to overcome problems and accelerant performance where necessary. (The basis of this narrative is what you had planned and how you are responding. for example, why something that was planned did not take place and what you plan to do about it).
* If finding are included in the report, make sure they are objectively verifiable.
* Be clear on your audience (directors, government, donor, technical persons, staff) and ensure that the information is meaningful and useful to the intended reader.
* Ensure timely of progress reports.
* Be consistent in your use of terminology, definitions and define any technical terms or acronyms.
* Present data with help of figure, summary tables, maps, photographs and graphs.
* Include references for sources and authorities (if any) and a table of contents.

*Progress report format*

**Cover page**

* Name of institution;
* Reporting period
* Name of person responsible for reporting/contact person
* Table of contents;
* Acronyms
* Executive summary
* This section should have one introductory paragraph and major highlights of findings and key lessons learned (1 to 2pages)

This section should consist of a table of the hierarchical objectives with a short paragraph describing significant outcome results, why your targets were met/not and what steps to take, lessons learned (If any) and highlights of activities for the next period. Tables, maps

**APPENDICES**

**Appendix 1- Form S11-Counter Requisition and Issue Voucher**

COUNTY REQUISITION AND ISSUE VOUCHER

Ministry \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dept/Branch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To (issue point) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pleas issue the items issued below (point of use)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Code No | Item description | Unit of issue | Quantity Required | Quantity issued | Value | Remaining |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Account No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requisitioning Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Issued by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Received by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix 2- Form S12 –Issue and Receipt Voucher**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | |  | |  | | Issue and receipt voucher | | | |  | | |  | | |  | |  |  |  |
| Ministry | | | | Issue Approved by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Min/Dept\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Indent approved by\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| Issuing unit | | | | Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Indenting Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Date | | | | | | | | |  |
| Address | | | | Stores packed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Adress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| Issuing officer | | | | Mode of dispatch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Receiving Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Receipt recorded by\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| Designation and stamp | | | |  | | | | | | Designation & Stamp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Charged to\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| Merchants | | | |  | | | | | |  | | | | Vote/Head\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| Address | | | |  | | | | | |  | | | | S/head/Item No\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |
| a) | b) | c) | | d) | | e) | | f) | | h) | i) | j) | |  | k) | | | i) | | m) | | |  |
| Item | Cat . No | Location | | Description of stores | | Unit | | Qty rqd/ordered | | Qty issue/rcd | Qty to follow | Rate | | Total value | | | | Stock balance | | Ledger folio no | | | Remarks |
| 1 |  |  | |  | |  | |  | |  |  |  | | kshs | | | Cents |  | |  | | |  |
| 2 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 3 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 4 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 5 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 6 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 7 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 8 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 9 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |
| 10 |  |  | |  | |  | |  | |  |  |  | |  | | |  |  | |  | | |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certified that the above items have been received/recorded on ledge/inventory**

**Signature of the issuing officer and Date signature of the receiving officer and date**

**Appendix 3-S13 Form –Counter Receipt Book**

**COUNTER RECEIPT BOOK**

Ministry/Dept/Branch

Received the items listed below from (sources)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Code** | **Item description** | **Unit** | **Quantity** | **Value** | **Remarks** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Order No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Invoice No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Issuing Officer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certified that the quantities received have been taken on charge

Appendix 4-S20-Local Purchase Order

LOCA PURCHASE ORDER

Suppliers are warned that this order is INVALID available funds is confirmed here below by the Accountant

|  |
| --- |
| To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quotation Reference No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contract Ref No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Requisition No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please deliver the goods listed here below to (full address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On terms and conditions stated at the back of the order, on or before\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and send the invoices immediately to Department/Ministry \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Item No** | **Description of goods** | **Quantity** | **Unit cost** | | **Total cost** | |
|  |  |  | shs | cts | Shs. | Cts. |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vote \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Station \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sub-head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Item \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A/C No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that the funds are available and that commitment has been made on the vote book

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accountant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplier

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge receipt

**Appendix 5-S21 –Local service Order**

LOCAL SERICE ORDER

Supplier are warned that this order is INVALID available funds is confirmed here below by the Accountant

To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tender/Quotation Ref No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contract References No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Requisition No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On terms and condition stated on the back of this order, on or before \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and send invoices immediately to Department/Ministry \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P.O. Box \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Item No** | **Description of service** | **Cost** | |
|  |  | **Shs** | **Cts** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Shs.** |  |  |  |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vote \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Station \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sub-Head \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that funds are available and that commitment has been noted on the vote book

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accountant

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplier

I acknowledge receipt of this order \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Appendix 6-The Vote Book

Appropriate Account for the year ended 31 December 2011

Vote R/D –Ministry/Department XYZ

|  |  |  |  |
| --- | --- | --- | --- |
| Sub – Vote X | Approved | Actual |  |
|  | Estimate | Expenditure | Variations |
| 000-personal Emoluments | 360,000.00 | 352,000.00 | 8,000.00 |
| 040- Gratuity and pension payments | 200,000.00 | 185,000.00 | 15,000.00 |
| 110-Travel and accommodation expenses | 50,000.00 | 48,000.00 | 2,000.00 |
| 121- Telephone expenses | 60,000.00 | 62,000.00 | (2,000.00) |
| 180- Hiring, Rent and rates | 45,000.00 | 46,000.00 | 1,000.00) |
| 191- Training Expenses | 10,000.00 | 10,000.00 | - |
| 200- Replacement of Motor Vehicle | 6,000.00 | 6,500.00 | (500.00) |
| 250- Grants in Aid | 50,000.00 | 52,000.00 | (2,000.00) |
| Gross Expenditure | 781,000.00 | 761,500.00 | 19,500.00 |

**Appendix 7-Imprest Request form**

Imprest request form

Pf No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Desgination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ JG\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extn \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the above mentioned wish to apply for an imprest of Kshs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In works, Kenya shillings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the following purpose (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I note that the imprest is not a loan and must be surrendered within 48 hours after the expiry of the journey or intended purpose, failure to which disciplinary measures should be taken against me as per Governments Financial Regulations and Procedures.

I understand to surrender the imprest in full on or before \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I will be liable to the penalties as per the Government Regulations and Procedures if I will not have surrendered the imprest aas stated in full as stated above.

Applicants signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PS/Head of Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CFO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Imprest Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAC process/do not process\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 8- Surrender of Imprest

Surrender of imprest

PF No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_JG\_\_\_\_\_\_\_\_\_\_\_

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extn \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the above mentioned wish to surrender the imprest of

kshs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in words \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

That was issued to me for the following purpose (s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attached herewith please find attached the copy of

the work ticket, air or bus ticket, copy of the passport,

clearance letter and copy of the imprest application letter

Applicant’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 9- Sample Payroll

Xyz Company Limited

Payroll for the month of December 2011

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME | GROSSPAY | ALLOWANCES | TOTAL GROSS PAY | PAYE | NSSF | NHIF | PENSION | SACCO | INSSUARANCE | TOTAL DEDUCTIONS | NETPAY |
| Employee 1 | 150,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 2 | 100,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 3 | 30,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 4 | 50,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 5 | 30,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 6 | 13,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 7 | 23,000.00 |  |  |  |  |  |  |  |  |  |  |
| Employee 8 | 7,000.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  | 420,000.00 | 63,500.00 | 433,500.00 | 107,123.68 | 1,400.00 | 2,000.00 | 17,000.00 | 8,000 | 95000.00 | 145,063.00 |  |

Appendix 10-Sample Pay slip

**Name: Employee 1**

**Title: Medical Officer**

|  |  |  |
| --- | --- | --- |
| **Gross Pay** |  |  |
| Basic Pay |  | 30,000.00 |
| Allowances |  | 5,000.00 |
| **Total Gross pay \_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_35,000.00** |
|  | | |
| **Chargeable pay** |  |  |
| Less: Pension –NSSF |  | 200.00 |
| Less: Insurance relief |  | 150.00 |
| **Chargeable Pay** |  | **34,850.00** |
|  | | |
| **TAX TABLES APPLICATION** | |  |
| **Ranges** | **Rate** |  |
| 1-10164 | 10% | 1,016.40 |
| 10165-19740 | 15% | 1,436.40 |
| 19741-29316 | 20% | 1,915.20 |
| 29317-34,850 | 25% | 1,383.25 |
|  |  |  |
| **Gross P.A.Y.E** |  | **5,751.00** |
| (-) Personal Relief |  | (1,162.00) |
|  |  | 4,589.00 |
|  | **Net tax Payable** | **4,589.00** |
| **DEDUCTIONS** |  |  |
| PAYE |  | **4,589.00** |
| NSSF |  | 200.00 |
| NHIF |  | 320.00 |
| Sacco deductions |  | 500.00 |
| Insurance |  | 500.00 |
| Pension contribution |  | 500.00 |
| **TOTAL DEDUCTIONS** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6,609.00 |
| **NET PAY** |  | **28,391.00** |

Appendix 11-Sample Muster Roll

XYZ Company

Muster roll for the month of December 2011

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** | **WAGE** | **PAYE** | **NSSF** | **NHIF** | **Total DEDUCTIONS** | **NET WAGE** | **SIGNATURE** |
| Casual worker 1 | 15,000.00 | 350.00 | 200.00 | 320.00 | 1,070.00 | 13,930.00 |  |
| Casual worker 2 | 10,000.00 | - | 200.00 | 220.00 | 420.00 | 9,580.00 |  |
| Casual worker 3 | 8,000.00 | - | 200.00 | 180.00 | 380.00 | 7,620.00 |  |
| Casual worker 4 | 7,000.00 | - | 200.00 | 160.00 | 360.00 | 6,640.00 |  |
| Casual worker 5 | 5,000.00 | - | 200.00 | 120.00 | 320.00 | 4,680.00 |  |
| Casual worker 6 | 4,000.00 | - | 200.00 | 100.00 | 300.00 | 3,700.00 |  |
|  |  |  |  |  |  |  |  |
| **Total** | **49,000.00** | **550.00** | **1,200.00** | **1,100.00** | **2,850.00** | **46,150.00** |  |

Appendix 12- Sample Cash and Bank Book

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sample Cash and bank book |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Period Ended 31 December | | | | | | | | | | | | | | | |
|  | | | | | | | Programme costs | | | | | Operational Cost | | | |
| Date | Payee | Description | Payment Voucher Number | Cheque Number | Total Receipts | Total Payments | Budget  line 1 | Budget line 2 | Budget line 3 | Budget line 4 | Budget line 5 | PERSONNEL Costs | Admin Costs | Petty Cash | Imprest |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  | Opening balance |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | - |  |  |  |  |  |  |  |  |  |  |
|  |  | Total |  |  | - | - | - | - | - | - | - | - |  |  | - |

Appendix 13- Summary Expenditure Report

**Sample summary Expenditure report as at 31 December 2011**

|  |  |
| --- | --- |
| **Expenditure** | **Amount** |
| Salary | 500,000.00 |
| Administrative costs | 200,000.00 |
| Programme costs | 700,000.00 |
| Monitoring and Evaluation | 150,000.00 |
| Audit | 100,000.00 |
| **Total** | **1,650,000.00** |

**Appendix 14- Bank Reconciliation Statement**

Sample Bank Reconciliation

Period ended 31 December 2011

Name of Account

|  |  |
| --- | --- |
| Bank Account No |  |
| Date | |

Kshs.

Balance as per bank Statement

Add:

Deposits made but not shown on statement

Total

Less:

Outstanding cheques

Balance as per Cash Book

Add:

Deposits made but not shown in cash book

Total

Less:

Bank Charges

Adjusted cash Book Balance

|  |  |  |
| --- | --- | --- |
|  | Signature | Date |
| Prepared By: | Accounts Clerk |  |
| Reviewed By: | Accountant |  |
| Approved By | Director |  |

**Appendix 15-Sample Ledger**

Sample Ledger Statement

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| XYZ Company Limited |  |  |  |  |  |  |
| Payee | Category | Billed | Due | Paid | Amount | Posted |
|  |  | Date | Date | Date | Paid | Date |
| Dial a cab | Travel |  |  |  |  |  |
| Uchumi Supermarket | Utilities |  |  |  |  |  |
| Safari Park Hotel | Workshop |  |  |  |  |  |
| Dawa Pharmaceuticals | Medical equipment |  |  |  |  |  |
| Uchumi Supermarket | Stationery |  |  |  |  |  |
| University of Nairobi | Staff training |  |  |  |  |  |

**Appendix 16- Sample Trial Balance**

**Sample trial Balance**

**Details of Expenditure form the Trial Balance as at 31st December 2011**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item** | **Details** | **Estimates** | **Actual** |
| 000 | Personal Emoluments | 360,000.00 | 350,000.00 |
| 040 | Gratuity and personal contributions | 20,000.00 | 18,000.00 |
| 050 | Other Personal Allowances | 88,000.00 | 81,000.00 |
| 140 | Telephone expenses | 14,000.00 | 10,000.00 |
| 180 | Hiring rent and rates | 38,000.00 | 32,000.00 |
| 191 | Training expenses | 17,000.00 | 16,000.00 |
| 300 | Grants in Aid | 3,000.00 | 2,500.00 |
|  |  |  |  |
| **Gross Expenditure** | | **540,000.00** | **509,500.00** |

**Appendix 17- Appropriation Accounts**

**Revenue return**

**Appropriation In Aid (AIA)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Account No** | **Details** | **Cumulative Total** | **Collection this month** | **Cumulative Totals** |
|  |  | **KSH** | | |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Copy to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

District Accountant

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix 18-Sample Cash Flow Forecast**

**Sample Cash Flow Statement**

**For the period ended 31 December 2011**

Cash Flow from Project Activities Kshs.

Net surplus deficit

**Adjustments for:**

Depreciation

Net cash flow before working capital changes

Increase in trade and other receivable

Decrease in trade payables

Cash generated from operations

Interest paid

Net cash from project activities

**Cash Flow from Investing activities**

Purchase from sale of equipment

Proceeds from sale equipment

Net flow from financing activities

Cash received from donors not used for projects

Net cash flow from financing activities

**Net increase in cash and cash equivalents**

Cash and cash equivalents, beginning of the period

Cash and cash equivalents, end of the period

**Net cash and cash equivalents.**

**Appendix 19- Sample Fund Account Statement**

**Sample Fund Accountability Statement**

**Period Ended 31 December 2011**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Actual** |  |  |  |
|  | **Budget** | **Precious** | **This** | **Cumulative** | **Budget** | **Budget** |
|  |  | **Period** | **Period** |  | **Balance** | **Spent** |
|  | **A** | **B** | **C** | **D=B+C** | **E=A-D** | **F=D/A %** |
| **Income** | **Shs.** | **Shs.** | **Shs.** | **Shs.** | **Shs.** |  |
| Grant |  |  |  |  |  |  |
| Interest |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total income** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Expenditure** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Programme** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Sub-total** |  |  |  |  |  |  |
| **Operating costs** |  |  |  |  |  |  |
| Personnel Costs |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Sub-total |  |  |  |  |  |  |
| **Administrative Costs** |  |  |  |  |  |  |
| Administrative |  |  |  |  |  |  |
| Sub-Total |  |  |  |  |  |  |
| **Sub – total** |  |  |  |  |  |  |
| **Total Expenditure** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Surplus (Deficit) |  |  |  |  |  |  |
| Balance Brought Forward |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Balance Carried Forward** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Represented By** |  |  |  |  |  |  |
| Petty Cash |  |  |  |  |  |  |
| Cash in Bank |  |  |  |  |  |  |
| Imprest |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Signature** | **Date** |
| Prepared: | Accounts Clerk |  |
| Received by: | Accountant |  |
| Approved By: | Director |  |

**Appendix 20-Sample Income and Expenditure Statement**

**Sample Income and Expenditure Statement**

As at xxx

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **Details** | **Current** | **Previous** | **Cumulative** |
|  | **Period** | **Periods** | **Balance** |
|  |  |  |  |
| **Income** |  |  |  |
| DANDA |  |  |  |
| USAID |  |  |  |
| CIDA |  |  |  |
| Sub-Total |  |  |  |
|  |  |  |  |
| Bank Interest |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Income** |  |  |  |
|  |  |  |  |
| **Expenditure** |  |  |  |
|  |  |  |  |
| Administration costs |  |  |  |
| Material Development |  |  |  |
| Workshop costs |  |  |  |
| Monitoring costs |  |  |  |
| Monitoring Evaluation & Audit |  |  |  |
|  |  |  |  |
| **Total Expenditure** |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Surplus (Deficit)** |  |  |  |
|  |  |  |  |

Prepared By:

Received By:

Approved By:

**Appendix 21- Sample Balance Sheet**

**Sample Balance Sheet**

**XYZ Balance Sheet**

**XYZ Limited**

**As at 31 December 2011**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | Perior Financial Years | Current Year | Total |
|  | Kshs | |  |
| **ASSETS** |  |  |  |
|  |  |  |  |
| **Non-Current assets** |  |  |  |
| Exchequer Account |  |  |  |
| Advance Accounts |  |  |  |
| Suspense Accounts |  |  |  |
| Imprests |  |  |  |
| Special Fund Investments |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **TOTAL** |  |  |  |
|  |  |  |  |
| **Liabilities** |  |  |  |
|  |  |  |  |
| General Account Vote |  |  |  |
| Excess AIA |  |  |  |
| Special Funds |  |  |  |
| Development revenue |  |  |  |
| Recurrent revenue |  |  |  |
|  |  |  |  |
| **Total** |  |  |  |
|  |  |  |  |