



Guidelines
for
District Health Management Boards,
Hospital Management Boards,
and
Health Centre Management Committees

December 2002

Government of Kenya
Ministry of Health
Nairobi, Kenya

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The contents of the Guidelines are based on procedures developed by the Division of Health Care Financing and tested through visits to facilities, provincial and district medical offices and in workshops with members of both District Health Management Boards and District Health Management Teams. Advice and comments from representatives of various departments at Ministry headquarters have also been incorporated.



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All Provincial Medical Officers
All Medical Officers of Health
All Officers in Charge of Health Centers
All District Accountants

RE: DISTRICT HEALTH MANAGEMENT BOARDS/HMB GUIDELINES

In order to improve the collection, management and use of FIF revenues, the ministry has put together the attached guidelines. This manual provides a complete set of guidelines for operations of the Boards and Committees. The guidelines should be read thoroughly and put into practice immediately.

The procedures set out in the manual should be regarded as superceding those set out in any previous Ministry of Health circulars. It should be noted that specific instructions which vary over time, such as fee levels or exemption categories, are not included in the manual and will instead continue to be communicated to you through periodic circulars.

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AIE	Authority to Incur Expenditure
CHWs	Commercial Sex Workers
DDC	District Development Committee
DEEC	District Executive Expenditure Committee
DHCF	Division of Health Care Financing
DHCF	Division of Health Care Financing
DHMB	District Health Management Board
DHMIS	District Health Management Information System
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
DSRS	Department of Standards and Regulations Services
FIF	Facility Improvement Fund
FIF	Facility Improvement Fund
GoK	Government of Kenya
HCDC	Health Centre Development Committee
HCMC	Health Centre Management Committee
HCMT	Health Centre Management Team
HIV	Human Immuno Deficiency Virus
HMT	Hospital Management Team
HQ	Headquarters
HS	Hospital Secretary
IMCI	Integrated Management of Childhood Illnesses
KEPI	Kenya Expanded Programme on Immunization
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund
P/PHC	Preventive and Primary Health Care
PGH	Provincial General Hospital
PGHMB	Provincial General Hospital Management Board
PHMT	Provincial Health Management Team
PMOH	Provincial Medical Officer of Health
PS	Permanent Secretary
RHFMCs	Rural Health Facility Management Committee
SDHs	Sub District Hospitals
TB	Tuberculosis
USAID	United States Agency for International Development
VHCs	Village Health Committees

1.0 ORGANIZATION OF HEALTH SERVICES IN KENYA

At headquarter level, the Ministry of Health (MOH) is responsible for setting policy, coordinating activities of Government and non-governmental organizations, managing the implementation of policy changes regarding Government services such as user charges, and monitoring and evaluating the impact of policy changes.

At the provincial level, the roles of the Provincial Medical Officer of Health (PMOH) and members of the Provincial Health Management Team (PHMT) are to act as a strong intermediary between the central Ministry and districts and to oversee the implementation of health policy (maintenance of standards of quality, performance, coordination, regulation and control of all health services in the public and private sectors in their areas of jurisdiction).

The role of the PMOH and PHMT with regard to the cost sharing programme is to issue Authority to Incur Expenditure (AIEs), guide, monitor and supervise the District Medical Officers of Health (DMOHs) and facility managers in the province in the management of cost sharing activities.

PMOs are ex-officio members of the District Health Management Boards (DHMBs) in their provinces. They receive copies of all minutes of DHMB meetings and all long-term plans for the district approved by the Board. The Boards should inform them of any suspected irregularities in the running of district health services.

At the district level, the DHMBs oversee all health sector activities and their functions are not limited to the management of cost sharing funds. The Government established DHMBs with representatives of consumers and other interested groups to ensure prudent use of such funds.

2.0 HEALTH SECTOR DEVELOPMENT

Kenya's Health Policy Framework (1994) provides an analysis of the current health sector, identifies specific strategic imperatives, and provides an agenda for reform. The overall goal of the health sector is:

To promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable.

The paper recognizes a number of critical problems facing the health sector, including growing financial pressures, over-stretched capacity of the public health care system, imbalances in MOH staffing, and health sector laws which are inadequately enforced or outdated.

To overcome these constraints and to achieve the stated goal of the health sector, the following six ***strategic imperatives*** have been identified:

- **Ensure equitable allocation of Government resources to reduce disparities in health status.** This involves the development and use of carefully formulated criteria for geographic distribution of facilities and allocation of resources to individual facilities.
- **Increase the cost-effectiveness and cost-efficiency of resource allocation and use.** This requires placing budgeting priorities on the most essential, cost-effective curative and preventive health services. Greater efficiency will be achieved through more careful allocation of personnel; sound management practices, contracting of selected services to the private and mission sectors, and improved use of information for planning.
- **Continue to manage population growth.** Managing population growth requires expanding the number of service delivery points, diversifying family planning services, focussing on areas of unmet need, and

increasing maternal literacy rates.

- Enhance the regulatory role of Government in all aspects of health care provision. This will be achieved by strengthening the Ministry's policy-making role, strengthening the provincial tier of the health system, extending the role of DHMBs, empowering local facilities through Health Management Boards (HMBs) and Health Centre Management Committees (HCMCs) to develop and manage health services, and building the capacity of districts in modern management and planning methods.
- Create an enabling environment for increased private sector and community involvement in health service provision and finance. This includes creating incentives to encourage greater use of non-governmental health services, streamlining registration and licensing of private, Non Governmental Organisation (NGO) and mission health providers as well as promoting the formation of health centre and dispensary committees.
- Increase and diversify per capita financial flows to the health sector. Health sector financing will be increased through the expansion and diversification of National Health Insurance Fund (NHIF) and other social health financing mechanisms, increasing cost sharing revenue, and expanding Bamako Initiative mechanisms for community financing.

Realization of these six strategic imperatives will depend to a very large measure on the extent to which they can be put into practice at the district level. Legislative, central budgetary decisions and certain other actions must be taken at headquarters. But the districts should be the focus for efforts to ensure equitable allocation of resources, increased cost-effectiveness and efficiency, greater control of population growth, greater private and community involvement in health, and increased cost sharing revenue.

National Health Sector Strategic Plan 1999-2004

In responding to the daunting challenge of operationalizing the 1994 Health Policy Framework Paper, the Ministry of Health with her development partners developed the National Health Sector Strategic Plan NHSSP (1999-2004) and set up the Health Sector Reform Secretariat to spearhead the reform process. The NHSSP seeks to implement appropriate structural, financial and organizational reforms within a sector wide approach to resolve the inherent constraints in the health sector. It specifically provides a well-articulated vision for health care financing as well as the requisite support systems, and governance structures. Through the NHSSP, the Ministry commits itself to decentralization by providing increased authority for decision-making, resource allocation and management of health care to the District and facility levels. This is in part to allow greater participation of the community in the management of health funds and implementation of the essential clinical and public health package at the lower levels.

In building commitment to the process of change, these guidelines have been developed to support the ongoing decentralization efforts aimed at strengthening the implementation of activities at the district level, fostering closer coordination and collaboration amongst the line ministries, donors, organizations and other stakeholders. The guidelines focus on appropriate health systems and improved co-ordination necessary for the delivery of efficient and effective health services at the district level. This is with emphasis on improvements in district level planning, budgeting and, financial management and control systems. Most notably, commitment is made to transferring financial management through the release of block grants. Enhancing the capacity of the local DHMBs and DHMTs and extending 'guided autonomy' to a few hospitals. In the efforts, the DHMTs and DHMBs would gradually assume responsibilities for running of the facilities under their jurisdiction through a single line grant, effective annual work plans and procurement plans. Meanwhile, centre support would be restricted to technical, logistic, financial and administrative issues.

The PMOH will help in coordinating the program activities including daily management of the DHMB/DHMT

building on the existing District Plans and internal monitoring systems. They will also collaborate with other agencies in the implementation of the District Health Plans.

Interventions to be given priorities should be based on the available data on the burden of disease, cost-effectiveness of the interventions, impacts of the interventions and health outcomes in relation to health expenditure used. From the national perspective however, the public health and clinical priority package includes: Malaria prevention and treatment, Reproductive Health, HIV/AIDS/TB prevention and management, IMCI and the Control and prevention of major environmental health related communicable diseases such as cholera, typhoid, and dysentery and food safety.

In the prioritization, expenditures should favour lower level facilities that have lower per capita costs to enhance efficiency and functioning of the referral system. If services are not available at the right level of facilities, people delay seeking treatment or get admitted to hospitals for conditions that could have been prevented much earlier. Under-funding of the rural health facilities that essentially provide P/PHC, coupled by the impression that the quality of care is better at the higher level hospitals, has led to many patients bypassing the primary facilities in preference for the costly district, provincial and national hospitals.

The co-ordination of cross-sectoral planning has been the responsibility of the District Development Committee (DDC), with health sector plans produced and submitted to the DDC by the DHMB. The District Local health planning has therefore, no reference to a realistic resource framework without 'budget ceilings' provided by the Ministry of Health. Still, the district plans are rarely taken into consideration in national planning and budgeting, and the central level does not usually provide any feedback to districts. Local planning and self-help efforts do not take into account national policy goals since they are usually concerned with capital development planning and "projects". There is thus, little relationship between plans, available funds and actual implementation.

3.0 DHMB/HMB/HCMC: ROLES AND RESPONSIBILITIES

District Health Management Boards were established in 1992 by Legal Notice No.162 of the Public Health Act (Cap. 242).

In general terms, their role is to:

- Represent the community interest in the health planning process;
- Review, approve and forward cost sharing AIE requests and estimates of recurrent and development budgets.
- Work with DHMTs, HMTs and HCMTs to coordinate and monitor the implementation of GoK and non-GoK health programmes;
- Identify implementation problems and seek corrective action;
- Advocate for cost sharing and promote health awareness among the general public and;
- Make policy recommendations to the Minister for Health on health matters through the PMO.

3.1 Health Services Planning and Development

Planning: Representatives of the DHMBs should participate with the DHMTs in all long-term health services planning and development activities in the district.

Submissions to the DDC: The DHMB should review and approve all submissions made by the DHMT to the District Development Committee.

Donors: The DHMB should review and approve all proposals submitted to local and external donors by or on behalf of the DHMT/HMT/HMB. DHMBs may initiate proposals for financial and technical assistance, with guidance from the District Health Management Team/Hospital Management Team.

Linkages: The DHMB should explore and develop structural linkages with HMBs, RHFMCs, VHCs, NGOs and other health care providers within the district. Two distinct linkages are hereby established:

- a) Administration and planning linkage; and
- b) AIE authority line.

The District stakeholder's forum will provide the avenue for the District enhanced collaboration at the sectorwide approach to programming. The forum will provide an opportunity for the Ministry and development partners to collaborate in a joint programme. This is in addition to providing an enabling environment for open, genuine, transparent dialogue and partnership with development partners, and improving the health status of the communities.

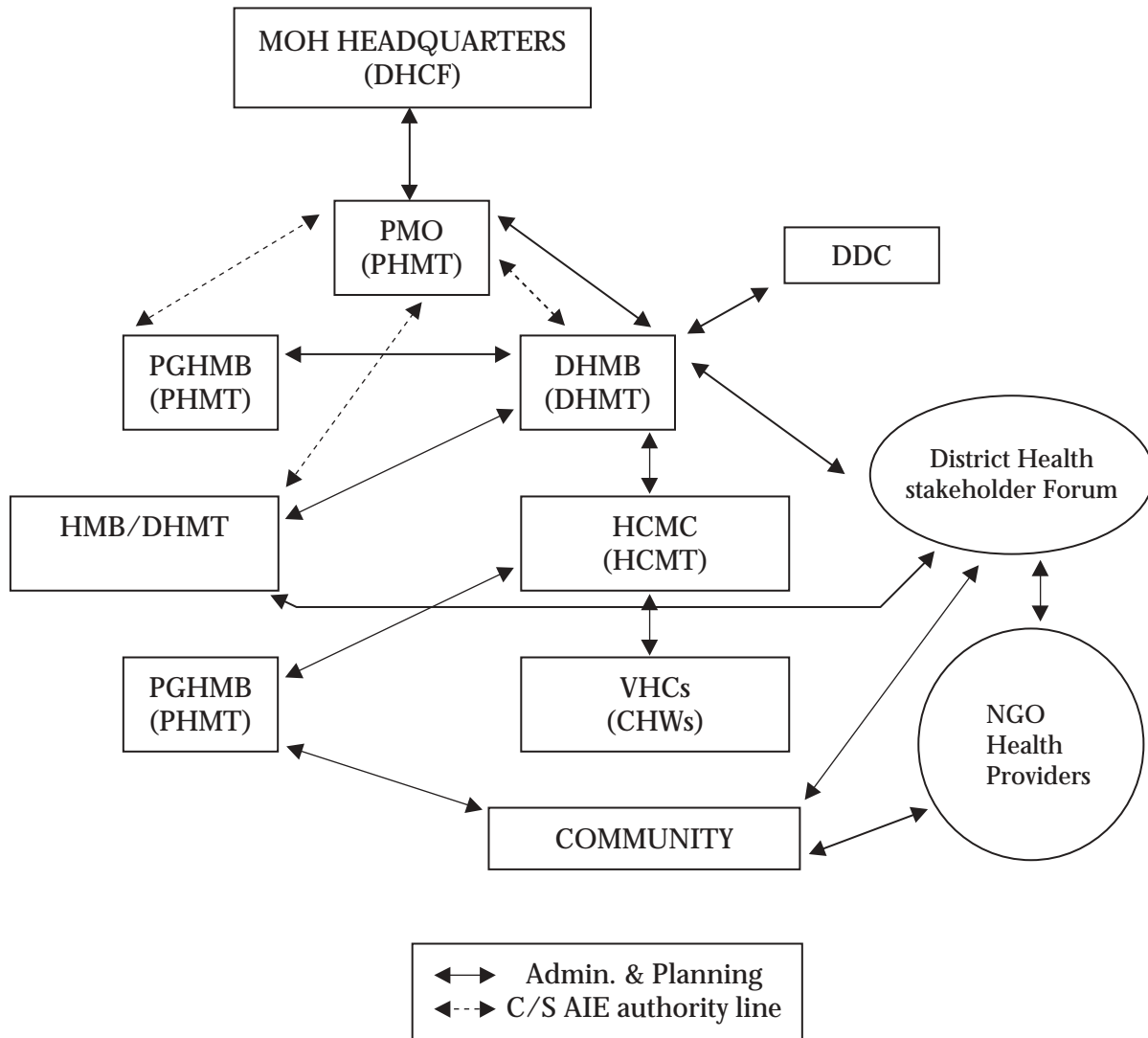
In this regard the Ministry proposes to strengthen the consultative arrangements currently in place at the headquarters, provincial and district levels in order to optimise on all available inputs from the development partners to realize the reform objectives as outlined in these guidelines.

The anticipated output of effective health sector programme governance would include:

- Effective legal and regulatory framework with the necessary capacities to implement health sector reforms in areas such as management, planning and budgeting.
- More equitable distribution of financial resources.
- Better co-ordination of health services promoted and provided by the various stakeholders including the MoH.

Figure 1: Administration, planning and AIE authority line links

The administration and planning linkages flow through to the DHMB /DHMT to the PMOHs office for onward transmission to the MOH Headquarters (DHCF) (shown by continuous line in Figure 1).



The AIE line authority flows from the health centre to the DHMB and to PMO's office for the district while for the individual Provincial General Hospitals (PGHs), District Hospitals (DHs) and Sub-District Hospitals (SDHs), it flows directly to the PMOs office (shown by dotted line).

3.2 Personnel

Receiving complaints. The DHMB/HMB/HCMC may receive complaints through the DMOH, Medical Superintendent, Medical Officer in Charge, Clinical or Nursing Officer in Charge and other members of the Boards, Committees (or from the public at large). Such complaints may be in respect of serious misconduct, negligence, illegality, or other misdeeds on the part of Ministry of Health employees in areas of their jurisdiction.

Requesting disciplinary action. Though the DHMB/HMB/HCMCs are not authorized to undertake disciplinary action on behalf of the Government, they may request specific investigations or other follow-up

action, such as verbal warnings, written warnings, 'show-cause' letters, surcharging, interdiction, and retirement in the public interest or criminal prosecution.

Taking follow-up action. In general, complaints about Ministry of Health staff in the district hospital or health centre should be referred to the District Medical Officer of Health/Medical Superintendent, or Medical Officer in Charge for action. If satisfactory action is not forthcoming, the DHMB/ HMT is obliged to refer the matter directly to the Provincial Medical Officer. If satisfactory action is still not forthcoming, the matter should be referred to the Permanent Secretary, Ministry of Health.

3.3 Financial Responsibilities

Priorities and District Plans. In line with the recommendations of the NHSSP 1999-2004, funds shall target cost effective interventions. This guideline supports the development of District Plans to favour expenditures on cost effective programs and interventions which will directly contribute to meeting the needs of the highest number of beneficiaries and reduce the burden of disease, improve health status of communities and bring about improved health outcomes over the period of the strategic plan. District level budgeting will lead to the increased involvement of the DHMBs in the budgetary process.

Approving AIEs. The DHMB/HMB approves requests for use of cost sharing revenue to the PMO for the issuing of the AIEs.

Information that should be provided to DHMBs/HMBs:

- In accordance with Legal Notice No. 162, the estimates of R11 (recurrent) and D11 (development) budgets for the district/hospital should be submitted to the Minister for Health through the DHMB/HMB.
- Every year, the DMOH, Medical Superintendent/Medical Officer in Charge should provide the chairpersons of their respective Health Management Boards with copies of the Forward Budgets and Printed Estimates for the district/hospital for both R11 and D11 budgets.
- The DMOH, Medical Superintendent/Medical Officer in Charge should provide the Chairpersons of their respective HMBs with copies of all Ministry of Health AIEs issued to the district/hospital, whether from R11, D11, and the FIF.

DHMB/HMB access to information. For monitoring purposes, the DHMB/HMB chairpersons or any member of the DHMB/HMB designated for such purposes is granted full access to all current district/hospital - (Ministry of Health)- financial records, including vote books for R11 and D11 funds, as well as the cost sharing revenue.

Dealing with serious situations. Where serious fraud, abuse or criminal financial activity are suspected, the DHMB/HMB is obliged to request an internal/external audit and, subsequently, refer the matter to the PMOH for further action.

Management of cost sharing revenue. The DHMB/HMB has an oversight role in relation to the management of the cost sharing revenue. Specifically, their responsibilities are to:

- Recommend to the Minister for Health areas to levy user charges.
- Review reports on collection, exemptions and waiver performance.
- Review plans for spending of cost sharing revenue and approve or suggest amendments.
- Arrange for regular audit of accounts

- Handle client complaints.
- Recommend disciplinary action to PMO and DHCF.

3.4 Communication with the Public

Representation. In as much as the DHMBs/HMBs represent community interests in the health planning process of districts/hospitals, their members can play an important role in continually advising the DHMTs/HMTs on community concerns and problems regarding health.

Information. Board/committee members should seek opportunities for informing their communities of the benefits of cost sharing, explaining how the money people pay in fees is spent, and supporting health education campaigns targeted to the general public as a way of community mobilization to educate the public on the procedures in place.

4.0 DHMB/HMB RELATIONSHIPS

4.1 Relationship with Ministry of Health Headquarters

Meeting the PS. At least once each year, the Permanent Secretary, Ministry of Health, convenes a national meeting of all DHMB/HMB chairpersons. This meeting allows the Ministry to brief the DHMBs/HMBs on current plans and operations, and offers an opportunity for the chairpersons to raise issues of concern directly with senior Ministry officials.

Minutes of meetings. Minutes of all DHMBs/HMBs and Standing Committee meetings should be forwarded to the PMOH within two weeks following such meetings for onward transmission to the PS.

Proposals on fees. Where DHMBs/HMBs want to propose new fees or changes to the old fee structure, they should do so through the PMO to the DHCF.

Disciplinary matters. Issues concerning theft of funds, spending of revenue before banking or without authority, fraudulent spending, abuse of exemptions and waivers, or other more serious problems, should be raised with the DHCF after the relevant district and/or provincial authorities have been informed.

Monitoring. The DHCF has a supervisory role over the entire cost sharing programme in Kenya and, therefore, monitors the performance of DHMBs/HMBs, through the PMOH. .

The PMOH will help in coordinating the program activities including daily management of the DHMB/DHMT building on the existing District Plans and internal monitoring systems. They will also collaborate with other agencies in the implementation of the District Health Plans.

Advice: The DHCF is always available to render advice to DHMBs/HMBs that may be experiencing difficulties or facing problems.

4.2 Relationship with the Provincial Health Management Team (PHMT)

Advice and information: The PMO, who chairs the PHMT, is an advisor to each DHMB/HMB in the province. The PMO should receive advance notice of all DHMB/HMB meetings held in the province and should promptly receive copies of all DHMB/HMB minutes of meetings. PMOs should meet boards in their provinces at least twice a year.

Monitoring: The PMO should be informed of all disciplinary initiatives taken by respective DHMBs/HMBs concerning facilities in the district. The PMO also exercises a supervisory role over all DHMBs/HMBs and DHMTs/HMTs in the province.

4.3 Relationship with the District Health Management Teams (DHMTs)

The DHMT is responsible for planning and coordinating health activities in the district. It prepares the cost sharing spending plans, which are scrutinised and approved by the DHMB. The board or committee also plays an advisory role in relation to the HMT. A close collaborative working arrangement between HMB members (especially the chairman) and key officials of the HMTs (especially the MOHs/clinicians and the HAOs) is crucial.

Secretariat. The DMOH/Medical Superintendent or Medical Officer in charge acts as the secretary of the respective boards or committees and records and distributes minutes of the board/committee meetings.

Ex-officio members. The DHMB/HMB/HCMC can invite other members of DHMT/HMT /HCMT to attend board/committee meetings as ex-officio participants whenever necessary.

Relationship with DHMT/HMT/HCMT. The DHMT is responsible for planning and coordinating health activities in the district, while the HMT undertakes the same for the hospital. HCMT carries these functions at the health centre level.

The HCMT prepares cost sharing revenue spending plans, which it submits to the HCMC for approval before submission to the DHMT. The DHMT prepares cost sharing funds spending plans for the district that are then scrutinised and approved by the DHMB. The same applies to HMTs for the hospitals, which submit their plans to HMBs.

5.0 DHMB/HMB STANDING COMMITTEES

5.1 Primary Health Care Committee

The Primary Health Care Committee oversees all preventive and primary health care (P/PHC) activities in the district or hospital. Its specific responsibilities are to:

- Participate with the Primary Health Care (PHC) Core Team in developing annual PHC plans. This involves a review of services, assessment of needs and setting of priorities for P/PHC activities in the district/hospital.
- Ensure that the DHMT is submitting plans for the expenditure of 25% of cost sharing revenue and is spending the funds as planned.
- Receive reports on preventive, promotive, community-based and primary health care activities in the district (GoK and NGO) or hospital.
- Obtain annual reports of health statistics with epidemiological data and preventive measures being taken to address the major problems.
- Promote inter-sectoral collaboration on issues of sanitation, water, nutrition and health education.
- If applicable, review reports on Bamako Initiative activities.
- Receive periodic reports from the PHC Coordinator on activities being carried out in each of the

components of PHC and insist on setting targets for expanding coverage of these services and, thereafter, monitor the achievement of these targets.

- Look into urban sanitation problems (e.g., inadequate refuse collection, unsafe water points, etc.), and promote clean-up and safe water supply operations where needed. Also receive complaints and recommend solutions.
- Work with the DHMT/HMT to establish contingency plans for epidemics and provide the necessary support during such epidemics.

5.2 Quality of Health Care Services Committee

In collaboration with the Department of Standards and Regulatory Services (DSRS) and District stakeholders, the Quality of Health Care Services Committee plays the essential role of overseeing the MOH's curative health services in the district, giving primary attention to hospital services. It focuses on the 75% portion of cost sharing expenditures. Specific responsibilities of the committee are as follows:

- Participate alongside hospital management teams and the DHMT on behalf of the boards in an annual review of services, assessment of needs and setting of priorities for health centres and hospitals; review annual cost sharing plans, and approve the proposed use of funds.
- Review any written complaints about the performance and quality of health services in the district or hospital and recommend remedial action.
- Receive regular reports on the availability of supplies in all facilities and contribute to the search for solutions and address shortfalls.
- Help organize periodic exit surveys to assess patient satisfaction with services received.
- Review quarterly workload indicators of the facilities in the district /hospital in relation to the relevant epidemiological data.
- The exact details of the responsibilities are contained in the Kenya Health Standards and Quality Master checklist for Health services and system, Monitoring and evaluation, recently developed in collaboration with the Department of Standards and Regulatory Services (DSRS) and District stakeholders,

5.3 Finance Committee

The specific responsibilities of this committee are to:

- Review revenue targets for facilities, comparing actual collections with targets.
- Review expenditure plans for health centres/DHMT/HMT, checking that funds are being spent in accordance with plans and AIEs.
- Obtain the cash analysis books (payments and bankings) and review the fund balances, bankings versus collections, expenditures versus AIEs, etc.
- Review the financial aspects of long-term and annual development plans.
- Monitor the continuing expansion of the NHIF claiming process for inpatients to meet revenue targets.

- Arrange for annual audits of cost sharing revenues by District Internal Auditors, and request special audits where irregularities are suspected.
- Present budgets to respective boards/committees for approval and forward the same for issuance of AIEs by the PMO.

6.0 BOARD AND COMMITTEE ACTIVITIES

This section focuses on three main activities of the Boards and Committees: holding meetings, monitoring health services in the district, and orientation of new members.

6.1 The Conduct of Meetings

Frequency of Meetings: The main business of the DHMB/HMB is carried out in the full Board meetings. Legal Notice No. 162 of the Public Health Act (Cap. 242) stipulates that there shall be a minimum of four board meetings per year and at least six meetings for each of the three standing committees. It also states that the standing committees should meet at least every two months.

Quorum. The quorum for the board has been fixed at five members, one of whom must be the secretary. As for the standing committees, the actual membership can be as low as three; hence, normal rules concerning a quorum do not apply.

Agenda. For efficient conduct of business, an agenda is vital. This should be drawn up by the secretary in consultation with the chairperson. However, if the standing committees are functioning as expected, the agenda should automatically emerge from the discussions and decisions of their meetings. If they do not meet regularly, then it will become almost impossible to avoid an overload of the board's agenda or, conversely, a general failure to identify important issues that should be dealt with.

Procedures. In chairing the meetings, a balance should be struck between following formal committee procedures (in the interest of keeping order) and informal discussion (in the interest of encouraging maximum participation).

Minutes. To keep track of business conducted and to follow-up on decisions arrived at, it is important that accurate and comprehensive minutes are taken for all meetings. The core element of the minutes should be a kind of action plan, stating:

- Decisions taken as a result of the meeting;
- The consequent actions to be taken;
- Who will carry out the actions?
- By when?
- With what resources?

Special Meetings. It may occasionally be necessary to call special meetings in response to specific crisis situations, such as when there is an epidemic outbreak or a situation that calls for disciplinary action.

6.2 Monitoring

The monitoring carried out by boards and committees is a three-step process:

- Performance monitoring;
- Checking for fraud and abuse; and
- Facility visits.

The details of these activities are described in the FIF Monitoring Manual.

6.3. Orientation of New Members

Orientation meeting. The main intention of these Guidelines is to orientate new members of boards and committees. However, it is suggested that the chairperson should hold a special meeting whenever there are a few newcomers. At such meetings, the chairperson can review the roles and responsibilities of members by going through the various sections of the handbook and by introducing other key documents, such as those listed in Annex A and the Legal Notice given in Annex B.

It would also be of great benefit to have presentations by the Secretariat and other key members of the DHMT/HMT on the main health problems and how they are being dealt with at such meetings.

Introductory visits. The chairperson should take new members on familiarization visits to respective health facilities and institutions.

6.4 Operations of Boards and Committees

The Secretariat shall facilitate the activities of the boards/committees and ensure their smooth operation.

7.0 COST SHARING OPERATIONS

Revenues generated from user charges and insurance claims (e.g., from the National Hospital Insurance Fund) are deposited into the Health Care Services Fund commonly known as the Facility Improvement Fund (FIF). These revenues are retained separately by the boards and are supplementary to budget allocations from the Treasury.

Cost sharing revenue is to be used to improve the quality of health services in facilities and support district-level preventive and primary health care (P/PHC) services.

7.1 Guiding Principles of the Cost Sharing Programme

The guiding principles of the cost sharing programme are:

- 100% local retention of revenue: Currently 75% of such revenue is allocated to the health facility collecting the funds and 25% to preventive and primary health care activities (P/PHC).
- Local planning for the use of revenue: Facility-level planning for use of facility funds, and district-level planning for use of P/PHC.
- The revenue is additive and "no-year": That is, Treasury should not reduce MOH allocation because of cost sharing revenue, and unspent funds can be carried to the next fiscal year.
- Inpatient and outpatient fees higher at hospitals, lower at health centres, and lowest (or free) at dispensaries.
- Vigorous pursuit of National Hospital Insurance Fund (NHIF) reimbursement for inpatients, which enhances the equity of the programme.
- Protection of vulnerable groups through discretionary waivers for the poor and exemptions for specific target services.

7.2 Managing for Success

In the recent past, some Government facilities have tripled their cost sharing revenue in one year whereas others barely improved. The reason some facilities were more successful than others was good management. Lessons on **good management** that have emerged from successful facilities are as follows:

- **There is no progress without people.** Both medical and administrative staff are closely involved in cost sharing activities. They receive support from the Health Management Boards and Health Management Teams.
- **Set performance targets.** It is vital that targets are set so that facilities and board members know how much revenue should be collected. Without targets it is not possible to tell if a facility is doing well or not.
- **Monitor performance.** Good record keeping involves maintenance by officers in charge of a chart showing actual collections against targets. Monthly reports on performance against targets are prepared and discrepancies investigated. Officers in charge walk around the facility from time to time, observing how systems are being implemented, and talk to staff and patients about problems and solutions.
- **Use the 80/20 rule for setting priorities.** Experience shows that 80% of collections comes from 20% of the departments. At the facility level, most of the collections should come from outpatient treatment fees, from drug items issued, and from inpatient NHIF claims. If officers in charge focused their efforts on these collections, the bulk of the revenue would be collected.
- **Spend money to make money.** To encourage departmental staff to participate fully, a percentage of the revenue collected by a department should be spent in the same department. Funds should be used to make selective, visible improvements (e.g., fixing up the waiting area), and to ensure that registers, receipt books and other critical stationery are always in supply.

Board members should bear in mind these five proven ingredients for cost sharing programme success as they meet with members of the DHMT/HMT and visit facilities in the district and the hospital, respectively.

7.3 Fees, Exemptions and Waivers

Changes in fees, waivers and exemptions are always clearly stated in MOH circulars. All concerned staff and board members should be informed immediately of changes.

Exemptions and waivers are meant to ensure that no Kenyan is denied essential health services. An **exemption** is an automatic excuse from payment based on the patient meeting certain criteria set down in circulars by the Ministry of Health. If the patient fits the criteria (e.g., is of a specified age or has one of the listed illnesses), they do not pay.

A **waiver** is a release from payment based on financial hardship. Patients must request a waiver and judgement must be made as to whether or not the patient is truly a hardship case.

DHMBs/HMBs are expected to review institutional reports on waivers and exemptions on a regular basis.

7.4 Cash Collection and NHIF Claiming

Specific procedures for cash collection and NHIF claiming are laid down in the cost sharing manuals listed in Annex A. DHMTs/HMTs should be held accountable for implementing these procedures.

The three major sources of cost sharing revenue should be:

- Outpatient treatment fees;
- NHIF claiming; and
- Inpatient cash collections.

NHIF claiming should be a major source of revenue for hospitals. Significant revenues can be collected, provided nursing and administrative staff collaborate in claiming. The major reasons for under-reimbursement are:

- Failure to identify NHIF beneficiaries in the hospital;
- Failure to complete claims once a beneficiary has been identified; and
- Failure of NHIF to pay claims promptly and in full.

Efficient cash collection requires that: all departments offering chargeable services maintain a patient register; each facility has a small number of conveniently located collection points; the best staff are placed at the most important (profitable) collection points; and all collection points have cash boxes and/or safes. Registers must also be maintained for daily cash collections, NHIF claims, and expenditures.

Inpatient cash collections are also a major source of hospital cost sharing revenue. But some facilities collect less than one-third of expected inpatient revenue. Collection losses are due to absconders, death (wrongly treated as an exemption by some facilities), lack of proper collection systems, and fraud by staff involved in the collection process.

The support of inpatient nursing staff is absolutely essential to the achievement of inpatient cash collection targets. Where nurses are supportive of the cost sharing programme, hospitals have high inpatient cash collection rates. Where they are indifferent or against cost sharing, collections are poor.

7.5 Expenditure Planning

Planning and budgeting for the expenditure shall be executed in accordance with the District Plans and in collaboration with the District stakeholders.

The primary purpose of the cost sharing programme is to improve patient care and the quality of services at Ministry of Health facilities. The intent is to allow Health Management Boards and District/ Hospital Management Teams maximum flexibility in the use of cost sharing revenue.

Planning responsibilities: Responsibilities for planning, approval and implementation of expenditures of the 75% funds are as follows:

- Hospital Management Team (HMT) prepares cost sharing annual plan;
- Hospital Executive Expenditure Committee (EEC) confirms cost sharing annual plan and prepares quarterly AIE requests;
- District Accountant certifies availability of uncommitted funds for the facility in the bank;
- HMB reviews, returns to EEC/HMT for modification as necessary, and approves annual plan and AIE requests;
- The PMO, on behalf of the Accounting Officer, issues AIEs;
- Hospital EEC directs expenditure according to GoK procurement regulations;
- Hospital EEC prepares monthly Payments Report, itemizing all expenditures; and
- HMB reviews monthly Payments Report to ensure proper expenditure of funds.

Planning Cycle: Planning for expenditure of cost sharing revenues should follow a routine schedule in line with the GoK budget cycle. Two types of plans are required, annual and quarterly.

DOCUMENT	SUBMISSION DATE	EXPENDITURE PERIOD
Annual FIF Expenditure Plan	15th June	1st July - 30th June
1st Quarter AIE Request	15th July	1st July - 30th September
2nd Quarter AIE Request	15th October	1st Oct. - 31st December
3rd Quarter AIE Request	15th January	1st January - 31st March
4th Quarter AIE Request	15th April	1st April - 30th June

Facilities are encouraged to spend cost sharing revenue in ways that contribute to visible improvements in the quality of patient care. HMBs should use their knowledge of their patients' needs and the needs of the community to plan the best use of cost sharing revenue. To encourage full collection of cost sharing revenue, preference in using such revenue should be given to those wards, outpatient services, and other units which achieve their collection targets.

HMB Finance Committee chairpersons should be thoroughly familiar with requirements for approval of AIE requests, which are outlined in the FIF Supervision Manual and occasional circulars.

7.6 Absolute Do's and Don'ts

Though the manuals listed in Annex A describe many specific cost sharing procedures, there are seven absolute do's and don'ts for cost sharing programme management:

- Every department must keep a complete revenue and service register;
- Every health centre, hospital and every district must maintain a cash collection analysis book and payments analysis book;
- All purchases must adhere to GoK local procurement requirements;
- Every collecting institution must submit a standard set of monthly cost sharing reports;
- There must be no theft of public funds;
- There must be no spending before banking; and
- There must be no spending without a properly obtained AIE.

Failure to adhere to the above rules may lead to verbal or written warning, a 'show-cause' letter, surcharge, interdiction, retirement in the public interest, or criminal prosecution.

It is the responsibility of the DHMBs/HMBs to ensure that the DHMTs/HMTs and other responsible individuals adhere to this list of do's and don'ts.

7.7 Cost Sharing Programme Monitoring

Monitoring of cost sharing involves three main activities:

- Regularly reviewing key cost sharing performance reports to identify performance problems with individual facilities;
- Checking for fraud and abuse;

- Conducting supervision visits to district treasuries and health facilities to: (a) verify the accuracy of performance reports; and (b) ensure that correct actions are being taken in problem areas.

Routine performance reports: DHMB/HMB chairpersons and the relevant DHMB/HMB standing committees should regularly receive the following routine performance reports from the DHMT/HMT and review them:

- **District reports**, submitted to the District Health Management Board and to the DHCF, include:
 - Banking Report;
 - Payments Report;
 - Quarterly Workload and Revenue Report;
 - Quarterly P/PHC Integrated Planning and Reporting Form; and
 - Bank Reconciliation Report.
- **Hospital Reports**, submitted to the Management Board, PMO and to DHCF on a monthly basis include:
 - Workload Report
 - Collections and Banking Report
 - Revenues Summary Report
 - NHIF Report
 - Payments Report
 - Bank Reconciliation Report.

Performance review questions: A careful review of these reports should allow DHMB/HMB members to answer the following critical questions:

- **Are cash collections sufficiently close to target?** Monthly collections should be compared with targets. Large gaps suggest either inefficient collection or theft.
- **Are NHIF collections sufficiently close to target?** NHIF reimbursements should be 50% of cost sharing revenue for most hospitals. Progress in improved NHIF collections should be monitored very closely.
- **Are available funds adequate for planned expenditures?** Cost sharing reports indicate amounts collected and amounts banked by facilities. DHMBs/HMBs must be very careful not to approve AIE requests that exceed collections for individual facilities.
- **Are 75% facility funds being spent as planned?** HMTs/HCMTs prepare and DHMBs/HMBs approve cost sharing expenditure plans. Reported expenditures should be compared against approved plans. Unauthorised deviations should not be accepted. Supervision visits should be made to verify that expenditures were actually made as stated in the cost sharing reports.
- **Are 25% PHC funds being spent as planned?** As with the 75% facility expenditures, P/PHC expenditures should conform to approved plans. Unauthorized deviations should be investigated.
- **Are waivers and exemptions at expected levels?** In general, low rates of waivers and exemption probably mean that some patients are being denied essential services. High rates may suggest fraud and/or abuse.

Performance targets: In order to plan for expenditures and monitor departmental and facility collection performance, each facility and district must set targets for expected cash collections and NHIF reimbursements: If you don't know where you're going, you can't tell if you're getting closer.

Targets should be set at least once each year, usually in May. This way, targets can be used to prepare annual

cost sharing plans. Targets should be revised whenever there are fee changes.

Setting of collection targets should generally be done by the DHMT/HMT. The information needed for setting targets should be readily available from Medical Records/HMIS staff at the district and facility level. The FIF Supervision Manual provides details on target setting.

Visits to health facilities: Regular visits to health facilities is critical to the proper establishment and operation of the cost sharing programme. Supervision should target problem facilities and districts, high revenue potential areas, and the functioning of control systems for revenue collection and expenditure. However, it is also useful to occasionally visit the best facilities to provide them with positive feedback on their work.

8.0 SETTING PHC PRIORITIES

8.1 What is Primary Health Care?

Preventive and Promotive Health Care (PHC) includes the basic clinical, preventive, and promotive health services that should be readily accessible to all members of the population. Emphasis is on improving family health, with particular focus on mothers and children; increasing coverage and accessibility of essential health services; improving the quality of services; and pursuing an integrated inter-sectoral and multi-disciplinary approach with community participation in the planning, delivery, and monitoring of health services.

Following from the World Health Organization's 1978 Alma Ata Declaration, Kenya has adopted twelve elements for Primary Health Care:

1. Health education
2. Nutrition
3. MCH/FP
4. Immunization (KEPI)
5. Environmental health
6. Control of communicable diseases (TB, STD, leprosy)
7. Curative services
8. Essential drugs programme
9. Mental health
10. Dental health.
11. Community Based Rehabilitation
12. HIV/AIDS and STI

8.2 Responsibilities for P/PHC Planning

Responsibilities for planning, approval and implementation of expenditures of the 25% P/PHC funds are as follows:

- PHC Core Team prepares annual plan and quarterly AIE requests for use of cost sharing revenue on P/PHC in consultation with all relevant district health staff, including the family planning coordinator, AIDS coordinator, KEPI coordinator, and others.
- DHMT confirms cost sharing annual P/PHC plan; prepares quarterly AIE requests.
- DHMB reviews and approves (or returns to DHMT for revision) annual plan and AIE requests.
- District Accountant certifies availability of uncommitted funds in bank.
- PMO issues AIEs on behalf of the Accounting Officer in accordance with current cost sharing expenditure rules.

The specific functions of the DHMB on 25% of cost sharing revenue are:

- Providing public education on P/PHC;
- Reviewing, advising on, and endorsing district annual cost sharing plan and budget for P/PHC;
- Reviewing, advising on, and endorsing district AIE requests on a quarterly basis; and
- Reviewing and commenting on the quarterly report of P/PHC activities and expenditures prepared by the P/PHC Coordinator (P/PHC Integrated Planning and Activity Report).

The last function is particularly important. The quarterly P/PHC Integrated Planning and Activity Report gives the DHMB a concise picture of activities planned, achievements made, funding sources (including GoK inputs and donor/NGO contributions), expenditures planned, expenditures made, and reasons for any differences.

8.3 Steps for P/PHC Priority-Setting and Budgeting

How can a district organize and use the diverse information required to set priorities among such widely different activities as AIDS prevention, provision of clean water, family planning services, immunization, and control of high-impact diseases such as malaria, diarrhoea, and acute respiratory infections (ARI)? How can districts plan to achieve the greatest health impact with the available resources?

To assist in making such decisions, the Ministry has developed guidelines on District P/PHC Priority-Setting (22 June, 1994). The district planning and budget process are tools to assist DHMTs and DHMBs to identify the major P/PHC problems in the district, set P/PHC programme priorities, and prepare district P/PHC plans. The intent of the Ministry is to allow the DHMTs, DHMBs and District P/PHC Core Teams maximum flexibility in the use of cost sharing revenue, subject only to the constraints and accountability requirements of the Government.

The steps in the district P/PHC priority-setting process are:

- ***Prepare the district health profile***
The District Medical Records/Health Management Information System (HMIS) office prepares a District Health Profile (DHP) to summarise all key health indicators. The district HMIS office should always be able to prepare the DHP from information routinely available from the HMIS reporting system, the District Health Management Information System (DHMIS), KEPI, family planning reports, district statistics office, district population officer, and other local sources.
- ***Identify the major health problems***
From the DHP it should be possible to identify the major health problems in the district. For instance, is maternal mortality unusually high? Is measles coverage below the national target? Is family planning coverage low in particular divisions? Is the incidence of malaria high in other divisions? Is the HIV positivity in ante-natal clinics increasing significantly?
- ***Choose cost-effective PHC interventions***
For each major health problem, there are several possible P/PHC activities. Malaria control may include distribution of impregnated bed nets, chemical spraying, improved diagnostic services, better drug supply, and so on. Choices must be made based on the most cost-effective measures i.e., which measures give the best value for money?
- ***Set one-year targets***
For each major health problem, a one-year target is set. For example, if measles immunization coverage is only 50%, the one-year target might be to increase it to 60%.

- ***Prepare the district PHC plan***

After the major problems have been identified, interventions have been selected and targets have been set, the P/PHC Core Team prepares the District P/PHC Plan. This plan should take the form of the P/PHC Integrated Planning and Activity Report described in the Facility Improvement Fund Supervision Manual.

- ***Agree on cost saving measures and prepare a budget***

Limited district funds for P/PHC can be stretched to have a greater impact through two main cost-saving measures: community participation and cost recovery

- Community participation can come in the form of community contributions of labour, locally available materials, or other in-kind donations for activities such as TBA training, spring protection, VIP latrines, and malaria control.
- Cost recovery usually means user charges for such things as bed nets, laboratory tests, and the treatment fee charged for drugs and other treatments provided at health centres and hospitals. Once P/PHC activities and cost-saving measures have been agreed, a budget should be prepared.

- ***Finalize plan and obtain approvals:***

The District P/PHC Plan and Budget should first be approved by the District P/PHC Core Team, then the DMOH and DHMT, and finally the DHMB. Once the plan has been thoroughly discussed and approved by the DHMB, it is forwarded to the PMO who issues the AIE.

- ***Monitor implementation of PHC plans***

Finally, the DHMT and DHMB are responsible for monitoring the implementation of P/PHC activities to ensure that funds are spent according to the plans and that the community is benefiting as intended. This means reviewing progress on the plans and submitting a quarterly P/PHC Integrated Planning and Activity Report, which should list the achievements for each planned activity, the funding source, and the actual expenditure.

8.4 Choosing among P/PHC programmes

If the District P/PHC Core Team is active, the demand for P/PHC funds will inevitably out-stretch the funds available. How can the DHMB decide which proposals to approve? There are at least five important questions that the DHMB should ask:

- **How important is the problem?** Based on the District Health Profile, the problem being addressed should be a major one for the district.
- **Are other funds available?** Check whether R11 funds have been allocated, and whether donors are active in the area.
- **Is the programme cost effective?** Annex C lists the relative cost-effectiveness for common P/PHC interventions.
- **Are cost sharing measures being taken?** Ways should be sought to reduce costs by encouraging greater community participation or through cost recovery initiatives.
- **Are non-core activities taking a larger share of the available resources?** Care should be taken to limit the percentage of funds being applied to non-core activities such as purchase of non-essential motor vehicles, decoration of offices, holding of numerous seminars and meetings, etc.

ANNEX A: KEY DOCUMENTS

Policy Documents

- 1 **Health Policy Framework**, Ministry of Health, Nairobi, June 1994.
- 2 **Strategic Action Plan for Financing Health Care in Kenya**, Ministry of Health, Nairobi, March 1993. (See also **Five-Year Implementation Plan for Financing Health Care in Kenya**, Ministry of Health, 13 August 1993)
- 3 **The Kenya National Drug Policy**, Ministry of Health, Nairobi, July 1994.
- 4 **Kenya National Development Plan, 1989-1993**, Chapter 10, Section 10.3, 'The Health System' and Section 10.4, 'Health Objectives and Strategies', Government of Kenya, Nairobi, 1989.

Legal Notices

- 1 **Health Care Services Fund**, The Exchequer and Audit Act (Cap. 412), Legal Notice No.268, 29 June 1990.
- 2 **District Health Management Board Rules**, The Public Health Act (Cap. 242), Legal Notice No. 162, 20 May 1992.
- 3 Ministerial circulars Nos.79/80 of 98.

Manuals

- 1 **Facility Improvement Fund Supervision Manual**, Health Care Financing Programme, Ministry of Health, 1 February 1994.
- 2 **District PHC Priority-Setting: Planning & Budgeting Process**, Primary Health Care Unit, Health Care Financing Programme, and Public Health Unit..
- 3 **Facility Improvement Fund Operations Manual**, Ministry of Health and Management Sciences for Health, 1992.
- 4 **Facility Improvement Fund Operations Manual for Health Centres**, Ministry of Health and Management Sciences for Health, March 1993.

Circulars

- 1 **Guidelines for Expenditure Under Health Care Services Fund**, Circular Ref. B/13/1/18C/(92), Ministry of Health, 17 December 1992.
- 2 National Health Sector Strategic Plan:1999-2004, Ministry of Health, Nairobi, Kenya
KQM
- 3 Decentralisation
- 4 Poverty Reduction Strategy Paper (2001) Ministry of Finance and Planning, Nairobi, Kenya

**ANNEX B: LEGAL NOTICE NO. 162.
THE PUBLIC HEALTH ACT (Cap. 242)**

IN EXERCISE of the powers conferred by section 78 (2) of the Public Health Act, the Minister for Health makes the following Rules.

THE PUBLIC HEALTH (DISTRICT HEALTH MANAGEMENT BOARDS) RULES, 1992.

1. These Rules may be cited as the Public Health (District Health Management Boards) Rules, 1992.
2. In these Rules -
"Board" means the District Health Management Board established under rule 3.
"Council" means a municipal or county council established under the Local Government Act;
"Hospital" includes a dispensary and health centre.
3. (1) The Minister may by notice in the Gazette, establish a District Health Management Board for any District or for such area or areas as may be specified in the notice.

(2) A notice under this section shall specify the area in which the Board concerned shall have jurisdiction.

(3) Each Board shall consist of not less than seven nor more than nine members constituted as follows-
 - (a) a chairman appointed by the Minister from the members of the Board;
 - (b) the area District Commissioner or his representative;
 - (c) the following persons appointed by the Minister-
 - (i) One person with experience in finance and administration from within the District.
 - (ii) Two persons nominated by Non-governmental Organizations recognized by the Minister, one whom shall represent the interests of religious and the other private health services.
 - (iii) One person nominated by the Local Authority having jurisdiction over the area;
 - (iv) Not more than three persons to represent community interests and
 - (v) The area Medical Officer of Health who shall be the secretary to the Board.
- 4 The members of the Board, other than the ex-officio members, shall hold office for a period of three years but shall be eligible for re-appointment.
- 5 The Board shall exercise its powers and perform its duties notwithstanding any vacancy in its membership.
- 6 The Minister shall appoint one member of a Board to be the Chairperson and the Board shall appoint the vice-chairperson.
- 7 (1) The Board shall appoint from among its members three committees to deal with-
 - (a) Finance and general purposes;
 - (b) Quality of curative services; and
 - (c) Public health care services.
(2) The Board may from time to time appoint from among the members of the public ad hoc committees to provide technical and specialist advice to the Board.

8. The functions of the Board shall be as follows:-

- (a) To superintend the management of hospital services;
- (b) To support public health care programmes;
- (c) To prepare and submit to the Minister for approval estimates of revenue and development expenditures;
- (d) To submit recommendations to the Minister on areas to levy user charges under the cost sharing programme as provided for use the Exchequer and Audit (Health Services Fund) Regulations, 1990;
- (e) To tender advice to the Minister on plans for development or promotion of the health services in the District L.N.268/1990 and to carry out such plans if approved;
- (f) To submit such statistical, financial and other reports as the Minister may require; and
- (g) To fulfil such other functions as the Minister may prescribe.

9. (1) The Board shall hold meetings quarterly, and the committees of the Board shall hold meetings at least once every two months.

- (2) The meeting shall be presided over by the chairperson or in his absence by the vice-chairperson
- (3) The quorum shall be five members one of whom shall be the secretary of the Board.
- (4) Subject to these Rules and save as otherwise may be prescribed, a Board shall regulate its own procedure.

10. (1) A sitting allowance in an amount to be determined by the Minister shall be payable to the members of the Board and its committees for all meetings attended.

- (2) The members of the Board and its committees shall be entitled to reimbursement of their costs of travel on official business upon production of receipts or mileage claim in accordance with the existing regulations.

11. (1) A member shall vacate his position on the Board in the following circumstances:-

- (a) if the member is absent without reasonable explanation from less than four consecutive meetings of the Board;
- (b) in the case of a member of Non-Governmental Organization, if he ceases to hold the office by virtue of which his nomination was made;
- (c) if the member is convicted of a criminal offence carrying the penalty of imprisonment; if the Minister in his discretion resigns his appointment to the Board.

(2) The Minister may appoint another person eligible under these Rules to take the place of any person who vacates his position under paragraph (1).

Made on the 20th May, 1992.

J.J.M. Nyagah
Minister for Health

ANNEX C: RELATIVE COST-EFFECTIVENESS OF COMMON PHC INTERVENTIONS

The following table summarizes the relative cost-effectiveness of some common PHC interventions. For example, treating one case of tuberculosis is expensive, but proper treatment is life saving, so the cost-effectiveness is high. Sophisticated treatment of AIDS complications is also expensive, but not very effective; it has low cost-effectiveness. But AIDS prevention is both reasonably inexpensive and reasonably effective. Thus, health education about safe sex, condom distribution, and screening of blood are all very cost-effective.

In the table, the relative cost-effectiveness of the interventions are categorized as:

- 1 = Highly cost-effective; best value for money
- 2 = Moderately cost-effective
- 3 = Least cost-effective; worst value for money.

The table also lists cost-sharing potential: possible opportunities to share cost with the community through user charges, local labour, or local contribution of materials

PROBLEM INTERVENTION	RELATIVE COST EFFECTIVENESS	COST SHARING POTENTIAL
HIV PREVENTION & AIDS CONTROL		
Health education (about safe sex)	1	No
Condom distribution	1	No (User fees?)
Treatment of STDs	1	No (User fees?)
Screening blood for transfusion	1	No
Treatment of AIDS complications	3	User fees
MALARIA		
Impregnated bed nets and/or mbu clothes	1	Sale of nets
Diagnosis & treatment at health facilities	2	User fees
Chemical spraying	2	None
Environmental control of mosquito breeding	2	Local labour
CHILD HEALTH		
Immunisation	1	No
ANC (for healthy newborns)	1	No
FP (child spacing)	1	No (User Fees?)
MATERNAL HEALTH		
FP	1	No (User Fees?)
ANC	1	No (User Fees?)
TBA training	2	TBAs locally paid
HC obstetric care (equipment, supplies, training)	2	User fees
Hospital obstetric care	2	User fees
Emergency referral transport	3	User fees

FAMILY PLANNING CBDC training HP family planning services	1 1	Local payment None Currently
ACUTE RESPIRATORY INFECTIONS Health facility case management CHW case management Immunisation (measles, DPT) Health Education for danger signs	1 1 1 1	User fees User fees No No
SEXUALLY TRANSMITTED DISEASES (STD) Clinical & Laboratory diagnosis Effective drug treatment Case finding	1 1 2	No (User fees?) No (User fees?) No
DIARRHOEA Breast feeding promotion Measles immunisation Health education (hand washing, clean food & water) Treatment with home fluids Treatment with ORS Clean water (well, springs) Sanitation (latrines)	1 1 1 2 2 2 2	No No No No User fees Local labour Local materials
MALNUTRITION Growth monitoring	2	None
OTHER COMMON DISEASES (intestinal worms, skin diseases, gastric up) Diagnosis & essential drug treatment Health education (personal hygiene, hand washing, etc) Water supply Sanitation	2 2 2 2	User fees No Local labour supplies Local labour supplies
BLINDNESS Trachoma case management Newborn prophylaxis Cataract surgery	1 1 2	User fees No User fees

ANNEX D

LEGAL NOTICE NO.170

THE PUBLIC HEALTH ACT (Cap. 242)

IN EXERCISE of the powers conferred by section 169 of the Public Health Act, the Minister for Health makes the following Rules:-

THE DISTRICT HEALTH (DISTRICT HEALTH MANAGEMENT BOARDS) (AMENDMENT) RULES, 1998

- 1 These Rules may be cited as the Public Health (District Health Management Boards) (Amendment) Rules, 1998.
- 2 The District Health (District Health Management Boards) Rules, 1992 are amended in Rule 8-
 - a. by inserting the following new paragraphs immediately after paragraph (e)-
 - f. to supervise, monitor and evaluate the management of the district health services;
 - g. to develop and implement plans for human resources development;
 - h. to facilitate the development and establishment of systems structures and resources in the district in support of public health services;
 - i. to ensure delivery of quality health services by all providers;
 - j. to approve plans and budgets, secure the necessary finances and oversee the implementation of quarterly or annual work plans;
 - b. by renumbering paragraphs (f) and (g) as (k) and (i) respectively.

Dated the 24th December, 1998

J. I. KALWEO
Minister for Health