COLONY AND PROTECTORATE OF KENYA

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Report of the Committee Appointed to Consider the Role of the Medical Services Rendered by the Missions in Relation to those Provided by Central and Local Government

Three Shillings – 1960

REPORT OF THE COMMITTEE APPOINTED TO CONSIDER THE ROLE OF THE MEDICAL SERVICES RENDERED BY THE MISSIONS IN RELATION TO THOSE PROVIDED BY CENTRAL AND LOCAL GOVERNMENT

1—INTRODUCTION

Consequent upon the growth of the medical services rendered by the Missions during recent years and in view of the importance of co-ordinating their activities with those of Central and Local Government, the Minister for Health set up a Committee in March, 1959, to advise on these matters. The terms of reference of the Committee were as follows:—

A—To consider the role of the medical services rendered by the Missions in relation to those provided by Central and Local Government;

B—To make recommendations to the Minister with regard to the efficient operation of Mission hospitals and to advise on the criteria to be used to determine the form and degree of assistance that may be needed now and in the future.

The Report of the Committee is now published.

2—COMMENTS OF THE GOVERNMENT ON THE RECOMMENDATIONS MADE BY THE COMMITTEE

The recommendations made by the Committee have been carefully considered by the Government and are accepted with the exception of the provisos set out hereunder.

The overriding factor in considering some of the recommendations is the financial implications arising therefrom and the adoption by Government of certain of the recommendations will have to be governed by the availability of finance.

3—SUMMARY OF RECOMMENDATIONS MADE BY THE COMMITTEE TOGETHER WITH GOVERNMENT'S COMMENTS THEREON

Recommendation No. 1

"That the important services rendered by the medical missions should be recognized and that every effort should be made to ensure that their contribution is preserved and developed."

The Government accepts this Recommendation.

Recommendation No. 2

"That a Central Advisory Committee should be set up with terms of reference as follows:—

'To advise the Minister for Health on all aspects of the Medical and Health Services rendered by the Churches and Missions in relation to those provided by Central and Local Government.'"

The Government accepts this Recommendation.

Recommendation No. 3

"That the Central Advisory Committee should be composed as follows:—

(1) *A Chairman to be appointed by the Minister for Health.*

(2) *The following bodies should be represented—*

(a) The Christian Council of Kenya;

(b) The Catholic Missions;

(c) The Association of Local Government Authorities in Kenya;

(d) African District Councils (as a group) if not covered by (c) above;

(e) The Ministry of Health; and

(f) a person appointed by the Minister to represent the interests of Child Health and Welfare."

The Government accepts this Recommendation with the following provisos:—

(i) *The Chairman of the proposed Central Advisory Committee shall, in the first place, be a professional officer of the Ministry of Health and Welfare.*

In view of the importance of co-ordinating the policy and services of the Government with the services provided by the Missions it is essential that, in the early stages, the Chairman of the Central Advisory Committee be an official of the Ministry of Health and Welfare.

(ii) *The representative shown in (2) (c) of the Recommendation to be a Councillor and not an official of a local authority. It is also noted that the appropriate body is the Association of Municipalities and County Councils.*

(iii) *The representative of the African District Councils—(2) (d) of the Recommendation—to be appointed by the Minister for Local Government and Lands, on the recommendation of the Advisory Committee on African District Councils.*

(iv) *The Ministry of Health and Welfare will provide a Secretary, from amongst its staff, to the Committee.*

Recommendation No. 4

"That each local health authority should be asked to advise its Medical Officer of Health to establish a Medical Advisory Committee to advise him on the professional aspects and co-ordination of the Medical and Health Services rendered by the Churches and Missions in relation to those provided by Central and Local Government.

The Committee should be under the Chairmanship of the Medical Officer of Health and should include representatives (preferably professional) of Medical Missions in the district. The Provincial Medical Officer should be invited to attend meetings of the Committee."

The Government accepts this Recommendation.

Recommendation No. 5

"That the aim should be to provide additional hospital beds in order to achieve a minimum spread of two beds per thousand of the population."

The Government notes this Recommendation and accepts it subject to the availability of finance and to the additional beds being consistent with the needs of the local population.

Recommendation No. 6

"That additional capital funds should be made available to assist in bringing Church and Mission hospitals up to a standard similar to equivalent Government hospitals and that this need should have priority over the provision of additional beds."

This Recommendation is accepted in principle subject to the availability of finance and to the hospital being consistent with the needs of the local population.

Recommendation No. 7

"That capital grants for improvements and extensions to existing medical Missions and for the building of new hospitals should normally be on a pound for pound basis but that in special cases and on the recommendation of the Central Advisory Committee the proportion of the grant to the total cost of the project may be varied: we also recommend that when capital grants are given to provide additional beds, recurrent grants should also be given."

This Recommendation is accepted in principal but its implementation will depend on the availability of funds.

Recommendation No. 8

"That charges for the basic standard of in-patients treated at all grant-aided hospitals shall be at the same rate as those levied at Government hospitals."

The Government accepts the desirability of this Recommendation but its implementation will depend entirely on the availability of funds to enable the grant structure projected in Recommendation No. 13 (as amended below) to be adopted.

Recommendation No. 9

"That there should be three types of accommodation, viz.:—

(a) basic standard beds;

(b) amenity beds;

(c) private beds;

and that recurrent grants-in-aid should be made in respect of all categories provided that the proportion of amenity and private beds to basic standard beds is as recommended by the Central Advisory Committee."

The Government accepts this Recommendation in principle but considers:—

(i) *The designations of the three types of accommodation should be altered to—*

(*a*) basic standard wards;

(*b*) amenity wards;

(*c*) private rooms.

(ii) *The words "and accepted by the Minister" should be added to the end of the Recommendation.*

Recommendation No. 10

"That Church and Mission hospitals should be required to submit annual statistical and financial returns in a prescribed form which should be as simple as possible and that these returns should be subject to scrutiny by the Government."

The Government accepts this Recommendation.

Recommendation No. 11

"That the recurrent grant-in-aid should be based on—

(a) the number of available non-maternity beds; and

(b) the number of non-maternity in-patient days;

subject to the adoption of approved standards for staffing and the provision of a dietary standard comparable with that followed in Government hospitals."

The Government accepts this Recommendation but it is unlikely that the Government will be able to move in the near future to the proposed grant formula; it is hoped, however, that gradual progress towards the full grant formula can be made over a period of years.

During this interim period it is proposed that additional funds which may become available should be applied as far as possible to bring all *existing* Mission hospitals which rank for a grant up to the present grant formula of 75 per cent of the approved formula. Once this position has been achieved and all hospitals are on an equal footing subsequent additional funds would be utilized progressively to reduce the fees charged in selected Mission hospitals; i.e. once all hospitals are equally grant-aided on the present formula the new proposed formula will then be applied progressively. Ultimately all hospitals would be on the proposed new grant basis and fees would equate with those charged in similar Government institutions.

Recommendation No. 12

"That in order to provide an incentive for Church and Mission hospitals to improve their standards and to form a basis for the provision of grants-in-aid these hospitals should be graded into three main categories, viz.:—

Grade 1;

Grade 2;

Grade 3."

The Government is unable to accept this Recommendation and considers that the grading suggested in the Report would have a retrograde effect on the development of medical services by the Missions. The limited funds available would be dissipated over the numerous "cottage hospitals" in the Colony to the detriment of the larger hospitals and the fact that a "cottage hospital" could qualify for a recurrent grant would tend to encourage the growth of this type of hospital, which is undesirable.

The Government proposes, therefore, that there will be one criterion only to be fulfilled before a Mission can qualify for a recurrent grant, viz., that of a resident doctor. If this criterion is met the adequacy (or otherwise) of staffing should be the subject of review by the Central Advisory Committee.

Recommendation No. 13

"That the following grant structure be adopted:—

Grade I Hospitals:

(a) £75 *per annum for each available non-maternity bed.*

(b) Sh. 2 *for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with a* 100 *per cent occupancy.*

Provided that—

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 20 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade II Hospitals:

(*a*) £40 *per annum for each available non-maternity bed.*

(*b*) *Sh.* 2 *for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with* 100 *per cent occupancy.*

Provided that—

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 30 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade III Hospitals:

(*a*) £20 *per annum for each available non-maternity bed.*

(*b*) *Sh.* 2 *for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with* 100 *per cent occupancy.*

Provided that—

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 50 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

The cost of implementing these recommendations will be approximately £145,000 per annum compared with £46,000 at present being made available."

In view of the Government's proposals set out in Recommendation No. 12, this Recommendation cannot be accepted as it stands.

Subject to funds being available the Government considers that an equitable grant structure to qualifying hospitals would be—

(*a*) £75 *per annum for each available non-maternity bed;*

(*b*) *Sh.* 2 *for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with* 100 *per cent occupancy;*

the above grant to be subject to being reduced proportionally should the revenue from Mission effort fall below 30 *per cent* of the gross maintenance expenditure of the hospital. (The approximate annual cost of implementing this proposal is £154,000.)

Recommendation No. 14

"That any rules governing the preparation and submission of annual financial statements should incorporate the following clauses—

(*a*) *that the cost of expatriate staff be reflected at figures at present* £1,700 *for a Medical Officer and* £1,000 *for a Nursing Sister.*

(*b*) *that expenditure incurred by Church and Mission hospital maternity services (to be calculated by the direct proportion of maternity beds to total beds) and revenue derived from Church and Mission hospital maternity services from any source be omitted.*

(*c*) *that revenue from hospital out-patient services should be disclosed. Charges should be not greater than the Government rate.*

The Government accepts this Recommendation.

Recommendation No. 15

"That the Central Advisory Committee should consider recommending special grants-in-aid to Church and Mission hospitals providing a specialized service in addition to the normal grant structure and varying with the special circumstances prevailing."

The Government notes this Recommendation. Special grants-in-aid would be dependent on funds being available at the time. It is considered that with the grant structure now proposed hospitals providing a specialized service would invariably be the larger hospitals and by virtue of their size would qualify for a larger grant.

Recommendation No. 16

"That the Central Advisory Committee should consider recommending a special grant to those Church and Mission hospitals undertaking essential training."

The Government notes this Recommendation.

4. In accepting this Report, subject to the provisions stated above, the Government notes the view expressed on page 25 of the Report, which reads—

> "We wish to point out again that, throughout our work, we have been governed by principles of need and have assumed that any additional funds which may be necessary as a result of our recommendations will be forthcoming. If our premise is incorrect, most of our recommendations will be impracticable and our Report of little value."

but considers that even if no extra money were available to implement the Recommendations now made, the Report is a valuable contribution towards the future development of Medical Missions.

Ministry of Health and Welfare, Nairobi.

November, 1960.

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REPORT OF MINISTERIAL COMMITTEE ON MISSION HOSPITALS

To: THE HON. W. B. HAVELOCK, M.L.C.,
MINISTER FOR LOCAL GOVERNMENT, HEALTH AND TOWN PLANNING,
NAIROBI.

SIR,

A Committee was set up by yourself in March, 1959, with the following terms of reference:—

"A.—To consider the role of the medical services rendered by the Missions in relation to those provided by Central and Local Government.

B.—To make recommendations to the Minister with regard to the efficient operation of Mission hospitals and to advise on the criteria to be used to determine the form and degree of assistance that may be needed now and in the future."

The Committee consisted of:—

Chairman.—Dr. T. F. Anderson, C.M.G., O.B.E.

Members—

The Rev. Father Colleton, C.S.Sp., Liaison Officer for the Catholic Missions.

Dr. Crowley, Medical Representative of the Catholic Missions.

Dr. N. R. E. Fendall, Assistant Director of Medical Services.

Mr. J. J. Hillman, Medical Secretary, Christian Council of Kenya.

The Hon. J. J. Nyagah, M.L.C.

Dr. W. Ouko, Medical Officer of Health, Central Nyanza.

Mr. A. C. Waine, M.B.E., Under-Secretary, Ministry of Health.

The Rev. Dr. J. Wilkinson, Medical Representative for the Christian Council of Kenya.

The Rt. Rev. R. Macpherson, Moderator of the Presbyterian Church of East Africa—attended the first two meetings in place of Mr. Hillman who was absent from the country. He was later co-opted as a member of the Committee.

Secretary.—Mr. R. L. Gosney, Hospital Group Secretary (Colony).

(2) Procedure

With a view to obtaining adequate publicity for the work of the Committee, action was taken as follows:—

(*a*) The Director of Information was asked to give the fullest publicity in the Press to the work of the Committee. The general public was invited to submit memoranda of personal views.

(*b*) Dr. Ouko, a member of the Committee, also broadcast a talk over the radio, again inviting the submission of memoranda to the Committee.

(*c*) A number of medical bodies and associations and all local government organizations—city, county and municipal councils and African district councils were invited to submit their views to the Committee.

(*d*) Units and staff of Medical Missions* engaged in medical work were invited by the Medical Secretaries of the two Mission Groups to submit memoranda.

* Throughout our report we have generally referred to the Churches and Missions which undertake medical work as "Medical Missions".

Twenty-eight replies were received to the Committee's invitation to submit memoranda. Twenty of these replies contained specific comments and recommendations and were considered by the Committee. We wish to record our appreciation for these memoranda. (*See* Appendix 1.)

The Committee met on five occasions.

The Committee set up a subcommittee to consider the financial aspects of its terms of reference. The subcommittee was composed as follows:—

Dr. T. F. Anderson (*Chairman*).
The Rev. Father Colleton.
Mr. J. J. Hillman.
Dr. N. R. E. Fendall.
Mr. A. C. Waine.
Mr. R. L. Gosney (*Secretary*).

Mr. H. L. Steel was co-opted as a member of the subcommittee and attended the first two of its meetings.

The subcommittee met on five occasions and submitted a report to the plenary committee.

Dr. the Hon. A. J. Walker, M.L.C., Chief Medical Officer, Ministry of Health, attended meetings of the Committee on two occasions and gave his views and advice. Dr. Hargreaves, Senior Medical Officer i/c Training, attended a session of the subcommittee and gave his views on the present and future training of nurses and medical auxiliaries.

PART I—THE ROLE OF THE MEDICAL SERVICES RENDERED BY THE MISSIONS

(3) History of Medical Missions

In the early days of missionary work in Kenya there was no cleavage between medical, school and evangelistic work. The needs of the people were obvious and Christian charity compelled the missionaries to undertake such therapeutic and preventive medical work for which their missionary training and experience had equipped them. Small hospitals or dispensaries were opened, often by missionaries' wives who were trained nurses or doctors.

The first missionary doctor recruited by the Church Missionary Society commenced his medical work at Mombasa in 1888.

In 1891 a Church Missionary Society hospital was built at Mzizima by a Church Missionary Society doctor who was also an engineer, on land presented by the Sultan of Zanzibar. Subsequently medical work by missionary doctors or nurses was extended throughout the Colony, the earliest being recorded at Kikuyu (1902), Kaimosi (1903), Kaloleni (1904), Maseno (1905) and Tumu Tumu (1910).

Dispensaries and maternity centres were also set up by the Protestant Missions as time went on and many of these often developed into hospitals staffed by doctors and nurses: this development represented the medical aspect of the total work and witness of a mission station which comprised evangelistic, educational, literature and medical work. The first Catholic hospital in the Colony was founded in 1940—the Mathari Hospital, Nyeri, run by the Consolata Fathers.

(4) Origin of Government Grants to Medical Missions

The first basis of an annual Government grant to Medical Missions was agreed in 1919 between the Governor of the East African Protectorate and the Foreign Mission Committee of the Church of Scotland. The terms of this agreement were:—

(i) A payment of 4,500 rupees (£300) per annum in respect of each doctor.

(ii) To build mission dispensaries at Government expense or to provide a payment of 1,500 rupees (£100) for each dispensary built by the mission.

(iii) A payment of 300 rupees (£20) per annum towards the running costs of each dispensary.

(iv) Free supply, by the Government, of all drugs, instruments, dressings and appliances.

Government grants on the above terms were given in respect of the Church of Scotland hospitals at Kikuyu and later at Tumu Tumu.

In 1920 the Government made a special provision for increased expenditure in the native reserves, which included grants at the rate of £1,572 for a full year to the following Mission hospitals, some of which were then in the course of construction:—

Kikuyu (Church of Scotland).
Butere (Church Missionary Society).
Maseno (Church Missionary Society).
Tumu Tumu (Church of Scotland).
Chuka (Chogoria) (Church of Scotland).
Meru (United Methodist).
Machakos (Africa Inland Mission).

Following criticisms in the Legislature in 1921 of the unlimited free supply of drugs, etc., to Mission hospitals it was decided to restrict such supplies to £200 per annum.

On grounds of economy, the Government terminated the 1919 agreement by giving six months' notice of its intention to do so in May, 1922.

Government grants, on a token scale, were resumed in 1925, following recommendations by a Select Committee of Legislative Council which sat in 1924 and such grants have continued at varying amounts up to the present time. (*See* Appendix 2.)

In 1927 the then Director of Medical and Sanitary Services submitted a paper to Government, entitled "A Health Scheme for the Colony", in which he proposed the following basis for calculation of grants to Medical Missions:—

(*a*) An overall bed spread of one bed per thousand of the population.

(*b*) A grant of £25 for each Medical Mission bed in areas where the ratio was below one bed per thousand of the population.

It is understood that this proposal was not accepted by the Government because of the financial considerations.

(5) Present Position of Mission Hospitals

There are at present 13 Protestant Mission and 22 Catholic Mission hospitals of over 25 beds, most of which have qualified resident medical and nursing staff. (Appendix 3 refers.) In addition there are several other smaller institutions which provide in-patient medical facilities. Government grants-in-aid are given to many of the longer established Protestant hospitals, but no subsidy, or in some cases only an *ad hoc* subsidy known as a token grant, is given to the Catholic hospitals.

(6) Development of Medical Missions

The work of the Medical Missions must be considered in the context of medical work generally in Kenya in so far as it affects the African population as Mission medical work has been carried out almost entirely amongst the indigenous population. The Protestant Churches were the pioneers of medical work in the country and employed doctors and nurses and established hospitals in a few centres at a time when the Government Medical Service was in a rudimentary stage. The early hospitals and their staffs were built and supported entirely by voluntary contributions from overseas. As time went on the medical and health service, provided by the Government and maintained by public funds, increased until it became far greater in its scope and activities than the services which the Medical Missions were able to provide. The increased cost of hospital services (which has been evident especially since the end of the Second World War) coincided with a relative reduction in contributions to Medical Missions from voluntary sources owing to the fall in the value of money. The first result of the growing disparity between income and expenditure was that Mission hospitals were forced to increase fees for their services until the apparent limit of the capacity of the African patient to pay was reached. The gap has had to be bridged by increased Government subsidy which, although it has probably had the effect of preventing certain Mission hospitals from closing down, has been inadequate for the needs of Mission medical services as a whole. It has not been sufficient to enable all Medical Missions to maintain standards, particularly in regard to accommodation, at the same level as the improved Government hospitals.

Having reviewed the work of the medical services rendered by Church and Mission bodies, the Committee came to the conclusion that these agencies are performing an essential service and have a distinctive contribution to make towards the medical services of the Colony. The Committee advises, in general terms, that every effort should be made to ensure that their contribution is preserved in any future organization.

In considering the background against which the work of Medical Missions must be viewed, the Committee was forced to the conclusion that not only was the Government subsidy inadequate but that the medical and health services as a whole had lagged behind those which can now be considered adequate. This is illustrated by the fact that in most of the rural areas of the country the number of beds available to African patients is considerably below two per 1,000 of the population. This will be referred to in more detail later in this report.

From an examination of the allocation of Government funds, both recurrent and capital, during the last ten years, it is apparent that whilst the disparity in the allocations of capital moneys as between the Education Department and the Medical Department is being evened out, there is still a wide disparity where recurrent funds are concerned. This is illustrated by the following figures:—

	Colony	%	Development	%	Total	%
	1949					
Education expenditure ..	1,028,658	9·9	997,297	23·6	2,025,955	13·9
Health expenditure ..	746,469	7·2	110,202	2·6	856,671	5·9
	1959/60 (Estimates)					
Education expenditure ..	6,314,764	16·2	774,842	9·6	7,089,606	15·1
Health expenditure ..	2,302,182	5·9	353,852	4·4	2,656,034	5·6

Thus, ten years ago, the annual recurrent budgets of the Education and Medical Departments were similar, whereas the Education Vote is now almost three times as great as the Medical Vote. We realize that no account is taken in these figures of funds provided by local authorities for health and medical services, but nevertheless it appears that the allocation of recurrent funds by Central Government to the Medical Department has lagged behind allocations to other departments of which we have taken the Education Department as an example.

It is self-evident that the Government subsidy to Mission hospitals is inadequate and that the Missions are finding it increasingly difficult to carry on their medical work.

We Therefore Recommend—

RECOMMENDATION NO. 1

That the important services rendered by the Medical Missions should be recognized and that every effort should be made to ensure that their contribution is preserved and developed.

(7) Co-ordination of Government and Mission Medical Services

The activities of the Mission hospitals have not always been fully co-ordinated with the Government medical service. In the period up to the outbreak of the 1939 War, Church and Mission hospitals were largely self-supporting and operated very much on their own. Gradually certain Missions became financially dependent to a great extent on Government grants-in-aid and this led to some degree of interdependence. A representative of the Protestant and later, of the Catholic Missions, was appointed to deal directly with Medical Headquarters. A further move was made to obtain closer co-operation between Government medical officers and Church and Mission doctors at district level. Medical representatives of Missions were invited to attend sometimes the whole or more often a part of the Provincial Medical Officers' conferences held centrally and the District Medical Officers' conferences held at provincial level.

This *ad hoc* arrangement helped to foster closer relations between the organizations responsible for medical work, but its success or failure depended very much on the personalities concerned and in practice the arrangement often broke down at district level.

We note, in passing, that although the Catholic Missions have now appointed a representative in view of the phenomenal increase in Catholic Mission hospitals, it would undoubtedly be advantageous to both the Government and the Catholic Missions if the Catholic Missions were able to make more adequate secretarial arrangements for their medical work as has been done by the Protestant Missions.

From evidence which has been presented to us, we understand that there is a strong desire on the part of the Churches and the Missions for closer co-operation or even for some degree of integration to prevent overlapping of services. It should be recognized that the interests of Medical Missions and Government in the medical field are identical and that closer co-ordination would result in increased efficiency and the avoidance of feelings of frustration sometimes experienced by the Medical Missions. With these views the Committee is in full agreement. We believe that closer co-operation can be achieved in the following ways:—

A—Central Advisory Committee

It is important that there should be a Standing Committee which can review all matters concerning Mission medical services including the scope of their

activities, their finances and plans for future expansion, and which can advise the Minister accordingly. These matters would have to be considered against the background of the medical services rendered by the Central Government and Local Government bodies. It would therefore be necessary for the Committee to be kept fully informed with regard to the general policy to be followed in the Central and Local Government health services, and to be advised of plans for the future expansion of such services. The terms of reference of this Committee should, it is suggested, be similar to paragraph B of our terms of reference.

We consider that the formation of a Central Advisory Committee is of the greatest importance and is fundamental to many of our subsequent recommendations. On the assumption that our recommendation in this respect will be accepted, we will have occasion constantly to refer to it in this report. We have endeavoured to confine our recommendations to general principles and to avoid unnecessary detail as we presume that detailed matters will be dealt with by the Central Advisory Committee.

We Therefore Recommend—

RECOMMENDATION NO. 2

That a Central Advisory Committee should be set up with terms of reference as follows:—

"To advise the Minister for Health on all aspects of the medical and health services rendered by the Churches and Missions in relation to those provided by Central and Local Government."

COMPOSITION OF THE CENTRAL ADVISORY COMMITTEE

It is clear that the proposed committee should include representatives of the Christian Council of Kenya, under whose auspices the Protestant Medical Missions operate, and of the Catholic Missions. The Ministry of Health must also be represented. In view also of the growing importance of the local authorities in the field of health, the committee should include representatives of the local health authorities. We will have occasion later in this report to refer to the responsibility of the Ministry for child health and welfare and to hope that Churches and Missions will interest themselves to an increasing extent in this important but hitherto largely unexplored field. We have therefore thought it proper to advise that a person should be appointed to the committee who would represent these interests.

We consider that the chairman of the committee should not be elected from amongst the members of the committee, all of whom represent special interests, but that an independent and impartial chairman should be appointed.

We Therefore Recommend—

RECOMMENDATION NO. 3

That the Central Advisory Committee should be composed as follows:—

(1) *A chairman to be appointed by the Minister for Health.*

(2) *The following bodies should be represented—*

(*a*) *the Christian Council of Kenya;*
(*b*) *the Catholic Missions;*
(*c*) *the Association of Local Government Authorities in Kenya;*
(*d*) *African district councils (as a group) if not covered by (c) above;*
(*e*) *the Ministry of Health; and*
(*f*) *a person appointed by the Minister to represent the interests of child health and welfare.*

We have considered the status of the committee as to whether or not it should be established by statute and have come to the conclusion that no useful purpose would be served by constituting the committee as a statutory body. We therefore advise that the Central Advisory Committee should be established by the Minister as a Ministerial Committee with advisory functions but without statutory powers.

B—District Medical Advisory Committees

The Committee considered, at some length, the question of the setting up of Medical Advisory Committees at provincial and district levels with the object of co-ordinating the work of the Missions, Central Government and local health authorities. The establishment of advisory bodies at provincial level was discussed but was rejected for two reasons. Firstly, it was felt that, as the district was a homogeneous unit, it was at this level that co-operation could best be achieved and also that individual districts in a province often had widely differing problems. Secondly, as the African district councils in the African land units and the municipal or county councils in the settled areas are the local health authorities, it was considered that the medical officer of health was the proper person to represent medical opinion to the local authority. It was thought that co-ordination at provincial level could be brought about by inviting the Provincial Medical Officer to attend meetings of the District Committee.

We therefore consider it desirable that in every district in which medical work is carried out by Churches and Missions there should be set up a District Medical Advisory Committee. It is important that such a committee should be an entirely advisory body which would in no way conflict with the statutory functions and responsibilities of the public health committee of the African district council. Indeed it is important that it should arouse no suspicion in the minds of members of the council that the committee was usurping their functions. We are of the opinion, therefore, that the District Medical Advisory Committee should be a purely professional body which by virtue of its composition would be immune from political pressures.

We have in mind a committee composed of the medical officer of health as chairman and a representative of each of the Medical Missions operating in the district. The representative of the Mission would normally be the doctor-in-charge, though in the case of a small Mission hospital without a resident doctor it might be a nursing sister or medical auxiliary. The medical officer of health who is the health and medical adviser of the local authority and who attends meetings of the public health committee in his official capacity would thus be able to represent the views of the professional committee to the council.

We advise further that in order to remove any suspicion that such a committee would usurp the function of the local authority, the committee should not be set up by administrative action by the Minister but that each local authority should be asked by the Minister to advise its medical officer of health to establish such a committee.

The view was expressed that it would be of advantage to include on the Advisory Committee a member of the health committee of the local authority, preferably its chairman, as this would have the effect of informing the member concerned as to professional opinions on medical matters. This proposal was rejected as it was felt that the medical officer of health was the proper person to represent the views of the committee to councillors. We suggest, however, that the committee should be given powers to co-opt additional members to provide for such representation in special cases.

It was also suggested in one of the memoranda which we received that the District Medical Advisory Committee should be a statutory body with functions and powers similar to those of the District Education Boards. We feel, however, that such a solution would be contrary to the terms of the African District Council Ordinance and that such a course would involve complicated amending legislation. Moreover, such an expedient would interfere with the responsibilities and powers of African district councils as local health authorities. This proposal was therefore rejected.

We Therefore Recommend—

RECOMMENDATION NO. 4

That each local health authority should be asked to advise its medical officer of health to establish a Medical Advisory Committee to advise him on the professional aspects and co-ordination of the medical and health services rendered by the Churches and Missions in relation to those provided by Central and Local Government.

The Committee should be under the chairmanship of the medical officer of health and should include representatives (preferably professional) of Medical Missions in the district. The Provincial Medical Officer should be invited to attend meetings of the Committee.

C—Provincial Specialist Services

The view was expressed by the Church and Mission representatives on the Committee that co-ordination would be greatly facilitated if they were able to take advantage of the specialist services which the Government provides, generally at the provincial general hospital level. Such services include visits by the Provincial Surgeon and Physician, the laboratory service and an X-ray department. The Committee supports this view but also notes that Church and Mission hospitals sometimes possess special facilities, such as X-ray equipment, which are not available at the district hospital. The Committee therefore hopes that it will be possible to co-ordinate all these services in order to ensure that they are used to the maximum capacity. Co-ordination in such matters should be effected by the District Medical Advisory Committee with the assistance of the Provincial Medical Officer.

It is further agreed that it would facilitate closer liaison at provincial level if doctors-in-charge of Medical Missions were always invited to attend the twice-yearly conferences of Government medical officers, held under the chairmanship of the Provincial Medical Officer.

(8) Services Provided by Churches and Missions

Churches and Missions undertaking medical work have to maintain legal and financial relationships with Central and Local Government. At this stage, therefore, it is appropriate to examine the relative responsibilities of Central and Local Government in regard to the various branches of the medical and health services. These responsibilities are now fairly well defined. The Central Government is responsible for the building, extension and maintenance of hospitals and assumes responsibility for the greater part of the training of nurses and medical and health auxiliaries. The Minister for Health or, as the Public Health Ordinance expresses it, the Director of Medical Services, is also generally responsible for the efficient operation of all medical and health services, including those performed by the local authorities and the Missions.

Local authorities are responsible for health centres and dispensaries, maternity services, ambulance services and for preventive and promotive medicine, including environmental sanitation. An exception to the latter is that large-scale projects for the control of disease are sometimes carried out by Central Government, though generally with the assistance of the local authority.

There remains another group of activities which may be classified as social medicine which includes such matters as the care of the handicapped of all ages and child health and welfare. This is a field of activity which is rapidly increasing in importance, responsibility for which lies with the Ministry of Health. The question as to whether executive responsibility for such services should be undertaken by Central Government or by local authorities has not yet been fully clarified.

The Committee examined the relationship of Medical Missions to these various activities:—

(*a*) *Hospitals*

From the earliest years of medical work in Kenya the Medical Missions have concentrated their efforts on the building and maintenance of hospitals with, as a secondary activity, the development of satellite dispensaries. Mission doctors have thus made their greatest contribution as clinicians whose main task has been the treatment of the sick. They have, partly by force of circumstances and partly by inclination, had very little to do with public health or preventive medicine. The Committee feels that the Churches and Missions have now and will have in the future an important part to play in maintaining existing hospitals, raising their standards where necessary, and it is to be hoped, in providing new hospitals in years to come. The Committee recognizes that there is a difference in atmosphere in Church and Mission hospitals as compared with Government hospitals. This is not to say that treatment is better—and, indeed, accommodation may not be so good—but there is often less pressure on beds, there is probably more individual attention, and a spiritual atmosphere which should be perpetuated.

(*b*) *Health Centres*

Health centres have been started in the last ten years on the initiative of and with financial aid from the Government, although their maintenance has been the responsibility of local authorities. The concept of health centres in Kenya is probably in advance of other countries in a comparable stage of development and has attracted considerable international attention. It is probable that in the future the main advance in promoting the health of the people will be achieved through health centres and their growth and expansion is not only desirable but inevitable. Owing to the importance of the health centre concept it is appropriate to quote here its definition as understood in Kenya:—

> "A health centre is an institution where all three branches of the health service, curative, preventive and promotive are co-ordinated and from which they radiate out into the homes and community." The word "health" is defined* by the World Health Organization as "a state of complete physical, mental and social well-being, and not the mere absence of disease or infirmity".

Individual Mission doctors have, from time to time, suggested that they should play a part in the development of health centres, though as far as we are able to judge, this demand has been neither widespread or insistent. The practical difficulty in arranging for Medical Missions to take their part in this activity is that the African district council is the responsible authority for public health and therefore any Church or Mission body entering the

* World Health Organization—Basic Documents, 8th Edition—"Constitution of the World Health Organization".

public health field must come under the jurisdiction of the medical officer of health who is the officer directly responsible to the public health committee of that council.

The Committee considered this matter and decided that many Mission doctors did not have the experience nor the desire to enter into the public health field. Where, however, Church and Mission medical personnel have the aptitude, experience and desire for this kind of work, they might be invited to take part in the public health activities of the districts, including those of health centres or other aspects of health work, provided that these activities remain under the overall control of the medical officer of health. In some cases it might be desirable for the Mission doctor to be appointed as assistant medical officer of health, but this appointment should be personal to the holder.

(*c*) *Dispensaries*

Mission dispensaries have been established in certain areas for many years as satellites of Mission hospitals. Many of them date from the time when Government, and later African district council, dispensaries were few or non-existent. African district council dispensaries are now as a rule organized as satellites of the health centres, and the growth of this service has not infrequently led to competition, friction and misunderstanding between the Churches and Missions and the African district councils.

Instances have been brought to our notice where an African district council dispensary has been built alongside a Medical Mission dispensary; this is an instance of lack of co-operation which it is hoped our recommendations will remove.

Another cause of difficulty and friction is a disparity of charges between Mission and African district council dispensaries.

It seems probable that Medical Mission dispensaries will to an increasing extent be taken over by the local health authority.

We wish to mention that visits by Mission doctors to outlying parts of the district are useful and should continue, subject to proper co-ordination by the medical officer of health.

(*d*) *Maternity Services*

Church and Mission hospitals have generally maintained a maternity ward or wards as an integral part of the institution; a few of the smaller hospitals are in charge of a midwife and cater solely for maternity cases. Medical Missions appear to the Committee to be especially suited to this type of work and it is hoped that this state of affairs will continue.

A complication arises in connexion with the subsidy for maternity beds as this service is the responsibility of the local health authority. Medical Missions have to obtain grants-in-aid from Central Government in respect of general beds and from the local authority in respect of maternity beds. This involves separate accounting, but should not present any difficulty if the grant structure recommended in Part II of this report is adopted.

We were informed that owing to shortcomings of annual budgeting, African district council grants-in-aid to Medical Missions are very inconstant and were often cut without warning which makes it difficult to maintain a continuous service. The Committee therefore suggests that such grants should be arranged so as to provide continuity for a period of several years.

(e) Training

Medical Missions have always taken an interest in training medical auxiliaries and a number of training schools for assistant nurses and midwives and a few for training hospital assistants are in operation at the present time and are recognized by the Nurses and Midwives Council. Evidence was given that the number of training schools throughout the country is now in excess of the number required to train staff for existing hospitals; the number of training schools would therefore have to be reduced. It is probable that the Medical Missions will wish to continue to train staff for their own needs. The number of schools which will be maintained to fulfil Colony-wide needs for staff will, it is assumed, be controlled by the Nurses and Midwives Council, though the Central Advisory Committee will no doubt wish to be kept informed of the position.

The Committee considers that the Medical Missions have special facilities for safeguarding the welfare of girls in training and therefore expresses the hope that the training of nurses and midwives at Medical Missions will continue.

If our recommendations with regard to expansion are accepted the whole question of training will have to be reviewed and a reassessment made of training needs and of the role of Mission hospitals in this respect.

(f) Social Medicine

It has become apparent recently that there is a great and growing need for an extension of welfare services to provide for the care of the following categories: —

(1) Deprived and handicapped children.

(2) Infirm and handicapped adults.

(3) The aged and the infirm.

Of these, the first, namely deprived and handicapped children, is undoubtedly of the most urgent importance to the future health and wealth of the country.

It is clear that there is a need for immediate action to meet this rapidly growing problem. The opinion was expressed that the Missions and Churches were particularly well suited to undertake this work. They have a wide knowledge of these social conditions, particularly in the vicinity of the Mission and have been able to observe them over a long period. They are therefore probably better adapted to deal with these problems than other agencies. The Church and Mission representatives on the Committee stated that although Medical Missions might be willing to add to their existing work of this nature they would be unable to do so unless they were adequately subsidized. Furthermore they were of the opinion that existing staff were not experienced in this type of work or trained to undertake it. Any extension of their activities in this direction would therefore involve recruiting suitably qualified expatriate staff and training local personnel.

The Committee agreed that the Central Advisory Committee when established should take cognizance of this problem and of the report of the Working Party on Child Welfare when available, with a view to enlisting the support of the Churches and Missions in dealing with this problem and in recommending the necessary financial provision.

PART II—THE EFFICIENT OPERATION OF CHURCH AND MISSION HOSPITALS AND THE FORM AND DEGREE OF FINANCIAL ASSISTANCE

(9) Financial Considerations

In considering the financial implications to the country we have, in the course of our deliberations and through our report, been guided by the need for ensuring that the Mission medical services are efficiently operated and that anomalies are removed. Our recommendations with regard to finance are therefore based on these principles, and, while bearing in bind that Kenya possesses limited financial resources, we have thought it proper to avoid being unduly influenced in our recommendations by present financial stringencies.

(10) Bed Statistics Related to Colony Need

We have examined the present ratio of general hospital beds at basic standards per thousand of the population in each district of the Colony. In a few districts a ratio of two beds per thousand has been reached but in the majority of districts the number of general beds per thousand of the population is between one and two. In two large districts, viz., South Nyanza and Kitui the ratio is as low as 0.5 per thousand. (A detailed analysis of bed states by districts is given at Appendix 4.) These figures compare most unfavourably with the ratio of beds per thousand of the population in the more highly developed countries, e.g. England and Wales where the ratio is approximately 11.5 beds per thousand of population (of which five beds per thousand are mental beds). We consider that existing hospitals, including Church and Mission hospitals, should be expanded and, where necessary, new hospitals built so as to raise the ratio to a minimum of two general beds per thousand of population. Priority in such a programme of expansion should be given to those districts which have the lowest ratio of beds per thousand. It is our opinion that a target figure of this order is a realistic one and that every effort should be made to attain it. Such a programme envisages providing approximately 4,000 new beds which, if built to a reasonable standard, would involve a capital expenditure in the region of £3,000,000.

We consider that all future expansion of Church and Mission hospitals to provide additional beds should receive the prior recommendation of the Central Advisory Committee. This body should be empowered to advise on all proposals to provide additional hospital beds maintained by voluntary agencies and to relate them to the Government development programme in order to achieve an overall spread of beds throughout the Colony. We recommend, however, that should a voluntary agency wish to build a hospital to provide additional beds in an area where the minimum requirements are already met, it should be allowed to do so but without any financial assistance from the Government.

We wish to emphasize that it would be wrong in principle to embark on the expansion recommended above without a corresponding expansion of the preventive and promotive health services. These services should therefore be developed at a comparable rate which would also require considerable additional expenditure, such expenditure being direct in the provision of new buildings and staff and indirect by subsidization of local health authorities.

We Therefore Recommend—

RECOMMENDATION NO. 5

That the aim should be to provide additional 'hospital beds in order to achieve a minimum spread of two beds per thousand of the population.

(11) Present Standard of Church and Mission Hospitals

We have already pointed out in Part I of this report that the present subsidies provided by the Government are insufficient to enable Medical Missions to maintain standards—particularly standards of accommodation—at the same level as that of the average Government hospitals. We consider that Church and Mission hospitals must be brought up to a standard comparable with similar Government hospitals and this will entail a building programme to improve and enlarge existing buildings and to replace temporary buildings by permanent structures. Standards of basic equipment, e.g. beds, will also have to be improved. We are of the opinion that such raising of standards should have priority over the provision of additional beds.

We Therefore Recommend—

RECOMMENDATION NO. 6

That additional capital funds should be made available to assist in bringing Church and Mission hospitals up to a standard similar to equivalent Government hospitals and that this need should have priority over the provision of additional beds.

(12) Capital Grants

Hitherto capital grants to Medical Missions to provide a basic service have usually been on pound for pound basis. The principle has much to recommend it as it provides an incentive to voluntary effort to raise funds both from outside the Colony and from the population in the area which the hospital is intended to serve.

It is clear that funds from voluntary sources will be insufficient to meet the needs of an expanded building programme and must be supplemented by Government financial assistance possibly to a greater extent than 50 per cent. For example, if a voluntary agency is prepared to assist in providing an additional hospital in an area where there is an urgent need for additional beds, such a project might well prove impossible unless the Government contribution is more than 50 per cent of the total capital cost. It has already been recommended that financial assistance towards provision of additional beds should be subject to the prior recommendation of the Central Advisory Committee.

We Therefore Recommend

RECOMMENDATION NO. 7

That capital grants for improvements and extensions to existing Medical Missions and for the building of new hospitals, should normally be on a pound for pound basis but that in special cases and on the recommendation of the Central Advisory Committee the proportion of the grant to the total cost of the project may be varied: we also recommend that when capital grants are given to provide additional beds, recurrent grants should also be given.

(13) Charges for Medical Services

It has become apparent in the course of discussion and from evidence which has been presented to us that there is a large body of public opinion in favour of abolishing the difference between fees charged at Church and Mission hospitals and those raised at Government hospitals. This difference has undoubtedly led to a good deal of criticism. Medical Missions are often blamed for levying higher charges although it is not generally realized that it is only by increasing their fees and economizing in various ways, that they have been able to carry on at all.

We consider, however, that it is inequitable that people living in an area served by a Government hospital should have to pay a fixed basic charge for in-patient treatment whilst others living near a Church or Mission hospital have to pay a higher rate. Medical Mission charges for in-patient treatment generally include a daily fee, and, in addition, special charges for drugs, dressings, injections and surgical operations. At Government hospitals on the other hand, a flat rate is charged which includes all services provided. We consider, therefore, that the subsidy provided by the Government to Medical Missions should be adequate to allow for a uniform charge for the basic standard service throughout the Colony. We consider this to be of fundamental importance and it is basic to our further recommendations.

We Therefore Recommend—

RECOMMENDATION NO. 8

That charges for the basic standard of in-patient treatment at all grant-aided hospitals shall be at the same rate as those levied at Government hospitals.

(14) Types of Beds Provided at Church and Mission Hospitals

Before discussing grants for recurrent expenditure we thought it advisable to discuss the type of accommodation needed in the Colony.

(*a*) BASIC STANDARD BEDS

By far the largest proportion of beds at Government and Medical Mission hospitals may be considered as providing a standard basic service, that is to say, they provide a standard of accommodation, diet, and quality of treatment which is reasonable and adequate. At the same time, these standards have been found in practice to be as high as the community can afford. The standard of accommodation available at the average Government district hospital may be taken as the normal basic standard. We have already noted that standards should be raised at other hospitals where this is not attained.

(*b*) AMENITY BEDS

We recognize that there is a growing demand amongst the more educated section of the community and amongst those who have attained a higher standard of living to be provided with certain amenities when admitted to hospital. Such amenities include a degree of privacy provided by smaller or single bed wards, improved furnishings and appointments in such wards, and a more varied diet. We therefore consider that the Church and Mission hospitals should provide such amenity beds where there is a public demand. The cost of providing these extra amenities should be borne by increased fees. We consider that such amenity beds should attract a Government grant at the basic rate provided that the additional charge is fair and reasonable, and that it is used for the provision of extra comforts and not for other purposes. It should of course be understood that the standard of medical treatment and nursing care and attention would be the same as that given in the basic service general wards.

(*c*) PRIVATE BEDS

There is a third type of accommodation sometimes provided in Church and Mission hospitals for persons in the higher socio-economic group who are prepared to pay the cost of such services. We consider that the same Government financial aid should be given to the provision of this type of accommodation, as to the other two categories.

We Therefore Recommend—

RECOMMENDATION NO. 9

That there should be three types of accommodation, viz.—

(a) Basic standard beds;

(b) amenity beds;

(c) private beds,

and that recurrent grants-in-aid should be made in respect of all categories provided that the proportion of amenity and private beds to basic standard beds is as recommended by the Central Advisory Committee.

(15) Grants for Recurrent Expenditure

(a) Prescribed Returns

As the expenditure of public funds is involved in the allocation of grants-in-aid to Mission hospitals, it follows that a pre-requisite of any grant structure must be the submission by such hospitals of a prescribed annual statistical and financial return. Having regard to the general level of efficiency of clerical staff, any such prescribed return should be as simple as possible and should contain only those essential statistics necessary for the assessment and calculation of grants-in-aid.

We are of the opinion that such returns should be certified as being correct, but that it is not necessary to require Medical Missions to employ qualified auditors for the purpose. The present practice of Medical Missions, whereby their accounts are inspected within their own organization, should continue but their prescribed returns should be subject to scrutiny by the Ministry of Health.

We Therefore Recommend—

RECOMMENDATION NO. 10

That Church and Mission hospitals should be required to submit annual statistical and financial returns in a prescribed form which should be as simple as possible and that these returns should be subject to scrutiny by the Government.

(b) Grant Structure

We have given careful consideration to the various factors on which a grant structure may be based. It may be based (*a*) on the numbers of trained staff employed allied to a training grant being given in respect of teaching staff and the numbers of students under training, or (*b*) it may be based on the number of beds available and/or the total number of in-patient days.

We have examined the grant structure adopted in Uganda, which is similar to that at present being followed in Kenya, and which is based on trained staff in addition to a training grant related to the number of students undergoing training. This structure involves considerable clerical work with complications arising from changes in staff. We consider that any grant structure should bear a definite relation to the needs of an area for hospital facilities, and not to training needs which is a separate issue. We do not therefore recommend a grant structure on these lines.

We consider that a grant structure based on bed occupancy, i.e. on the number of in-patient days, is realistic in that the grant bears a direct relation to the number of patients who have to be fed, accommodated and treated. It may be

argued that a grant structure based on available beds may develop a tendency to increase the number of beds at the expense of trained staff which could lead to a lowering of the standard of nursing care and attention. We consider that this problem may be obviated by (*a*) the scrutiny of the Central Advisory Committee with regard to any provision of additional beds and (*b*) rules governing the minimum proportions of staff to beds.

We have noted that there is at present, a wide variation in the standard of diet, and therefore the cost of diets, between the existing Church and Mission hospitals in the Colony. In general, the dietary standards of Church and Mission hospitals differ from those in Government hospitals which follow diet scales laid down by central authority, and it is evident that there are wide variations in the quality of the diet as between different Church and Mission hospitals. We therefore consider it desirable that if the grant structure is related to in-patient days the dietary standards should be comparable with Government hospital standards.

We have come to the conclusion that a simple, and at the same time, equitable, formula on which grants-in-aid are given should be based on two main points, firstly, a factor for each available non-maternity bed and secondly, a factor for each non-maternity in-patient day.

We Therefore Recommend—

RECOMMENDATION NO. 11

That the recurrent grant-in-aid should be based on—

(*a*) *the number of available non-maternity beds, and*

(*b*) *the number of non-maternity in-patient days subject to the adoption of approved standards for staffing and the provision of a dietary standard comparable with that followed in Government hospitals.*

(*c*) *Grading of Hospitals*

We have examined certain statistical and financial information provided by the Christian Council of Kenya in respect of the Protestant Mission hospitals which disclose wide differences in hospital costs and usage. From these facts we have also inferred that there is a wide difference in standards at these hospitals which we feel is also common to Catholic hospitals. In addition to these differing standards relating to accommodation and maintenance, there also exists differing standards of efficiency in administration and treatment. Such differences will be disclosed by visits of inspection carried out by professional officers of the Ministry of Health and may also be reflected by the popularity or otherwise with which hospitals are regarded by the general population in the areas they serve.

We are therefore of the opinion that a system of grading of Church and Mission hospitals should be adopted.

We Therefore Recommend—

RECOMMENDATION NO. 12

That in order to provide an incentive for Church and Mission hospitals to improve their standards and to form a basis for the provision of grants-in-aid, these hospitals should be graded into three main categories namely—

Grade 1
Grade 2
Grade 3.

Suggested criteria for grading are contained at Appendix 5. It should be realized that these requirements are not rigid and should be applied sympathetically.

It will be seen that the type of hospital envisaged within the grading of "Grade 3" is that usually termed "cottage hospital", that is of from 25-34 beds, without a resident doctor but with a resident nursing sister and adequate qualified nursing auxiliaries. Under the provisions of the Medical Practitioners and Dentists Ordinance, such a hospital must be under the supervision of a visiting medical officer.

Before making our recommendations we considered the need of such hospitals for grants-in-aid, and were particularly concerned that the admission of Grade 3 hospitals to the grant structure should not merely create a wider dispersal of funds to the detriment of existing grant-aided hospitals.

We wish to point out again that, throughout our work, we have been governed by principles of need and have assumed that any additional funds which may be necessary as a result of our recommendations will be forthcoming. If our premise is incorrect, most of our recommendations will be impracticable and our report of little value.

We feel that cottage hospitals, properly staffed and administered, play an important part in the provision of hospital services, for example Kolanya, Kilungu and Kalimoni hospitals. We consider that exclusion of such hospitals from any grant structure would deprive them of aid to enable them to continue to give a vital, essential and effective service. While we consider that the recognition or otherwise for grants-in-aid for any hospital should be decided solely by the needs of the community it serves, we consider that the interests of existing grant-aided hospitals need to be protected.

We do not consider that it is our responsibility to determine into which category existing Church and Mission hospitals should be placed. We are of the opinion that such classifications should be an administrative function of the Ministry.

We have examined financial statements of income and expenditure in respect of many existing Protestant Church and Mission hospitals, bearing in mind the principle of an even schedule of fees being adopted, in order to assess the degree of grants-in-aid which it will be necessary to make available.

We are of the opinion that the present voluntary efforts made by the Medical Missions should be encouraged and fostered. To ensure this, we propose that the revenue to be derived from Church and Mission voluntary efforts should be not less than a prescribed percentage of the gross maintenance expenditure of the hospital.

We consider that any savings on voluntary effort which may result from the provision of Government grants should be used towards extending or improving existing hospital services.

We have recognized, however, that with the present variation in standards and costs, a rigid formula for application to each hospital may produce anomalies and we therefore consider that the Central Advisory Committee should recommend the raising or lowering of the grant when special circumstances exist.

We Therefore Recommend—

RECOMMENDATION NO. 13

That the following grant structure be adopted:—

Grade I Hospitals

(*a*) £75 *per annum for each available non-maternity bed.*

(*b*) *Sh.* 2 *for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with a* 100 *per cent occupancy.*

PROVIDED THAT:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 20 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade II Hospitals

(*a*) £40 *per annum for each available non-maternity bed.*

(*b*) *Sh.* 2 *for each non-maternity in-patient day, subject to a maximum of in-patient days obtainable with a* 100 *per cent occupancy.*

PROVIDED THAT:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 30 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade III Hospitals

(*a*) £20 *per annum for each available non-maternity bed.*

(*b*) *Sh.* 2 *for each non-maternity in-patient day, subject to a maximum of in-patient days obtainable with a* 100 *per cent occupancy.*

PROVIDED THAT:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 50 per cent of the gross maintenance expenditure of the hospital and THAT the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

The cost of implementing these recommendations will be approximately £145,000 per annum compared with £46,000 at present being made available.

(*d*) *Standard Presentation of Accounts*

To ensure that the grant formula is fair and uniform to all hospitals, it is essential that a common method must be employed in drawing up the statement of income and expenditure which each hospital will be required to submit.

We have noticed, for example, the wide variations in the allowances provided for expatriate doctors and nursing sisters. We consider, therefore, in order to make inter-hospital cost comparisons, that the cost of such expatriate staff should be reflected in the statement of expenditure at the following figures as at present:—

Expatriate medical officer	£1,700 p.a.
Expatriate nursing sister	£1,000 p.a.

We feel that any maternity services which may be operated by Medical Missions should be a matter for discussion and decision by the district medical advisory committee, the appointment of which we have recommended in Part I of this report. We have therefore excluded maternity services from ranking for grants-in-aid from Government and it therefore follows that deduction from the gross expenditure should be made for the cost of maintaining maternity beds. We consider that this deduction should be in the direct proportion that the maternity

beds relate to the total beds of the hospital. Similarly any revenue received in respect of the maternity services, whether by grants or from fees should be omitted from the Revenue Account. We have considered, in making our recommendations of a grant structure, the out-patient services provided at Church and Mission hospitals. We do not feel that the fees charged for such services should necessarily be the same as those at Government hospitals, but should not be more than the Government rate. The revenue from these services must be disclosed in the accounts submitted, and taken into consideration.

We Therefore Recommend—

RECOMMENDATION NO. 14

That any rules governing the preparation and submission of annual financial statements should incorporate the following clauses:—

(*a*) *That the cost of expatriate staff be reflected at figures at present* £1,700 *for a medical officer and* £1,000 *for a nursing sister.*

(*b*) *That expenditure incurred by Church and Mission hospital maternity services (to be calculated by the direct proportion of maternity beds to total beds) and revenue derived from Church and Mission hospital maternity services from any source be omitted.*

(*c*) *That revenue from hospital out-patient services should be disclosed. Charges should be not greater than the Government rate.*

(16) Special Recurrent Grants

There are, at present, a few Church and Mission hospitals which provide special medical facilities of a higher standard than normally found at a Government district hospital, e.g. X-ray facilities, advanced surgical treatments, and possibly training facilities. Hospitals providing special services should be dealt with on a separate basis from that of the acute general hospital.

We consider that provided that the district advisory committee are satisfied that such services fulfil a local need which is not being met by Government services and that such services are available to all residents in that area, a case exists for a special recurrent grant-in-aid towards the additional expenditure incurred.

We Therefore Recommend—

RECOMMENDATION NO. 15

That the Central Advisory Committee should consider recommending special grants-in-aid to Church and Mission hospitals providing a specialized service, in addition to the normal grant structure, and varying with the special circumstances prevailing.

(17) Training Grants

We have earlier referred in Part I of our report to the future role of Medical Missions in the training of nurses and midwives. We have been informed that the Nurses and Midwives Council are to introduce new and improved standards for training and that many Medical Missions will find difficulty in meeting these new standards in view of the increased number of lectures and lack of tutorial staff. We have therefore concluded that although the main recurrent grants-in-aid should not be related to training needs it is likely that certain Church and Mission hospitals playing an important part in training will require some financial assistance towards the cost of the necessary tutorial staff.

We Therefore Recommend—

RECOMMENDATION No. 16

That the Central Advisory Committee should consider recommending a special grant to those Church and Mission hospitals undertaking essential training.

(19) Acknowledgement

Finally we should like to place on record our appreciation of the invaluable assistance given to us in our deliberations by our Secretary, Mr. R. L. Gosney.

We have the honour to be, Sir,

Your obedient servants,

(Signed) DR. T. F. ANDERSON (*Chairman*).
THE REV. FATHER COLLETON (*Member*).
DR. CROWLEY (*Member*).
DR. N. R. E. FENDALL (*Member*).
MR. J. J. HILLMAN (*Member*).
THE HON. J. J. NYAGAH (*Member*).
DR. W. OUKO (*Member*).
MR. A. C. WAINE (*Member*).
THE REV. DR. J. WILKINSON (*Member*).
THE RT. REV. R. MACPHERSON (*Member*).
MR. R. L. GOSNEY (*Secretary*).

Nairobi,
January, 1960.

APPENDIX 1

LIST OF ORGANIZATIONS AND INDIVIDUALS WHO SUBMITTED MEMORANDA

Mr. T. A. Watts, District Commissioner, Machakos.

Mr. Inuani Kilavuka, Baringo District.

Dr. A. T. G. Thomas, Medical Officer of Health, Nairobi City Council.

Mr. C. J. Denton, District Commissioner, Narok.

The Association of Surgeons of East Africa.

The Municipal Board of Kitale.

The Nakuru County Council.

The Meru African District Council.

The Friends' Hospital, Kaimosi.

The Chairman, Kiambu African District Council.

The South Nyanza African District Council.

Dr. W. Brown, Church of Scotland Mission, Tumutumu.

The East African Yearly Meeting of Friends.

The Interim Hospital Board for Maseno Hospital.

The Nyeri African District Council.

The Chairman, Kitui African District Council.

The Elgeyo-Marakwet African District Council.

The Elgon Nyanza African District Council.

The Central Nyanza African District Council.

The Kenya Association for the Prevention of Tuberculosis.

APPENDIX 2

EXAMPLES OF GOVERNMENT GRANTS-IN-AID PAID TO MEDICAL MISSIONS

	£	
1918/19	300	(Kikuyu).
1919/20	300	
1920/21	7,860*	includes special provision to Medical Mission units in Native Reserves.

(*Increased to £11,790 on revaluation of the rupee.)

1922	4,604	
1923 + 1924	Nil	(Period of retrenchment).
1926	1,000	
1927	1,000	
1928	1,400	
1929	2,900	
1930 to 1938	3,700	(average).
1942	5,800	
1946	6,763	
1948	11,000	
1950	17,000	
1952	20,450	
1955/56	34,950	
1959/60	46,000	to be distributed as follows:—

	£	
CHRISTIAN COUNCIL OF KENYA—		
Maseno	4,325	based on existing formula.
Kaloleni	4,016	
Kikuyu	4,691	
Tumu Tumu	4,528	
Chogoria	4,323	
Maua	3,816	
Kaimosi	4,413	
Kendu Bay	3,812	
Kapsowar	1,745	
Ngao	1,790	
CATHOLIC MISSIONS—		
Ortum	900	Token grant.
Nkubu	900	
Gaicanjiro	900	
Kititu	900	
Nyabondo	900	
Muthale	900	
CHRISTIAN COUNCIL OF KENYA—		
Mwihila	900	
CATHOLIC MISSIONS—		
Nyeri	400	Training grant.
CHRISTIAN COUNCIL OF KENYA—		
Kikuyu	600	
Maua	600	
Kendu Bay	600	
	45,959	
Balance	41	
	£46,000	

STATISTICS: EXISTING MISSION HOSPITALS

Hospital	Location	Expatriate Staff		Beds			Number of In-Patients			In-Patient Days			Fees	
		Dr.	N/S	Gen.	Mat.	Total	Gen.	Mat.	Total	Gen.	Mat.	Total	Basic Rate	If all inclusive*
Under the aegis of the Christian Council of Kenya														
Maseno ..	C. Nyanza ..	2	2	75	30	105	2,386	742	3,128	20,237	9,949	30,186	Sh. 4 p.d. first week. Sh. 3 p.d. second and subsequent weeks.	No
Kaloleni ..	Kilifi	2	2	80	17	97	2,066	472	2,538	24,431	4,442	28,873	Sh. 15 p.w. first week, Sh. 10 p.w. second and subsequent weeks.	No
Kikuyu ..	Kiambu	1	2	89	16	105	2,820	914	3,734	43,008	5,730	48,738	Sh. 1 p.d. for 30 days, Sh. 1/50 p.w. subsequently.	No
Tumutumu	Nyeri	1	1	100	15	115	1,712	520	2,232	33,304	9,996	43,300	60 cents per day.	No
Chogoria ..	Meru	2	2	99	6	105	4,156	537	4,693	48,585	2,481	51,066	Sh. 1 to Sh. 1/50 p.d.	No
Maua ..	Meru	1	2	61	24	85	1,380	350	1,730	22,180	5,600	27,780	Sh. 2/50 p.d.	No
Ngao ..	Tana River ..	1	—	31	7	38	656	86	742	12,143	1,133	13,276	Sh. 15 for up to 3 weeks.	No
Kaimosi ..	N. Nyanza ..	2	3	123	6	129	2,019	184	2,203	34,578	5,107	39,685	Sh. 2 p.d.	No
Kendu Bay	S. Nyanza ..	2	4	91	20	111	4,003	586	4,589	32,459	2,344	34,803	Sh. 3 p.d.	No
Kapsowar	Elgeyo–Marakwet	1	2	25	10	35	864	221	1,085	11,473	2,367	13,840	Sh. 5 p.w. or 80 cents p.d.	No
Kolanya ..	Elgon Nyanza ..	—	2	24	12	36	699	85	784	3,170	595	3,765	Sh. 2 p.d.	Yes
Mwihila ..	N. Nyanza ..	2	3	48	7	55	1,910	183	2,093	19,958	1,359	21,317	Sh. 2/50 p.d.	No
Tenwek ..	Kericho	—	2	24	10	34	603	252	855	6,475	3,469	9,944	Sh. 1/75 p.d.	No
Catholic Mission Hospitals—														
Kalimoni ..	Thika	—	1	34	4	38	201	37	238	N.A.	N.A.	N.A.	Sh. 2 p.d.	No
Kilungu ..	Machakos ..	—	1	20	7	27	277	51	328	N.A.	N.A.	N.A.	Sh. 4/50 p.d.	Yes
Nyeri ..	Nyeri	2	4	64	21	85	1,020	312	1,332	N.A.	N.A.	N.A.	Sh. 2 or Sh. 3 p.d.	No
Nkubu ..	Meru	2	6	104	20	124	2,200	380	2,580	N.A.	N.A.	N.A.	Sh. 1/50 p.d.	No
Gekondi ..	South Nyeri ..	1	1	18	11	29	287	105	392	N.A.	N.A.	N.A.	Sh. 2 p.d.	No
Kyeni ..	Embu	1	2	70	10	80	2,020	57	2.077	N.A.	N.A.	N.A.	Sh. 1/50 p.d.	No
Fort Hall	Fort Hall ..	1	3	33	12	45	663	179	842	N.A.	N.A.	N.A.	Sh. 3 p.d.	Yes
Sega ..	C. Nyanza ..	—	1	22	6	28	871	210	1,081	N.A.	N.A.	N.A.	Various.	—
Butula ..	E. Nyanza ..	—	—	19	7	26	1,006	64	1,070	N.A.	N.A.	N.A.	Sh. 4 to Sh. 5 p.d.	No

*i.e. whether the basic fee charged covers drugs, dressings, injections, operations, etc.
N.A. = not available.

STATISTICS: EXISTING MISSION HOSPITALS—(*Contd.*)

HOSPITAL	LOCATION	EXPATRIATE STAFF		BEDS			NUMBER OF IN-PATIENTS			IN-PATIENT DAYS			FEES	
													Basic Rate	If all inclusive*
		Dr.	N/S	Gen.	Mat.	Total	Gen.	Mat.	Total	Gen.	Mat.	Total		
CATHOLIC MISSION HOSPITALS —(*Contd.*)														
Amukura	E. Nyanza ..	—	—	41	16	57	940	157	1,097	N.A.	N.A.	N.A.	Various.	—
Nyabondo	C. Nyanza ..	1	2	67	31	98	1,049	381	1,430	N.A.	N.A.	N.A.	Various.	—
Mukuma ..	N. Nyanza ..	—	3	44	9	53	3,657	312	3,969	N.A.	N.A.	N.A.	Sh. 6 p.d.	No
Kaplong ..	Kericho	1	3	104	4	108	1,590	65	1,655	N.A.	N.A.	N.A.	Sh. 5 p.d.	Yes
Eregi ..	N. Nyanza ..	—	—	24	6	30	901	75	976	N.A.	N.A.	N.A.	Adults Sh. 10 p.d., Children Sh. 5 p.d.	Yes
Rangala ..	C. Nyanza ..	—	1	36	13	49	568	420	988	N.A.	N.A.	N.A.	Various	—
Misikhu ..	Elgon Nyanza	1	2	50	20	70	1,500	146	1,646	N.A.	N.A.	N.A.	Various	—
Mumias ..	N. Nyanza ..	—	1	28	4	32	860	106	966	N.A.	N.A.	N.A.	Sh. 4 p.d.	No
Nangina ..	C. Nyanza ..	—	1	38	20	58	1,462	215	1,677	N.A.	N.A.	N.A.	Sh. 4 p.d.	No
Nyamagwa	S. Nyanza ..	—	—	16	9	25	1,320	100	1,420	N.A.	N.A.	N.A.	Sh. 4 p.d.	No
Muthale ..	Kitui	1	—	32	6	38	250	30	280	N.A.	N.A.	N.A.	Sh. 15 and Sh. 25 (Maternity)	No
Ortum ..	West Suk ..	1	2	29	3	32	677	32	709	N.A.	N.A.	N.A.	50 cents p.d.	No
Kititu ..	Thika	1	2	25	—	25	—	—	—	N.A.	N.A.	N.A.	Not known	—

*i.e. whether the basic fee charged covers drugs, dressings, injections, operations, etc.
N.A. =not available.

FEES FOR THE BASIC IN-PATIENT ACCOMMODATION AT GOVERNMENT HOSPITALS:—

At the King George VI Hospital, Nairobi and the Coast Province General Hospital, Mombasa.	Adults	Sh. 15	Flat admission fee inclusive of all services and irrespective of length of current stay.
	Children (up to the apparent age of 16 years) ..	Sh. 5	
At all other Hospitals	Adults	Sh. 10	
	Children (up to the apparent age of 16 years) ..	Sh. 5	

APPENDIX 4

SPREAD OF BEDS PER THOUSAND OF POPULATION

District	*Total hospital beds*	*Estimated African population*	*Beds per 1,000*
Nairobi	964	127,482	7.5
Central Province			
Nyeri	446	213,259	2.0
Kiambu	337	300,668	1.1
Fort Hall	354	353,746	1.0
Meru	436	364,546	1.1
Thika	201	77,442	2.5
Embu	258	235,474	1.0
Nanyuki	56	38,192	1.4
Provincial Sub-total ..	2,088	1,583,327	1.3
Nyanza Province			
Central Nyanza	576	539,128	1.0
North Nyanza/Elgon Nyanza	896	738,105	1.2
South Nyanza	350	635,255	0.5
Kericho	492	247,687	1.9
Provincial Sub-total ..	2,314	2,160,175	1.0
Rift Valley Province			
Trans Nzoia	132	71,560	1.8
Uasin Gishu	115	92,609	1.2
Nakuru (including Naivasha)	436	232,041	1.8
Nandi	102	93,854	1.0
Elgeyo Marakwet ..	69	75,088	0.9
Baringo	72	83,918	0.8
Laikipia	62	39,522	1.5
West Suk	70	49,833	1.4
Samburu	30	30,290	0.9
Provincial Sub-total ..	1,088	768,715	1.4
Coast Province			
Mombasa	473	64.583	7.3
Kwale	133	134,131	0.9
Kilifi	230	211,359	1.0
Lamu-Tana River ..	95	40,537	2.3
Teita	189	71,607	2.6
Provincial Sub-total ..	1,120	522,217	2.1

APPENDIX 4

SPREAD OF BEDS PER THOUSAND OF POPULATION—(*Contd.*)

Southern Province			
Machakos	329	415,374	0.7
Kitui	132	245,566	0.5
Narok	80	43,621	1.8
Kajiado	105	33,768	3.1
Provincial Sub-total ..	646	738,329	0.8
Northern Province ..	226	217,272	1.0
TOTAL	8,446	6,117,517	1.3

In addition to above, there are 637 mental beds at Nairobi, representing 0.1 per 1,000 of the Colony population.

APPENDIX 5

GRADING OF HOSPITALS

Suggested Minimum Requirements

GRADE 1 HOSPITALS

Staff

Doctors (Resident)	1 per 75 beds.
Nursing Sisters (Resident) ..	1 per 75 beds with a minimum of 2 when non-training and 3 when training.
Enrolled Assistant Nurse Grade I	1 per 30 beds plus 1 for Out-patients' Department.
Nursing Staff	1 per 3.5 beds of whom one-third should be graded.
Qualified Dispensers and Qualified Laboratory Assistants	To be in possession of either a Medical Training School Certificate, Tanganyika, Uganda or Army Certificate.

Assistant Radiographers/Graded Dressers minimal for X-ray Department.

Beds

75 plus.

Minimum of three wards (including a children's ward) with isolation facilities. Sidewards for amenity patients.

Buildings

Permanent (subject to approval).

Facilities

Operating theatre.

Separate out-patient department with reception, treatment and consulting rooms.

Separate dispensary.

Separate laboratory.

Kitchen/laundry/stores.

Mortuary.

Piped water and waterborne sanitation.

Lecture classroom for training.

Sterilizing and auto-claving facilities.

Diets

Comparable with Government hospital standards with facilities available for special diets.

Housing

Students: residential accommodation with feeding arrangements.

Adequate (sufficient living room, safe water and adequate sanitation).

Grade 2 Hospitals

Staff

Full-time Doctor (Resident) ..	1.
Nursing Sister (Resident) ..	1.
Enrolled Assistant Nurse Grade I	1 per 30 beds (with a minimum of 2 unless there are 2 doctors or 2 nursing sisters in post).
Nursing Staff	1 per 3.5 beds of whom one-third should be graded.

Beds

From 35 to 74 with a minimum of 2 wards with isolation facilities.

Facilities

Operating theatre.
Separate out-patient facilities.
Dispensary/laboratory.
Kitchen/laundry/stores.
Ward and theatre sterilizing facilities.

Buildings

Permanent (subject to approval).

Diets

Comparable to the Government hospital standards.

Housing

Adequate.

Grade 3 Hospitals

Staff

Doctor (Visiting)	
Nursing Sister (Resident) ..	1.
Enrolled Assistant Nurse Grade I	1.
Nursing Staff	1 per 3.5 beds of whom one-third should be graded.

Beds

From 25 to 34 (25 being an absolute minimum necessary for recognition).
Two wards.

Facilities

In-patient and out-patient only. Ward sterilizing.

Diets

Comparable to the Government hospital standard.

Buildings

Permanent (subject to approval).

Housing

Satisfactory.

Note.—The term "beds" indicates all beds including those provided for maternity cases.

APPENDIX 6

Summary of Recommendations

No. 1

"that the important services rendered by the Medical Missions should be recognized and that every effort should be made to ensure that their contribution is preserved and developed." (Page 1.)

No. 2

"that a Central Advisory Committee should be set up with terms of reference as follows:—

'to advise the Minister for Health on all aspects of the medical and health services rendered by the Churches and Missions in relation to those provided by central and local Government'." (Page 1.)

No. 3

"that the Central Advisory Committee should be composed as follows:—

(1) A chairman to be appointed by the Minister for Health.

(2) The following bodies should be represented:—

(*a*) The Christian Council of Kenya.
(*b*) The Catholic Missions.
(*c*) The Association of Local Government Authorities in Kenya.
(*d*) African District Councils (as a group) if not covered by (*c*) above.
(*e*) The Ministry of Health, and
(*f*) A person appointed by the Minister to represent the interests of child health and welfare.

(Page 2.)

No. 4

"that each local health authority should be asked to advise its Medical Officer of Health to establish a Medical Advisory Committee to advise him on the professional aspects and co-ordination of the medical and health services rendered by the Churches and Missions in relation to those provided by central and local government.

The Committee should be under the chairmanship of the Medical Officer of Health and should include representatives (preferably professional) of Medical Missions in the district. The Provincial Medical Officer should be invited to attend meetings of the Committee." (Page 2.)

No. 5

"that the aim should be to provide additional hospital beds in order to achieve a minimum spread of two beds per thousand of the population." (Page 2.)

No. 6

"that additional capital funds should be made available to assist in bringing Church and Mission hospitals up to a standard similar to equivalent Government hospitals and that this need should have priority over the provision of additional beds." (Page 3.)

No. 7

"that capital grants for improvements and extensions to existing Medical Missions and for the building of new hospitals, should normally be on a pound-for-pound basis, but that in special cases and on the recommendation of the Central Advisory Committee the proportion of the grant to the total cost of the project may be varied: we also recommend that when capital grants are given to provide additional beds, recurrent grants should also be given." (Page 3.)

No. 8

"that charges for the basic standard of in-patient treatment at all grant-aided hospitals shall be at the same rate as those levied at Government hospitals." (Page 3.)

No. 9

"that there should be three types of accommodation, viz.:—

(*a*) basic standard beds,
(*b*) amenity beds,
(*c*) private beds,

and that recurrent grants-in-aid should be made in respect of all categories provided that the proportion of amenity and private beds to basic standard beds is as recommended by the Central Advisory Committee." (Page 3.)

No. 10

"that Church and Mission hospitals should be required to submit annual statistical and financial returns in a prescribed form which should be as simple as possible and that these returns should be subject to scrutiny by the Government." (Page 3.)

No. 11

"that the recurrent grant-in-aid should be based on—

(*a*) the number of available non-maternity beds, and

(*b*) the number of non-maternity in-patient days,

subject to the adoption of approved standards for staffing and the provision of a dietary standard comparable with that followed in Government hospitals." (Page 4.)

No. 12

"that in order to provide an incentive for Church and Mission hospitals to improve their standards and to form a basis for the provision of grants-in-aid, these hospitals should be graded into three main categories, namely:—

Grade 1,
Grade 2,
Grade 3."

(Page 4.)

No. 13

"that the following grant structure be adopted:—

Grade 1 *Hospitals*

(*a*) £75 per annum for each available non-maternity bed.

(*b*) Sh. 2 for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with a 100 per cent occupancy.

Provided that:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 20 per cent of the gross maintenance expenditure of the hospital and that the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade 2 *Hospitals*

(*a*) £40 per annum for each available non-maternity bed.

(*b*) Sh. 2 for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with a 100 per cent occupancy.

Provided that:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 30 per cent of the gross maintenance expenditure of the hospital and that the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist.

Grade 3 *Hospitals*

(*a*) £20 per annum for each available non-maternity bed.

(*b*) Sh. 2 for each non-maternity in-patient day subject to a maximum of in-patient days obtainable with a 100 per cent occupancy.

Provided that:

Such grant shall be reduced proportionately should the revenue from Church and Mission voluntary effort fall below say 50 per cent of the gross maintenance expenditure of the hospital and that the Central Advisory Committee may advise raising or lowering the grant where special circumstances exist."

(Page 4.)

No. 14

"that any rules governing the preparation and submission of annual financial statements should incorporate the following clauses:—

(*a*) that the cost of expatriate staff be reflected at figures at present £1,700 for a medical officer and £1,000 for a nursing sister;

(*b*) that expenditure incurred by Church and Mission hospital maternity services (to be calculated by the direct proportion of maternity beds to total beds) and revenue derived from Church and Mission hospital maternity services from any source be omitted;

(*c*) that revenue from hospital out-patient services should be disclosed. Charges should not be greater than the Government rate."

(Page 5.)

No. 15

"that the Central Advisory Committee should consider recommending special grants-in-aid to Church and Mission hospitals providing a specialized service, in addition to the normal grant structure, and varying with the special circumstances prevailing." (Page 6.)

No. 16

"that the Central Advisory Committee should consider recommending a special grant to those Church and Mission hospitals undertaking essential training." (Page 6.)

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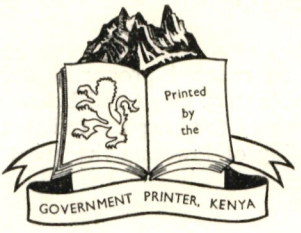
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