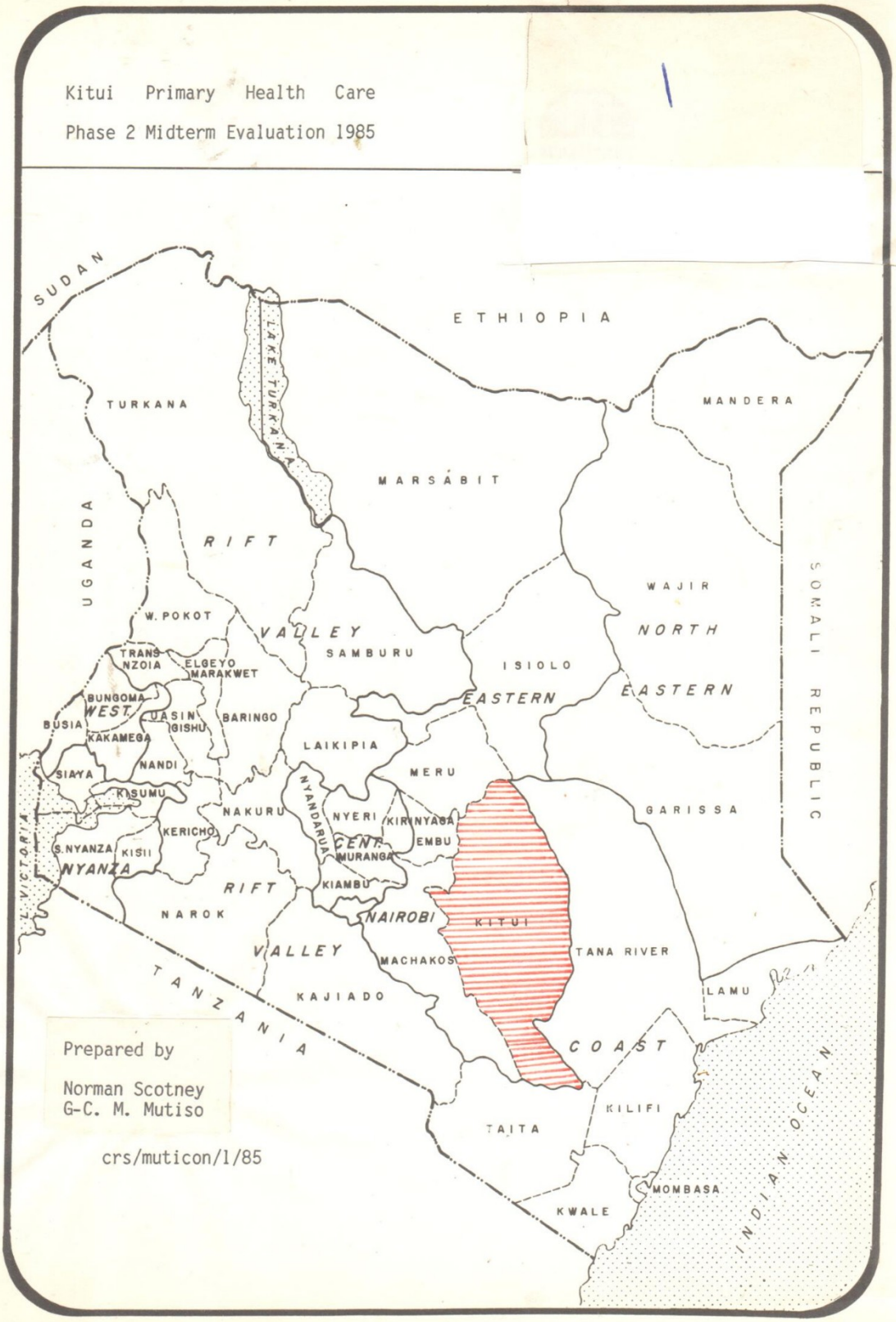
Kitui Primary Health Care

Phase 2 Midterm Evaluation 1985



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Executive Summary.

Examination of documents showed that the Kitui Primary Health Care program originated from, firstly, the expertise and resources deriving from a Catholic Relief Services feeding program which in December 1976 was being discontinued, and secondly from a scheme for a P.H.C. program in Wei Wei, Kerio Valley, written by Dr. Marita Malone. The new project was presented to USAID - Kenya for funding by Mr. Patrick Cullen of CODEL New York in January 1977 and accepted for funding by USAID in February 1979. Bridging finance during the interval was provided for a mobile unit operating from Mutomo Hospital of the Catholic Diocese of Kitui by CODEL.

The P.H.C.P. with the Diocese of Kitui as executing agency was to be based on four mobile units operating respectively from Mutomo, Mutito, Kimangao and Muthale stationary medical facilities. Each unit - team was to provide at sixteen centres per month M and CH care including ante-natal and post-natal services, immunizations, and family planning referral, also simple curative treatment and health education. The project period was to be 1st February 1979 to 31st October 1982.

By January 1980 the four teams were operative but Dr. Malone, who was consultant, during the year became unavailable and the plan for medical students from the University of Nairobi to do survey monitoring was dropped.

Dr. John Bennett, in November 1980, in an evaluation recommended community participation to meet more of the WHO - Alma Ata Criteria for a Community Health Care Program. His report "did not meet USAID expectations" and was followed in mid-1981 by a report of Drs. Rita Morris and Sally Smith who attributed an increase in hospital deliveries and a fall in immunizable child-hood diseases to the program.

They recommended a clinic sampling procedure to assess the impact of the program.

In 1982 the records show some success in immunization, less progress in ante-natal care and in school and community health education as well as in work with traditional birth attendants.

In February 1982 unspent funds were found to be sufficient for the program to be continued to March 31st 1983. Dr. Marian Dolan - medical officer in charge of Mutomo Hospital - who had taken on the responsibilities of Dr. Marita Malone arranged for the preparation of the Phase 2 project proposal.

This was accepted by USAID in June 1983 funding to run from April, 1983 to March 31, 1986.

The project agreement mentioned increases in health education and natural family planning but also preparation for a progressive hand over after 18 months to the projected "MOH/USAID Rural Health Program". To strengthen health education to each team a community nurse and an enrolled midwife were to be seconded by the Ministry of Health for work in the villages. At October 1985, 20 project staff were to be transferred to the Ministry of Health. On August 20, 1984, however USAID - Kenya notified the ministry that as the obligations the ministry had undertaken had not been fulfilled the Kitui Rural Health Project was cancelled.

After reviewing some limitations of previous evaluations and discussing the methods we ourselves have utilised - including use of Kamba Language - we consider, in Chapter II, the limitations and strengths of key project assumptions. We then review the inputs of CRS staff, which often we feel could have been augmented and might have strengthened the Diocese of Kitui leadership. In the field we feel that three of the four teams have been led outstandingly well but found only one team consistently has retained the same Nurse - Midwives over periods longer than six months. The contribution of Nurse - Aides has not been sufficiently appreciated, and we feel a scheme of recruitment, training and service would assist, especially in closer contact with communities.

Funding flows have presented more problems than can be justified and there is currently 20 per cent under-spending which may not be appreciated.

Vaccine supplies from Kitui Hospital have been satisfactory and vehicle operation remarkably effective, though repairs done in Kitui instead of Nairobi could reduce costs.

Project management, we feel, has been less satisfactory at the higher levels where resourcefulness might have overcome rigidities inherent in the project design. More intercharge of experiences by all staff would help these rigidities to be better understood.

Implementation of this kind of project would seem to require additional expertise in planning and in project administration within the Diocese of Kitui staff. The changes introduced by the new "District Focus" policy will mean there has to be closer coordination with district staff of the ministries and especially with Locational, Divisional and District Development Committees.

We also discuss (in Chapter VII) a number of "Unplanned Effects" arising from the program. Midwives graduating from Mutomo Hospital school have had an apprenticeship to community nursing from which some other projects may benefit.

The Nurse - Aides, whose role has been in particular, communicating with patients may, despite lack of formal training, form the nucleus of useful community health work.

The mobile units, as the only health resource available in many areas, elicit a curative demand. To meet this for boys and men as well as for females is important if units are to retain community respect. There were pressing reasons for linking up drought hit families with feeding centres as the drought began to bite. The projected "relief risk family selection" scheme should also be fed with data by the project.

CHAPTER: I. PROJECT BACKGROUND.

The Proposal of CODEL.

On behalf of CODEL (New York) Mr. Patrick Cullen visited Kenya in January 1977. He reported "as originally planned, Dr. Marita Malone's Primary Health Care Program for Kerio/Wei Wei, Rift Valley Province, Kenya, attracted considerable attention and favourable comment at Johns Hopkins University, in AID (Washington) and among CODEL's members. The program, with suitable modifications, is now proposed for implementation in Kitui District, Kenya. Dr. Malone now lectures in the Department of Community Health, University of Nairobi, and will be able to advise on the project and help with University interest in it" (p.12)

Dr. Malone explained to Mr. Michael Rugh (USAID - Nairobi) "the various pieces of planning that had been made already" and "events and posibilities in the district" mentioning :-

"a) The withdrawal of the CRS nutrition intervention program in December 1976."

"b) The local mobile replacement for the CRS program which the Diocese put into the field from Mutomo Hospital in January 1977."

"c) The presence in Kitui District of several women's groups which have been organised and motivated for development and which are now ready to participate in the PHCP."

"d) The possibility of selecting and training women from these groups who could act as Village Health Workers on a voluntary basis."

"e) A number of on-going projects in the District with which the PHCP can be linked and supported."

"f) The support and participation of the Ministry of Health at local level and the posibility of the Department of Community Health, University of Nairobi, using the program for practical field work."

Mr. Cullen states that "CODEL would consider funding the pilot phase from its DPG funds on the understanding that the whole program would move into DPG funding on the successful completion of the pilot phase. The pilot phase would be ready to go into operation by the middle of 1977 and the full program by the end of 1977."

Robert Lucas of CRS told Cullen that " all CRS mobile activity has been stopped in Kitui, the CRS "static" program continues and where this can assist the new program for PHC a tie-in will be welcome".

In Kitui the Provincial Medical Officer, District M.O.H. (Dr. Odongo) and District Health Officer (Mr. Mathenge) at a meeting with Cullen put "stress" on "the happy relationships that exist throughout the District between the government and voluntary medical services. Plans for the Primary Health Care program are being put together with the closest of consultation and working together and, where posible other government departments helping out."

At Mutomo Hospital Mr. Cullen was told "at the end of 1976 Kitui Diocese, faced with the responsibility of maintaining as much as possible of the intervention program, decided to use the established contacts to move the whole program into one of Primary Health Care. Two teams, sponsored by the Diocese, commenced a mobile health service on January 1, 1977 into 25 centres.

"This is the nucleus from which the Kitui PHCP will develop ..... involvement of existing women organisations and their training as village workers will form an important part of the program."

Two year passed, though, before USAID support for the project was secured.

The Project Grant (USAID Grant No.0185 - 1 - 904.

By a letter dated February 18, 1979 USAID granted $.413,000. to CODEL to cover the period February 1, 1979 to October 31, 1982.

The "Program Description" under specific objectives states that "CODEL will operate four mobile teams which will each visit seventeen village or communal gathering sites each month."

"Each team will have the capability of offering the following services :-

a) Mother and child health care, including ante-natal and post-natal care.

b) Immunizations.

c) Family Planning referral.

d) Simple curative treatment, and

e) Health education."

"Each team and its equipment and records will be self-contained in a four - wheel drive vehicle. Over the three - year life of this project - it is estimated that the four mobile teams will each reach 10,000 to 12,000 people, about 10 percent of the population of Kitui District presently without access to any health facilities at all."

Under "Implementation" the Diocese of Kitui is designated the implementing agency and its "four stationary medical facilities" - Kimangau, Muthale, Mutomo and Mutito - mentioned as the bases for the four mobile teams. The teams are to work each week four days in the field and use a fifth day for "the preparation of records, equipment, drugs, etc." One team, it is mentioned, is already functioning from Mutomo Hospital funded by CODEL, Ministry of Health and Diocese of Kitui.

The Project completion date is stated as October 31, 1982.

"Maximum use of community groups in particular women's groups in the area will be made." p.5.

"Dr. Marita Malone, ... will act as technical consultant adviser throughout the program. Under her supervision medical students from the University of Nairobi will carry out surveys on a per-diem basis."

"Baseline surveys will be conducted for each dividion, one at about eighteen months after commencement of full project activities and one at the end of the project. These resurveys ..... will be part of the mid-project and final project evaluations and will provide the basic data for the monitoring and evaluation system developed by CODEL for the project."

The reference here is to a document-undated and without attribution - "A Monitoring and Evaluation System for the Primary Health Care Program "which describes surveys to be made by University of Nairobi medical students using three questionnaire forms :

a) "Household form" (for "Household Census", "Disease Patterns" Nutrition/Food Patterns "and" Environmental Health." In all 71 items to be coded).

b) "Child Form." ("Ante-natal care" "Nutrition/Immunization" etc. - 50 items).

c) "Health Knowledge, Attitudes and Practice Form" (5 pages).

However provision is made for Semi-Annual Reports (CODEL to USAID - Kenya) and an evaluation plan with a joint first evaluation in October/November 1980 and a final evaluation in May/June 1982.

CODEL was also to undertake an "internal review of the pilot phase of the project in March/April 1979" that is at the starting date - with a view to adjustments in project activities and to "discuss the findings with the USAID project manager who will also visit the project site at this time."

No documents or references to documents covering these activities have been located.

The budget provides for $.2,800 for data processing and $.4,000 for consultants in each year, and $.2,500 for evaluation in the second and third years.

Project Development. Phase I.

The mobile team operating from Mutomo Hospital was augmented by a second team from Kimangao in July 1979, a third team from Muthale in December 1979 and a fourth from Mutito - subsequently from Nuu - in January 1980.

In November 1980 Dr. F.J. Bennett (Community Health Advisor UNICEF - East Africa Region) made a five day visit to Kitui and noted that Dr. Malone had handed over the responsibility of technical adviser and consultant to Sr. (Dr.) Marian Dolan, Medical Officer in-charge of the 140 bed Mutomo Hospital.

Dr. Bennett listed the goals of the four mobile teams as to :

"a) Improve the quality of life using the limited resources available;"

"b) Change behaviours and attitudes to ones more conducive to health;"

"c) Immunize children;"

"d) Provide ante-natal and post-natal care;"

"e) Provide limited curative care;"

"f) Improve community nutrition, sanitation."

He found the four mobile units were conducting clinics in areas without other services consistently, but "the PHC. project had become largely synonymous with the mobile MCH clinics" which " were not considered .....as mobile extension of a basic service." There seemed to be little community participation in planning, management, and evaluation.

The training of community women, even at Mutomo, was limited, "In summary, 14 women have received from 7 to 20 days of training ..... No men have ever been trained."

He calculated that 5433 (about 9 per cent of the 0 to 4 years old) were seen in February 1980 by the four mobile units and felt that nutritional surveillance should be reorganised from attention to individuals to assessment of community nutritional levels. On water and sanitation little progress was reported but he was impressed by the attendance for immunization of under one year olds.

He said "a higher coverage of pregnancies must be achieved" and "the health education is of the stereo-typed lecture type with pictures "and felt "the impact of this on behaviour would be slight." "Malaria prophylaxis for under 5s is not undertaken".

He proposed that "the road to health chart for the children should be kept by the mother" (This has been implemented and the response has been good.)

He concludes "Community based work is at such a minimum level that the program can hardly be called a primary health care project in the Alma Ata sense".

Though Dr. Bennett made numerous suggestions his report "did not meet USAID expectations."

In June, July and August 1981 a "Mid-Term Evaluation of the Kitui Primary Health Care Project" was undertaken by Drs. Rita Morris and Sally Smith (August 1981).

They examined records of Mutomo and Muthale mission hospitals which showed over a five year period a doubling of abnormal ante-natal cases seeking hospital deliveries" which could be attributed to ante-natal care given by the mobile teams in these areas." They also thought the incidences of immunizable childhood diseases were "no longer major childhood problems at Muthale." Conversely they found "The numbers of children very anaemic and severely ill from malaria have increased", also "Diarrhoeas remain a prevailing problem."

They emphasize that : "Great difficulties were experienced in the monitoring and evaluation system designed at the beginning of the project. While the objectives were sound, the methodology was inherently weak."

"The assumption that data collection and analysis would be done by medical students of the University of Nairobi was the underlying problem ..... there was no formal agreement. The whole program hinged on the good will and co-ordination of the project - consultant ..... since the consultant left the project (early in 1980) the whole system collapsed."

Morris and Smith make a general comment : "The collection of data by household surveys is both time consuming and expensive ..... The value from such information is marginal in relation to the personnel needed, time and expense."

Finally, interviewing 60 women seen at clinics conducted by Mutomo, Muthale and Kimangao mobile units with a 13 item questionnaire, they attempt "an assessment

Financing.

Bridging finance for the period March 1,1982 to March 31, 1983 was largely found in the unspent balance of February 28, 1982 of $.107,000. made up principally of :

Salaries	$.35,000.
Health Education	$.14,000.
Medical Supplies	$.41,000.
Data Processing and Evaluation	$.12,000.

Planning Phase 2.

Planning for Phase 2 envisaged additional inputs in Health Education, Training of Village Health Workers and Traditional Birth Attendants, Family Planning and Community sensitization.

It was anticipated that "Additional government officers are being seconded to the program to work with visiting teams. A staggered hand-over to the Ministry is planned in the second half of the coming three - year period so that at April, 1986 the Kenya Government will have taken over responsibility for the work ..... Catholic Relief Services are acting as the private Voluntary Organisation for Phase 2 instead of CODEL for reasons of convenience and smooth running of the program."

Phase 2 Proposal.

Early in 1982 the Phase 2 Proposal was developed by the Diocese of Kitui. Dr. Marian Dolan in the pre-amble stresses that "traditional healers function within the psychological framework of their clients beliefs, cultures, and expectations" and that "there is mutual trust, confidence, and complete rapport between practitioner and patient." She then adds "it is this rapport that we as health educators are trying to cultivate in the Primary Health Care Program among the village health workers we are endeavouring to train. Our main teaching method presently is the psycho-social method whereby the trainees are given opportunity and help to identify their own needs and the best method of solving these needs.

This method we have found is more acceptable with adults and its effects more lasting."

Again, in reference to the PHCP, Dr. Dolan stated "it is a relatively easy exercise to asimilate the T.B.As into the peripheral delivery services after a period of training directed towards the practice of asepsis, hygiene and the early recognition of problem cases ..... this aspect to the program is to be stepped up, and intensified during Phase II. Greater numbers are to be reached by week long courses ..... extra medical personnel will be soconded by the Ministry of Health for health education purposes." Later she states "We were constrained by the workload in the services field, the limited staff, time and expertise avilable ..... extra input in the area of staff is envisaged with a new and increased emphasis on health education at all levels". (p. 6)

"Phase II plans a more intensive and structured Natural Family Planning program for the District." "Teacher training will be done centrally under the personal supervision of the Program Superviser who is a trained tutor."

No changes - apart from Ministry seconded staff - were envisaged in personnel except a seconded PH Nurse, after 1½ years, to understudy and take over from Sr. Teresa as Program Supervisor.

The Specific Targets for Phase II are :-

"a) Reaching an increasing number of mothers and children in the area of preventive and curative care and ante-natal care."

"b) Putting more emphasis on health education by recruiting and training increased number of local people as village health workers."

"c) From convinced efficient users of Natural Family Planning to identify and train teachers of the method ..... "

"d) To familiarise personnel of the "MOH/USAID Rural Health Program" with the project so as to facilitate the transfer of responsibilities to them."

"Health Education will be promoted considerably by the gradual addition of both a community nurse and an enrolled midwife to each team "....." (Then) each team will recruit and train health leaders from the more remote villages. Short courses of about five days will be held three times a moth ..... Visitation of these health workers shall be undertaken periodicallly ....."

Morbidity data will be collected for some "indicator diseases eg. scabies, chronic cough (3 weeks), bilharzia, eye infection, malaria, measles, whooping cough, polio, malnutrition, diarrhoea and vomiting." (p. 10)

Monitoring will be "at the daily mobile curative clinics and at the static health facilities so that areas of greatest needs may be identified and available resources directed towards improvement."

The Grant for Phase 2.(USAID Grant No.615 - 0219.)

By letter dated June 16, 1983, the USAID Director - Kenya, agreed to provide for support of the Kitui Primary Health Care Project to Catholic Relief Services the sum of $.500,000. The period was to be April 1, 1983 to March 31, 1986.

Specifically mentioned were :

"a) To intensify health education and natural family planning among the population served."

"b) To begin the transfer of activities and responsibilities of the project to the Government of Kenya."

Phase 2. Budget.

For the 3 year budget total USAID commitment was US.$.500,000. The GOk contribution was US.$.370,100. which was to be in form of medical supplies - vaccines only. The DOK contribution was US.$.33,100. which was to be in form of offices and housing for project staff.

The USAID component line items for year 1 are equal to :

	Year 1.	Year 1 - 3.
a) Transport	52.3% *	42,4%
b) Salaries	18.4%	21.2%
c) Health Education/Family Planning	5.4%	8.2%
d) Per diems	5.1%	5.4%
e) Medical supplies	4.9%	5.7%
f) Equipment	2.9%	3.0%
g) Evaluation/Data Collection	2.7%	6.0%
h) Overhead CRS/N.Y	8.4%	8.4%

* (This, however, includes vehicle purchases in year 1. In years 2 and 3 the transport items are 36.8% and 29% respectively).

The grant document specified that :-

"The project will be evaluated approximately 18 months following its effective date and again following its completion."

Implementation Process.

The CRS was required to submit :-

a) A plan of the functional organisation - all agencies - of Kitui District's health services and delivery system as envisaged;

b) An implementation plan "describing the planned steps to eventual integration of the grant activity "in the GOK health services delivery system or, "how services will be continued after AID financing terminates," and

c) " A detailed implementation plan for the first year's activity" and during the year similar plans for years 2 and 3.

The aim was "to sustain the strengths of Phase I and correct its major deficiencies". " Where time and conditions allow home visits will be made and village health workers will be trained."

The specific objectives of Phase II were stated as :-

"a) To provide preventive and curative care to an increased number of mothers and children."

"b) To place greater emphasis upon provision of training for community health workers education by recruiting and training from the local population."

"c) To develop a program of natural family planning education through volunteers who have successfully adopted N.F.P methods."

"d) To insure a full and routine transition of responsibility ..... from the Diocese to the MOH ..... by involving MOH personnel in project activities on a gradually increasing basis."

Few changes were envisaged from Phase I activities but "maximum use of community groups, in particular women's groups from the area, will be utilised." An "integrated 3 days workshop for government officers" was envisaged and it was stated that "relevant government officers" should attend the bi-annual team leader's and team's meetings. Take-over of centres by MOH was also envisaged.

Centrality of Health Education.

To strengthen health education, the Ministry of Health was to second a community nurse and an enrolled midwife for this purpose to each team to train groups of 6 - 10 people from villages over a 5 day period 3 times a month, 8 months a year. The work of the seconded officers was to include :

"a) Sensitizing the community to an awareness that they can take some responsibilities in looking after their health."

"b) Facilitating community organisations which would enable such participation eg. health committees."

"c) Initiating the selection of VHWs by villagers."

"d) Training VHWs and TBAs."

"e) Carrying out simple community diagnosis and keeping records of relevant data under the guidance of the coordinator."

"f) Carrying out most of the health education and school health activities."

Schemes are also outlined for the selection and training of VHWs and TBAs and working with "existing health committees or the establishment of new ones."

Lastly a "project - design summary - logical framework" is appended.

Staffing.

By letter dated 2nd February 1984 the CRS Kenya Director reiterated to Dr. Maneno (ADMS - Ministry of Health) the main points agreed at a meeting on 31st January which included persistence of DOK staff for 2½ years from April 1, 1983 and secondment of two MOH officers in June and July 1984 respectively. Further, after the end of Phase 2, the project work will be continued jointly with 4 teams of 6 persons, DOK - CRS paying for Team Leaders and the Consultant and meeting administrator's costs. For curative services people will have to pay for medicines. Salaries for 8 enrolled mid-wives, 8 nurse aids and 4 drivers will - if Ministry clearance is obtained - be paid by M.O.H. This was never put in to effect.

Planned Administration and Takeover.

The agreement between CRS and Diocese of Kitui was also transmitted to MOH. The Activity Implementation Schedule was forwarded to Dr. Rose Britanak (USAID/Kenya) on 23rd March 1984 by the Kenya Director CRS but implies that takeover by Kenya MOH may not be completed until 1988. It specifies activities for each month up to October 1985 when it is envisaged that 20 project staff will, as agreed, be entering the employment of the Ministry of Health.

GOK/USAID Kitui Rural Health Project.

Since completion of the Kitui Arid and Semi-Arid Lands Prefeasibility Study in 1978, USAID started discussions on the possibility of having a health project in Kitui which would involve MOH as distinct from Kitui Primary Health Care Project.

The project was authorised by USAID on January 22nd, 1982 and an agreement with GOK was signed on June 6th 1982. The project was supposed to take off in August 1982.

By May 1983 Allison B. Herrick, USAID Director, Kenya, was writing to the P/S. MOH complaining that the activities which GOK should have taken to initiate the project had not been undertaken.

Many meetings and exchanges took place between USAID and MOH on ways of getting the project off the ground. However USAID instituted its 60 day project suspension of the project effective on September 26, 1983, by a letter from Allison B. Herrick to P/S MOH.

The suspension procedure allowed MOH to resuscitate the project if specific "corrective actions" were undertaken.

Evidently these were not, since on Nov. 25th 1983 Allison B. Herrick wrote to P/S. MOH informing him that AID was initiating the internal processes for cancellation of Kitui Rural Health Project. Formalistically the 'de-obligation' process was completed in a letter from Charles L. Gladson to P/S Finance and Planning and P/S MOH of August 20th 1984, which states that the funds could be renegotiated for other activities. We have not found evidence of negotiations for their use in Kitui Primary Health Care Project or other health related projects in the district.

Environment and Demography.

Kitui District in Kenya's Eastern Province has an area of 31,000 sq. kms but 6,300 sq. kms is occupied by Tsavo national game park which was cleared of population in 1948. That area, parts of which get good rainfall, used to be the residence of population which was trapped in Southern(Mutomo) Division which is prone to drought.

The western side of the District has hills and ridges based upon clusters of inselbergs which in general have a north/south orientation and, in good seasons, a moderate rainfall. Because the soils are fertile and the higher rainfall probability, the population density in Central Division exceeds 60 person per km. sq. and in Mwingi (Near Northern) Division exceeds 20 per km.sq. It is suggested by some studies that these densities are beyond the carrying capacity of the land and poor people are migrating to the other divisions which are even more marginal.

The other Divisions, Kyuso (or Far North), Eastern and Southern have generally lower rainfall, the inselbergs are generally fewer and soils and/or drainage often poorer. Permanent water is not easily available other than in the big hills (Mutito, Makongo Endau and Mumoni) or in the Thua and Tiva flood plains and channels. Large areas are therefore only suitable for low density rangelands or marginal farming.

Further, rainfall is unreliable, years of drought tending to pre-dominate, and precipitation being frequently of high intensity and short duration. In consequence much of the settlement is semi-permanent despite the lower than Kenyan average population ratio of 3.1 per cent for the District as a whole.

There are only two perennial streams - the Athi and Tana Rivers. The former marks the South - Western border of the District and the Tana having only a short section in the District in the extreme West and North. The other rivers are usually dry but can quickly become fast flowing torrents cutting communications.

Some estimates suggest that other than at vacations 40 per cent of adult males work outside the District. This is reflected in the Age-Sex pyramid (FIG I)

In recent years, tracks have become roads and the Rural Access Roads improvement program and similar programs are making it possible not only for people to take up land in previously inaccessible areas but also for mobile units to reach these areas.

CHAPTER II. E V A L U A T I O N M E T H O D O L O G Y.

Limitations of Previous Evaluations.

We have tried to avoid the invalid assumptions made in previous attempted evaluations. In particular, firstly, that the impact of the Kitui Primary Health Care Project could be assessed by changes in mortality - specifically the infant Mortality Rate - and by changes in morbidity.

Changes in mortality cannot by assessed without :

a) Data indicating the numbers of persons at risk and

b) The numbers of deaths within that population in a fixed period.

Since registration of births in District, though encouraged, is very incomplete - especially in the thinly populated areas of the project - and since customs in recognition of births as 'live' give rise to under-recording, especially of neo-natal deaths, the number of babies can only be determined by costly "vital events" survey machinery.

Morbidity data of statistical value is at least equally difficult to obtain, especially in an area where cyclical migration persists.

Finally, the succession in the District of drought episodes with periodic serious widespread malnutrition would make impossible realistic assessment of the consequences of any health intervention program.

Previous evaluations have also tended to include statements made by personnel involved in the project without finding means to check these statements.

By interviewing many village people, as well as junior staff of the project, in the Kikamba language, we have been able to go much further in our investigations despite the restrictive time limit - 12 days - of our field study.

Baseline Data.

At the outset it was envisaged that the project would involve not only collection of baseline data and also an on-going monitoring and evaluation process. Neither of these materialised though budgetary items were allowed for the purpose. The scheme for utilising the services - on a per diem basis - of University of Nairobi Medical School Students under the direction of Dr. Marita Malone, had serious limitations.

Exercises appropriate for the training of medical students are rarely pursued with the rigours required for the sustained observation needed for program monitoring. Secondly, the program envisaged in the document "Monitoring and Evaluation ..... " submitted on behalf of Dr. Malone and CODEL at the inauguration of the project, shows signs of having been written without experience of the problems and cost of field enquiries in an African rural setting, in local language, and in an area where the economy is predominantly still based upon providing the necessities for subsistence. Thirdly, within less than a year of the commencement of the program, Dr. Malone, whose students had not infact been in the field at all - was no longer in the same post. Her successor, Dr. Marian Dolan of Mutomo Hospital, was, understandably not been able to resuscitate the proposed data collection method.

Specific Methods Used in Conducting the Evaluation.

a) Document and Content Analysis.

The project was first discussed by CODEL in 1977, with project proposals for Phase I (1979) and Phase 2 (1983). Evaluations were scheduled in 1980, 1981 and 1982. Correspondence between the several bodies involved is massive. These together with Project Grant Agreements give substantive background documentation.

To this corpus of information must be added the continuing project information originating from the project staff and Diocese of Kitui. Study of this documentation is essential if the gaps between expectations and results attained are to be comprehended.

We have also paid particular attention both to project statistics, and to accounts/cash flows.

b) Discussions and Interviews.

1. We have held discussions with all available staff working in the project both in Kitui and Mutomo, and also in Nuu, Kimangau and Muthale.
2. We have further held discussions concerning the project with senior staff in Kitui District in the Ministry of Health, Provincial Administration, District Development Officer, donors operating in the District and with associated staff of the Diocese of Kitui.

C) Observation Visits.

We travelled with the Mobile Unit Teams to clinic sites and villages to observe methods used in the clinics, relations of staff with patients and village people, and - where they exist - Health Committees as well as Traditional Birth Attendants, and traditional medicine men.

d) Interviews Elsewhere.

1. To clarify some issues we interviewed the clinical officers operating the Kibwezi AMREF Primary Health Care Project.
2. We also interviewed two administrators of the Machakos Diocese Primary Health Care Project.
3. Finally we interviewed assorted people who have been related to the program at CRS and USAID.

e) Personal Discussions with Local People.

These included school staffs, and local administration personnel, Chiefs and Sub-chiefs. Kikamba, Kiswahili or English languages were used as appropriate. The goal was to understand current attitudes to the project, their health knowledge and health needs and problems of people.

f) Independent Visits to Villages and Settlements.

It was important to hold discussions with local leaders, both formal and informal, without being identified with the project personnel. This yielded views of the target population of the project.

g) Reviewing Our Conclusions.

After our fieldwork we held extensive discussions with key personnel, especially the administrator at Kitui, and the project consultant and supervisor at Mutomo.

The methods employed have made it possible to check many of the more important statements made and opinions expressed about the program by reference to other persons affected by it but in different capacities.

Without appropriate baseline or survey data, and limited to twelve days in Kitui District, and finally, without resources for the employment of survey staff under our direction, the methods used in this evaluation must inevitably be less than optimum. The need for limited sample surveys using carefully selected indicators and based upon structured interviews with beneficiaries, is not obviated by the record of work presented here.

To assess the impact of the program upon people on a long-term basis, more resources than were made available to the consultants would, in practice, be essential.

CHAPTER III. K E Y P R O J E C T A S S U M P T I O N S.

Project Goal.

Stated in many project documents since inception is the following :

"The improvement of the quality of life in rural areas through the attainment of an optimum level of health within the constraints of an existing and developing economy and in line with the National Health System."

This remains a valid goal. The implication that the project should have reference to the state of the economy - presumably both national and local - is important but often ignored, as is the implication that the project should interdigitate with the National Health System.

Project Purpose.

Since inception the project purpose is stated as :- "The provision of mobile health care services to rural areas of Kitui which lacked government or mission medical services."

Though a valid project purpose per se, the implication of the project title - "Kitui Primary Health Care Project" - that primary health care is the objective may have been overlooked by implementers, donors and financial administrators leading to a narrowing of the focus of activities which more clearly define any project's objective.

To bring some services to remote areas has value but the complex of needs of people should not be lost sight of. It seems to us that all primary health care activities can be assessed in terms of W.H.O. criteria distilled after many years of assessment.

W.H.O. Primary Health Care Requirements.

The declaration of Alma Ata (September 1978) stated that a Primary Health Care program should include :-

a) Education about prevailing health problems and methods of preventing and controlling them.

b) Promotion of food supply and proper nutrition.

c) An adequate supply of safe water and basic sanitation.

d) Maternal and child health, including family planning.

e) That for Team Leaders only a limited knowledge of the Kamba language is required.

Though fluent Kikamba may not be essential for Team Leaders, it might improve intra-team relations and especially relations with beneficiaries and so health education effectiveness.

f) That a program concentrated upon infants - under one year of age - and their immunisation can form the basis of a child health program for under 5s.

A serious episode in child rearing occurs at weaning. This usually happens on the second year of life. Success in the transition depends upon both feeding protein rich supplementary foods and avoidance of diarrhoeas as well as infectious diseases.

Fewer children attend in the second year. Mothers cannot carry two infants the vast distances to the clinics. There is doubt about the success of this aspect of the program.

g) Vaccines are supplied by Kenya Government through Ministry of Health and are effective.

The vaccines are available in adequate quantity and regularly. They appear to be potent. Mothers understand the importance of their children receiving the full schedule of immunizations and most ensure that this occurs. There is some circumstantial evidence that the incidence of some immunisable diseases may have been reduced. This is based, though, upon hospital admissions.

h) Specific training for the program as opposed to "on the job training" is limited to two meetings each year of staff of duration 2 days, with occasional visits to teams of the supervisor.

This may not be adequate especially for the development of skills in non-clinical areas, for instance team co-operation, health education and work with health committees and community groups.

For Achieving Objectives.

a) The project has throughout emphasized prevention.

Prevention is the goal of the child health program which is based, firstly, upon weighing and recording against the age in months of the child on a MOH "Road to Health" card, the progress made. Secondly the card provides a record of immunizations. Dried skimmed milk is provided for mothers.

Mothers seem to understand the importance of completing the immunization schedule but may not understand some elements of the weight recording program. The weight track is based on the Harvard Standard and most rural African children do not, even though healthy, adhere to these standards.

b) Prevention of birth complications and foetal and maternal loss is the objective of the ante-natal program.

A carefully prepared Kitui PHC card is used at the examination for assessing the risk category of the mother and so whether the delivery should be at home or in health facility.

Most mothers attend only in the eighth and ninth month of pregnancy and most make no more than two attendances. As many as 50 per cent are classified as requiring institutional delivery but infact most deliver at home with Traditional Birth Attendants. Distances to institutions and the costs of delivery there must be a factor. The program offers little assistance.

Only a small proportion of pregnant mothers in the clinic catchment area - mostly younger - make ante-natal attendances. The reasons for this are not known.

c. The program - emphasising prevention - offers little curative treatment and few drugs are carried. Children and ante-natal mothers are treated.

Men rarely attend. The day - to - day health needs arising from accidents and disease episodes are not treated by the mobile units but patients may be transferred, when mobile units are visiting.

d. "Health education" is conducted at the clinics of the mobile units mainly through talks and demonstrations which mothers of children must attend before being seen at the child welfare clinics.

Methods used include programmed talks by nurse -aides and midwives, discussion based upon pictures and cooking demonstrations.

Mothers show limited interest, even objecting if they have heard the program before. That changes in child rearing and home care practices will result is not obvious. Reinforcement through home visits and the necessary evaluative assessments are rarely made. Program schedules and the emphasis on clinic work tend to inhibit these. Little time is provided for discussion at the clinical examinations.

e) "Health Committees" have been formed at some of the areas served by clinics with the object of supplementing the work of the clinics.

The Health Committees have usually been formed upon the advice of local leaders and clinic attenders. They are not based upon existing and functioning community groups.

In consequence they may not be truly representative or persist without guidance.

The responsibilities of Health Committees are not clear. Effective committees could, through conducting community health education and through joint action, assume responsibility for some of the Alma Ata PHC requirements. This is not, so far, taking place. Few committee members have had training or experience to equip them for new roles in the community.

f) "Traditional Birth Attendants" - with assistance - can, it is hoped, improve local obstetric services. Some - but few - have been called to a central point for training sessions.

The TBAs are rarely given roles in the ante-natal clinics. Relations with TBAs seem, generally, not to have a stable foundation. Progress made must inevitably be uneven but seems to be slow even though the numbers of TBAs within a mobile unit area can be several hundreds.

g) School Health Work - though never a major commitment - was to be an activity of teams.

Inspecting BCG scars and giving initial or-for older children, booster doses could be a useful activity, as could health education on, for example, worms and toilet hygiene, malaria, school infections, etc.

Schools are sometimes visited "when clinics are light" and/or staff are free early in the day. This is not, though, a welcome activity in the eyes of most teams. Training selected school staff members might be a partial solution.

h) Family planning has been adopted as an activity in the form of Natural Family Planning.

FP, in any form, is at present sought by few rural people.

"Natural FP" depending upon a joint decision of husband and wife and requiring a careful sequence of instruction, must represent difficulties. Though assistance is offered by mobile unit teams, not surprisingly, progress in motivating acceptors and in training teachers has, so far, been very limited. There may, however be a "ripple effect" from acceptors teaching their friends.

CHAPTER IV. I N P U T S.

Inputs : CRS Staff and Supervision.

Since July 1st 1983 the top administration of the project at Catholic Relief Services have been the CRS Program Director initially Palmari H. de Lucena who had been involved in the negotiations for the project since inception in 1979. The CRS post of Program Director was filled by John G. Connolly during the evaluation period. This coupled by the fact that the CRS Projects Officer responsible for Kitui Primary Health Care Project - Ezra Mbogori - left CRS early in 1985 has led to some unease on the ground particularly since enquiries from Kitui cannot always be directed to the busy CRS top administration in Nairobi.

However we should state that we have not found any major project activity delayed because of these changes. What we have found at Kitui, and incidentally USAID, is unease about dealing with several individuals on Kitui matters.

CRS has already interviewed some people for the post of Projects Officer and as soon as the post is filled we are assured they will be assigned daily administration of the project. Meanwhile queries will be handled by the Program Director and/or his assistant or whoever else they designate.

Project field staff argue that CRS has not actively managed the project in the recent past.

A significant related detail is the issue of budgeting information. Below the administrator nobody seems to have any idea on budgets available. There is thus no coherent foward planning of activities. There is no reason why the hiearchy down to the Team Leaders should not know the budgets. After all they are the ones who make spending decisions.

Inputs : Diocese of Kitui Project Staff.

Administrators :

The top administrators for DOK with respect to this project have been Rev. Father Noel. S. Bouchier - Administrator, Sister (Dr.) Marion Dolan - Consultant; Sister Teresa Connolly - Supervisor. They have all held their respective positions during the period under assessment.

Several important points are worth highlighting with respect to their management of the project during the period under review.

Sister Dolan runs Mutomo Hospital with a capacity of 140 beds. By training she is a Physician/Surgeon. This load and her professional past and interests militate against her putting extensive conceptual and administrative time to the project.

Ideally the consultant should have been a person of her rank who had extensive training/experience in community medicine. There maybe a case for finding such a person to be the consultant if the program is to be extended. Another alternative is to keep her as the medical consultant and appoint another consultant in community health/social work.

Sister Teresa has suffered from serious ill health which has limited closer top supervision of the project on a day to day basis. To some extent her role has been back stopped by the administrator but the detailed coordination and program decisionmaking of the four teams has been affected.

Team Leaders :

The Team Leadership has been stable during the period under review. However the project lost Sister Paschal Crawford who had been identified with the project since inception as the Kimangau Team Leader. She left the project in March 1984 when she was replaced by Sister Eileen Bishop.

The other teams have been led by the same individuals with nursing backgrounds during the assessment period.

Of the four teams three have extremely able managers and experienced Team Leaders. The assessment team was concerned about the management (personnel and program activity) of one team leader but we believe with support by other project staff there could be improvements.

We urge that project to use the talent it has at the team leader level to upgrade continuously project management. This can be achieved by greater sharing of program experience by team leaders.

Midwives/Nurses.

At the Midwife/Nurse level there has been unsatisfactory rapid turnover of staff. Only one team out of four has managed to retain their Midwife/Nurse level staff since inception. We are told that the average service period for this level staff, who are really the backbone of the project as conceived, in SIX MONTHS.

There are recruitment problems. Since inception and with exception of one Nurse - Midwife all those filling the posts have come from Mutomo Hospital which has a midwife training program. Mutomo has had problems finding good students from the communities being served. As a result many of the trainees are from outside the district. On completion of their course, we were told, they are ASKED to serve in the project.

Many of those 'posted' to the project are not serving in their home areas. They thus seek the first opportunity to get out of the project. Project personnel explain this in terms of the project areas being underdeveloped and lacking in career opportunities, with special emphasis on stability in government health system and personal opportunities (including getting husbands).

The midwives we talked to,for their part, emphasise that their colleagues and themselves leave for personnel management problems internal to the project primarily and the reasons above secondarily.

Midwives are not the most suitable personnel for this project. Ideally a team should have a midwife and a community health nurse. We believe that to some extent the preponderance of midwives at this level can partly be explained by the catchment pool of Mutomo Hospital graduates.

Given the fact that Mutomo Hospital MAY begin to train Enrolled Community Nurses in 1986 they may produce the relevant staff. However since the entry qualifications for the Enrolled Community Nurse Program are more stringent than for Midwives, it is likely that some centres will fail to attract personnel from their catchment areas who are willing to stay in their areas of origin, as career and marriage demands will force them to move out. This fact leads us to question the relevance, then, of planning the project, as was done in the past, to rely so heavily on this level of staff.

This staffing bottleneck suggests that the project should be restructured to put more emphasis on VHW/Nurse aides, possibly staying in their communities and not being transported around. We are told that such restructuring is problematic but we believe that closer attention to recruitment in communities would lead to identification of useful personnel.

Nurse Aides :

The project did not conceptualise this level of staff coherently. As a result two different sets were recruited. Some are trained at Muthale Hospital and are equivalent to GOK's Patient Attendants. Others are recruited randomly and without a specified educational level.

This incoherent conception has led to serious dissatisfaction at this personnel level particularly since both categories are paid the same salary. There is no scheme of service for them as for everybody else. They have been told bluntly that at project termination they will have to find posts for themselves.

In our fieldwork we talked to nurse aides extensively. We are convinced that contrary to their assigned minor role in the project they have been its backbone. They are mainly from the communities they serve. As a result they are accepted. They, more often than not, are committed to the project goals and are highly motivated, in contrast to the midwife/nurse staff. They do most of the Health Education work which is (and should be) a significant component of any primary health care work. Finally, they have been in the project longest.

We believe the project, if extended, should review its staff use and emphasise the recruitment of nurse aides from local communities. A scheme of service for them, with salary benefit for the two district groups equivalent to similar ranks in government service, should be implemented for them. Their numbers should be increased so that they can be based full time in the community if the delivery system is to be changed to reflect ongoing community education rather than single-day monthly delivery to a point. Savings to finance this should come out of transport savings and the program restructuring discussed elsewhere.

Inputs : Funding Flows.

USAID/CRS.

Pursuant to a meeting between USAID and CRS officials on December 20th 1983 the discussions of which were formalised in a letter by Palmari H. de Lucena to Rose Britanak on December 22nd 1983, a quarterly financial reporting system was worked out. It identifies line items, budgets for plan period, total expenditure, cumulative expenditure including the reporting period, and planned estimated expenditure to be billed to AID the next quarter.

This system was followed for the assessment period.

The detailed data up to March 31st 1985 is found in Annexe . CRS funding is replenished by AID on the basis of this agreed format.

A closer look at this annexe shows that over the 18 months of the assessment period the project has underspent by nearly 20%.

The DOK Administrator has been so advised by CRS, yet the level below him expressed anxiety whether there are funds for continuing the project. We do not therefore understand the information put to project staff that the termination date is October 1985. This was in a general meeting of all staff and has contributed to low morale.

In the grant agreement there is provision for shifting 15% of the amounts of budgeted line items to others. We have not seen any evidence of this.

CRS/DOK.

CRS reimburses DOK on presentation of accountability which is essentially total claims backed by receipts. Semi-annually DOK makes detailed financial returns to CRS on line items. This arrangement seems to be satisfactory to both parties. Furthermore DOK holds a project revolving funds of Shs.200,000, as agreed by both parties and endorsed in a letter by Palmari de Lucena to Rev. Noel Bouchier of 24th January 1984.

One issue we would, though, like to raise is on grant overheads. CRS New York takes 8.5% of all grant monies it administers. In a telegram to Cathwell (CRS Region III) from Bishop Broderick (CRS NY) of 24th February 1983, CRS NY insisted that the 8.5% be remitted, and promised to contribute 4% back to DOK. This was a rejoinder to CRS Kenya's and DOK's position that since the understanding was clear it should only remit to CRS NY only 4.5% and retain the 4% of the total grant for DOK.

We have not seen evidence that DOK has received the 4%. We urge CRS Kenya to pursue this matter on behalf of Kitui.

DOK central administrators are unhappy about purported delays in getting funds. It seems as if the CRS/USAID link does not expedite funds to DOK on request. On the other hand it is difficult for us to understand how with a float of Shs.200,000 the DOK central administration can fail to replenish teams when they need funds.

DOK Administration/Project Teams.

The administrator maintains a cash book for the project. However, there is little evidence of detailed foward budgeting. The cash book has many revisions suggesting that the accounting procedure have not been routinised and thus professionalised. No budgetary information is passed downward.

The 4 project team leaders get reimbursed on claiming (with receipts) from the project administrator. This is done randomly, thus creating operational bottlenecks inspite of the fact that some funds are held in a float. Decisions on how much should be spent in each of the four project areas are made at random at the administrator level. It was explained to us that this is based on "need" as determined by the Team Leaders.

Our view is that such procedure is not sensitive to need and is not a good resource allocation procedure since our interviews with Team Leaders did not elicit detailed planning needs based on the varied travel, population shifts and changing disease patterns. We were not able to cost alternative plans within the time frame. We suggest this is done with a view to expanding activities as the project is underspending.

We were not able to make a judgement on details of administrative costs. Neither are we able to explain the expenditures on evaluation and data collection during the period although these appear in returns.

Inputs : Vaccines.

According to the project document GOK is to finance vaccines. For some curious reason in the Phase 2 project document this is seen as a "hidden cost"!

Since they are so, nobody seemed to have set up an accounting procedure for them. As a result Team Leaders have been picking vaccines at random from Kitui Hospital throughout the assessment period. Lately the Kimangau central has been picking vaccines from Mwingi Hospital. This has resulted in a significant saving to them.

Kitui Hospital records did not in the available time lend themselves to detailed analysis of vaccine costs. However, in the words of team leaders it is important to note that the project has not suffered from lack of vaccines. The KEPI program expanded into Kitui in September 1984. This has assured easy availability of the immunisation vaccines to the project.

Inputs : Vehicles.

The four landrovers envisaged in the project document were bought and on time. They have been used only in the project. None have been in accidents and thus off the road. Three of them are in very good condition. Credit goes to the drivers and team leaders who have ensured that they are so well kept.

The fourth landrover is in bad shape. It has been handled by three drivers during the assessment period. The team leader is not experienced in terms of vehicle management and the current driver cannot do minor repairs.

We have made representations to the Team Leader, Supervisor, Consultant and Administrator on the importance of closer supervision of this vehicle for if the present level of mismanagement continues, it will not last through the project period.

DOK is lucky to have a village polytechnic where minor repairs can be done on the vehicles. Unfortunately servicing is still undertaken in Nairobi. It should be possible to get a local garage to do it well in Kitui with considerable savings on petrol and charges to the project. This should not affect quality of maintenance.

One of the MAJOR findings of our fieldwork was that no clinic was missed because of vehicle problems. When vehicles were in for service, Team Leaders borrowed from other programs within DOK. This has been a significant contribution for a missed clinic leads to an immediate drop in attendance since clients invest a lot in attending. Compliments go to DOK for supplying the vehicles and to Team Leaders for proper planning of vehicle use and initiative in finding alternative transport at the odd times when the landrovers are stuck at Coopers in Nairobi.

Inputs : Housing for Project Staff.

Curiously DOK's contribution of staff housing and offices is seen in the project document as a"hidden cost"! This, however, has not kept DOK from providing housing on a generous basis to all staff.

Inputs : Project Management and Supervision.

Financial and personnel management comments are found elsewhere in this chapter. Here we want to comment on overall project management response to opportunities.

We have already mentioned positively the scheduling of transport. Team Leaders have been highly innovative in relocating clinics particularly during the drought when the populations were moving. This is very commendable but it needs to be integrated to GOKs clinic operations by further discussion.

Teams have anticipated crises and responded to them. In one area the response to a rabies 'epidemic' was outstanding. In another area reaction to a measles 'epidemic' was another meaningful response to a crisis. In more than one area switching to anti-cholera extension work probably saved significant number of people.

Possibly the greatest innovation in this project was the simultaneous use of clinics for health and supplimentary feeding of the children. 3,500 kg of DSM and 1,750 kgs of beans were given out monthly during all of 1984 when the drought was at its peak. It is indicative of the misunderstanding of the process between the donors and implementers that this activity was kept out of the formal reports. It is doubtful whether there would have been any clinics at all if the extra funds for supplimentary feeding had not been found. The project design should have allowed for this type of innovation for who would be interested in clinic attendance during such a vicious drought ?

Having said all this, though, we were discouraged by several management issues. The most outstanding one is the rigidity of making all teams equal in terms of personnel and other resources inspite of different workloads. If one aggregates demographic, distance and social factors, Kimangau possibly needs extra petrol allocation given its additional expense. Muthale and Mutomo need extra staff and different circuits to cover the population in greater depth.

Particularly disconcerting is the deliberate misinformation on funding to all and sundry. It is bad enough that project personnel do not know the available budgets. It is reprehensible to give the impression that funds will terminate six months before contracted project time.

Related to this is the issue of central management style which leaves Team Leaders essentially on their own. Most teams are very good but, there is reason to believe that one team needs both horizontal and top support. The Supervisors ill-health has contributed to this, no doubt, but the project should have generated backup resources. Given the RIGIDITIES OF THE DESIGN and the inability of the Consultant, Administrator and Supervisor, and CRS to ENCOURAGE REDESIGN during implementation,

CHAPTER V. OUTPUTS / BENEFICIARIES.

Outputs : The Population Covered.

The population of Kitui District are indirect beneficiaries of the project whose impact spillover can be great as better health is a precondition for development. As shown in Annexe 1(p.59), CBS estimates that Kitui population was 576,602 in 1984. Of this, 77.2% are the direct beneficiaries of the project since they are in areas covered by the project teams. This is shown in Annexe 2(p.60) which breaks the project area population into the 4 sub-units. Muthale and Mutomo units, whose populations are just about equal, command just above 50% of the total district population.

One would then imagine that the project coverage should concentrate the activities in Muthale and Mutomo. Such a strategy would not be in the spirit of the project which specifically stated that "The program is (sic) directed to providing (sic) a primary health care delivery system to a population remote from existing government and mission medical services"! To the extent that the project has continued to press resources into the Nuu and Kimangau units, and the least populated areas of Muthale (towards Tana River to the West) and Mutomo (Yatta and Mutha areas) it is within the spirit of the proposal.

In the next Chapter, External Factors we will discuss the impact of drought on the demographics of the project area. All we want to point out here is that impressions we have gathered during field work suggest that the population in the project area was significantly mobile during the assessment period. As part and parcel of their traditional drought adjustment mechanism, they went out to work in other areas. They collapsed into the central Kitui hill massif which is outside the project area. They exited from the district into Machakos, Meru, Embu etc.

There are many references in project documents mentioning these migrations but no hard data. Other migrations were triggered by the plethora of feeding stations established. The OP has some data on this but it is still confidential.

We therefore suggest that in future Team Leaders be responsible for collecting data on feeding programs in their areas and on out migration. Such data is of great value for activity programming within the project. It can be used to service those areas in greatest food need for they are the most vulnerable to diseases.

The project can collect this data in conjunction with or from the CBS, which is in the process of setting up food risk statistical data to service the needs of districts.

To give credit where it is due, we noted earlier under management that clinic sites were changed when populations dwindled in some areas. However, we were not able to establish whether this related to migration patterns in a meaningful way. For example it would have been extremely imaginative to tie primary health care clinics to the large feeding centres by holding them in the same place even if not on the same day. That would have ensured a ready catchment. Perhaps the clear reductions in Ante-natal Clinic attendance in Table 1(p.76) and Children Immunisation in Table 2(p.77) and Curative in Table 4(p.79) reflects the fact that there was significant outmigration. There also was the pre-occupation of many in attending food distribution and food-for-work programs.

No data exists for time use patterns during the assessment period but many mothers explained to us that they could not attend clinics when they also had to queue for food and take part in food-for-work programs.

Outputs : Clinical Services.

Antenatal Clinics Attendance:

There was a significant drop in ante-natal clinic attendances as shown in Table I. For the whole project area this dropped from 37% to target population to 27.8% and finally 21.98% in six month intervals during the first eighteen months of the project. It is expected that it will pick up and be apparent, when the last six months data is tabulated.

Children Immunisations:

These dropped from 56.17% of target population for the whole area in the first six months of the assessment to 44.97% during the next 6 months and finally rose slightly to 47.17 in the last six.

There were increased attendances in the last three months of 1984 suggesting either parallel attendance - for immunization and curative assistance for children - or people returned to home areas as the rains broke.

Adult Immunizations.

These show similar pattern to children as shown in Table 2, particularly in Kimangau and Mutomo.

The deviant pattern in Nuu can be explained by the traditional movement where hardsmen at Syengo (stock camps) in the drier Eastern statelands collapse back to around Nuu Hill as the the drought bites. It this explanation is valid then the drop, as the rains return, reflects movement of people back out again. In total there were 10,727 adult immunisations.

We would urge the project to intensify immunisation of pregnant mothers with tetanus toxoid - 2 doses at an interval of one month - to avoid tetanus of the newborn.

Curative Services.

In a coherent primary health care program one would expect response to episodic diseases. Elsewhere we have touched on those handled in 1985. Aggregated data for the first 18 months, as shown in Table 4, shows increases as the drought bites and reductions towards the last months. 6,725 patients were attended to as shown in Table 4.

This curative activity is mainly confined to mothers and children. Under "Unplanned Effects" we discuss the implications of this restriction.

Malaria.

We believe that malaria should be central in any primary health care program in Kitui. Yet we did not find evidence of project personnel thinking and doing something about it. What would be needed is a generalised community reduction in plasmodium through prophylaxis and early treatment with management of infestation from without.

This calls for a different type of project activity which we were told was not possible since the program only sanctioned the monthly clinics.

Of course aggressive presentation to the donor of this issue by the central administration of the project might have led to redesign of the project during implementation. We recommend that DOK and the donors consider this during the next drought since many people are vulnerable to serious malaria (particularly cerebral) after loosing their immunity during drought. Since malaria hits at peak labour demand periods, its control would lead to fantastically high socio-economic benefits.

Health Education.

In Clinics.

There is little that is good about Health Education in the project. One team leader told us that a woman told her point blank that she did not want to hear the stuff anymore since she had heard it for so long.

We observed peculiar"rattling off" of facts by midwives who did not understand the local idiom. At another centre we saw a midwife and a local nurse aide talk almost simultaneously since the keeper of the "sacred knowledge" (midwife) was not fluent in the local language. At another centre women are forced to listen to the monologue by withholding the numbers tickets which entitle them to attend the child welfare clinic. This is supposed to be an innovation !

We saw terrible posters. Granted, the team leader said they were bad, but she had not drawn on the resources of another team which had better posters (although the colours were not positive in the cultural setting).

Above all we saw the worst of LECTURING AT people.

In extension work, particularly health education, the dialogic method is most efficacious. We understand one team uses it extensively.

Role playing is supposed to be used. We cannot comment on its quality since we did not see any.

We would urge the project to initiate serious dialogic method for the extension of the health knowledge. Good posters are cheap and easy to produce if the project teams work together with other resource people (painters etc.) in the region. The project staff could learn from other development projects designing similar materials both in Kitui and in adjoining districts.

In Schools.

Health education according to the project is also delivered to schools. The Semi Annual Reports for the period identify 79 school visits. We gather that these have been increased in 1985. Assuming that most talks are to the two top classes, the 'talks' could have theoretically reached 10,000 students from estimates in the reports. Any guess work on impact is without evaluation, folly compounded.

In Homes.

Health education is also supposed to be delivered to homes. A previous consultant said health education was viewed as a subsidiary activity in the project. From the Semi-Annual Reports we can only identify 1,470 visits. Thus we must concur with the previous consultant. Home visits are subsidiary activities undertaken "when there is time".

Everybody we talked to agrees that home visits are important but can only be done when clinics finish early (undesirable since the staff only reach those in proximity of clinics) and the one day weekly when there are no clinics. This of course simply means servicing families near the base. We are not sure that they are the neediest.

Among TBAs.

TBAs are in fashion. We agree they have a very important role to play since for the foreseeable future they will continue to handle more than 75% of all deliveries in Kenya. We cannot determine how many TBAs have been upgraded. However there have been 35 TBA/VHW courses. This is an improvement over the previous period.

We are encouraged that two teams have been pursuing this need of TBA's systematically. One team has even identified a "consultant" TBA who handles risk cases after reference from other TBAs. More of these individuals should be identified. Where a consultant TBA has been identified they should be used in 'training' the others.

Again the essence of 'training' should be dialogic and conducted in their home setting. The project should be seen to be outreaching to the community not bringing the TBAs to hospitals or Pastoral Conference Centre situations which essentially threaten them and are not conducive to contextualising the hygene and health problems they have to improve on. Young midwives are not likely to be particularly effective as their teachers as this violates deeply ingrained cultural practices.

We noted, with delight, that some of the TBA courses have been conducted in conjunction with the District Public Health Nurse. This type of coordination and programming should be encouraged.

On a final note, TBA's selection for training methods should be tightened possibly using performance criteria, ie. number of deliveries in recent past. One program used 5 for the previous month. This would quickly weed out the masqueraders. It would also keep out those referred to by some staff as "witchdoctors" when they meant waganga(awe). The word is perjorative and should not even be used in reports. In anycase until the project develops a public psychiatry program waganga have only a minor role of referring to hospitals those they cannot treat.

Herbalists.

We were struck by the fact that nowhere in the program do professional traditional herbalists feature. We only point this out and offer no solutions since the pharmaceutical problems they present in a primary health care system are phenomenal. Perhaps the teams can begin to think about their role particularly since it is informed opinion that there is unsatisfied curative demand in these remote areas.

Public Baraza's.

Public Barazas are not very effective information dissemination channels unless there is an emergency problem like an outbreak of cholera, or an effort at campaigning for project support. We are told by Team Leaders that they and their staff have attended many more than the 10 identified in the reports over the period. Such time should be better used elsewhere.

Health Committees.

Reportedly there are 17 Village Health Committees formed up to December 1984. More are being formed.

Recent extension thinking argues that community response is better if ALREADY EXISTING community institutions are utilised for many functions. The reason is simply that too many agencies and state departments are busy creating committees at the grassroots. These are hijacked by self-appointed leaders or formal leaders like chiefs who use them for their own ends and not to meet community needs.

Unfortunately identifying community leadership is a long process for which donors and implementing agencies or government departments do not have funding and/or time. If a community health program is to succeed there must be a careful process by means of which the community chooses the representatives. A simplified methodology of this follows.

The idea of the need and tasks and qualifications expected of the community organisation and representatives should be introduced to the localities formal leaders - government, ALL churches, harambee groups and clan leaders. Adequate time should be allowed for discussion of the health problem. There then should be public meetings where those proposing the service and the community discuss the project preferably under government aegis. The representatives of the community should be selected in public. Of course details will vary in each case. The public choices MUST BE HONOURED. Too many agencies keep to their personnel networks at fantastic cost to projects.

We only examined one community health committee in great detail and have communicated our findings to the Team Leader.

We are not convinced that greatest care has been taken in finding community institutions to deliver primary health care. This should be a priority issue during the rest of the project period.

Respiratory Tract Infection.

This appears in the reports as "coughs". It is thus difficult to assess its import in the project. However it raises the important issue of unsatisfied curative demand in postnatal care. Further documentation of this by the project to establish its saliency is needed.

ORT.

Inspite of the squabbles about ORT delivery information in rural areas we consider the extension of ORT, particularly with locally available materials and measures, (definitely not imported packages) important. It tends to be upstaged by bad nutrition teaching, a situation which should be reversed in the project.

We were struck by a case of an old lady (past 70) who knew how to prepare ORS. She arrived with the ingredients on a roadside scene when one of the team midwives was attending to her husband who was vomiting and had bad diarrhoea Again coordination with public health and nutrition MOH staff would be useful.

Unsatisfied Curative Demand.

Populations of the remoter areas have a crying need for curative services which we believe has been triggered by the reliability of the visits of the clinics. Particularly important in this respect are adults, especially males, and school children. They are patently discriminated against in the clinics. This is a design problem of the project. The donor did not want to emphasize curative health. The project again was structured in such a way that it did not, as we would prefer, have personnel who are living in the communities as the main project delivery channels.

Simple curative services particularly of malaria and other fevers, diarrhoeas, worms and anti-tuberculosis immunisation (perhaps triggered by the project) should be tied to the program.

This has staff mix implications (community nurse or clinical officer rather than second midwife as is the case in many teams now and/or nurse aides in situ as village health workers) and transport cost implications. If slightly more curative care is offered and/or nurse aides/village health workers are put in situ there would be a big drop in unit transport cost. Such a saving could, in turn, be used to expand the project within the communities served.

Schools.

Two areas of special concern for the schools have been unanimously identified by all teams. These are upgrading immunisation and reproduction education for standard 8 (especially girls). We agree they are of importance and should be implemented as soon as possible. On immunisation we think the strategy should be to start with pre-school children and move up to the higher classes since it would take little time and there aren't major impediments.

Sex education is a little more problematic. The project should initiate discussion with the school supervision hierarchy to plan the best strategy and discuss how such information would dovetail into the newly introduced health education curriculum.

Environmental Health.

The project has not systematically thought much about this and drawn in those concerned.

We found that in one Team's area there are no toilets in 10 centres where the clinics take place. Another team has no toilets in 2 places they hold clinics. It is true that Mutomo, through the public health technician and harambee groups is doing some extension on toilets. All are not involved to as a great degree as current needs demand.

Sound toilets are central to a decent community health program. There are public health technicians in the minor towns/locations who could be encouraged by the project to do more extension work, to spread the knowledge on how to measure toilet holes, what wood from local trees does not rot from urine when used for the slab and above all maintainance of toilets.

The project can draw in the chiefs and sub-chiefs who have explicit orders from OP to ensure that toilets are not only built in every homestead but used. The project can thus act as a resource. It could catalyse communities to act independently.

Protecting water sources is another activity in which the project could act as a resource.

For these to take place, though, the project will have to break out of its female target population focus and become truly community oriented.

Reliability of Service.

The MOST DRAMATIC POSITIVE finding of the assessment is the fact tha ALL the planned clinics have taken place in the period under review. 1152 clinics were planned in all the four centres. Only 60 clinics ie. 5.2% were missed. Of the 60 missed clinics 39 (3.38%) were in Nuu; 17 (1.47%) were at Mutomo and 4 (0.34%) were at Muthale. Kimangau has the achievement of not having missed a single clinic.

It is a mark of how seriously vehicles and personnel are managed by the Team Leaders, Supervisor and Administrator that none of then were off the road to limit operations although in a few instances the project had to borrow a vehicle from other projects. Clinics were only missed because roads and bridges had been washed away.

Natural Family Planning.

The only evidence gleaned from the Semi-Annual Reports and interviews is that there are 3 tutors, one each at Nuu, Mutito and Mutomo. About 21 couples have been trained in Natural Family Planning from July 1983 - Dec. 1984. This includes the 12 teachers of the method and those actively practicing. Many more have attended a session here and there but are not active. Project staff confess that it is hard to find many couples committed to this method.

The method for training is to bring the individauals to a centre and hold a 2 day seminar. Some seminars for one week have been held for the teachers.

In summary, the impact of Natural Family Planning seems to be insignificant in terms of numbers reached by the program and the resource people to teach it. One centre report states another reason - perceived infertility - as the problem. To quote the Nuu KPHC Project Semi-Annual Report, July - Dec. 1983 :- "Efforts to promote family planning met with poor response. The problem of infertility is seen as greater than that of fertility by most families."

The curriculum of NFP depends on personal relationship particularly those of couples and their teachers.

On the wider issue of Family Planning (spacing and terminating reproduction), all project staff state emphatically that in Kitui it is not seen as a priority by the population. It will take along time to secure a meaningful output from this activity.

CHAPTER VI. EXTERNAL FACTORS.

Impact of Drought on the Project.

During the period under review there has not been a good crop in the District. In fact the last crop which partly met the subsistence needs of the people of Kitui was the long rains of 1983. This was during the period when the KPHC Project was being run with the remainder of the CODEL Grant. The subsequent short rains in 1983 and long and short rains of 1984 failed totally. 1985 long rains are good in the district with the exception of Southern(Mutomo) Division where it is estimated there will only be 25% food self-sufficiency

Since this evaluation is for the period April 1, 1983 to April 1985 the statement on lack of food is firm for the whole period.

As the January/June 1985 Semi-Annual Report is not complete, it is not possible to show the detailed impact of the drought up to the last half year. However, for the whole assessment period the district has been receiving 1500 metric tons of grain and 500 tons of DSM monthly. 90% of the population was at risk. This food support is continuing.

In 1984 Kitui was so badly hit that it is estimated that only 20% of the acreage usually planted during the short rains (October/November.) - which are the main crop rains in the district - was planted because seeds were not available. Maize seeds were Sh.20 a kg. and cowpeas Shs.60 in November 1984. Up to now (May 1985) the district is still under famine relief. Furthermore, whatever was planted in October/November 1984 was eaten by army worms. However, there was some replanting.

Ironically, after the army worm attacks of October/November 1984, the rains have persisted since then to now (May 1985) with good consequences for livestock. The famine reserve for the district is shoats and cattle. Their prices collapsed completely during 1984 so that Sh.10 could buy a shoat, Shs.2 a chicken and Shs.200 a full grown ox. Current (May 1985) prices are Shs.200 per shoat, Shs.50 for a chicken and Shs.3,000 per full grown ox. This simply reflects the fact that people want to rebuilt herds within the traditional drought adjustment patterns.

On the food side, subsistence self-sufficiency is expected at the end of current rains in general if rains persist for another month with the exception of Southern (Mutomo) Division where it is estimated there will only be 25% self sufficiency.

These clinic figures would have fallen to zero if the project had not fed attendants.

Having looked at the impact of the drought on the project one would like to pose this question : "What is the role of a primary health care project in drought ?"

First, it seems to us that the project should anticipate drought conditions by analysing its clinic data. It should be aware of the possible migration patterns and should adjust its project activities to handle more effectively drought derived stress and disease.

Therewere individual staff and team initiatives covering aspects of this response in Kitui but given the unimaginative design and administration at the project core (DOK and CRS/USAID) the project as a whole did not make coherent responses.

If it had, its delivery mixture would have changed eg. to giving general nutrition support including vitamins, relocating clinics more systematically to take advantage of feeding program centres, not worrying about the maternity deliveries drop at Mutomo Hospital, and moving into the curative and food clinics.

Such imaginative reprogramming during crises calls for a much more sure, astute and fast responding project management than the nervous "layback" style we have encountered. It calls for drawing on extra resources within and without DOK and specific proposals to the donor who, in this case, was involved in feeding and other drought related activities in the District.

Roads.

The donor, and project planners within CRS andDOK, and previous evaluators, do not seem to have been on top of the problem of road plans for their expansion and population shifts which accompany new communication networks. More importantly, the project could have played an advocative role in the district planning process to argue for some key roads to concentrations of populations eg. Lundi Valley at Nuu, thereby increasing the cost effectiveness of project transport. Many roads were being done under the food-for-work program. If all parties were attentive to the inter-relations of these factors much more flexibility would have been BUILT INTO PROJECT IMPLEMENTATION.

Although we are aware that this might have called for much more social science input into project planning, and implementing methods/activities by people with more extensive district knowledge, the Diocese does not seem to have drawn deeply upon its personnel who have some of this knowledge but who were in other programs.

Again, it is a problem of the project being seen in narrow medical terms and being handled wholly be personnel so oriented. District GOK officials (especially DDO) would have been important sources of this planning information.

Specifically there are major road plans which have opened up the Yatta area for much more dense settlement than was apparent at project inception. This should be taken advantage of. Still in Southern Division, there are roads under construction in the Eastern extremity of the district which will be a factor in the demographics of the area. Road networks linking Tsavo with Northern Kitui in the Eastern statelands will stabilise some of the populations there and therefore create demand for health services. So will road proposals for opening the triangle of Mwingi, Thatha Hills and Tana River. Others proposals are for the Tana, Katse and Tsaikuru area. These are the remote areas upon which the project rationale is based.

Previous work in the district has established that Kitui population responds to communication systems expeditiously. This should always be incorporated in project design, implementation and monitoring and evaluation.

Cancellation of USAID Kitui Rural Health Project.

On August 20th 1984, the proposed Kitui Rural Health Project, which was to be funded by USAID, was formally cancelled although the de-obligation date was November 25th 1983. This was the project which the DOK expected would take up the responsibilities of its primary health care activities. We would like to go on record in support of the then proposed project.

Sometime this year, in January/February, USAID informally spread the word that it was not interested in refunding primary health care for CRS/DOK. This has been communicated to project staff and they are in panic particularly since other information suggests that the termination date is October 1985.

The USAID Kitui Rural Health Project was ostensibly cancelled because MOH did not get budget allocation for it formally. In the cancellation letter an opening was left for reprogramming the funds.

The USAID Health and Population Program has shifted in emphasis over the last two years to concentrate on population matters (including natural family planning). This is an opportunity which CRS/DOK could explore for possible future support. The net effect of the cancellation by USAID, and the program shift in CRS, is that personnel in the project are unsure of the future since they tell us they expect the project to end in October 1985 in spite of the fact that the project documents state that the Project Termination date is March 30th 1986.

We believe this confusion arose out of a cautionary letter from CRS about spending rates in 1983. However the project is currently underspending.!

USAID/CRS have responsibilities in clarifying this point to the staff. DOK has responsibilities for clarifying the employment situation to staff, particularly the nurse aides, and drivers. We are told that promises were made to midwives/ nurses but not any of the others.

Integration of DOK Planning/Implementation Processes.

Theoretically all development activities of the DOK are under the Development Coordinator who does not seem to have planning staff. This project was administered under the Health Office. It is not our business to tell DOK how to run its hierarchy but some pertinent issues impinging on the project under assessment need to be raised.

First, there was not systematic planning of the project. Secondly, there were too unrealistic demands from the donor accepted by the DOK on specific monitoring issues like demographics, mortality rates etc. which with proper planning inputs should not have been accepted since they COULD NOT in any way be achieved within the budget, personnel and time frames in the document.

Third, the internal planning and implementation coordination within the subunits of the DOK did not seem to be supportive of the project under assessment. True, resources (especially transport and maintenance knowledge) were borrowed but this is random activity.

Fourthly, and perhaps most importantly, DOK sub-units have many conflicting goals. Even within the project under assessment understanding of goals, and means to them, seems to depend on DOK sub-unit origins of the individual and their positions on some basic issues within the DOK.

Fifthly, given the political and medical push for static facilities within Kitui, it seems to us that this project with its pioneering thinking could form the basis of long-term meaningful development. This calls for a much more active role - in conjunction with GOK District Health Officials - which used to exist in the past. The cancellation by USAID of the KPHC Project seems to have rent all and sundry asunder.

It is, though, important that the project staff liase with GOK Health Officials on the clinic need patterns now that the following static health facilities are to start functioning;

Kaui, Miambani, Mwitika, Kanyangi, Kwamutonga, Nzawa, Kasala, Tiva, Kauma, Kaumu, Katyethoka, Winzie, Kisayani, Ilengi, Tyaa Kamuthale.

District Focus.

As is the case with many NGO's, CRS/DOK will have to adjust to the new District Focus for Rural Development which was introduced by GOK in July 1983 and whose impact on NGO activities is yet to be fully felt.

Central to District Focus is the idea that ALL PROJECTS will have to be INITIATED by local communities. They will have to be prioritized by LOCATIONAL DEVELOPMENT COMMITTEES and move up to DIVISIONAL DEVELOPMENT COMMITTEES and finally be prioritised for funding and implementation by the District DEVELOPMENT COMMITTEES.

The DOK does not do this with respect to this project. The point is simply that almost all feeding clinics could theoretically be closed now if challenged. The era when NGO's could initiate THEIR programs is over. We would be irresponsible if we did not point this out.

Rectification of this omission should be a priority IMMEDIATELY, for sins of omission are not acceptable defenses whether in law or politics. Any sub-chief, Chief, DO, and ultimately the DC, can close any of the project activities on the basis that they were not passed by communities. By the way, the fact that sub-chiefs, chiefs, DOs or even the DC or MP "knows",as project personnel told us, is immaterial. It must be the community, pure and simple. If it is to be general development it cannot be church only.

The new District Focus Training Framework also expects NGOs to fit into an overall district development training program which shows how skills of those employed are to be upgraded on the job. DOK should participate in this activity in Kitui.

We are informed that a District Health Committee is being planned as a sub-committee of the Executive Committee of the DDC. The project should seek representation in this.

CHAPTER VII. U N P L A N N E D E F F E C T S.

Sources of Nurses.

As a result of this project Mutomo Hospital became the source of project 'nurses'. Of course they are trained as midwives and not community nurses. We have not seen evidence that there were general attempts to find such community nurses who are the personnel most suited to this type of project.

Elsewhere we have pointed out that these midwives stay in the project on average six months. The project is a training ground in community health for midwives ! Perhaps this will be of use to some other projects later on. Midwives career advancement demands that they work in maternity wards delivering babies. Nobody should be surprised that they leave the project

Nurse Aides.

The project developed demand for nurse aides to handle the work-load in the clinics. Although the initial rationale was for non-technical activities like weighing, they have developed to be the main communicators of public health education. This has been so since many of them, unlike the midwives, are from the District, and, speak the local language. This gives them a communicating edge. The project never envisaged this and as a result they do not have maningful scheme of service. Many are apprehensive about their future if the project ends.

DOK assures us that something will be found for them. Since they have the project experience, they should form a useful pool of community health workers if somebody can plan their utilisation in local communities.

Unsatisfied Curative Demand.

The project is a female project run by females. An old man came to a clinic during our field work and since the only males he could see were the consultants, he gravitated to these 'doctors'. He talked at length about the unfairness of the project.

It is true that the only medical personnel seen in the remote environs are the female project personnel. Since most of the people cannot get any medical help locally, and, distances are too vast to travel, the curative demand triggered by the project's presence is unsatisfied.

The donor has of course stressed health education, training of TBAs, natural family planning, and de-emphasised curative. We believe that inclusion of a clinical officer/nurse in the project to handle simple curative issues would have been prudent. It should not have led to large cost variations.

For the future the donor, and primary health care project implementers, should be aware that any outreach into the really in-accessible areas is discriminatory unless it services some of the curative demand it generates.

Ironically needing curative services women, girls and children, can get into the clinics and be served or referred. It is the men and boys who cannot. The ante-natal and immunisation emphasis, together with the all female staffing means their presence is not tolerated. The simple curative care demand generated is for malaria, diarrhoeas, coughs, bites, and dressing of wounds.

Feeding Centres.

As discussed elsewhere Kitui District was hit by a serious drought during the period under assessment. Very many feeding centres were set up by GOK and NGOs. There was therefore some confusion in the public mind that the project clinics were feeding centres. Perhaps it was this which led to the pressure by DOK to CRS to get some food to use in the clinics for feeding. That however is not our main concern here.

Our concern is the fact that the clinics had some good data on children at risk. Given that those children were identified, it would have helped the GOK and other NGO feeding programs if the families of the children at risk were followed, identified and linked to the sub-locational famine relief committees. These were the committees handling the bulk of famine relief food.

No district-wide system existed during the drought for selecting mothers and children at risk and putting them and their families into the main GOK feeding programs. Since the project had been attending to many families, their data could have been used to feed into the selection of families at risk for three quarters of the district. In some basic sense it is counter-productive to give out food to children coming to clinics while the family is without food. The food gets shared as project people know.

A national famine relief risk family selection system is being designed. Its major concern, during future droughts, will be to merge all data on families under risk and to ensure that health and feeding program respond to FAMILIES and not INDIVIDUAL CHILDREN or MOTHERS. Perhaps the project can contribute to Kitui district thinking on this as it claims to handle 77% of the population.

CHAPTER VIII. L E S S O N S L E A R N E D.

USAID.

USAID intended to use the DOK/PHC project as the pilot for the more comprehensive Kitui Rural Health Program. This later program did not take off since GOK could not come up with the local component funds on time, or award contracts

A lesson learned out of this with respect to the project under assessment is that USAID should not have used an NGO pilot project as a planning base for a GOK program. If the GOK through DMOH Kitui had been involved in implementation of PHC project initially, perhaps the foward planning for MOH to include local contributions to Kitui Rural Health Program would have taken place.

USAID should be aware that feasibility of a project like this must be assessed having regard not only to the resources anticipated to be available, but to the time frame of the project, and also to the nature and strength of the impediments to success. The impediments in the KPHC project as well as distances, road conditions, floods, vehicle limitations also included beliefs, attitudes, knowledge and pre-program life-styles as well as poverty, and propensity to migration.

It is not easy to pilot a project through an NGO and then transfer it to GOK operations. Ideally the two sectors should work together on pilot projects.

CRS.

CRS got into KPHC as a result of terminating its feeding project which went on during the 1974 drought. Whereas a feeding project has few flow steps, mobile clinics have many flows and implementation problems. To begin with are issues of site selection. CRS should have got more planning into the location of the clinics. This would have enabled other resources, like personnel and transportation costs to be adjusted to the differing demands of the four sub-units. They should have insisted on flexibility in personnel and implementation methods.

It should be pointed out however that CRS sees itself as only a 'conduit' for the funds. Be that as it may, they should have given better planning and leadership of the project.

DOK.

It is useful at times to distinguish between soft and hard donors. The former are typified by the missionary boards who send money to implementers and rarely ever require continuous program accounting, monitoring and evaluation, other than in the most general way. USAID on the other side is a hard donor requiring detailed feasibility, planning and evaluation and monitoring processes. Such monitoring must be a built-in evaluative component of the project with a budgetary item and a defined minimum procedure. If sampling through home visiting is essential, this must be a component. The expertise needed for this component should be a consideration in project staffing.

Most of the DOK people in KPHC had never administered program funds from a hard donor like USAID. As a result there has been less than smooth handling of finances, collection of statistics and general accountability.

Significant proportions of DOK staff do not understand why monies do not flow smoothly. When we were in the field, one team leader was complaining she could not get replenished by the Administrator since CRS had not sent the money. On its part CRS, argued it had put claims to USAID more than a month before. On our part we do not understand the problem since there is a Shs.200,000 float based at DOK.

DOK staff are still bitter about the fact that between April and June 1983 they operated without DOK funds being replenished.

The basis of these complaints seem to us to fall on the filure to clearly think of an accountability, monitoring, data and money flow systems. If such systems were set up within reach of DOK resources, there would have been less misunderstanding.

The other key lesson in activity planning the DOK has learned out of this is the inadequacy of its central planning mechanism of only an Administrator and a Consultant. They are too busy with normal Diocese work to be expected to administer, and coordinate field activities. They have not been able to keep up with the required data reporting by the donor. This problematique of overworked core administrative staff being required by donors to report on the project in some measure explains the DOK hostility to evaluation. It also means that there cannot be systematic thought given to the redesign of the project during implementation.

Sustained direction of the project by persons having appropriate status and experience should have been a criterion for project authorisation and support.

Such project leaders must make an appropriate commitment but need the advice and support of a project steering committee which embodies not only appropriate expertise,

but also the wider view point of the bodies and agencies directly and indirectly involved. Direction must not be remote and sporadic and based only upon transmission of reports.

The DOK could have set up a cheap project data gathering system for the Teams. Such a system would have produced information for redesigning the project as well as the desired donor project information.

Such reports should embrace all key activities of the project and be presented largely in statistics of activities with the narrative component dealing with explanatory information.

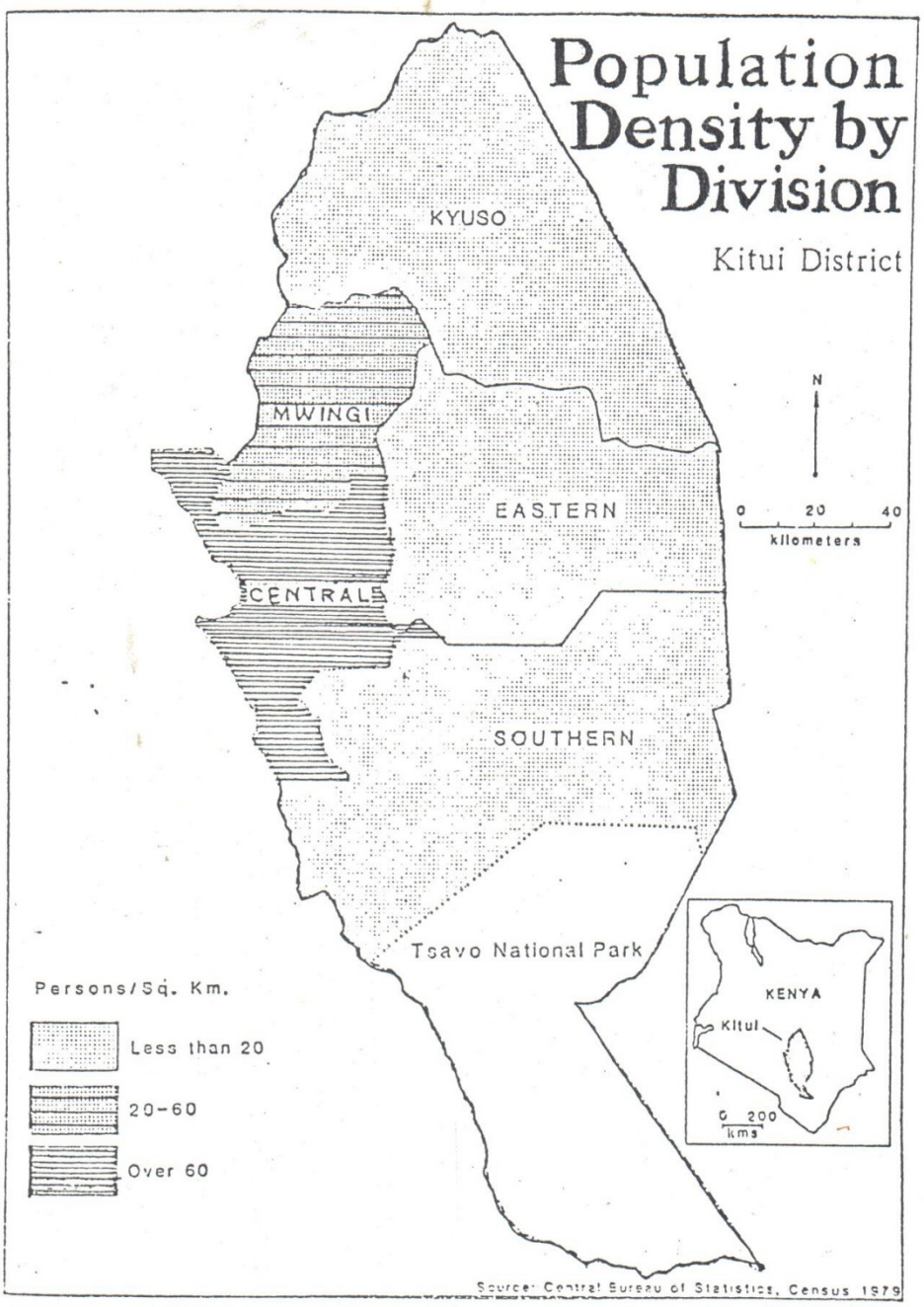
Monitoring and evaluation information is most efficiently collected by implementers. It is a necessary procedure for hard donor funding. Implementers should, out of the feasibility studies, have done some baseline studies. Although these would not have been comprehensive, they could have focussed on a number of key indicators including changes in behaviour and enhanced capacity for self-care which can, despite constraints, be monitored at reasonable cost.

In a program with the goal of "the improvement of life in (underserved) rural areas" progress will largely depend on strengthening the capacity of the village community to help itself, so, strengthening existing local groups and where necessary encouraging the formation of new groups, strengthening leadership capacity, increasing health awareness - especially by a two - step process of leadership training - is likely to prove the most efficient approach to securing health improvement.

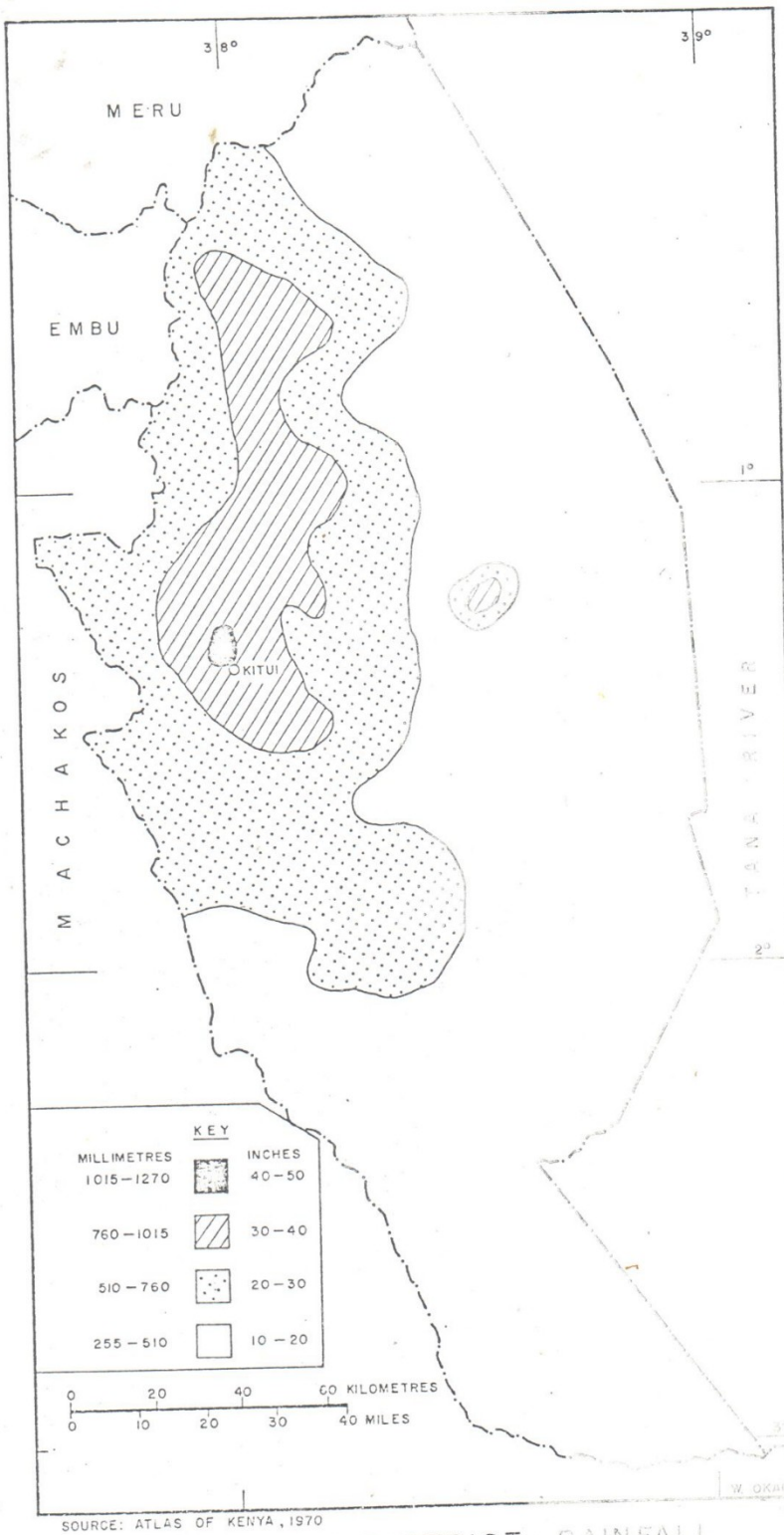
Health education "would be understood as planned efforts to secure beneficial behaviour change." It depends for success more upon establishing a relationship, that is upon "source credibility", than upon techniques derived from the methods of formal education. This different approach necessitates professionals assuming a new spectrum of roles as counsellors, advisers, co-workers, and friends of the community. Training is needed for these new roles and the transition may, in practice, not be made without difficulty by some professionals.

To derive a new and effective program partly from residual elements of a previous program with a different set of purposes may seem socially desirable and likely to bring economic advantages but may in fact be far more difficult to implement than is appreciated. A drastic rethinking, with reorientation of staff, is highly desirable.

Worthwhile projects are innovative and require of staff skills and capacities which usually have not been a part of their preparation or experience. Training and staff development, with career enrichment, should be pre-planned and continuously reviewed during the project.

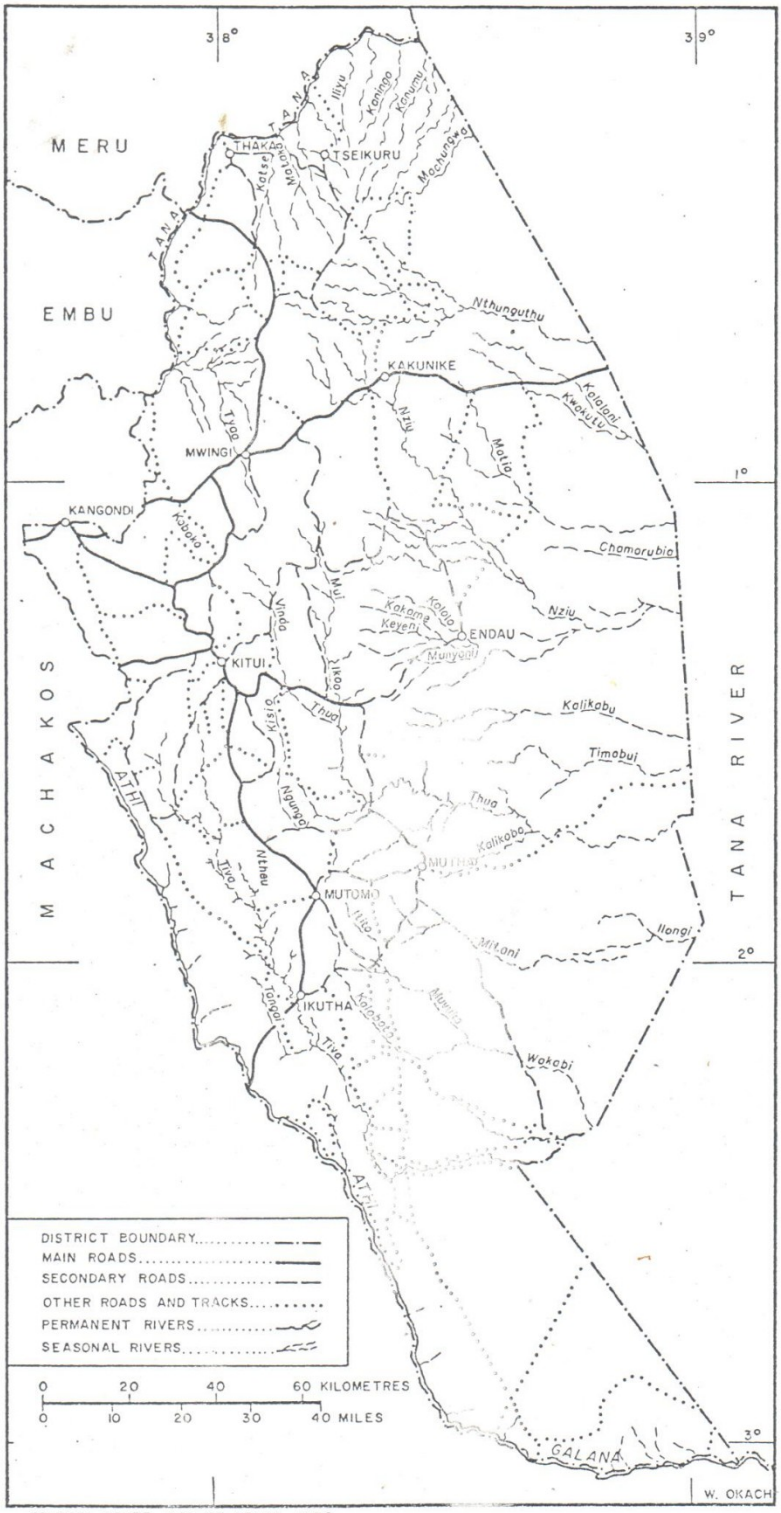

Population Density by Division
Kitui District
KYUSO
MWINGI
EASTERN
CENTRAL
SOUTHERN
Tsavo National Park
N
0 20 40
kilometers
Persons/Sq. Km.
Less than 20
20-60
Over 60
KENYA
Kitui
0 200
kms
Source: Central Bureau of Statistics, Census 1979

MAP 1



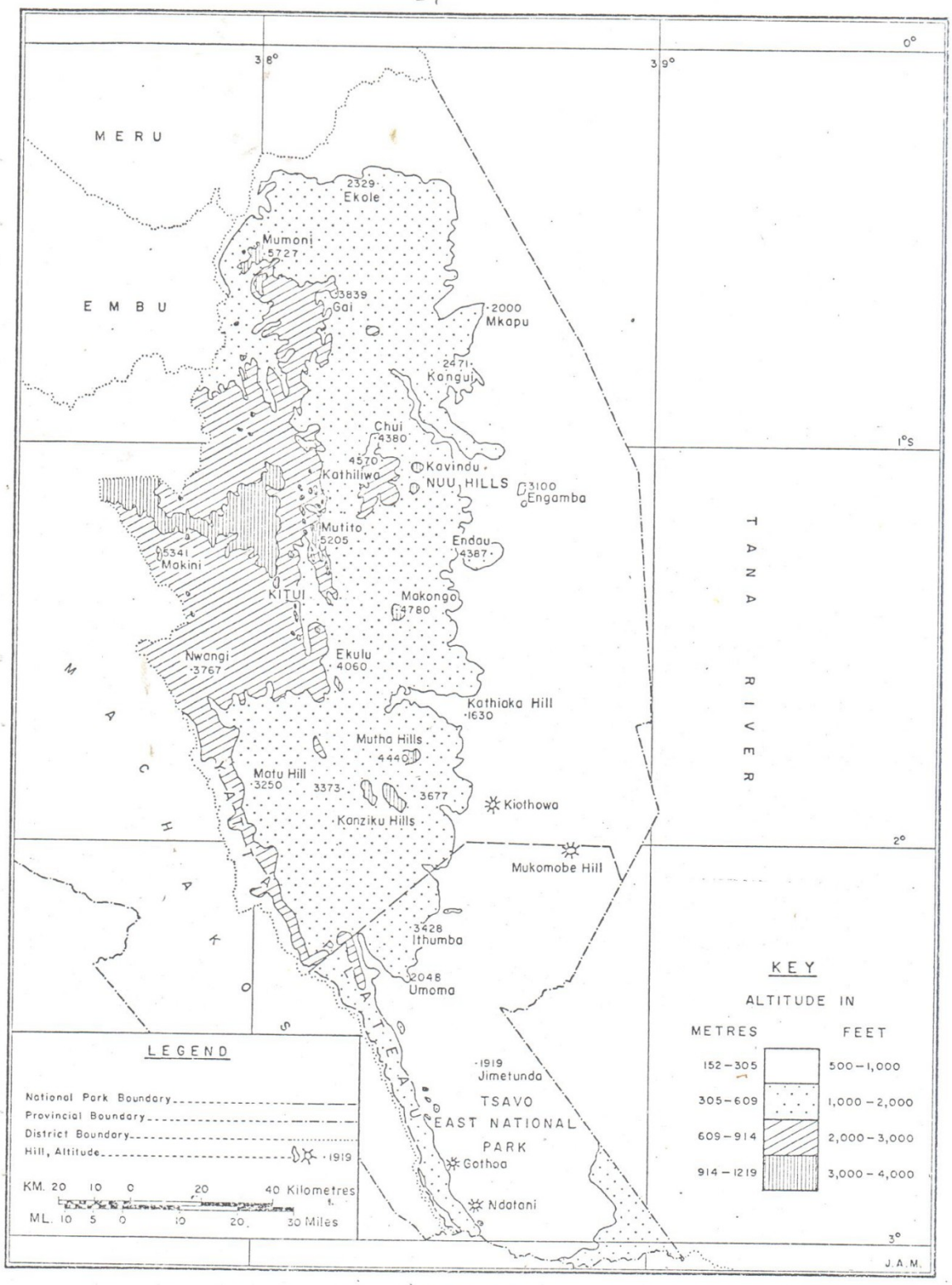
SOURCE: ATLAS OF KENYA, 1970

MAP 3: KITUI DISTRICT: RAINFALL



SOURCE: ROUTE MAP OF KENYA, 1972

MAP 4: KITUI DISTRICT: COMMUNICATIONS & DRAINAGE



MAP **5** KITUI DISTRICT : GENERAL

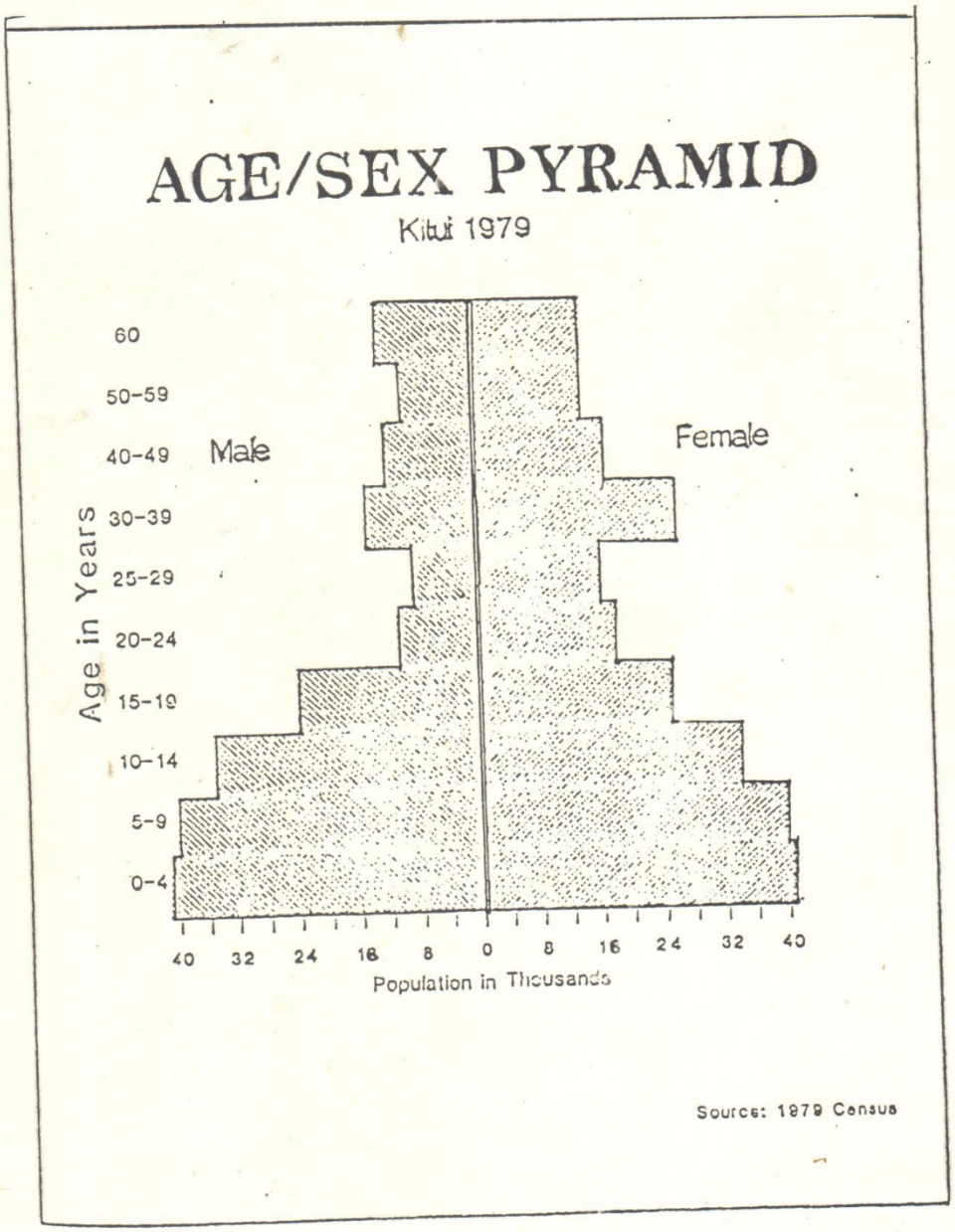

AGE/SEX PYRAMID
Kitui 1979
Male
Female
Age in Years
60
50-59
40-49
30-39
25-29
20-24
15-19
10-14
5-9
0-4
40 32 24 16 8 0 8 16 24 32 40
Population in Thousands
Source: 1979 Census

FIGURE 1

Annexe 1.

Kitui Demographics (CBS 1984)

1.	District	Project Area
1. Estimated Total Population	576,602	445,137
2. Estimated Population 0 - 5 years	107,247	82,795
3. No. of Deaths 0 - 1 year	1,604	1,238
4. No. of Deaths 0 - 5 years	2,713	2,094
5. No. of Pregnancies	16,658	12,860
6. No. of Live births	14,992	11,574

Annexe 2

Project Area Demographics by Centre 1984.

	Kimangau	Muthale	Mutomo	Nuu
1. Estimated Total Population	85,337	152,222	145,880	61,696
2. Estimated Population 0 - 5 years	15,873	28,313	27,133	11,475
3. Estimated No. of Deaths 0 - 1 years	237	424	406	172
4. Estimated No. of Deaths 0 - 5 years	402	716	687	290
5. Estimated No. of Pregnancies	2,465	4,398	4,214	1,782
6. Estimated No. of Live births	2,219	3,958	3,793	1,604

Annexe 3

KITUI PRIMARY HEALTH CARE PROJECT - MUTHALE SAFARIS 1985.

Clinic	Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Kikeani	Tue	11 Fri.	5	5	2	7	4	2	6	3	1	5	3
Kiseveni	Wed	2	6	6	3	8	5	3	7	4	2	6	4
Kivou	Thur	3	7	7	4	9	6	4	8	5	3	7	5
Kamuthulani	Fri	4	8	8	1 Mon.	10	7	5	9	6	4	8	6
Mutonga	Mon	7	11	11	12 Fri	13	10	8	12	9	7	11	9
Kanyaa	Tue	8	12	12	9	14	11	9	13	10	8	12	10
Kweluu	Wed	9	13	13	10	15	12	10	14	11	9	13	11
Thaananzau	Thur	10	14	14	11	16	13	11	15	12	10	14	13
Nzawa	Mon	14	18	18	15	20	17	15	19	16	14	18	16
Thitani	Tue	15	19	19	16	21	18	16	20	17	15	19	17
Kakumuti	Wed	16	20	20	17	22	19	17	21	18	16	20	18
Nzeluni	Thu	17	21	21	18	23	20	18	22	19	17	21	19
Mbondoni	Mon	21	25	25	22	27	24	22	26	23	21	25	23
Ngutani	Tue	22	26	26	23	28	25	23	27	24	22	26	31 St.
Kitutu	Wed	23	27	27	24	29	26	24	28	25	23	27	30 Mon.
Ithumbi	Thu	24	28	28	25	30	27	25	29	26	24	28	27 Fri.

Annexe 4

KITUI PRIMARY HEALTH CARE PROJECT - MUTOMO SAFARIS 1985.

Clinic	1st Week	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Katyethoka	Monday	DEC.* 31st	4th	4th	1st	6th	3rd	1st	5th	2nd	SEPT. 30th	4th	2nd
Kisauni	Tuesday	4th*	5th	5th	2nd	7th	4th	2nd	6th	3rd	1st	5th	3rd
Ndiini	Wednesday	2nd	6th	6th	3rd	8th	5th	3rd	7th	4th	2nd	6th	4th
Syomunyu	Thursday	3rd	7th	7th	4th	9th	6th	4th	8th	5th	3rd	7th	5th
	2nd Week.												
Kyamatu	Monday	7th	11th	11th	12th*	13th	10th	8th	12th	9th	7th	11th	9th
Voo	Tuesday	8th	12th	12th	9th	14th	11th	9th	13th	10th	8th	12th	10th
Mutha	Wednesday	9th	13th	13th	10th	15th	12th	10th	14th	11th	9th	13th	11th
Ikanga	Thursday	10th	14th	14th	11th	16th	13th	11th	15th	12th	10th	14th	13th*
	3rd Week												
Kinakoni	Monday	14th	18th	18th	15th	20th	17th	15th	19th	16th	14th	18th	16th
Kanziko	Tuesday	15th	19th	19th	16th	21st	18th	16th	20th	17th	15th	19th	17th
Kavisuni	Wednesday	16th	20th	20th	17th	22nd	19th	17th	21st	18th	16th	20th	18th
Kanyongonyo	Thursday	17th	21st	21st	18th	23rd	20th	18th	22nd	19th	17th	21st	19th
	4th Week												
Monguni	Monday	21st	25th	25th	22nd	27th	24th	22nd	26th	23rd	22nd*	25th	23rd
Kasaala	Wednesday	23rd	27th	27th	24th	29th	26th	24th	28th	25th	23rd	27th	24th*
Nzaini	Thursday	24th	28th	28th	25th	30th	27th	25th	29th	26th	24th	28th	20th*
Kisasi	Friday	25th	March 1st	29th	26th	31st	28th	26th	30th	27th	25th 1 WK	29th	27th

Annexe 5

KITUI PRIMARY HEALTH CARE PROJECT - NUU SAFARIS 1985.

Clinic	1st Week	Jan.	Feb.	Mar.	Apr.	May.	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
Yatwa	Monday	7th	4th	4th	12th*	6th	3rd	8th	5th	2nd	30th	4th	2nd
Mutiangome	Tuesday	8th	5th	5th	9th	7th	4th	9th	6th	3rd	1st	5th	3rd
Mikuyuni	Wednesday	9th	6th	6th	10th	8th	5th	10th	7th	4th	2nd	6th	4th
Tuvaani	Thursday	10th	7th	7th	11th	9th	6th	11th	8th	5th	3rd	7th	5th
	2nd Week.												
Wingemi	Monday	14th	11th	11th	15th	13th	10th	15th	12th	9th	7th	11th	9th
Kalitini	Tuesday	15th	12th	12th	16th	14th	11th	16th	13th	10th	8th	12th	10th
Mwitika	Wednesday	16th	13th	13th	17th	15th	12th	17th	14th	11th	9th	13th	11th
Mui	Thursday	17th	14th	14th	18th	16th	13th	18th	15th	12th	10th	14th	* 13th
	3rd Week.												
Nyaani	Monday	21st	18th	18th	22nd	20th	17th	22nd	19th	16th	14th	18th	16th
Zombe	Tuesday	22nd	19th	19th	23rd	21st	18th	23rd	20th	17th	15th	19th	17th
Twambui	Wednesday	23rd	20th	20th	24th	22nd	19th	24th	21st	18th	16th	20th	18th
Endau	Thursday	24th	21st	21st	25th	23rd	20th	25th	22nd	19th	17th	21st	19th
	4th Week												
Makuka	Monday	28th	25th	25th	29th	27th	24th	29th	26th	23rd	21st	25th	20th*
Katumbi	Tuesday	29th	26th	26th	30th	28th	25th	30th	27th	24th	22nd	26th	21st*
Lawala	Wednesday	30th	27th	27th	1st	29th	26th	31st	28th	25th	23rd	27th	30th*
Lundi	Thursday	31st	28th	28th	2nd	30th	27th	1st	29th	26th	24th	28th	31st*
				*			*				*		

Annexe 6

KITUI PRIMARY HEALTH CARE PROJECT KIMANGAU SAFARIS 1985.

Clinic	Day	January	Feb.	March	April	May	June	July	Aug.	Sept	Oct.	Nov.	December.
Musavini	Monday	7.28	25		1:29	27		1:29	26		7:28	25	
Nthangani	Tuesday	8.29	26		2:30	28		1:30	27		1:29	26	
Masyungwa	Wednesday	2:30	27		3	15:29		3:31	28		2:30	27	
Tyaa-Muthale	Thursday	3:31	28		4	2:30		4	1:29		3	7:28	
Nguuku	Monday	14	4	4	15	6	3	8	5	2	14	4	2
Kaningo	Tuesday	15	5	5	9	7	4	9	6	3	8	5	3
Ukasi	Wednesday	9	6	6	10	8	5	10	7	4	9	6	4
Maseki	Thursday	10	7	7	11	9	6	11	8	5	10	14	5
Katse	Friday	11	8	8	12	10	7	12	9	6	11	8	6
Nduuni	Monday	21	11	11	22	13	10	15	12	9	21	11	9
Kamwongo	Tuesday	22	12	12	16	14	11	16	13	10	15	12	10
Kandwia	Wednesday	16	13	13	17	22	12	17	14	11	16	13	11
Ngungani	Thursday	17	14	14	18	16	13	18	15	12	17	21	13
Syambyu	Tuesday	25	19	19	23	21	18	23	20	17	22	19	17
Musosya	Wed.	23	20	20	24	20	19	24	21	18	23	20	18
Mitamisyi	Thursday	24	21	21	25	23	20	25	22	19	24	22	19

Annexe 7.

KITUI PRIMARY HEALTH CARE PROJECT: PHASE II

AID GRANT NO: 615 - 0219

QUARTERLY GRANT FINANCIAL REPORTS IN US DOLLARS.

Period: July 1 To September 30, 1983

Line Items	Grant/Budget Amounts Year 1 FX	Total Expenditure this period FX	Cumulative Expenditure Including this period FX	(Advance) Estimated Expenditure to be billed to AID next period FX
Salaries	-			
Vehicles	50,000			50,000
Transport	-			
Equipment	6,700			
Health Education and FP.	-			
Per diems	-			
Medical Supplies	11,400			
Evaluation	-			
Data Collection	6,400			
Overhead	18,800			14,100
Totals	93,300			64,100

Ctd.

Period January 1 to March 31, 1984.

Salaries	-	2,031.80	44,198.60	
Vehicles	50,000			
Transport	-			
Equipment	6,700			
Health Education and F.P.	-			
Per diems	-			
Medical Supplies	11,400			
Evaluation	-			
Data Collection	6,800			
Overhead	18,800		10,199.97	13,599.96
Totals	93,300	2,031.80	54,398.57	13,599.96

Ctd.

Period : April 1 to June 30, 1984.

Salaries	-	-	-	-
Vehicles	-	-	44,198.60	-
Transport	-	-	-	-
Equipment	5,000.00	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400.00	-	-	-
Evaluation	4,800.00	-	-	4,800.00
Data Collection	6,700.00	-	-	6,700.00
Overhead	13,400.00	13,599.96	23,799.93	-
Totals	41,300.00	13,599.96	67,998.53	11,500.00

Ctd.

Period July 1, to September 30, 1984

Salaries	-	-	-	-
Vehicles	-	-	-	-
Transport	-	-	44,198.60	-
Equipment	5,000.	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	-
Evaluation	4,800	-	-	-
Data Collection	6,700	-	-	-
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	-

Ctd.

Period : October 1, to December 31, 1984

Salaries	-	-	-	-
Vehicles	-	-	44,198.60	-
Transport	-	-	-	-
Equipment	5,000	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	4,800
Evaluation	4,800	-	-	6,700
Data Collection	6,700	-	-	
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	11,500

Ctd.

Period : January 1, to March 31, 1985

Salaries	-	-	-	-
Vehicles	-	-	44,198.60	-
Transport	-	-	-	-
Equipment	5,000	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	-
Evaluation	4,800	-	-	-
Data Collection	6,700	-	-	-
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	-

Annexe 8.

KITUI PRIMARY HEALTH CARE PROJECT

PROJECTED BUDGET JULY 1983 TO JUNE, 1984 AID-615-0219

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May.	June	Cumulative Total
Salaries	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	40,800
Vehicles	-	-	50,000	-	-	-	-	-	-	-	-	-	50,000
Transport	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	67,400
Equipment	-	2,000	-	-	-	1,500	-	2,000	-	-	-	-	5,500
Education &FP	-	2,006	1,000	1,000	1,000	1,000	-	2,006	1,000	1,000	1,000	1,000	12,012
Per Diem	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
Medical Supplies	-	-	-	5,700	-	-	-	-	5,700	-	-	-	11,400
Evaluation	-	-	-	-	-	-	-	-	-	-	-	-	-
Data Collection	-	-	-	-	-	3,200	-	-	-	-	-	3,200	6,400
Overhead	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	18,792
Total	11,583	15,589	62,583	18,283	12,583	17,283	11,583	15,589	18,283	12,583	12,583	15,783	224,308

Annexe 9.

KITUI PRIMARY HEALTH CARE PROJECT

AID-615-0219

PROJECTED BUDGET APRIL 1984 TO MARCH 1985

Line Items	April	May	June	July	August	Sept	October	Nov.	Dec.	Jan.	Feb.	March	Cumulative Totals
Salaries	3,400	3,400	3,400	3,411	3,411	3,411	3,411	3,411	3,411	3,411	3,411	3,411	40,899.00
Vehecles	-	-	-	-	-	-	-	-	-	-	-	-	-
Transport	5,617	5,617	5,617	4,873	4,873	4,873	4,873	4,873	4,873	4.873	4,873	4.873	60,700.00
Equipment	-	-	-	-	-	2,000	-	-	3,000	-	-	-	5000.00
Health Ed./FP.	1,000	1,000	1,000	4,400	-	-	4,400	-	-	4,400	-	-	16,200.00
Per Diem	875	875	875	875	875	875	875	875	875	875	875	875	10,500.00
Medical Supplies	950	950	950	950	950	950	950	950	950	950	950	950	11,400.00
Office and Housing	-	-	-	-	-	-	-	-	-	-	-	-	-
Evaluation	-	-	-	-	4,800	-	-	-	-	-	-	-	4,800.00
Data Collection	-	-	3,200	-	-	-	-	3,500	-	-	-	-	6,700.00
Overhead	13,599.96	-	-	-	-	-	-	-	-	-	-	-	13,599.96
	25,441.96	11,842	15,042	14,509	14,909	12,109	14,509	13,609	13,109	14,509	10,109	10,101	169,798.96

Annexe 10.

KITUI PRIMARY HEALTH CARE PROJECT

PROJECTED BUDGET APRIL 1985 - MARCH 1986

Line Items	April	May	June	July	Aug.	Sept	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Cumulative Total
Salaries	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	46800
Vehicles	-	-	-	-	-	-	-	-	-	-	-	-	-
Transport	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	33600
Equipment	-	-	-	-	-	2000	-	-	3000	-	-	-	5000
Health Ed./FP.	350	350	350	350	-	-	3500	-	-	4500	-	-	9400
Per Diem	550	550	550	550	550	550	550	550	550	550	550	550	6600
Medical Supplies	800	800	800	800	800	800	800	800	800	800	800	800	9600
Office and Housing	-	-	-	-	-	-	-	-	-	-	-	-	-
Evaluation	12800	-	-	-	-	-	-	-	-	-	-	-	12800
Data Collection	3500	-	-	-	-	-	-	-	-	-	-	-	3500
Overhead	7500	-	-	-	-	-	-	-	-	-	10100	-	17600
Totals	32200	8400	8400	8400	8050	10050	11550	8050	11050	12550	18150	8050	144900

Annexe 11.

BUDGET - KITUI PRIMARY HEALTH CARE PROGRAM PHASE 2.

US DOLLARS.

	Year 1			Year 2			Year 3		
	USAID	GOK	DOK	USAID	GOK	DOK	USAID	GOK	DOK
1. Salaries	42400	-	-	40900	-	-	22800	-	-
2. Transport	120200	-	-	60700	-	-	30500	-	-
3. Equipment	6700	-	-	5000	-	-	3200	-	-
4. Health Ed/FP.	12500	-	-	16200	-	-	12100	-	-
5. Per Diems	11700	-	-	10500	-	-	4800	-	-
6. Medical Supplies	11400	147900	-	11400	148800	-	5600	73400	-
7. Office and Housing	-	-	13200	-	-	13300	-	-	6600
8. Evaluation	-	-	-	-	-	-	12800	-	-
9. Data Collection	6200	-	-	6700	-	-	4800	-	-
10. Overhead CRS/NY 8.5%	18800	-	-	13400	-	-	8600	-	-
Totals	229900	147900	13200	164800	148800	13300	105200	73400	6600

Three year Totals :	USAID	GOK	DOK	TOTALS
	499,900	370,100	33,100	903,100

Table 1

Ante-natal Clinic Attendances.

	July - Dec. 83		Jan - June 84		July - Dec. 84	
	No.	% Target	No.	% Target	No.	% Target
Kimangao	829	43	877	35.6	723	29.3
Muthale	1052	31	1022	23.2	871	19.8
Mutomo	1043	32	1229	29.2	852	20.2
Nuu	410	29.4	456	26.4	381	21.4
Total	3334	37%	3584	27.87%	2827	21.98%

Table 2

Children Immunisation

	July - Dec.83		Jan. - Jun. 84		July - Dec. 84			
	No.	%	No.	%	No	%	Total	%
Kimangao	8882	61.91	8772	55.26	7794	49.10	25448	55.21
Muthale	12796	50.03	11381	40.19	11323	39.99	35500	43.18
Mutomo	15553	63.45	12168	44.84	10175	37.50	37896	48.10
Nuu	4892	46.32	4914	42.82	4849	42.25	14655	43.73
Total	42123	56.17	37235	44.97	34141	41.23	113499	47.17

Table 4

Curative Clinic Attendances.

	July - Dec. 83			Jan - Jun. 84			July - Dec. 84		
	Children	Adults	Total	Children	Adults	Total	Children	Adult	Total
Kimangao	1176	0	1176	1176	96	1273	508	1044	1552
Muthale	1571	647	2218	1784	506	2290	1695	N/A	1695
Mutomo	338	3378	3716.	556	1081	1637	2179	784	2963
Nuu	687	817	1504	235	352	587	335	180	515
	3772	4842	8614	3751	2036	5787	4717	2008	6725

Table 5 Monthly Expenditures.

A. Mutomo.

	Salaries Per diems	Transport	Equipment	Health Education	Medical Supplies
April '83	10,028	-	-	-	-
May	9,608	6,681	350.	98.80	4,282.50
June	9,608	-	550.	-	-
July	19,445.	8,840	65.	-	-
Aug.	22,781	5,326	1,653.	413.	-
Sep.	13,701	4,187	830	2,232.	4,001.
Oct.	13,776	17,468	1,560.	3,090.	7,471.
Nov.	13,821	5,456	-	-	-
Dec.	14,591	4,256	95.	-	-
Sub-total	127,779	52,214	5,103	5,833.80	15,754.50
Jan '84	13,649	4,464	115.	20	1,057.
Feb.	459	22,390	3,353.	1,076	6,591.
Mar.	14,100	7,510	1,045	720.	-
April	14,017	4,477	-	2,680	10,904
May	14,757	5,613	550	-	-
June	11,560	11,654	1,752	1,600	-
July	11,814	8,642	720	4,676	-
Aug.	10,799	3,324	35	4,445	-
Sept.	10,244	2,000	50	161	-
Oct.	11,812	6,956	133	12,595	6,260
Nov.	11,179	10,781	130	-	-
Dec.	10,884	1,532	55	2,780	-

A. Mutomo ctd.

	Salaries Per Diems	Transport	Equipment	Health Education	Medical Supplies
Jan '85	12,614	18,864	3,172	3,190	-
Feb.	11,609	13,290	19	2,497	28.
March.	14,279	841	3,126	-	7,448
Sub-total	173,776	122,338	14,255	36,440	32,288

B. Muthale.

April '83	6,547	-	-	-	-
May	6,424	40	38	-	-
June	8,990	-	-	-	-
July	14,679	6,432	-	958	-
Aug.	10,682	2,975	142	197	6,605
Sep.	9,109	-	1,662	340	2,213
Oct.	11,275	14,172	578	525	-
Nov.	10,672	2,538	357	300	3,537
Dec.	12,992	8,431	421	-	-
	91,370	34,588	3,198	3,815	12,355

B. Muthale ctd.

	Salaries Per Diems	Transport	Equipment	Health Education	Medical Supplies
Jan '84	8,427	91	186	-	-
Feb.	11,600	1,309	1,719	300	-
March	10,784	12,683	465	-	5,465
April	11,973	2,491	197	847	3,208
May	12,042	7,814	484	24	3,731
June	12,262	4,088	311	210	-
July	12,605	3,474	239	-	5,719
Aug.	11,322	5,696	181	-	-
Sept.	10,570	-	364	-	-
Oct.	9,012	6,802	476	108	2,375
Nov.	13,954	3,870	312	404	-
Dec.	10,048	-	179	290	-
Sub-total	134,599	48,412	5,113	2,183	20,498
Jan '85	14,691	8,372	129	-	4,021
Feb.	9,606	2,317	125	225	-
March	14,219	6,780	133	202	4,135
Sub-total	38,516	17,469	387	427	8,156

C. Kimangau.

	Salaries Per Diems	Transport	Equipment	Health Ed/F.P.	Medical Supplies.
May '83	5,753	3,199	130	4	0
June	8,223	2,010	207	0	0
July	16,167	2,600	0	58	0
Aug.	9,797	4,538	260	0	1,645
Sept.	10,977	4,075	386	0	1,035
Oct.	6,574	3,084	0	0	0
Nov.	12,122	2,526	355	376	730
Dec.	10,388	3,767	1,320	189	1,345
Sub-total	80,001	25,799	2,658	627	4,755
Jan '84	9,714	110	1,089	446	1,072
Feb.	11,620	7,833	131	270	1,885
March	10,154	4,495	234	216	0
April	6,815	4,555	113	121	3,790
May	10,459	3,706	60	125	0
June	9,402	4,434	810	159	1,010
July	10,177	37,899	631	100	0
Aug.	10,061	3,306	248	25	2,195
Sept.	11,363	3,323	106	20	0
Oct.	10,287	1,638	80	1,435	0
Nov.	10,387	3,905	581	51	2,035
Dec.	10,608	4,969	143	70	200
Sub-total	121,047	80,173	4,226	3,038	12,187

C. Kimangau ctd.

	Salaries Per Diems	Transport	Equipment	Health Ed/FP.	Medical Supplies
Jan. '85	9,066	7,317	0	263	1,278
Feb.	12,532	1,661	938	0	0
March	9,240	90	218	115	25
April	8,803	200	329	113	40
Sub-total	39,641	9,268	1,482	491	1,343

D. Nuu.

April'83	8,197	0	0	0	0
May	157	1,135	0	0	0
June	8,520	267	216	0	0
July	566	9,709	980	0	0
Aug.	10,519	7,620	515	0	9,013
Sept.	9,975	9,255	827	690	0
Oct.	10,135	750	509	1,068	0
Nov.	10,005	12,136	499	155	8,548
Dec.	11,542	4,228	385	280	0
Sub-total	69,616	45,100	3,931	2,193	17,561

D. Nuu. ctd.

	Salaries Per Diems	Transport	Equipment	Health Ed/FP.	Medical Supplies
Jan '84	10,285	7,562	399	0	0
Feb.	10,135	3,243	698	1,554	0
March	10,842	3,457	607	100	4,816
April	9,562	6,678	5,195	97	6,044
May	9,240	3,835	470	816	0
June	9,240	6,199	280	406	0
July	9,083	1,272	0	461	0
Aug.	9,155	6,650	280	135	0
Sept.	9,235	6,777	694	130	0
Oct.	9,668	3,693	112	783	3,950
Nov.	9,385	4,960	419	355	0
Dec.	10,735	0	219	240	0
Sub-total	116,565	54,326	9,373	5,077	14,810
Jan. '85	9,021	8,644	725	205	8,208
Feb.	9,140	8,505	547	180	0
March	10,795	5,308	118	0	3,705
Sub-total	28,956	22,457	1,390	385	11,913

Appendix 1

Terms of Reference

Mid Term Evaluation Plan For

Kitui Primary Health Care Project Phase II.

A. Objectives.

To assess progress of project activities and to specifically determine progress since the evaluation of August - November, 1982 as follows :-

1. To determine extent the stated project purpose and outputs have been achieved, as defined by objective of verifiable indicators, and whether there have been unintended side effects.
2. To determine extent inputs have been appropriate to achievement of project outputs and purpose.
3. To determine status of past evaluation recommendations and their relationship to achievement of the project purpose.
4. To identify lessons learned to date.

B. Scope of Work.

1. Assessment of the project goal "The improvement of quality of life in rural areas through attainment of optimum level of health within the constraints of existing and developing economy and in line with the National Health Systems" in terms of the degree of achievement attained which will be determined by the use of the following indicators :
   a) Growth of community participation in work on priority health needs.
   b) Improvement in the health practices of the people (perception of health practices; education activities; latrines; immunization).
   c) Cost effectiveness and budget analysis (direct costs) of this project.
2. The extent to which the project purpose "The provision of a mobile primary health care services to rural areas of Kitui which lacked government/or mission medical services" has been achieved will be determined as follows :

a) Target population reached by the project.

b) Services provided by the mobile teams in terms of adequacy to meet the felt needs of the population served.

c) The extent to which joint planning with other services is carried out.

d) The extent of recognition of women leaders in community health work.

e) The extent of community support for the approaches used.

Include a summary of the attainment of the Project's purpose.

The examination of project reports, hospitals and clinic records will be made, and selected interviews conducted where necessary to elicit information.

3. The outputs targeted by the project are as follows :-

a) Mobile health delivery (services rendered, regularity of services, type of services delivered).

b) Maternal and child health care and disease prevention.

c) Preventive and curative services (balance between the two; promotional/educational activities).

d) Training and instruction for women's groups/community volunteers.

e) Promotion and instruction of natural family planning.

f) Community leaders trained in simple health remedies and techniques.

The above will be evaluated to determine the degree of success achieved, problems encountered and the solutions used. In the case of unrealistic goals, re-evaluation of project outputs will be made particularly in the light of project experience gained and minimum acceptable standards for quality health care.

Training and instructions for women's groups and community groups will be assessed in terms of numbers trained, type of curriculum used, and the kind of return provided by the trainees.

4. Project inputs will be examined to evaluate suitability to project performance for remainder of project and the proposed Phase II Project.

and where necessary additional resources or cutbacks will be recommended in the following :

a) Personnel.

b) Equipment.

c) Vehicle operation and maintenance.

d) Local resources.

e) USAID funding support.

This will serve more as a guide for future outside funding requirements in Phase III.

5. The cost of services (time to beneficiary is a cost,cost (bus fare), cost in time for travelling to centres) to project beneficiaries, including those support costs not covered by the project (MOH supplies vaccines, ORT from UNICEF) will be analysed and presented.

6. Review the Grant to assess compliance with its provisions.

7. A written report of the Evaluation will be submitted in the required (5) number of copies.

muticon/mywo/1/85

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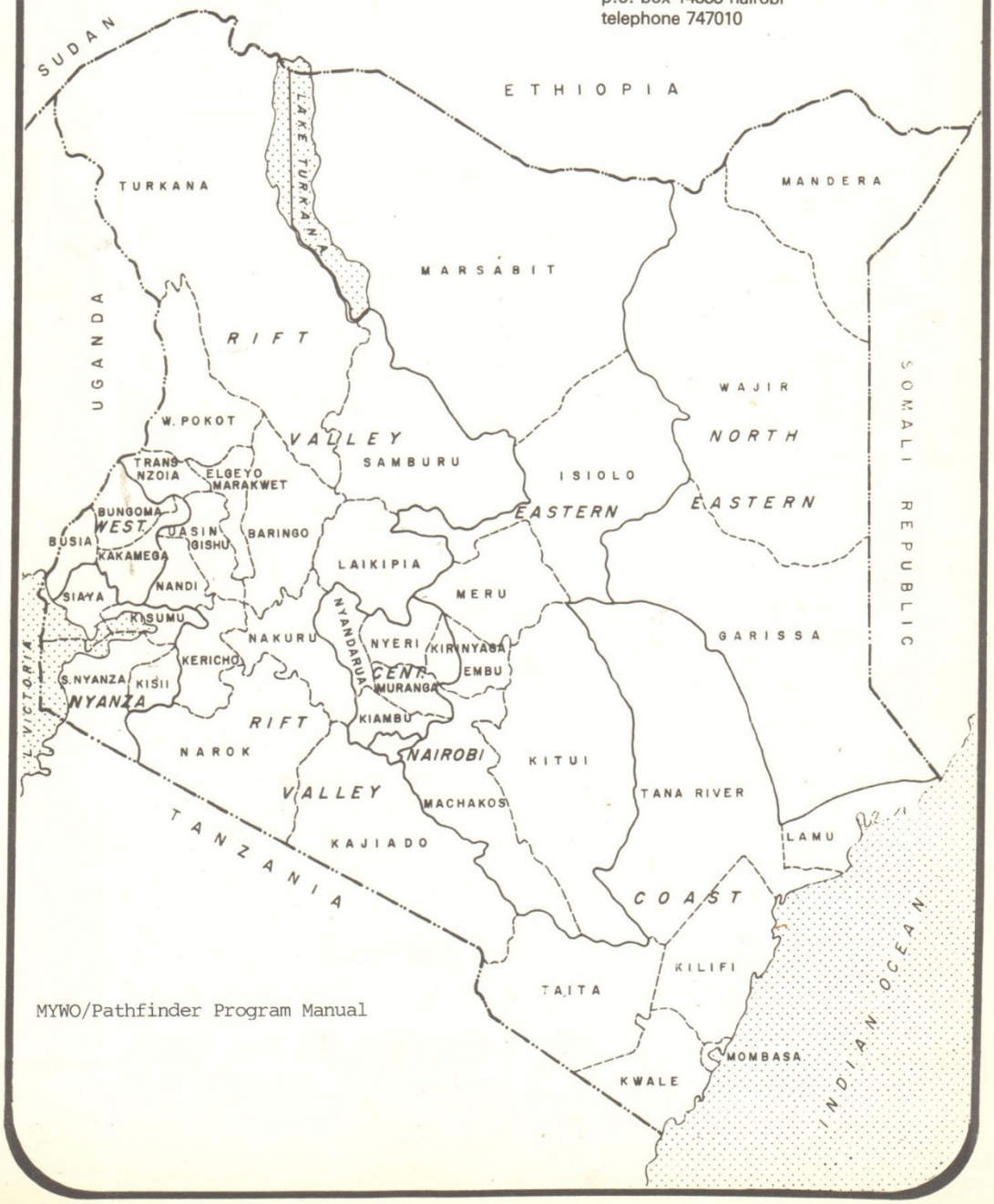


MYWO/Pathfinder Program Manual

TEBLE OF CONTENT.

INTRODUCTION.

This consultancy was requested by Pathfinder and Maendeleo ya Wanawake Organisation.

Its output was to be a manual which would be used for management of the MYWO/CBD Program.

The report which follows consists of Parts I and 2. Part One, Program Structure and Staff identifies the policy, management and field implementation levels of the program and specifies the responsibilities of committees and individuals.

Part Two, Program Information, proposes a recording and reporting system which will facilitate a) more systematic record keeping b) easy retrieval of information for management, planning and financing needs and c) better accountability at all levels.

Towards the design of the manual 4 out of the 11 contracted days were spent in the field in Kandara and Emuhaya discussing the existant system with the Program Manager, Provincial Supervisors, District Nurse Coordinators, Locational/Sublocational/Group Supervisors and Distributors. Drafts were put to all for discussion. The final draft was therefore derived from discussion. It is the consultants hope and wish that it will be extensively field tested later.

At a conceptual level two management issues struck the consultant as being significant enough to require further thought by Maendeleo ya Wanawake and Pathfinder. They are the span of control from the Program Manager to the Distributor, and the uniqueness of the program in terms of policy-making and implementation being the domain of volunteers but management is by paid staff.

On span of control, one wonders about the utility of the Provincial Supervisors. They are not technical staff in either health or family planning. If one tries to justify them in terms of supervision then one runs in to the classic trap of a non-professional supervising technical staff.

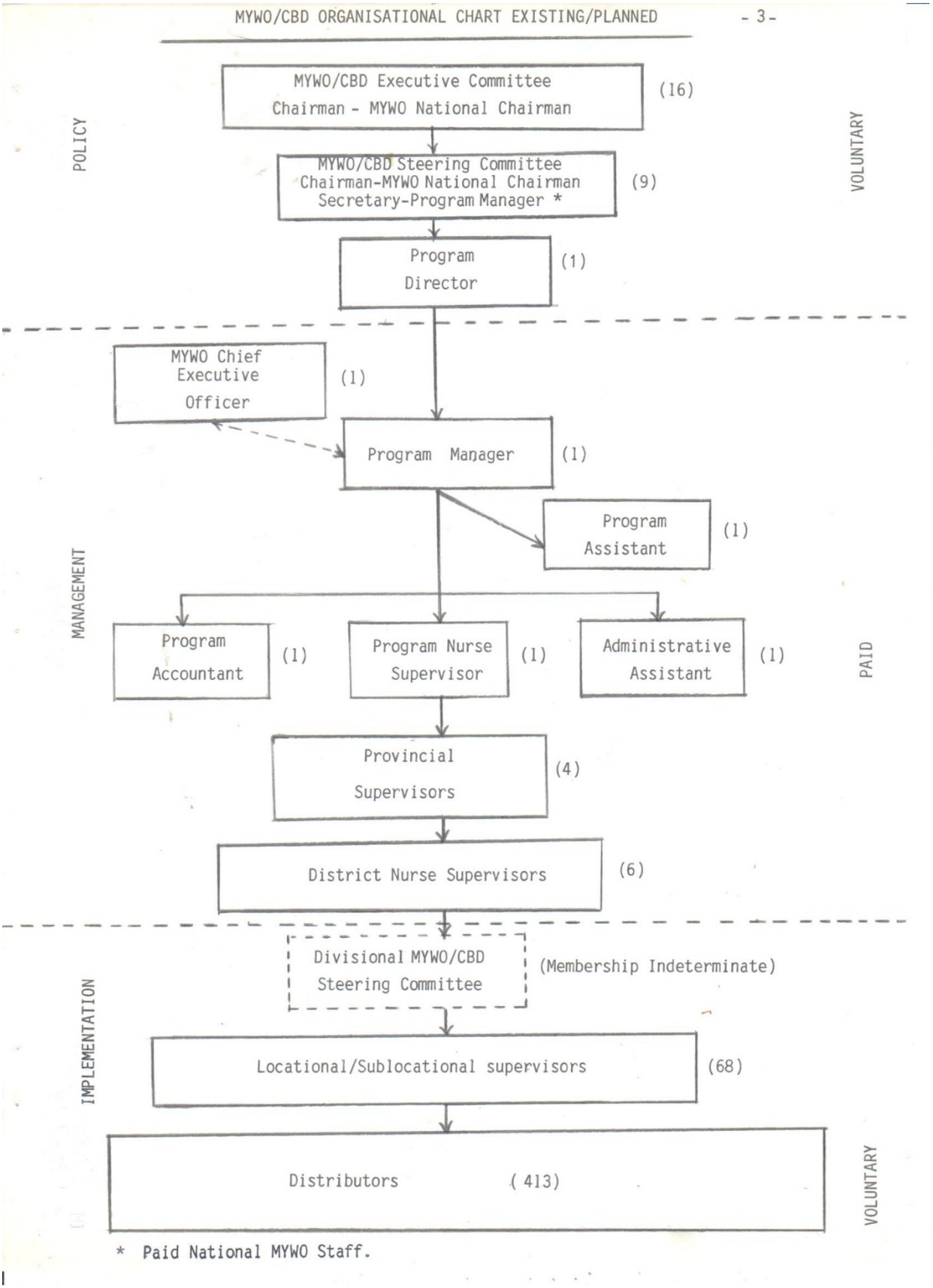
District Nurse Coordinators are clearly technical staff. Perhaps the program can rethink their role.

On the other issue in span of control is the creation of the MYWO/CBD Steering Committee at the Divisional level. One has to weigh whether it will give any advantages other than increasing supervision steps and tying the District Nurse Coordinators and possibly Locational/Sublocational/ Group Supervisors in more meetings.

On the policy level and the implementation level being voluntary and management being paid, I think MYWO has a good system going. The only problem seems to be the dearth of management staff. During the consultancy there was not a Program Assistant, Program Accountant, or Administrative Assistant. The Program Nurse Supervisor was nowhere to be found.

Private Voluntary Organisations in Kenya have problems attracting specialist staff and retaining them lately since the market is turbulent. It seems to me important that the specialised staff be found and hired immediately for the supervisory load to the Program Manager level is heavy if these staff are not on board. Lack of these staff will lead to loose project management.

MYWO/CBD ORGANISATIONAL CHART EXISTING/PLANNED



* Paid National MYWO Staff.

PART I. PROGRAM STRUCTURE AND STAFF.

1. POLICY LEVEL.

The Policy Level for this project is made up of the MYWO/CBD Steering Committee and the Program Director who is the National Chairman of Maendeleo ya Wanawake. As shown in the Organisational Chart, this level is voluntary.

a) MYWO/CBD Steering Committee.

1. Introduction

The MYWO Steering Committee, under the chairmanship of the National Maendeleo ya Wanawake Chairman, is the overall supervising body of the CBD Program jointly implemented by the MYWO and the Pathfinder Fund.

The Program Manager should be the member secretary of the committee.

The MYWO/CBD Steering Committee meets once every two months, or as often as necessary to review the project, including staff performance.

The MYWO/CBD Steering Committee is responsible for disciplining staff on the advise of the Project Manager.

2. Membership.

The membership shall be made up as follows :

- Program Director - who is the National Chairman of MYWO.
- Program Manager - MYWO/CBD.
- Chief Executive of MYWO.
- National Treasurer of MYWO.

- provincial MYWO Chairmen (4);
- representative of MOH;
- representative of NCPD;
- representative of Pathfinder Fund;

3. Responsibilities.

The responsibilities of the MYWO/CBD Steering Committee shall fall into 4 distinct areas. These are : CBD Expansion, Project Performance Supervision, Financial Supervision and Project Personnel Management.

i) CBD Expansion.

The expansion of the MYWO/CBD program demands that new areas for coverage be identified.

Experience from the pilot project areas will be used in assessing :-

- new areas of CBD demand;
- availability of volunteers supervisor and distributors who are members of those communities;
- possibilities of coordination with community and governmental and non-governmental organisations in those communities;
- liaison with National Council of Population and Development (NCPD) on linkages with existing and planned CBD activities to minimise overlaps and uncoordinated projects;

ii) Project Performance Supervision.

- review quarterly project performance relative to annual objectives;
- in case of shortfall in performance, determine the cause and recommend appropriate course of action to the Program Manager;

iii) Project Personnel Management.

- selection of the Program Manager, the Program Assistant, Program Accountant, Administrative Assistant and the National Nurse Supervisor will be done by MYWO in consultation with Pathfinder Fund, Nairobi;

- recruitment of other project staff will be made by the Program Manager and the MYWO/CBD Steering Committee with approval of the Pathfinder Fund, Nairobi;

- firing of project staff on the recommendation of the Program Manager for one or more of the following reasons;

  . unauthorized or extended absence beyond the conditions of service for Pathfinder - funded projects;

  . poor performance for three continuous months relative to the performance of the other field-workers;

  . improper behaviour in the community or in the office;

  . false reporting;

  . granting leave without pay, as detailed in the service condition;

iv) Project Financial Supervision.

- at the two monthly meeting, the Chairman of the MYWO/CBD Steering Committee will review the monthly Bank Reconciliation Statements to verify that the cash balance shown in the checkbook agrees with the actual or net balance available in the bank at the end of each month;

- the Chairman of the MYWO/CBD Steering Committee will make periodic spot checks of the accounting records to ensure appropriate maintenance of accounts;

- the Chairman of the MYWO/CBD Steering Committee will review and give prior approval for all purchases in excess of K.Shs.5,000. All purchases will be made in the open market;

b) Program Director (20% of time)

1. Line Responsibility .

- responsible to the MYWO National Executive Committee through the MYWO/CBD Steering Committee Membership;

2. Qualifications.

- not applicable as she is the National MYWO Chairman;

3. Responsibilities.

- overall Director and Supervisor of the program activities and the Program Manager;
- responsible and accountable for the Pathfinder Fund program funds in accordance with standard terms of Pathfinder Fund Awards to the Pathfinder Fund;
- submits quarterly programmatic, narrative and financial reports to the Pathfinder Fund, the MYWO/CBD Steering Committee and the Ministry of Health;
- maintains close coordination with relevant government and non-governmental agencies through regular attendance of coordinating meetings of the National Council for Population Development and the National CBD Technical and Coordinating Committee;
- works as the Chairman and Chief Advisor of the MYWO/CBD Steering Committee;
- responsible for advertising for vacant posts and recruiting new program staff;
- makes one site visit to each program area per year;
- meets with the Program Manager fortnightly for consultations, briefings on progress of program and planning for the month;

2. MANAGEMENT LEVEL.

This level consists of the paid staff recruited by MYWO to run this program other related Maendeleo work.

a) Program Manager (100% of time)

1. Line Responsibility.

   - responsible to the Program Director and through her to the MYWO/CBD Steering Committee;

2. Qualifications.

   - university graduate in Social Sciences, Education or any other relevant disciplines;
   - should have post-graduate training in Population, Community Health or Nutrition;
   - should have at least 3 years working experience in health-related community-based programmes as administrator;
   - mature and with keen interest in women programmes;

3. Responsibilities.

   - responsible to the Program Director and works in close consultation with her;
   - acts as technical advisor to the Program Director;
   - overall manager and coordinator of MYWO Maternal Child Health and Family Planning Program;
   - responsible for day-to-day management of all program activities funds equipment and supplies;
   - participates in recruitment of program staff and responsible for training, on-the-job orientation and supervision;

- provides direction and guidance to program staff in program of work, particularly planning, programming, reporting and evaluation of activities;

- plans, designs and develops training programs for staff;

- plans new year program activities and prepares and designs draft program proposals and budgets for review and discussion with the Program Director;

- implements the approved program activities;

- drafts program financial, programmatic and narrative progress reports for review and discussion with Program Director and for subsequent submission to donor agency other relevant bodies and government departments;

- makes one site visit to each district in the program quarterly to :
  - monitor program activities;
  - assess progress;
  - hold consultative meetings with the field staff;
  - ensure coordination between MYWO and other field agencies;

- attends relevant meetings, seminars and workshops;

- member of the National CBD Technical and Coordinating Committee;

- holds fortnightly consultative meetings with the Program Director;

- holds quarterly (or as need be) consultative meetings with the Pathfinder Fund program officer;

- carries out any other functions as may be necessary in the implementation of the program or as may be required of her by MYWO/CBD Steering Committee.

- assists in the training, supervision and monitoring activities of the project;
- responsible for logistics and supplies of the project;
- assists in planning, designing and development of refund project proposals;

c) Program Accountant (100% of time)

1. Line Responsibility.

- responsible to the Program Manager and through her the Program Director;

2. Qualifications.

- a university graduate with a Bachelor of Commerce with accounting option;
- should possess the Certified Public Accounts Certificate Part 1 or above;
- at least two years of practical experience in an accounts office of a reputable organization;

3. Responsibilities.

- works under the direction and supervision of the Program Manager;
- understands and adhers to the Pathfinder Fund grant guidelines;
- responsible for all project accounts, ie. (i) maintenance of the Cash Book, Journal, Ledger, General and Petty Cash Books; ii) Preparation of payment vouchers, project staff payrolls and statutory deductions; iii) Preparation of monthly postings and bank reconciliations;
- compiles and prepares monthly, quarterly and annual financial reports for review by the Program Director, Program Manager and the MYWO/CBD Steering Committee;

- assists and advises the Program Manager, Program Director and the MYWO/CBD Steering Committee in the control and management of project funds;

- maintains a comprehensive project assets register/inventory and ensures proper maintenance of office equipment and supplies;

- prepares books for auditing;

d) National Nurse Supervisor (100% of time)

1. Line Responsibility.

- operates under the direction and supervision of the Program Manager and works in close consultation with her;

2. Qualifications.

- Kenyan Registered Nurse or equivalent;
- post-graduate training in Public Health, including Maternal Child Health/Family Planning;
- at least three years post-qualification working experience in rural Kenyan communities;
- mature, preferrably over 25 years of age;
- sound record of good managerial and organizational qualities and integrity;
- personal initiative and enthusiasm;
- demonstrated ability to work in harmony with all levels of people and communities;
- willing to travel extensively with the Republic of Kenya;
- keen interest in women programs;

. **3.** Responsibilities :

- assists the Program Manager and Program Assistant to plan, design and develop appropriate training curriculum and materials for the program staff and volunteers;

- assists other program staff and volunteers to implement the under-mentioned training :-

  - conduct six 1-day refresher courses for the old distributors yearly;
  - conduct eleven 2-week training workshops for new distributors yearly;
  - conduct six 1-day refresher courses for old Sub-locational and Locational supervisors yearly;
  - conduct two 2-week follow-up workshops for new Sub-locational and Locational supervisors yearly;

- conducts two supervisory/monitoring field trips to each program area to meet with the Sub-locational and Locational supervisors and District Nurse Coordinators; during such visits, she will make stop checks of the records, deal with identified technical problems and identify strengths and weaknesses of the program for discussion with the Program Manager and Program Assistant;

- assists in the on-the-job training and orientation for the Nurse Coordinators and Program Assistant;

- provides needed technical materials for the training of volunteers on the program;

- assists other program staff and volunteers in planning and developing draft renewal proposal;

- holds fortnightly consultative meetings with the Program Manager;
- prepares monthly schedules and reports of her activities for submission to and discussion with the Program Manager;
- works in close coordination with other program staff and the volunteers;

e) Administrative Assistant.(100% of time)

1. Line of Responsibility.

- responsible to the Program Manager and through her, the Program Director;

2. Qualifications.

- should possess at least Division II Ordinary Level of Kenya School Certificate of Education with a good credit in the English language;
- must be a qualified secretary with speeds of at least 50 words per minute in typing and 120 words per minute in shorthand of Pitman's or Kenya Examination Council;
- mature, competent and with at least three years of working experience as a personal secretary in a reputable organisation;

3. Responsibilities.

- responsible for all secretarial work of the project including, typing, filing, correspondences;
- maintains and ensures safe storage of all project documents, files and office supplies and stationery;
- responsible for petty cash of the project and submits weekly and monthly returns to the Program Manager;

f) Provincial Supervisor (100% of time).

1. Line Responsibility.

- works under the direction and supervision of the Program Manager;

2. Qualifications.

- must be a Certified Community Development Officer or Social Worker with Public Health experience;

- at least 7 years field experience in a program supervisory capacity;

- must have had short courses in either project planning field extension work;

3. Responsibilities.

- responsible for day-to-day monitoring and supervision of the program activities and program staff and volunteers in the Province;

- assists other program staff to :

  - conduct six 1-day refresher workshops for old Distributors;

  - conduct eleven 2-week training workshops for new Distributors;

  - conduct six 1-day refresher workshops for old Locational/ Sub-locational Supervisors and two 2-week training workshops for new Locational/Sub-locational Supervisors;

- conduct two 2-week training workshops and two 2-week follow-up workshops for new Locational/Sub-locational Supervisors;

- identification of new areas and groups and relevant staff for program expansion in her Province;

- assists in the on-the-job training and orientation for new District Nurse Coordinators and Program Assistant;

- conducts monthly supervisory/monitoring site visits in her respective project area;

- meets quarterly with the Provincial MYWO Committee and the Provincial Development Committee;

- conducts monthly staff meetings for her Nurse Coordinators, Locational and Sub-locational Supervisors;

- ensures that the District Nurse Coordinators' reports on the Locational/Sub-locational Supervisors performance are submitted accurately and punctually every month and that she provides necessary feed-back on time;

- identifies problems and assists the Nurse Coordinators and the Locational/Sub-locational Supervisors to resolve them;

- responsible for the stocks on contraceptives and other supplies in her Province and ensures regular and adequate supplies to the District Nurse Coordinators;

- provides on-going education to the District Nurse Coordinators;

- coordinates visits to the project;

- maintains smooth coordination of program activities with relevant officials of the government and other agencies in the Province through regular quarterly coordinating meetings and progress reports;

- prepares and submits her work programs and reports monthly to the Program Manager;

- assists in preparation of renewal proposal drafts;

- participates in follow-up, evaluation and research activities of the program ;

g) District Nurse Coordinator (100% of time).

1. Line Responsibility :

- answerable to the Provincial Supervisor and through her, the Program Manager;

2. Qualifications :

- EITHER Community Nurse training OR Enrolled Nurse/Midwife plus in-service training Family Planning or Public Health;

- practical field experience of at least three years;

- knows the community, its tradition and culture;

- respected by the CBD community;

- resident of the selected CBD Program area;

3) Responsibilities :

- responsible for the day-to-day monitoring and supervision of program activities at the Locational/Sub-locational/Group - Supervisors in her district;

- prepares and submits her work program monthly to the Provincial Supervisor;

- compiles Locational/Sub-locational progress reports and submits them monthly to the Program Manager with copies to the Provincial Supervisor and provides relevant feed-back on time;

- attends quarterly the local MYWO Committee and acts as its secretary;

- assists in :

  - conducting of six 1-day refresher workshops for old distributors and eleven 2-week training workshops for new distributors;

  - conducting of six 1-day refresher workshop for old Locational/Sub-locational Supervisors and two 2-week training workshops and two 2-week follow-up workshops for new Locational/Sub-locational Supervisors;

- identification of new areas and groups and new Distributors and Locational/Sub-locational Supervisors for the expansion program;

- conducts weekly monitoring/supervisory site visits to Locational/Sub-locational Supervisors and Distributors;

- holds monthly staff meetings with Locational/Sub-locational Supervisors and Distributors;

- maintains an up-to-date record of her stock of contraceptives and other supplies and ensure regular replenishing of the Locational/Sub-locational Supervisor's stocks;

- attends the District Divisional Development Committees' Meetings and Reports to them regularly on the progress of the program;

- liaises and coordinates with relevant officials of the government and other agencies;

- makes monthly visits to the service delivery points for follow-up of referred clients and maintains good coordination with clinic staff;

- provides needed technical advise to program staff and clients on MCH/FP methods and services in her district;

- conducts regular blood pressure checks/examinations of clients;

- provides the injectables to clients in need of the contraceptive method;

- identifies problems in the program and assists in resolving them;

- participates in follow-up, evaluation and research activities of the program;

3. FIELD IMPLEMENTATION LEVEL.

This level is voluntary . It is the real base of the program in the sense that it is in daily touch with the clients in their communities.

a) Divisional MYWO/CBD Steering Committee.

The formation of this body is under discussion and its functions and role are yet to be spelled out in detail.

b) Locational/Sub-locational/Group Supervisor.

1. Line Responsibility :

- works under the direction of the District Nurse Coordinator.

2. Qualifications :

- minimum O-level education; preference will be given to the candidates having A-level education;
- married women, minimum age 20 years;
- area resident, amiable personality;
- experience in family planning or social work;
- effective interpersonal communication skills for field work;
- proven leadership skills;
- ability to travel independently;

3. Responsibilities :

- identification and registration of all eligible couples; identify those interested in family planning; educate clients for acceptance of family planning; provide contraceptives to users through household visits; ensure a one-month reserve supply for users AT ALL TIMES;
- accompany clients interested in IUD's or injectables to the cooperating family planning clinic; refer clients desiring sterilization to a cooperating hospital/clinic and accompany client to and from service site;

- follow-up visits to Distributors for resupply and reassurance;

- follow-up of clinical contraceptors and ensure continuation of use; deal with complications by referring such cases to the family planning clinics;

- refer clients requesting care for gynecological complaints and pre- or post-natal care to family planning clinics, refer clients and/or children needing immunization; supply iron capsules, multivitamins and other medicines as and when available upon approval from the program;

- assists the Distributor in the MYWO group activities;

- maintain accurate record of users/couples in appropriate recording format;

- updating couple registration data on a continuous basis;

c) Distributor.

1. Line Responsibility :

- works in conjunction with the Locational/Sub-locational/Group supervisor;

2. Qualifications :

- qualified extension worker from a government institution; or a community leader with training in family planning from a recognized government or private institution;

PART II. PROGRAM INFORMATION SYSTEM.

In this part we propose an information structure which will enable the MYWO to have a comprehensive reporting system for purposes of monitoring the activities of all levels as well as building information for eventual impact evaluation.

In doing this we have specifically kept the information load for Distributors low. We have arrived at this design after discussions in the field.

This system is so designed as to be compatiable with micro-computer data processing.

It also significantly borrows from the experience of the past MYWO/CBD reporting system and Pathfinder experience in designing the Bangladesh CBS Manual which was supplied to the Consultant during briefing.

a) CBD Project Couple Registration.

1. Purpose.

In community-based distribution projects, Couple Registration constitutes and important management tool. Couple Registration is designed to provide information to the Program Manager and staff about contraceptive practice in a given project area, and to identify women at risk of unwanted pregnancy.

Couple Registration is designed to be conducted in the first (1) month of a new project and may be conducted again at a later date. As soon as the staff is hired and trained, registration begins. The Couple Registration provides baseline data on the Contraceptive Prevalence (what proportion of couples use a family planning method) in the project area.

Couple Registration should be done in a new area by a team made up of Provincial Supervisor, District Nurse Coordinator, Locational/ Sub-locational/Group Supervisors and Distributors. Before it is initiated coordination with Provincial Administration is mandatory.

The Couple Registration plan calls for a uniform definition of "eligible couple"

Eligible couples are women who are married, under 50 years of age and living with their husbands. Eligible couples include women who are currently pregnant because they are eligible to receive family planning information and pre-and post-natal care. After the delivery, they will be eligible for family planning services.

2. Work Plan.

In the planning of MYWO/CBD Program the Program Manager assigns specific Distributors to specific groups. Locational and Sub-locational/Group Supervisors and assigned to specific areas so that:

- all Distributors and Supervisors have approximately the same number of couples;

- boundaries are clear so that no eligible couples are omitted or registered by more than one Supervisor;

- each Supervisor registers the couples she will continue to serve in so far as possible;

Every group is visited by the Locational/Sub-locational Supervisors.

Every eligible couple is registered, including pregnant women. A client card (in duplicate) is completed for every eligible couple registered.

- The Locational/Sub-locational Supervisor verifies the results of the registrations of each Distributor under her supervision. The Registration Team goes to the field for two purposes : first, to determine that the Distributor can correctly identify an eligible couple (that is, the Distributor does not register couples who are not eligible for family planning information and services and conversely, the Distributor does register all eligible couples); and second, to determine whether the Distributor can correctly gather and record the information required in the MYWO/CBD CLIENT CARD. If problems are identified, the Team retrains the Distributor and helps her to collect accurate and complete information.

  The Registration Team makes first verifications early in the registration so that mistakes can be quickly corrected.

- When the registration is completed each District Nurse Coordinator adds the couples who are currently pregnant and users of family planning methods. Each District Nurse Coordinator verifies the totals of the Locational/Sub-locational/Group Supervisors under her supervision and submits the verified totals to the Provincial Supervisor.

- The Provincial Supervisor is responsible at all stages of the Couple Registration for assuring that accurate and complete data are collected, and that good relations are created with the community. The District Nurse Supervisor conducts periodic reviews of the registration and provides technical assistance where needed.

- The District Nurse Supervisor submits the RESULTS OF COUPLE REGISTRATION using Recording Form 2 to the MYWO/CBD office in Nairobi within 7 days of completion of the Couple Registration.

3. Instructions for Filling in Couple Registration Form.

- Registration Number.

Each woman has a separate line on the Couple Registration Form. If one man has two wives, the wives do not share a line. Each wife has her own line and registration number.

The Team assigns a registration number to each eligible couple. The Supervisor numbers all the eligible couples in each community or MYWO Group assigned from one to the end. The eligible couple's registration number is the MYWO group dash (-) serial number. For example, the third eligible couple registered in the Kandara Maendeleo is 37 - 3 because the Program Manager assigned the number 37 to Kandara Maendeleo. After the whole MYWO group is covered and all eligible couples are registered, the Supervisor leaves several pages blank and she/he starts Couple Registration work in the next group say Kirima Maendeleo, 38.

- Wife's Name/Husband's Name.

The Supervisor asks the wife's name and the husband's name and records these and the address in the appropriate column.

- Wife's Age.

The Supervisor asks the wife's age and records it in number of completed years.

- Wife's Education.

The Supervisor asks the wife's education and records the level of education, (i.e., up to standard V, O-level, A-level etc.)

- Number of Living Children.

  The Supervisor records the number of living sons (M) and doughter (F) she does not record children who have died.

- Number of Children under Five Years.

  The Supervisor records the number of children under 5 years of age.

- Age of Youngest Child.

  The enters the age of the youngest child in completed years or/and months.

- Want any more Children.

  The Supervisor then asks the couple whether they want any more children and records a tick in the form in the appropriate clumn.

- Currently Pregnant.

  The Supervisor asks whether the women is currently pregnant. The answer is recorded in the appropriate column.

  If the wife is pregnant, skip to "Ever Used a Method in Past" column.

- Whether Using any Family Planning Method.

  If the wife is not pregnant, the Supervisor asks the eligible couple if they are practicing any family planning method. If the answer is yes, the Supervisor asks what method they are using and puts a tick under the appropriate method. (Dates for IUD and sterilization are to be recorded in the appropriate column;). If the answer is negative and the Supervisor suspects that the client does not understand the question, the Supervisor may prompt the client by mentioning some methods.

If prompting brings an affirmative reply, the Supervisor asks to see the brand and records the method. If the couple is not using a family planning method, the Supervisor ticks "none".

- Ever Used a Method in Past.

If anybody reports using methods in the past, but is not a current user, this should be recorded under the "Ever Used a Method in Past" column.

For each completed page of the Couple Registration, the Supervisor tabulates data from the "Currently Pregnant" through "None" column; the Supervisor records the sums in the row marked "TOTAL" at the bottom of each page and she verifies the data tabulated for each page.

- Remarks.

The Supervisor may write observations about or conditions of the couple in the column under "Remarks".

The Supervisor enters the names of new couples who move into the project area in the Couple Registration Book. She/he puts the names of new couples of different groups in appropriate blank pages with the registration number and date. She/he crosses out the names of couples who leave the area. No one who resides outside the project area is registered in the Couple Registration book.

After completion of the Couple Registration, the book is used for planning educational and motivational work in new program area. The priority couples to be selected for family planning education are those who report :

- they want no more children;
- or they have at least one child;
- or the youngest child is less than one year of age
- or the couple is newly married;

COUPLE REGISTRATION FORM 29 Form 1.

Group Name : _____ / Code No._____ Location : _____ Code No._____ Registration Date : _____

Village : _____ / Code No._____ District : _____ Code No._____ Distributor : _____

Sublocation: _____ / Code No._____ Province : _____ Code No._____ Supervisor : _____

Regi-stration Number	FAMILY DATA												WHETHER USING ANY FAMILY PLANNING METHOD									Ever Used a Method in Past	
	1. Wife's Name 2. Husband's Name	W's Age	W's Edu.	No. Liv. children M	F	No.children under 5 yrs.	Age of Youngest child	Want more children Yes	No	Currently Pregnant Yes	No	Pill	Condom	Foam	IUD	Inj	TL	Vas	Other Specify	None	Yes	No
	TOTAL																					

Form 2.

ANALYSIS OF COUPLE REGISTRATION

Submit to MYWO/CBD Program Manager within 7 days of completing Couple Registration.

Village : _____ / Code No._____
Sub-location : _____ / Code No._____
Location : _____ / Code No._____
District : _____ / Code No._____

Province : _____ / Code No._____
Reg. Date : _____ / Code No._____
Distributor: _____ / Code No _____
Supervisor : _____ / Code No._____

Group Code No.	Name of Distributor	Total No. Registered Couples	No. Currently Pregnant	NO. OF COUPLES USING FAMILY PLANNING								
				Pill	Condom	Foam	IUD	Inj.	T.L	Vas	Other, Specify	None
A	B	C	D	E	F	G	H	I	J	K	L	M
Total :												

C = D + E + F + G + H + I + J + K + L + M

Contraceptive Prevalence = Total $\frac{(E + F + G + H + I + J + K)}{\text{Total C}}$ X 100

Pregnancy Prevalence = $\frac{\text{Total D}}{\text{Total C}}$ x 100

b) Family Planning Acceptors & MCH Record.

1. Purpose.

The Locational/Sub-locational Supervisor uses this book to keep a record of all Family Planning, MCH and educational activities in the area assigned to her Distributors. The book helps the Supervisor to be sure that all clients have an adequate supply of contraceptives, and it enables her to have an up-to-date count of all active family planning users in her area.

2. Procedure.

After Couple Registration all clients are entered in the FAMILY PLANNING MCH RECORD (Recording Form 3). As users shift from the project area they are crossed out of the Record. New clients who come to the area are entered in the FAMILY PLANNING & MCH RECORD.

The FAMILY PLANNING & MCH RECORD is divided into different sections so that all the users in one group are kept together just like the Couple Registration book. (All family planning users from outside the project area are kept in a separate book.) The FAMILY PLANNING & MCH RECORD is kept in the project office. The Supervisor makes all entries in the record using the red client cards of the Distributors.

- The first column is the client registration number assigned during Couple Registration.

- The name of the new acceptor and her husbands are entered in the column Name/Address in sequence.

- The rest of the record is used to record project activities. The Supervisor enters in the monthly columns the method used by the client if any, the date of the mome visit, or any MCH activity.

If the Distributor supplies pills, foam or condoms, the Supervisor also enters the amount given. If the client is a market client, the Distributor enters "market" and the method.

3. Examples.

The 12 columns represent the calendar months; if the Distributor recruits a new acceptor for Pill in January, the entry is the number of cycles given and the date. Also, "NA" is entered for a New Acceptor. If the Distributor gives 2 cycles of pills on the fifth day of January, the entry in the column looks like:

Jan.	Feb.	Mar.
2 pills 5 NA		

If the Distributor makes a visit to the above acceptor on the 3rd day of February and provides one more cycle of pills, the entry looks like :

Jan.	Feb.	Mar.
2 pills 5 NA	1 pill 3	

If a Distributor makes a follow-up visit to the above acceptor on the 15th day but does not provide more pills, the entry is "Follow-up" and the date :

(Follow-up)
15

When a Distributor provides condoms, the Supervisor records the number of condoms and the day of the month. For example, if the Distributor provides 10 condoms on the 3rd day of the month the entry is :

10 Condoms
3

A new acceptor of an IUD, injection, ligation or vasectomy is recorded only after the client starts the method. For example, if the Distributor educated a woman for ligation on the 3rd, the woman obtained the ligation on the 10th and the Distributor visited the home on the 16th to learn of the ligation, the entry is :

Lig
10

When a client accepts sterilization, the entry records the acceptance with the day of the month. The Supervisor draws a line across the rest of the page so that the sterilization acceptor is never counted as a drop-out. The entry looks like:

Jan.	Feb.	Mar.	Apr.	May	Jun.	etc.
	Lig / 20					

If a client drops out and has no supplies on hand the entry is an "X" on the box. For example, if an IUD acceptor has the IUD removed in March, the entry looks like :

Jan. Feb.	Mar.
IUD / 20	X

FAMILY PLANNING ACCEPTORS & MCH RECORD. 35 Form 3.

Group Name : _____/ Code No._____
Village : _____/ Code No._____
Sub-Location: _____/ Code No._____
Location : _____/ Code No._____
District : _____/ Code No._____

Province : _____/ Code No._____
Reg. Date : _____/ Code No._____
Distributor : _____/ Code No._____
SB/L Supervisor : _____/ Code No._____
DN Supervisor : _____/ Code No._____

Client Reg.No.	NAME/ADDRESS	CALENDAR MONTHS, 198__											
		Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec

c) Client Card Instructions.

The Client Card (Recording Form 4) has two identical parts. A blue card is given to the client, and a red card is kept by the Distributor. Both are completed for all eligible couples in the group at the time of Couple Registration. A card is also completed for a visitor who accepts a family planning method from a Distributor. Every time the Distributor visits a client or meets the group, she records the event on both cards.

The Distributor keeps her red cards at home. They are arranged according to the date she plans to meet various group members. The Distributor carries the red cards corresponding to the clients she plans to meet. She takes the red cards with her to all group meetings. She should always carry spare client cards as well as her diary.

At the end of the day/week the Supervisor, with the help of the concerned Distributor, records all activities from the red cards into the FAMILY PLANNING & MCH Record (Recording Form 3).

The Supervisor uses the client card to make spot checks to verify the Distributor's performance. Every week the Supervisor selects a sample of each Distributor's red client cards. The Supervisor visits the clients home/group and verifies that the information is the same on the blue client card. If the client is a new acceptor, the Supervisor should also ask the client to repeat the instructions for using the method. In this way, the Supervisor verifies that the client knows how to use the method properly. The Supervisor signs and dates both the blue and red cards.

The Supervisor and Distributor can arrange the red cards so that clients who live close together will be visited on the same day if they are not met in group meetings. This will save the Distributor from unnecessary travel.

Each card contains the registration number assigned at the time of Couple Registration. This number makes it easy for the Supervisor to find the client's name in the FAMILY PLANNING & MCH RECORD.

When a client drops out, her card should either be placed in a drop-out file kept by a Supervisor or filed by the Distributor for a visit at a later date to remotivate the woman for family planning. The date and reason for the drop-out should be noted on the client card and the FAMILY PLANNING MCH RECORD.

If a Distributor provides a service to a client when she is not carrying the red client card, this service is recorded in her diary. Upon return to her home, the service is recorded on the client card.

Reg. No. : _____/Name _____
Age : _____/ Code No._____
Marital Status : _____/ Code No._____
Groups Name : _____/ Code No._____
Village : _____/ Code No._____
Sublocation : _____/ Code No._____

Husband's Name _____
Location : _____/ Code No._____
District : _____/ Code No._____
Province : _____/ Code No._____
Distributor : _____/ Code No._____
Supervisor : _____/ Code No._____

Tarehe	VIFAA NA MWEZI AMEPATA					MWEZI ANAPATA VIFAA												SABABU YA KUTUMWA						MAWAZO
	Tembe za Kumeza		Kirimu Ya Uke	Tembe za Uke	Mpira wa Ume	J	F	M	A	M	J	J	A	S	O	N	D	Kupasuliwa	Sindano	Koili	Kupimwa	Matatizo ya vifaa	Ugonjwa	
	Aina	Kiasi	Kiasi	Kiasi	Kiasi																			

d) CBD Daily Distribution Log.

1) Purpose.

The Distributor keeps a record of the number of clients, she/he supplies with contraceptives and the amount of contraceptives she distributes in the DAILY DISTRIBUTION LOG (Recording Form 5).

2) Procedure.

At the end of each day, the Distributor records the methods given to the clients in the CBD DAILY DISTRIBUTION LOG using the red client cards. (The cards contain the record of all the Distributors' visits on one day to new and active users and the amount of supplies provided.)

All distribution is recorded in the log whether the client lives inside or outside the project area. However, market clients or clients who are visited for education but do not receive methods from the Distributor are not recorded in the log.

The Distributor makes daily entries on the line corresponding to the date of distribution (date on the client card). At the end of the month all the columns are totalled by the Supervisor. The totals are recorded on the DISTRIBUTOR'S MONTHLY PERFORMANCE REPORT (Recording Forms 6.)

Form 5.

MYWO/CBD DAILY DISTRIBUTION LOG.

Distributor : _____ Code : _____ Month : _____ 198 ____

DAY OF MONTH	PILL		CONDOM		CREAM JELLY		FOAM	
	No. Clients	No. Cycles	No. Clients	No. Pieces	No. Clients	No. Vials	No. Clients	No. Tablets
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
TOTAL								
Starting Balance								
Received From Store								
Distributed to Clients								
Balance on Hand								

e) Monthly Distributor's Performance Report.

1. Purpose.

This form has several uses. The Sub-locational/Locational/Group Supervisor uses it to prepare the monthly performance of individual Distributors under her supervision. Then she compiles the service statistics of all the Distributors and submits the report to the District Nurse Coordinator. She inturn submits a copy with the performance of all the Distributors to the MYWO/CBD Program Manager.

2. Procedure.

- Contraceptives distributed are recorded on this MONTHLY DISTRIBUTOR PERFORMANCE REPORT (Recording Forms 6) using the total figures from the DAILY DISTRIBUTION LOG (Recording Form 5).

- Only clients in the project area are counted. A new acceptor is a client who was not previously using a method but accepts one either in the CBD program or from another source. A previous drop-out is a new acceptor when she starts a method again.

- Couples who are practicing family planning at the time of Couple Registration are not new acceptors when they are transferred from the Couple Registration book to the FAMILY PLANNING & MCH RECORD.

- Drop-outs in the project area are counted from the FAMILY PLANNING & MCH RECORD:

- Total eligible couples of Distributors is recorded from the Couple Registration Forms.

- The CPL (or the Contraceptive Prevalence Level) is one of the most important indicators of the Distributors achievement in her family planning work. The CPL is always a percentage. It is calculated by dividing the total number of active users by the number of eligible couples.

The "Couples Visited for Family Planning Education or Referral" are counted from the FAMILY PLANNING & MCH RECORD. Every couple who receives a visit for a Family Planning purpose (other than to supply a method) is counted. This is a count of couples visited, not number of visits.

From the assorted MONTHLY DISTRIBUTOR'S PERFORMANCE REPORTS, the District Nurse compiles a SUB-LOCATIONAL/LOCATIONAL/GROUP PERFORMANCE SUPERVISOR REPORT (Form 7).

DISTRIBUTOR'S MONTHLY PERFORMANCE REPORT

Form 6.

SL/L Supervisors Name : _____ / Code No._____
Sublocation : _____ / Code No._____
Location : _____ / Code No._____
District : _____ / Code No._____
Province : _____ / Code No._____

MONTH ____ 198 ____

Kikundi Code No.	Mgawanyaji/ Code No.	Wanaotumia Mpango wa Uzazi	WALIOTUMWA KLINIKI NA SABABU YA KUTUMWA							VIFAA WALIOPATIWA								WALIOACHA NA SABABU (DROP-OUTS & REASONS)							MAWAZO JUU YA Kikundi Mgawanyaji
			Sindano	Koili	Mpira wa Ume	Kufungwa	Kufungwa Kwa Mme	Kupimwa	Ugonjwa	Tembe za Kumeza (Pills)		Mpira wa Ume (Condom)		Tembe za Uke		Mafuta ya Uke		Ugonjwa	Bwana Kukataa	Mke Kukataa	Uvumi	Matatizo ya Vifaa	Mimba	Hakuna Sababu	
										Watu	No.	Watu	No.	Watu	No.	Watu	No.								
		Wapya																							
		wa Zamani																							
		Wapya																							
		wa Zamani																							
		Wapya																							
		wa Zamani																							
		Wapya																							
		wa Zamani																							

Form 7.

SL/L/G/SUPERVISORS MONTHLY PERFORMANCE REPORT

SL/L/G Supervisor : ________ / Code No. ________
District Nurse Supervisor : ________ / Code No. ________
District : ________ / Code No. ________
Province : ________ / Code No. ________

MONTH ____ 198 ____

1. Sub-location 2. Code No.	TYPE OF CLIENT	REFERRAL AND REASONS							METHODS GIVEN									DROP - OUT AND REASON							REMARKS
		Coil	Injection	Tubaligation	Check - ups	Disease	Side Effects	TOTAL	PILL		CONDOM		FOAM TABS		CREAM JELLY		TOTAL	Rumour	Disease	Side Effects	Religion	Pregnancy	No Reason	TOTAL	
									Amount	No. of People	Amount	No.of People	Amount	No. of People	Amount	No. of People									
	New Acceptors																								
	Old Clients																								
	New Acceptors																								
	Old Clients																								
	New Acceptors																								
	Old Clients																								
	New Acceptors																								
	Old Clients																								
	New Acceptors																								
	Old Clients																								

1. TOTAL NO. OF REFERRALS

Coil : ....
Injection : ....
T/L : ....
Check - ups: ....
Disease : ....

2. METHODS GIVEN | AMOUNT | NO. OF CLIENTS

2. METHODS GIVEN	AMOUNT	NO. OF CLIENTS
The Pill	......	....
Condom	......	....
Foam Tabs ...	......	....
Cream/Jelly ..	......	....

3. DROP- OUTS & REASON

Rumour :......
Disease : .....
Side Effects:......
Religion : .....
No Reason : .....
Pregnancy : .....

4. TOTAL NEW ACCEPTORS

Pill : ....
Condom : ....
Foam Tabs : ....
T.L : ....
Injection : ....
IUD : ....
Cream/Jelly ....

f) Program Manager's District Quarterly Performance Report.

1. Purpose.

The DISTRICT QUARTERLY PERFORMANCE REPORT (Recording Form 8) summarizes the contraceptives distributed during a 3 - month period. The information, when compiled for a particular project period, will help calculate couple years of protection provided by the project during the period.

2. Procedure.

This report may be filled out either in its entirety (monthly + total) or by simply giving the totals for the quarter.

This should include distribution of all contraceptives by all field staff during the quarter in the project office or in the community.

For purposes of reporting to the Pathfinder Fund, data tabulated in DISTRICT QUARTERLY PERFORMANCE REPORTS is aggregated in districts to give the NATIONAL QUARTERLY PERFORMANCE RECORD (Recording Form 9).

Form 8.

PROGRAM MANAGER - DISTRICT QUARTERLY PERFORMANCE REPORT.

Project Title : MYWO/CBD Program

Program Manager : _____ / Code No. _____

District : _____ / Code No. _____

Period Starting : _____ Ending _____ Year _____

		1st Month	2nd Month	3rd Month	TOTAL
1. No of Distributors Reporting					
2. Referrals -- Sterilization -- IUD -- Injectable -- Side effects -- Disease -- F/P check up					
3. New Acceptors -- Pill -- Condom -- Foam/Jelly -- IUD -- Injectable -- Sterilization					
4. Visitors Served					
5. Active User	New Clients				
	Continuing				
6. Drop - outs - Reasons : 1. Husband/Relative disagree 2. Method side effects 3. Gone away 4. Death 5. Pregnancy or disease 6. Rumours 7. No need/Reason 8. Unrelated disease 9. Other					

PROGRAM MANAGER - NATIONAL QUARTERLY PERFORMANCE RECORD

Form 9.

Project Title : MYWO/CBD Program

Program Manager : _____/ Code No. _____

Period Starting : _____ Ending _____ Year _____

		x	Muranga	Emuhaya	x	x	x
1. No of Distributors Reporting							
2. Referrals -- Sterilization -- IUD -- Injectable -- Side effects -- Disease -- F/P check up							
3. New Acceptors - -- Pill -- Condom -- Foam/Jelly -- IUD -- Injectable -- Sterilization							
4. Visitors Served							
5. Active Users	New Clients						
	Continuing						
6. Drop-outs - Reasons : 1. Husband/Relative disagree 2. Method side effects 3. Gone away 4. Death 5. Pregnancy or disease 6. Rumours 7. No need/Reason 8. Unrelated disease 9. Other							

g) Spot Verification of Distributor's Performance.

1. Purpose.

Spot verifications have three purposes :

- to verify that all new acceptors know how to use their new method, and to provide new instructions if the client has forgotten;

- to verify that each Distributor makes the home visit recorded in the FAMILY PLANNING & MCH RECORD, and that the Distributor supplies the exact amount of contraceptives recorded;

- to identify any problems that a Distributor may have in her work so that she may be helped to improve her performance;

2. Procedure.

Sub-locational and Locational Supervisors or District Nurse Supervisor will verify all new acceptors. Each week, the Supervisor will select the red client cards of all new acceptors from the previous week. The Supervisor will visit each new acceptor and ask the client to describe how she uses the method. If the client cannot describe proper use of the method, the Supervisor will re-instruct her.

The Supervisor should also visit TEN PERCENT of each Distributor's old clients every month. The Supervisor should select active users whom she has not visited before, or where there appears to be some problem.

When the Supervisor makes spot verifications, she carries the spot verification Register and the red client cards to the field with her. At the end of the spot verification, the Supervisor records her findings in the SPOT VERIFICATION REGISTER (Recording Form 10). If the Supervisor identifies any problems, she should discuss them immediately with the District Nurse Coordinator or Provincial Coordinator, so that steps may be taken to improve the Distributor's performance.

At the end of each month, each Supervisor submits to the District Nurse Coordinator a MONTHLY REPORT ON SPOT VERIFICATION (Recording Form 11). A copy of this monthly report is sent to MYWO/CBD Program Office, Nairobi.

Any of the CBD officials can use the SPOT VERIFICATION FORM as a management tool for monitoring the performance of all levels of the program.

SPOT VERIFICATION REGISTER

Form 10.

Name : _____

Designation : _____/ Code No. _____

Date of Spot Verification	Name of Distributor Code No.	Reg. No.	Name and Address of Client	New (N) or old (O) client	If new client, does she know how to use method Y/N	Method and Amount Given at last visit		Any Problem found Y/N	Describe Problem and Proposed Solution
						Yellow Client Card	From Spot verification		

Form 11

MONTHLY REPORT ON SPOT VERIFICATION

Project Title : _____

Report for the Month of : _____

Submitted by : _____ /Code No.

Designation : _____

Name of Fieldworker/Code No.	No. New Acceptors this Month	No. New Acceptor verified	No. old Users	No. old Users verified.
TOTAL				

Describe major problems :

Signature : _____

Date : _____

Annexe 1. - MYWO CBD PILOT PROJECT

CLINIC REFERRAL FORM

Date : .....

To Sister/Nurse In-Charge,

.....

Health Centre/Hospital/Clinic (delate whichever is not relevant):

.....

This is to introduce Mr./Mrs./Miss .....

who is being referred to you for the following reasons :-

(i) Routine check up

(ii) Family Planning

(iii) Side effects

(iv) Antenatal care

(v) Health problem

(vi) Immunizations

(vii) Nutritional counselling

(viii) Others .....

.....

Please do kindly assist her/him as much as you can.

Yours sincerely,

.....

DISTRIBUTOR

PROJECT AREA: .....

Annexe 2 MYWO-MCH/FP MOTIVATIONAL SERVICES

SUPPLIES DEMAND VOUCHER (SDV)

SDV NO.....

To: .....

Address: .....

.....

Please supply the following items by personal collection/delivery (delete whichever not applicable).

ITEM DESCRIPTION	UNIT	QUANTITY	STOCK BALANCE	REMARKS

Requisitioning Officer : .....

Address : .....

.....

.....

SIGNATURE: ..... DATE: .....

FOR OFFICIAL USE ONLY

AUTHORISED: ..... DATE: .....

OTHER REMARKS: .....

.....

.....

3

KITUI PRIMARY HEALTH CARE

PHASE 2. MIDTERM EVALUATION

MAY/JUNE 1985

Prepared by

G-C. M. Mutiso

Norman Scotney

October, 1985.

TABLE OF CONTENTS.

Abbreviations

ADMS	Assistant Director of Medical Services
CBS	Central Bureau of Statistics
CHC	Community Health Co-ordinator
CODEL	Coordination in Development Inc.
CRS	Catholic Relief Services
DC	District Commisioner
DDC	District Development Committee
DDO	District Development Officer
DHC	District Health Committee
DMOH	District Medical Officer of Health
DO	District Officer
DOK	Diocese of Kitui
DSM	Dry Skimmed Milk
FP	Family Planning
Fr	Father
GoK	Government of Kenya
KPHCP	Kitui Primary Health Care Project/Program
MCH	Maternal and Child Health
MOH	Ministry of Health
MP	Member of Parliament
NGOs	Non-Governmental Organisations
NFP	Natural Family Planning
OP	Office of the President
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Theraphy
PHC	Primary Health Care
P/S	Permanent Secretary
Rev	Reverend
Sr	Sister
TBA	Traditional Birth Attendant
USAID	United States Agency For International Development
VHW	Village Health Worker
WHO	World Health Organisation

CONSULTANT'S SUMMARY OF CONCLUSIONS.

SECTION 1.

PROJECT GOAL. 'THE IMPROVEMENT OF QUALITY OF LIFE IN RURAL AREAS THROUGH ATTAINMENT OF OPTIMUM LEVEL OF HEALTH WITHIN THE CONSTRAINTS OF EXISTING AND DEVELOPING ECONOMY AND IN LINE WITH THE NATIONAL HEALTH SYSTEMS'

The contribution made to the 'QUALITY OF LIFE' in the Divisions of Kitui District served by the four Mobile Units of the Diocese of Kitui is not easily assessed. Women living in the remote villages and settlements reached by the teams are only able to obtain health assistance from any alternative source by walking over difficult terrain distances of the order of 20 kilometres as a minimum. Assistance provided for women facing the crisis of maternity, or the anxieties of infantile sickness represents help when it is most urgently needed.

Visits on one day each month by a mobile unit from a distant base are not sufficient to ensure 'GROWTH OF COMMUNITY PARTICIPATION IN WORK ON PRIORITY HEALTH NEEDS'. But by December 1984 seventeen 'Village Health Committees' had been formed by the Mobile Health teams. Concentration upon maternal and child health needs, though an obvious first priority, has tended to emphasize the roles in community health promotion of women. Too little attention has been given to environmental improvement. Except for the work of the Mutomo team the difficult task of encouraging latrine building has not been adequately stressed.

One Village Health Committee has built a shelter for meetings connected with the visits of Units. Members of VHCs are selected who receive a small supply of non-prescription drugs and treat patients with uncomplicated conditions.

Some local people tend to identify the program with the Catholic Church. This tends to limit the commitment to the work encouraged by the VHCs, which need to be established on the broadest possible representative basis for community wide involvement.

'IMPROVEMENTS IN THE HEALTH PRACTICES OF THE PEOPLE' depend upon effective health education which is one of the less successful activities of the teams. Better models are needed for this part of the program. Training in clinical roles does not equip people for health education and specific training is needed for this activity.

Attendances for the full sequence of immunizations are exceptionally high. Women show sustained interest in the care of their children. School staffs are pleased when team personnel find time to make a contribution to their health programs.

To determine the COST EFFECTIVENESS of the program is difficult. Firstly, there is a deficiency of alternative models since the Kenya Ministry of Health has not, so far, been able to extend the provision of comparable services to the populations of semi-arid, low density areas. Secondly, though mission services are uniformly provided at lower unit cost than Government services, no cost analysis of similar mission services could be obtained by the consultants. The data made available to us suggest that the service is run with exceptional economy.

SECTION 2.

PROJECT PURPOSE. 'THE PROVISION OF MOBILE PRIMARY HEALTH CARE SERVICES TO RURAL AREAS OF KITUI WHICH LACKED GOVERNMENT OR MISSION MEDICAL SERVICES.'

The project purpose, as stated, has in a large measure been met. The WHO (Alma Ata) specification for Primary Health Care services is a comprehensive, target setting definition. In the more remote and inaccessible Divisions of the 25,000 square kilometres of Kitui District the program has made a significant step towards this goal.

The 'TARGET POPULATION REACHED BY THE PROJECT' has fluctuated during the assessment period. The recent drought - the most severe in fifty years - deflected people's attention (from early 1984) to the search for food to survive.

Many left some areas but immunizations dropped only from 56 per cent of target population to 45 percent, and have begun to increase again.

Ante-natal clinics attract especially the younger mothers. Older women feel less need for assistance. The attendance reached a commendable 37 percent of the estimated target population and only sagged-with the drought-to 22 percent.

Examining 'SERVICES PROVIDED IN TERMS OF ADEQUACY TO MEET FELT NEEDS OF THE POPULATION SERVED' the picture is mixed. Satisfaction with the immunisation and ante-natal services was evident. The proportion of mothers classified in ante-natal clinics as 'at risk' was, overall, 50 percent. Without special provision for them to reach in-patient maternity facilities at term, anxiety might be accentuated.

Men felt that they also need services, but that those provided were intended for women. The work of the Mobile Units has probable created a demand for curative services - especially for malaria - which previously was latent.

'JOINT PLANNING WITH OTHER SERVICES' whilst it is accepted as desirable both by program staff and by Ministry of Health staff has an uneven history. 'Integration' was envisaged in the planning for Phase 2. Staff were to be incorporated into a planned Kitui Rural Health Scheme to be funded in part by USAID. The plan was abandoned. Secondment of two staff by the Ministry partly to strengthen health education, was postponed occurring only at the time of the consultant's visit. A seconded Public Health Technician was, by mutual agreement, withdrawn.

The plan for 'STAFF OF RELEVANT MINISTRIES' to attend the bi-annual meetings of the project staff has not succeeded but the new plan for District Health Committee may change the picture. The plan for the Ministry of Health to supply vaccines to the program has worked well.

Joint Ministry/project courses for traditional birth attendants have been held through co-operation with the District Public Health Nurse. Co-operation at the local level seems easier to effect than joint planning.

'RECOGNITION OF WOMEN LEADERS IN COMMUNITY HEALTH WORK' has been promoted by the program. In Village Health Committees women predominate. The Mobile Unit teams are - with the exception of the drivers - exclusively female and provide role models as well as encouragement to emerging women village leaders. The women have experience in leadership functions which is not otherwise available.

Thirty-five Traditional Birth Attendant/Village Health Worker courses have been conducted to equip the women participating to assume greater responsibility in community health work.

Insufficient resources have, though, been devoted to 'SECURING COMMUNITY SUPPORT FOR THE APPROACHES USED.' Village Health Committees should have been the foundation of the program from its initiation. So conceived that is, as a community based program, the scheme would more nearly have coincided with community expectations and needs. Not only would valuable lessons have been learnt but community inputs would have been a more significant component of the program. (See 'Recommendations'.)

SECTION 3.

PROJECT OUTPUTS.

The 'MOBILE HEALTH DELIVERY OF SERVICES' - as described - has been maintained with remarkable regularity. In the period under review only 60 clinics were missed, that is 5.2 percent. When necessary vehicles were borrowed. Only when roads or bridges were washed away did the teams fail to reach clinic sites.

Except for the midwives attached to three of the teams there was very small turnover of staff. Schedules limited work in the schools. In practice the demands of a satisfactory school health program would require much greater resources than the program, as planned, could hope to command.

Because distances and the difficult terrain restricted the work to the holding of one clinic each day, visits were limited to one each month. More might be accomplished if it was possible for teams to stay overnight at some remote settlements. Provision for this was not, though, made in the initial planning. A clinic limited to one day in a month has, of course, its deficiencies.

A sound balance between 'PREVENTIVE AND CURATIVE SERVICES' is only attained with a profound knowledge of the community. Working with the community a more imaginative approach to prevention can be implemented. In the program the limited effectiveness of the health education component has, in turn, limited work on prevention. Children are, though, presented at the clinics with a level of cleanliness and care that is evidence that progress has been made.

'TRAINING AND INSTRUCTION FOR WOMEN'S GROUPS/COMMUNITY VOLUNTEERS', as has been mentioned, has been a part of 35 courses given. These have mostly been conducted in hospitals or at a centre in Kitui. With women of limited educational background the venue tends to limit the spontaneous contributions made by participants. In a village setting more dialogue could be expected including more open discussion of problems and needs. More progress is usually made with homogenous groups and when participants are familiar with one another. This is more easily secured if a central village is selected for the program. Practical demonstrations are more easily arranged in the same setting that gives rise to the problems.

'PROMOTION OF AND INSTRUCTION IN NATURAL FAMILY PLANNING' are new activities and rural, low population density areas, where traditional patterns of living persist, are not the obvious choice for such programs. The centres have three trained tutors and they have trained 21 couples between July 1983 and December 1984, 12 of whom have become teachers of the method. One Semi-Annual Report records: 'Efforts to promote family planning met with poor response. The problem of infertility is seen as greater than that of fertility by most families'. It would seem that promotion of natural family planning has proved not only expensive but not obviously effective. This would justify the limited emphasis being placed upon this component of the Mobile Unit program.

The training of 'COMMUNITY LEADERS IN SIMPLE HEALTH REMEDIES AND TECHNIQUES' has been a part of the Village Health Committees program. Progress has been made and as more VHCs are established it is envisaged that more training will be arranged for village health workers. Development of this aspect can help to meet the demand for curative services and so strengthen community support for the work of the Mobile Unit teams.

CONCLUDING.

The Kitui Primary Health Care Program has experienced several changes. Staff have had to adjust to problems arising from the initial planning and from changing conceptions of the goals and methods of such a program but these problems are small when compared to the problems of the people served, and then the strength of the program, that is the commitment of the staff and their effectiveness are revealed.

Our report draws attention to many aspects of the program which we feel should be reinforced or developed. This does not mean that we are unaware of the real and valuable achievements of those who have committed themselves to the welfare of some of the people of Kitui District who are living in circumstances of extreme difficulty. We hope that our report will prove both instructive and source of encouragement.

CHAPTER: I. PROJECT BACKGROUND.

The Proposal of CODEL.

On behalf of CODEL (New York) Mr. Patrick Cullen visited Kenya in January 1977. He reported "as originally planned, Dr. Marita Malone's Primary Health Care Program for Kerio/Wei Wei, Rift Valley Province, Kenya, attracted considerable attention and favourable comment at Johns Hopkins University, in AID (Washington) and among CODEL's members. The program, with suitable modifications, is now proposed for implementation in Kitui District, Kenya. Dr. Malone now lectures in the Department of Community Health, University of Nairobi, and will be able to advise on the project and help with University interest in it" (p.12)

Dr. Malone explained to Mr. Michael Rugh (USAID - Nairobi) "the various pieces of planning that had been made already" and "events and posibilities in the district" mentioning :-

"a) The withdrawal of the CRS nutrition intervention program in December 1976."

"b) The local mobile replacement for the CRS program which the Diocese put into the field from Mutomo Hospital in January 1977."

"c) The presence in Kitui District of several women's groups which have been organised and motivated for development and which are now ready to participate in the PHCP."

"d) The possibility of selecting and training women from these groups who could act as Village Health Workers on a voluntary basis."

"e) A number of on-going projects in the District with which the PHCP can be linked and supported."

"f) The support and participation of the Ministry of Health at local level and the posibility of the Department of Community Health, University of Nairobi, using the program for practical field work."

Mr. Cullen states that "CODEL would consider funding the pilot phase from its DPG funds on the understanding that the whole program would move into DPG funding on the successful completion of the pilot phase. The pilot phase would be ready to go into operation by the middle of 1977 and the full program by the end of 1977."

Robert Lucas of CRS told Cullen that " all CRS mobile activity has been stopped in Kitui, the CRS "static" program continues and where this can assist the new program for PHC a tie-in will be welcome".

In Kitui the Provincial Medical Officer, District M.O.H. (Dr. Odongo) and District Health Officer (Mr. Mathenge) at a meeting with Cullen put "stress" on "the happy relationships that exist throughout the District between the government and voluntary medical services. Plans for the Primary Health Care program are being put together with the closest of consultation and working together and, where posible other government departments helping out."

At Mutomo Hospital Mr. Cullen was told "at the end of 1976 Kitui Diocese, faced with the responsibility of maintaining as much as possible of the intervention program, decided to use the established contacts to move the whole program into one of Primary Health Care. Two teams, sponsored by the Diocese, commenced a mobile health service on January 1, 1977 into 25 centres.

"This is the nucleus from which the Kitui PHCP will develop ..... involvement of existing women organisations and their training as village workers will form an important part of the program."

Two year passed, though, before USAID support for the project was secured.

The Project Grant (USAID Grant No.0185 - 1 - 904.

By a letter dated February 18, 1979 USAID granted $.413,000. to CODEL to cover the period February 1, 1979 to October 31, 1982.

The "Program Description" under specific objectives states that "CODEL will operate four mobile teams which will each visit seventeen village or communal gathering sites each month."

"Each team will have the capability of offering the following services :-

a) Mother and child health care, including ante-natal and post-natal care.

b) Immunizations.

c) Family Planning referral.

d) Simple curative treatment, and

e) Health educatio "

"Each team and its equipment and records will be self-contained in a four - wheel drive vehicle. Over the three - year life of this project - it is estimated that the four mobile teams will each reach 10,000 to 12,000 people, about 10 percent of the population of Kitui District presently without access to any health facilities at all."

Under "Implementation" the Diocese of Kitui is designated the implementing agency and its "four stationary medical facilities" - Kimangau, Muthale, Mutomo and Mutito - mentioned as the bases for the four mobile teams. The teams are to work each week four days in the field and use a fifth day for "the preparation of records, equipment, drugs, etc." One team, it is mentioned, is already functioning from Mutomo Hospital funded by CODEL, Ministry of Health and Diocese of Kitui.

The Project completion date is stated as October 31, 1982.

"Maximum use of community groups in particular women's groups in the area will be made." p.5.

"Dr. Marita Malone, ... will act as technical consultant adviser throughout the program. Under her supervision medical students from the University of Nairobi will carry out surveys on a per-diem basis."

"Baseline surveys will be conducted for each dividion, one at about eighteen months after commencement of full project activities and one at the end of the project. These resurveys ..... will be part of the mid-project and final project evaluations and will provide the basic data for the monitoring and evaluation system developed by CODEL for the project."

The reference here is to a document-undated and without attribution - "A Monitoring and Evaluation System for the Primary Health Care Program "which describes surveys to be made by University of Nairobi medical students using three questionnaire forms :

a) "Household form" (for "Household Census", "Disease Patterns" Nutrition/Food Patterns "and" Environmental Health." In all 71 items to be coded).

b) "Child Form." ("Ante-natal care" "Nutrition/Immunization" etc. - 50 items).

c) "Health Knowledge, Attitudes and Practice Form" (5 pages).

However provision is made for Semi-Annual Reports (CODEL to USAID - Kenya) and an evaluation plan with a joint first evaluation in October/November 1980 and a final evaluation in May/June 1982.

CODEL was also to undertake an "internal review of the pilot phase of the project in March/April 1979" that is at the starting date - with a view to adjustments in project activities and to "discuss the findings with the USAID project manager who will also visit the project site at this time."

No documents or references to documents covering these activities have been located.

The budget provides for $.2,800 for data processing and $.4,000 for consultants in each year, and $.2,500 for evaluation in the second and third years.

Project Development. Phase I.

The mobile team operating from Mutomo Hospital was augmented by a second team from Kimangao in July 1979, a third team from Muthale in December 1979 and a fourth from Mutito - subsequently from Nuu - in January 1980.

In November 1980 Dr. F.J. Bennett (Community Health Advisor UNICEF - East Africa Region) made a five day visit to Kitui and noted that Dr. Malone had handed over the responsibility of technical adviser and consultant to Sr. (Dr.) Marian Dolan, Medical Officer in-charge of the 140 bed Mutomo Hospital.

Dr. Bennett listed the goals of the four mobile teams as to :

"a) Improve the quality of life using the limited resources available;"

"b) Change behaviours and attitudes to ones more conducive to health;"

"c) Immunize children;"

"d) Provide ante-natal and post-natal care;"

"e) Provide limited curative care;"

"f) Improve community nutrition, sanitation."

He found the four mobile units were conducting clinics in areas without other services consistently, but "the PHC. project had become largely synonymous with the mobile MCH clinics" which " were not considered .....as mobile extension of a basic service." There seemed to be little community participation in planning, management, and evaluation.

The training of community women, even at Mutomo, was limited, "In summary, 14 women have received from 7 to 20 days of training ..... No men have ever been trained."

He calculated that 5433 (about 9 per cent of the 0 to 4 years old) were seen in February 1980 by the four mobile units and felt that nutritional surveillance should be reorganised from attention to individuals to assessment of community nutritional levels. On water and sanitation little progress was reported but he was impressed by the attendance for immunization of under one year olds.

He said "a higher coverage of pregnancies must be achieved" and "the health education is of the stereo-typed lecture type with pictures "and felt "the impact of this on behaviour would be slight." "Malaria prophylaxis for under 5s is not undertaken".

He proposed that "the road to health chart for the children should be kept by the mother" (This has been implemented and the response has been good.)

He concludes "Community based work is at such a minimum level that the program can hardly be called a primary health care project in the Alma Ata sense".

Though Dr. Bennett made numerous suggestions his report "did not meet USAID expectations."

In June, July and August 1981 a "Mid-Term Evaluation of the Kitui Primary Health Care Project" was undertaken by Drs. Rita Morris and Sally Smith (August 1981).

They examined records of Mutomo and Muthale mission hospitals which showed over a five year period a doubling of abnormal ante-natal cases seeking hospital deliveries" which could be attributed to ante-natal care given by the mobile teams in these areas." They also thought the incidences of immunizable childhood diseases were "no longer major childhood problems at Muthale." Conversely they found "The numbers of children very anaemic and severely ill from malaria have increased", also "Diarrhoeas remain a prevailing problem."

They emphasize that : "Great difficulties were experienced in the monitoring and evaluation system designed at the beginning of the project. While the objectives were sound, the methodology was inherently weak."

"The assumption that data collection and analysis would be done by medical students of the University of Nairobi was the underlying problem ..... there was no formal agreement. The whole program hinged on the good will and co-ordination of the project - consultant ..... since the consultant left the project (early in 1980) the whole system collapsed."

Morris and Smith make a general comment : "The collection of data by household surveys is both time consuming and expensive ..... The value from such information is marginal in relation to the personnel needed, time and expense."

Finally, interviewing 60 women seen at clinics conducted by Mutomo, Muthale and Kimangao mobile units with a 13 item questionnaire, they attempt "an assessment

of the extent of improvement in health practices" utilising "data from clinic records." "The decrease in the incidense of scabies is evidence that personal hygene practices have improved despite scarce water supplies."

Unfortunately the method of selecting those to be interviewed, the language used - the questionnaire is in English - and the selection and preparation of interviewers are not discussed.

Morris and Smith recommend a sample procedure - selecting 10 out of each 16 clinic, ie. a population of 1200.

All are to be sampled using a duplicate health record and an additional data sheet, with each team augmented by "an additional helper to help with interviews and recording." They also recommend sampling 1200 randomly chosen "new ante-natal patients under five months of pregnancy" not, perhaps, being aware that most ante-natal patients make their first attendance at the mobile unit clinics in the third trimester.

They make eighteen specific recommendations which could, though, each have been reinforced with specific objectives.

Initial Staffing.

The concluding Semi - Annual Reports for 1982 showed the staff of the project as follows :-

Each team :	1 Team Leader (KRN etc.)			
	2 Midwives (KEM.)			
	4 Nurse aids (On-the - job training)			
	1 Driver.			
Total	8	x 4 Teams	=	32 persons.

In addition the Mutomo team included one (M.O.H seconded) Public Health Technician. The Mutomo Team Leader was also Program Supervisor. The Consultant to the program (part-time) was also based at Mutomo (Dr. Marian Dolan).

The Administrator (part-time) Rev. Fr. Noel S. Bouchier, was based at Kitui. Thus, whole time staff numbered 33, and part-time 2.

Initial Activities.

In the whole year 1982, 38,000 immunizations were given, about 7,360 children receiving the complete set. 2,923 pregnant women received the first dose of tetanus toxoid but only 1,168 the second "booster" dose. "New" ante-natal cases numbered 6,418 in the year, of whom about half were classified as "risk" cases. They made - on average - a total of 3 attendances.

Following a suggestion of Dr. Morris a "master chart" was made of children's weights at each clinic from July to December. The combined results show high levels of children over 80% of the Harvard Standard Weight. But most children seen were under two and still breast-feeding. Nutritional problems though, usually come with weaning. It was decided to discontinue the use of master charts.

A limited amount of curative care was given by each team, 80% of it to children and mostly for malaria, respiratory tract-infections, diarrhoeas, and conjunctivitis.

At Mutomo the MOH seconded P.H.T. conducted health education sessions in schools, and for ineresting local women. "Whilst recognised as a valuable asset to the Mutomo team it was nevertheless concluded by the Project Superviser that a community nurse would be better able to meet the needs of the community."

At Mutomo "Some mothers are very slow to participate, respond or ask questions during health education sessions and it is necessary to repeat the same information many times before they can assimilate it".

Educational work in schools, with community women, traditional birth attendants and traditional healers continued at a low level. At Kimangao 6 to 10 mothers - at the end of clinics - and 4 schools were assisted : Muthale gave five in-service courses of two days for 5 women, on each occasion including some T.B.As but also two one-day seminars in remote locations and a one-day baraza with 150 people. They also gave health talks in Muthale Hospital. At Nuu 3 women who had attended a health education workshop held meetings in villages to encourage latrine building.

The Semi - Annual Reports do not aggregate any data there may be on health and community education. Though project goals emphasize the importance of health education, clinically oriented activities seem to have a consistently higher priority in schedules.

Financing.

Bridging finance for the period March 1,1982 to March 31, 1983 was largely found in the unspent balance of February 28, 1982 of $.107,000. made up principally of :

Salaries	$.35,000.
Health Education	$.14,000.
Medical Supplies	$.41,000.
Data Processing and Evaluation	$.12,000.

Planning Phase 2.

Planning for Phase 2 envisaged additional inputs in Health Education, Training of Village Health Workers and Traditional Birth Attendants, Family Planning and Community sensitization.

It was anticipated that "Additional government officers are being seconded to the program to work with visiting teams. A staggered hand-over to the Ministry is planned in the second half of the coming three - year period so that at April, 1986 the Kenya Government will have taken over responsibility for the work ..... Catholic Relief Services are acting as the private Voluntary Organisation for Phase 2 instead of CODEL for reasons of convenience and smooth running of the program."

Phase 2 Proposal.

Early in 1982 the Phase 2 Proposal was developed by the Diocese of Kitui. Dr. Marian Dolan in the pre-amble stresses that "traditional healers function within the psychological framework of their clients beliefs, cultures, and expectations" and that "there is mutual trust, confidence, and complete rapport between practitioner and patient." She then adds "it is this rapport that we as health educators are trying to cultivate in the Primary Health Care Program among the village health workers we are endeavouring to train. Our main teaching method presently is the psycho-social method whereby the trainees are given opportunity and help to identify their own needs and the best method of solving these needs.

This method we have found is more acceptable with adults and its effects more lasting."

Again, in reference to the PHCP, Dr. Dolan stated "it is a relatively easy exercise to asimilate the T.B.As into the peripheral delivery services after a period of training directed towards the practice of asepsis, hygiene and the early recognition of problem cases ..... this aspect to the program is to be stepped up, and intensified during Phase II. Greater numbers are to be reached by week long courses ..... extra medical personnel will be soconded by the Ministry of Health for health education purposes." Later she states "We were constrained by the workload in the services field, the limited staff, time and expertise avilable ..... extra input in the area of staff is envisaged with a new and increased emphasis on health education at all levels". (p. 6)

"Phase II plans a more intensive and structured Natural Family Planning program for the District." "Teacher training will be done centrally under the personal supervision of the Program Superviser who is a trained tutor."

No changes - apart from Ministry seconded staff - were envisaged in personnel except a seconded PH Nurse, after 1½ years, to understudy and take over from Sr. Teresa as Program Supervisor.

The Specific Targets for Phase II are :-

"a) Reaching an increasing number of mothers and children in the area of preventive and curative care and ante-natal care."

"b) Putting more emphasis on health education by recruiting and training increased number of local people as village health workers."

"c) From convinced efficient users of Natural Family Planning to identify and train teachers of the method ..... "

"d) To familiarise personnel of the "MOH/USAID Rural Health Program" with the project so as to facilitate the transfer of responsibilities to them."

"Health Education will be promoted considerably by the gradual addition of both a community nurse and an enrolled midwife to each team "....." (Then) each team will recruit and train health leaders from the more remote villages. Short courses of about five days will be held three times a moth ..... Visitation of these health workers shall be undertaken periodicallly ....."

Morbidity data will be collected for some "indicator diseases eg. scabies, chronic cough (3 weeks), bilharzia, eye infection, malaria, measles, whooping cough, polio, malnutrition, diarrhoea and vomiting." (p. 10)

Monitoring will be "at the daily mobile curative clinics and at the static health facilities so that areas of greatest needs may be identified and available resources directed towards improvement."

The Grant for Phase 2.(USAID Grant No.615 - 0219.)

By letter dated June 16, 1983, the USAID Director - Kenya, agreed to provide for support of the Kitui Primary Health Care Project to Catholic Relief Services the sum of $.500,000. The period was to be April 1, 1983 to March 31, 1986.

Specifically mentioned were :

"a) To intensify health education and natural family planning among the population served."

"b) To begin the transfer of activities and responsibilities of the project to the Government of Kenya."

Phase 2. Budget.

For the 3 year budget total USAID commitment was US.$.500,000. The GOk contribution was US.$.370,100. which was to be in form of medical supplies - vaccines only. The DOK contribution was US.$.33,100. which was to be in form of offices and housing for project staff.

The USAID component line items for year 1 are equal to :

	Year 1.	Year 1 - 3.
a) Transport	52.3% *	42,4%
b) Salaries	18.4%	21.2%
c) Health Education/Family Planning	5.4%	8.2%
d) Per diems	5.1%	5.4%
e) Medical supplies	4.9%	5.7%
f) Equipment	2.9%	3.0%
g) Evaluation/Data Collection	2.7%	6.0%
h) Overhead CRS/N.Y	8.4%	8.4%

* (This, however, includes vehicle purchases in year 1. In years 2 and 3 the transport items are 36.8% and 29% respectively).

The grant document specified that :-

"The project will be evaluated approximately 18 months following its effective date and again following its completion."

Implementation Process.

The CRS was required to submit :-

a) A plan of the functional organisation - all agencies - of Kitui District's health services and delivery system as envisaged;

b) An implementation plan "describing the planned steps to eventual integration of the grant activity "in the GOK health services delivery system or, "how services will be continued after AID financing terminates," and

c) " A detailed implementation plan for the first year's activity" and during the year similar plans for years 2 and 3.

The aim was "to sustain the strengths of Phase I and correct its major deficiencies". " Where time and conditions allow home visits will be made and village health workers will be trained."

The specific objectives of Phase II were stated as :-

"a) To provide preventive and curative care to an increased number of mothers and children."

"b) To place greater emphasis upon provision of training for community health workers education by recruiting and training from the local population."

"c) To develop a program of natural family planning education through volunteers who have successfully adopted N.F.P methods."

"d) To insure a full and routine transition of responsibility ..... from the Diocese to the MOH ..... by involving MOH personnel in project activities on a gradually increasing basis."

Few changes were envisaged from Phase I activities but "maximum use of community groups, in particular women's groups from the area, will be utilised." An "integrated 3 days workshop for government officers" was envisaged and it was stated that "relevant government officers" should attend the bi-annual team leader's and team's meetings. Take-over of centres by MOH was also envisaged.

Centrality of Health Education.

To strengthen health education, the Ministry of Health was to second a community nurse and an enrolled midwife for this purpose to each team to train groups of 6 - 10 people from villages over a 5 day period 3 times a month, 8 months a year. The work of the seconded officers was to include :

"a) Sensitizing the community to an awareness that they can take some responsibilities in looking after their health."

"b) Facilitating community organisations which would enable such participation eg. health committees."

"c) Initiating the selection of VHWs by villagers."

"d) Training VHWs and TBAs."

"e) Carrying out simple community diagnosis and keeping records of relevant data under the guidance of the coordinator."

"f) Carrying out most of the health education and school health activities."

Schemes are also outlined for the selection and training of VHWs and TBAs and working with "existing health committees or the establishment of new ones."

Lastly a "project - design summary - logical framework" is appended.

Staffing.

By letter dated 2nd February 1984 the CRS Kenya Director reiterated to Dr. Maneno (ADMS - Ministry of Health) the main points agreed at a meeting on 31st January which included persistence of DOK staff for 2½ years from April 1, 1983 and secondment of two MOH officers in June and July 1984 respectively. Further, after the end of Phase 2, the project work will be continued jointly with 4 teams of 6 persons, DOK - CRS paying for Team Leaders and the Consultant and meeting administrator's costs. For curative services people will have to pay for medicines. Salaries for 8 enrolled mid-wives, 8 nurse aids and 4 drivers will - if Ministry clearance is obtained - be paid by M.O.H. This was never put in to effect.

Planned Administration and Takeover.

The agreement between CRS and Diocese of Kitui was also transmitted to MOH. The Activity Implementation Schedule was forwarded to Dr. Rose Britanak (USAID/Kenya) on 23rd March 1984 by the Kenya Director CRS but implies that takeover by Kenya MOH may not be completed until 1988. It specifies activities for each month up to October 1985 when it is envisaged that 20 project staff will, as agreed, be entering the employment of the Ministry of Health.

GOK/USAID Kitui Rural Health Project.

Since completion of the Kitui Arid and Semi-Arid Lands Prefeasibility Study in 1978, USAID started discussions on the possibility of having a health project in Kitui which would involve MOH as distinct from Kitui Primary Health Care Project.

The project was authorised by USAID on January 22nd, 1982 and an agreement with GOK was signed on June 6th 1982. The project was supposed to take off in August 1982.

By May 1983 Allison B. Herrick, USAID Director, Kenya, was writing to the P/S. MOH complaining that the activities which GOK should have taken to initiate the project had not been undertaken.

Many meetings and exchanges took place between USAID and MOH on ways of getting the project off the ground. However USAID instituted its 60 day project suspension of the project effective on September 26, 1983, by a letter from Allison B. Herrick to P/S MOH.

The suspension procedure allowed MOH to resuscitate the project if specific "corrective actions" were undertaken.

Evidently these were not, since on Nov. 25th 1983 Allison B. Herrick wrote to P/S. MOH informing him that AID was initiating the internal processes for cancellation of Kitui Rural Health Project. Formalistically the 'de-obligation' process was completed in a letter from Charles L. Gladson to P/S Finance and Planning and P/S MOH of August 20th 1984, which states that the funds could be renegotiated for other activities. We have not found evidence of negotiations for their use in Kitui Primary Health Care Project or other health related projects in the district.

Environment and Demography.

Kitui District in Kenya's Eastern Province has an area of 31,000 sq. kms but 6,300 sq. kms is occupied by Tsavo national game park which was cleared of population in 1948. That area, parts of which get good rainfall, used to be the residence of population which was trapped in Southern(Mutomo) Division which is prone to drought.

The western side of the District has hills and ridges based upon clusters of inselbergs which in general have a north/south orientation and, in good seasons, a moderate rainfall. Because the soils are fertile and the higher rainfall probability, the population density in Central Division exceeds 60 person per km. sq. and in Mwingi (Near Northern) Division exceeds 20 per km.sq. It is suggested by some studies that these densities are beyond the carrying capacity of the land and poor people are migrating to the other divisions which are even more marginal.

The other Divisions, Kyuso (or Far North), Eastern and Southern have generally lower rainfall, the inselbergs are generally fewer and soils and/or drainage often poorer. Permanent water is not easily available other than in the big hills (Mutito, Makongo Endau and Mumoni) or in the Thua and Tiva flood plains and channels. Large areas are therefore only suitable for low density rangelands or marginal farming.

Further, rainfall is unreliable, years of drought tending to pre-dominate, and precipitation being frequently of high intensity and short duration. In consequence much of the settlement is semi-permanent despite the lower than Kenyan average population ratio of 3.1 per cent for the District as a whole.

There are only two perennial streams - the Athi and Tana Rivers. The former marks the South - Western border of the District and the Tana having only a short section in the District in the extreme West and North. The other rivers are usually dry but can quickly become fast flowing torrents cutting communications.

Some estimates suggest that other than at vacations 40 per cent of adult males work outside the District. This is reflected in the Age-Sex pyramid (FIG I)

In recent years, tracks have become roads and the Rural Access Roads improvement program and similar programs are making it possible not only for people to take up land in previously inaccessible areas but also for mobile units to reach these areas.

CHAPTER II. EVALUATION METHODOLOGY.

Limitations of Previous Evaluations.

We have tried to avoid the invalid assumptions made in previous attempted evaluations. In particular, firstly, that the impact of the Kitui Primary Health Care Project could be assessed by changes in mortality - specifically the infant Mortality Rate - and by changes in morbidity.

Changes in mortality cannot by assessed without :

a) Data indicating the numbers of persons at risk and

b) The numbers of deaths within that population in a fixed period.

Since registration of births in District, though encouraged, is very incomplete - especially in the thinly populated areas of the project - and since customs in recognition of births as 'live' give rise to under-recording, especially of neo-natal deaths, the number of babies can only be determined by costly "vital events" survey machinery.

Morbidity data of statistical value is at least equally difficult to obtain, especially in an area where cyclical migration persists.

Finally, the succession in the District of drought episodes with periodic serious widespread malnutrition would make impossible realistic assessment of the consequences of any health intervention program.

Previous evaluations have also tended to include statements made by personnel involved in the project without finding means to check these statements.

By interviewing many village people, as well as junior staff of the project, in the Kikamba language, we have been able to go much further in our investigations despite the restrictive time limit - 12 days - of our field study.

Baseline Data.

At the outset it was envisaged that the project would involve not only collection of baseline data and also an on-going monitoring and evaluation process. Neither of these materialised though budgetary items were allowed for the purpose. The scheme for utilising the services - on a per diem basis - of University of Nairobi Medical School Students under the direction of Dr. Marita Malone, had serious limitations.

Exercises appropriate for the training of medical students are rarely pursued with the rigours required for the sustained observation needed for program monitoring. Secondly, the program envisaged in the document "Monitoring and Evaluation ..... " submitted on behalf of Dr. Malone and CODEL at the inauguration of the project, shows signs of having been written without experience of the problems and cost of field enquiries in an African rural setting, in local language, and in an area where the economy is predominantly still based upon providing the necessities for subsistence. Thirdly, within less than a year of the commencement of the program, Dr. Malone, whose students had not infact been in the field at all - was no longer in the same post. Her successor, Dr. Marian Dolan of Mutomo Hospital, was, understandably not been able to resuscitate the proposed data collection method.

Specific Methods Used in Conducting the Evaluation.

a) Document and Content Analysis.

The project was first discussed by CODEL in 1977, with project proposals for Phase I (1979) and Phase 2 (1983). Evaluations were scheduled in 1980, 1981 and 1982. Correspondence between the several bodies involved is massive. These together with Project Grant Agreements give substantive background documentation.

To this corpus of information must be added the continuing project information originating from the project staff and Diocese of Kitui. Study of this documentation is essential if the gaps between expectations and results attained are to be comprehended.

We have also paid particular attention both to project statistics, and to accounts/cash flows.

b) Discussions and Interviews.

1. We have held discussions with all available staff working in the project both in Kitui and Mutomo, and also in Nuu, Kimangau and Muthale.
2. We have further held discussions concerning the project with senior staff in Kitui District in the Ministry of Health, Provincial Administration, District Development Officer, donors operating in the District and with associated staff of the Diocese of Kitui.

C) Observation Visits.

We travelled with the Mobile Unit Teams to clinic sites and villages to observe methods used in the clinics, relations of staff with patients and village people, and - where they exist - Health Committees as well as Traditional Birth Attendants, and traditional medicine men.

d) Interviews Elsewhere.

1. To clarify some issues we interviewed the clinical officers operating the Kibwezi AMREF Primary Health Care Project.
2. We also interviewed two administrators of the Machakos Diocese Primary Health Care Project.
3. Finally we interviewed assorted people who have been related to the program at CRS and USAID.

e) Personal Discussions with Local People.

These included school staffs, and local administration personnel, Chiefs and Sub-chiefs. Kikamba, Kiswahili or English languages were used as appropriate. The goal was to understand current attitudes to the project, their health knowledge and health needs and problems of people.

f) Independent Visits to Villages and Settlements.

It was important to hold discussions with local leaders, both formal and informal, without being identified with the project personnel. This yielded viewsof the target population of the project.

g) Reviewing Our Conclusions.

After our fieldwork we held extensive discussions with key personnel, especially the administrator at Kitui, and the project consultant and supervisor at Mutomo.

The methods employed have made it possible to check many of the more important statements made and opinions expressed about the program by reference to other persons affected by it but in different capacities.

Without appropriate baseline or survey data, and limited to twelve days in Kitui District, and finally, without resources for the employment of survey staff under our direction, the methods used in this evaluation must inevitably be less than optimum. The need for limited sample surveys using carefully selected indicators and based upon structured interviews with beneficiaries, is not obviated by the record of work presented here.

To assess the impact of the program upon people on a long-term basis, more resources than were made available to the consultants would, in practice, be essential.

CHAPTER III. K E Y P R O J E C T A S S U M P T I O N S.

Project Goal.

Stated in many project documents since inception is the following :

"The improvement of the quality of life in rural areas through the attainment of an optimum level of health within the constraints of an existing and developing economy and in line with the National Health System."

This remains a valid goal. The implication that the project should have reference to the state of the economy - presumably both national and local - is important but often ignored, as is the implication that the project should interdigitate with the National Health System.

Project Purpose.

Since inception the project purpose is stated as :- "The provision of mobile health care services to rural areas of Kitui which lacked government or mission medical services."

Though a valid project purpose per se, the implication of the project title - "Kitui Primary Health Care Project" - that primary health care is the objective may have been overlooked by implementers, donors and financial administrators leading to a narrowing of the focus of activities which more clearly define any project's objective.

To bring some services to remote areas has value but the complex of needs of people should not be lost sight of. It seems to us that all primary health care activities can be assessed in terms of W.H.O. criteria distilled after many years of assessment.

W.H.O. Primary Health Care Requirements.

The declaration of Alma Ata (September 1978) stated that a Primary Health Care program should include :-

a) Education about prevailing health problems and methods of preventing and controlling them.

b) Promotion of food supply and proper nutrition.

c) An adequate supply of safe water and basic sanitation.

d) Maternal and child health, including family planning.

e) Immunization against infectious diseases.

f) Prevention and control of endemic diseases.

g) Appropriate treatment of common diseases and injuries.

h) Provision of essential drugs.

A program based on monthly one day visits, each of approximately six hours, by a mobile unit and staffed by nurses and nurse - aides can, by its nature, meet only certain aspects of these criteria. Items numbers c, g, and h would seem to require a continuing presence in the locality.

Effectiveness in meeting criteria numbers a, b, d, and f would seem to depend in large part upon the effectiveness of the educational program utilised. Only item number e - "immunization" - can (presuming an excellent community response) clearly be met by the Kitui PHC mobile units.

In Providing Inputs.

a) That monthly visits by mobile teams using landrovers can sustain the program.

This assumption has been justified in respect of a limited service of immunisation and, less clearly, ante-natal care.

b) That unit teams consisting of one European Nursing Sister (Team Leader), two trained midwives and four on - the - job trained nurse aides with a driver can meet the needs of the program.

This assumption is only justified if the program limits are accepted. Moreover continuity of staff for the development of program related skills is essential to improve performance.

c) That venues selected for clinics may include churches, schools and buildings (eg. unused shop premises) in market centres.

Churches frequently lack available toilets. They may also, in the minds of some ante-natal mothers, be so inappropriate for clinical examinations as to be rejected. Study is needed of responses to particular clinic venues.

d. That a satisfactory service can be provided even when the distance between one clinic site and the next is twenty kilometers.

The problems of mothers with infants or young children, and of women in an advanced stage of pregnancy walking 10 kms and more have not, so far, been studied in Kitui.

e) That for Team Leaders only a limited knowledge of the Kamba language is required.

Though fluent Kikamba may not be essential for Team Leaders, it might improve intra-team relations and especially relations with beneficiaries and so health education effectiveness.

f) That a program concentrated upon infants - under one year of age - and their immunisation can form the basis of a child health program for under 5s.

A serious episode in child rearing occurs at weaning. This usually happens on the second year of life. Success in the transition depends upon both feeding protein rich supplementary foods and avoidance of diarrhoeas as well as infectious diseases.

Fewer children attend in the second year. Mothers cannot carry two infants the vast distances to the clinics. There is doubt about the success of this aspect of the program.

g) Vaccines are supplied by Kenya Government through Ministry of Health and are effective.

The vaccines are available in adequate quantity and regularly. They appear to be potent. Mothers understand the importance of their children receiving the full schedule of immunizations and most ensure that this occurs. There is some circumstantial evidence that the incidence of some immunisable diseases may have been reduced. This is based, though, upon hospital admissions.

h) Specific training for the program as opposed to "on the job training" is limited to two meetings each year of staff of duration 2 days, with occasional visits to teams of the supervisor.

This may not be adequate especially for the development of skills in non-clinical areas, for instance team co-operation, health education and work with health committees and community groups.

For Achieving Objectives.

a) The project has throughout emphasized prevention.

Prevention is the goal of the child health program which is based, firstly, upon weighing and recording against the age in months of the child on a MOH "Road to Health" card, the progress made. Secondly the card provides a record of immunizations. Dried skimmed milk is provided for mothers.

Mothers seem to understand the importance of completing the immunization schedule but may not understand some elements of the weight recording program. The weight track is based on the Harvard Standard and most rural African children do not, even though healthy, adhere to these standards.

b) Prevention of birth complications and foetal and maternal loss is the objective of the ante-natal program.

A carefully prepared Kitui PHC card is used at the examination for assessing the risk category of the mother and so whether the delivery should be at home or in health facility.

Most mothers attend only in the eighth and ninth month of pregnancy and most make no more than two attendances. As many as 50 per cent are classified as requiring institutional delivery but infact most deliver at home with Traditional Birth Attendants. Distances to institutions and the costs of delivery there must be a factor. The program offers little assistance.

Only a small proportion of pregnant mothers in the clinic catchment area - mostly younger - make ante-natal attendances. The reasons for this are not known.

c. The program - emphasising prevention - offers little curative treatment and few drugs are carried. Children and ante-natal mothers are treated.

Men rarely attend. The day - to - day health needs arising from accidents and disease episodes are not treated by the mobile units but patients may be transferred, when mobile units are visiting.

d. "Health education" is conducted at the clinics of the mobile units mainly through talks and demonstrations which mothers of children must attend before being seen at the child welfare clinics.

Methods used include programmed talks by nurse -aides and midwives, discussion based upon pictures and cooking demonstrations.

Mothers show limited interest, even objecting if they have heard the program before. That changes in child rearing and home care practices will result is not obvious. Reinforcement through home visits and the necessary evaluative assessments are rarely made. Program schedules and the emphasis on clinic work tend to inhibit these. Little time is provided for discussion at the clinical examinations.

e) "Health Committees" have been formed at some of the areas served by clinics with the object of supplementing the work of the clinics.

The Health Committees have usually been formed upon the advice of local leaders and clinic attenders. They are not based upon existing and functioning community groups.

In consequence they may not be truly representative or persist without guidance.

The responsibilities of Health Committees are not clear. Effective committees could, through conducting community health education and through joint action, assume responsibility for some of the Alma Ata PHC requirements. This is not, so far, taking place. Few committee members have had training or experience to equip them for new roles in the community.

f) "Traditional Birth Attendants" - with assistance - can, it is hoped, improve local obstetric services. Some - but few - have been called to a central point for training sessions.

The TBAs are rarely given roles in the ante-natal clinics. Relations with TBAs seem, generally, not to have a stable foundation. Progress made must inevitably be uneven but seems to be slow even though the numbers of TBAs within a mobile unit area can be several hundreds.

g) School Health Work - though never a major commitment - was to be an activity of teams.

Inspecting BCG scars and giving initial or - for older children - booster doses could be a useful activity, as could health education on, for example, worms and toilet hygiene, malaria, school infections, etc.

Schools are sometimes visited "when clinics are light" and/or staff are free early in the day. This is not, though, a welcome activity in the eyes of most teams. Training selected school staff members might be a partial solution.

h) Family planning has been adopted as an activity in the form of Natural Family Planning.

FP, in any form, is at present sought by few rural people.

"Natural FP" depending upon a joint decision of husband and wife and requiring a careful sequence of instruction, must represent difficulties. Though assistance is offered by mobile unit teams, not surprisingly, progress in motivating acceptors and in training teachers has, so far, been very limited. There may, however be a "ripple effect" from acceptors teaching their friends.

CHAPTER IV. I N P U T S.

Inputs : CRS Staff and Supervision.

Since July 1st 1983 the top administration of the project at Catholic Relief Services have been the CRS Program Director initially Palmari H. de Lucena who had been involved in the project since 1982. He left in 1984.

The CRS post of Program Director was filled by John G. Connoly during the evaluation period. This coupled by the fact that the CRS Projects Officer responsible for Kitui Primary Health Care Project - Ezra Mbogori - left CRS early in 1985 has led to some unease on the ground particularly since enquiries from Kitui cannot always be directed to the busy CRS top administration in Nairobi.

However we should state that we have not found any major project activity delayed because of these changes. What we have found at Kitui, and incidentally USAID, is unease about dealing with several individuals on Kitui matters.

CRS has already interviewed some people for the post of Projects Officer and as soon as the post is filled we are assured they will be assigned daily administration of the project. Meanwhile queries will be handled by the Program Director and/or his assistant or whoever else they designate.

Project field staff argue that CRS has not actively managed the project in the recent past.

A significant related detail is the issue of budgeting information. Below the administrator nobody seems to have any idea on budgets available. There is thus no coherent foward planning of activities. There is no reason why the hiearchy down to the Team Leaders should not know the budgets. After all they are the ones who make spending decisions.

Inputs : Diocese of Kitui Project Staff.

Administrators :

The top administrators for DOK with respect to this project have been Rev. Father Noel. S. Bouchier - Administrator, Sister (Dr.) Marion Dolan - Consultant; Sister Teresa Connolly - Supervisor. They have all held their respective positions during the period under assessment.

Several important points are worth highlighting with respect to their management of the project during the period under review.

Sister Dolan runs Mutomo Hospital with a capacity of 140 beds. By training she is a Physician/Surgeon. This load and her professional past and interests militate against her putting extensive conceptual and administrative time to the project.

Ideally the consultant should have been a person of her rank who had extensive training/experience in community medicine. There maybe a case for finding such a person to be the consultant if the program is to be extended. Another alternative is to keep her as the medical consultant and appoint another consultant in community health/social work.

Sister Teresa has suffered from serious ill health which has limited closer top supervision of the project on a day to day basis. To some extent her role has been back stopped by the administrator but the detailed coordination and program decisionmaking of the four teams has been affected.

Team Leaders :

The Team Leadership has been stable during the period under review. However the project lost Sister Paschal Crawford who had been identified with the project since inception as the Kimangau Team Leader. She left the project in March 1984 when she was replaced by Sister Eileen Bishop.

The other teams have been led by the same individuals with nursing backgrounds during the assessment period.

Of the four teams three have extremely able managers and experienced Team Leaders. The assessment team was concerned about the management (personnel and program activity) of one team leader but we believe with support by other project staff there could be improvements.

We urge that project to use the talent it has at the team leader level to upgrade continuously project management. This can be achieved by greater sharing of program experience by team leaders.

Midwives/Nurses.

At the Midwife/Nurse level there has been unsatisfactory rapid turnover of staff. Only one team out of four has managed to retain their Midwife/Nurse level staff since inception. We are told that the average service period for this level staff, who are really the backbone of the project as conceived, in SIX MONTHS.

There are recruitment problems. Since inception and with exception of one Nurse - Midwife all those filling the posts have come from Mutomo Hospital which has a midwife training program. Mutomo has had problems finding good students from the communities being served. As a result many of the trainees are from outside the district. On completion of their course, we were told, they are ASKED to serve in the project.

Many of those 'posted' to the project are not serving in their home areas. They thus seek the first opportunity to get out of the project. Project personnel explain this in terms of the project areas being underdeveloped and lacking in career opportunities, with special emphasis on stability in government health system and personal opportunities (including getting husbands).

The midwives we talked to,for their part, emphasise that their colleagues and themselves leave for personnel management problems internal to the project primarily and the reasons above secondarily.

Midwives are not the most suitable personnel for this project. Ideally a team should have a midwife and a community health nurse. We believe that to some extent the preponderance of midwives at this level can partly be explained by the catchment pool of Mutomo Hospital graduates.

Given the fact that Mutomo Hospital MAY begin to train Enrolled Community Nurses in 1986 they may produce the relevant staff. However since the entry levels for the Enrolled Community Nurse Program tend to be higher than for Midwives, it is likely that some centres will fail to attract personnel from their catchment areas who are willing to stay in their areas of origin, as career and marriage demands will force them to move out. This fact leads us to question the relevance, then, of planning the project, as was done in the past, to rely so heavily on this level of staff.

This staffing bottleneck suggests that the project should be restructured to put more emphasis on VHW/Nurse aides, possibly staying in their communities and not being transported around. We are told that such restructuring is problematic but we believe that closer attention to recruitment in communities would lead to identification of useful personnel.

Nurse Aides :

The project did not conceptualise this level of staff coherently. As a result two different sets were recruited. Some are trained at Muthale Hospital and are equivalent to GOK's Patient Attendants. Others are recruited randomly and without a specified educational level.

This incoherent conception has led to serious dissatisfaction at this personnel level particularly since both categories are paid the same salary. There is no scheme of service for them as for everybody else. They have been told bluntly that at project termination they will have to find posts for themselves.

In our fieldwork we talked to nurse aides extensively. We are convinced that contrary to their assigned minor role in the project they have been its backbone. They are mainly from the communities they serve. As a result they are accepted. They, more often than not, are committed to the project goals and are highly motivated, in contrast to the midwife/nurse staff. They do most of the Health Education work which is (and should be) a significant component of any primary health care work. Finally, they have been in the project longest.

We believe the project, if extended, should review its staff use and emphasise the recruitment of nurse aides from local communities. A scheme of service for them, with salary benefit for the two district groups equivalent to similar ranks in government service, should be implemented for them. Their numbers should be increased so that they can be based full time in the community if the delivery system is to be changed to reflect ongoing community education rather than single-day monthly delivery to a point. Savings to finance this should come out of transport savings and the program restructuring discussed elsewhere.

Inputs : Funding Flows.

USAID/CRS.

Pursuant to a meeting between USAID and CRS officials on December 20th 1983 the discussions of which were formalised in a letter by Palmari H. de Lucena to Rose Britanak on December 22nd 1983, a quarterly financial reporting system was worked out. It identifies line items, budgets for plan period, total expenditure, cumulative expenditure including the reporting period, and planned estimated expenditure to be billed to AID the next quarter.

This system was followed for the assessment period.

The detailed data up to March 31st 1985 is found in Annexe . CRS funding is replenished by AID on the basis of this agreed format.

A closer look at this annexe shows that over the 18 months of the assessment period the project has underspent by nearly 20%.

The DOK Administrator has been so advised by CRS, yet the level below him expressed anxiety whether there are funds for continuing the project. We do not therefore understand the information put to project staff that the termination date is October 1985. This was in a general meeting of all staff and has contributed to low morale.

In the grant agreement there is provision for shifting 15% of the amounts of budgeted line items to others. We have not seen any evidence of this.

CRS/DOK.

CRS reimburses DOK on presentation of accountability which is essentially total claims backed by receipts. Semi-annually DOK makes detailed financial returns to CRS on line items. This arrangement seems to be satisfactory to both parties. Furthermore DOK holds a project revolving funds of Shs.200,000, as agreed by both parties and endorsed in a letter by Palmari de Lucena to Rev. Noel Bouchier of 24th January 1984.

One issue we would, though, like to raise is on grant overheads. CRS New York takes 8.5% of all grant monies it administers. In a telegram to Cathwell (CRS Region III) from Bishop Broderick (CRS NY) of 24th February 1983, CRS NY insisted that the 8.5% be remitted, and promised to contribute 4% back to DOK. This was a rejoinder to CRS Kenya's and DOK's position that since the understanding was clear it should only remit to CRS NY only 4.5% and retain the 4% of the total grant for DOK.

We have not seen evidence that DOK has received the 4%. We urge CRS Kenya to pursue this matter on behalf of Kitui.

DOK central administrators are unhappy about purported delays in getting funds. It seems as if the CRS/USAID link does not expedite funds to DOK on request. On the other hand it is difficult for us to understand how with a float of Shs.200,000 the DOK central administration can fail to replenish teams when they need funds.

DOK Administration/Project Teams.

The administrator maintains a cash book for the project. However, there is little evidence of detailed foward budgeting. The cash book has many revisions suggesting that the accounting procedure have not been routinised and thus professionalised. No budgetary information is passed downward.

The 4 project team leaders get reimbursed on claiming (with receipts) from the project administrator. This is done randomly, thus creating operational bottlenecks inspite of the fact that some funds are held in a float. Decisions on how much should be spent in each of the four project areas are made at random at the administrator level. It was explained to us that this is based on "need" as determined by the Team Leaders.

Our view is that such procedure is not sensitive to need and is not a good resource allocation procedure since our interviews with Team Leaders did not elicit detailed planning needs based on the varied travel, population shifts and changing disease patterns. We were not able to cost alternative plans within the time frame. We suggest this is done with a view to expanding activities as the project is underspending.

We were not able to make a judgement on details of administrative costs. Neither are we able to explain the expenditures on evaluation and data collection during the period although these appear in returns.

Inputs : Vaccines.

According to the project document GOK is to finance vaccines. For some curious reason in the Phase 2 project document this is seen as a "hidden cost"!

Since they are so, nobody seemed to have set up an accounting procedure for them. As a result Team Leaders have been picking vaccines at random from Kitui Hospital throughout the assessment period. Lately the Kimangau central has been picking vaccines from Mwingi Hospital. This has resulted in a significant saving to them.

Kitui Hospital records did not in the available time lend themselves to detailed analysis of vaccine costs. However, in the words of team leaders it is important to note that the project has not suffered from lack of vaccines. The KEPI program expanded into Kitui in September 1984. This has assured easy availability of the immunisation vaccines to the project.

Inputs : Vehicles.

The four landrovers envisaged in the project document were bought and on time. They have been used only in the project. None have been in accidents and thus off the road. Three of them are in very good condition. Credit goes to the drivers and team leaders who have ensured that they are so well kept.

The fourth landrover is in bad shape. It has been handled by three drivers during the assessment period. The team leader is not experienced in terms of vehicle management and the current driver cannot do minor repairs.

We have made representations to the Team Leader, Supervisor, Consultant and Administrator on the importance of closer supervision of this vehicle for if the present level of mismanagement continues, it will not last through the project period.

DOK is lucky to have a village polytechnic where minor repairs can be done on the vehicles. Unfortunately servicing is still undertaken in Nairobi. It should be possible to get a local garage to do it well in Kitui with considerable savings on petrol and charges to the project. This should not affect quality of maintenance.

One of the MAJOR findings of our fieldwork was that no clinic was missed because of vehicle problems. When vehicles were in for service, Team Leaders borrowed from other programs within DOK. This has been a significant contribution for a missed clinic leads to an immediate drop in attendance since clients invest a lot in attending. Compliments go to DOK for supplying the vehicles and to Team Leaders for proper planning of vehicle use and initiative in finding alternative transport at the odd times when the landrovers are stuck at Coopers in Nairobi.

Inputs : Housing for Project Staff.

Curiously DOK's contribution of staff housing and offices is seen in the project document as a"hidden cost"! This, however, has not kept DOK from providing housing on a generous basis to all staff.

Inputs : Project Management and Supervision.

Financial and personnel management comments are found elsewhere in this chapter. Here we want to comment on overall project management response to opportunities. We have already mentioned positively the scheduling of transport. Team Leaders have been highly innovative in relocating clinics particularly during the drought when the populations were moving. This is very commendable but it needs to be integrated to GOKs clinic operations by further discussion.

Teams have anticipated crises and responded to them. In one area the response to a rabies 'epidemic' was outstanding. In another area reaction to a measles 'epidemic' was another meaningful response to a crisis. In more than one area switching to anti-cholera extension work probably saved significant number of people.

Possibly the greatest innovation in this project was the simultaneous use of clinics for health and supplimentary feeding of the children. 3,500 kg of DSM and 1,750 kgs of beans were given out monthly during all of 1984 when the drought was at its peak. It is indicative of the misunderstanding of the process between the donors and implementers that this activity was kept out of the formal reports. It is doubtful whether there would have been any clinics at all if the extra funds for supplimentary feeding had not been found. The project design should have allowed for this type of innovation for who would be interested in clinic attendance during such a vicious drought ?

Having said all this, though, we were discouraged by several management issues. The most outstanding one is the rigidity of making all teams approximately equal in terms of personnel and other resources inspite of different workloads. If one aggregates demographic, distance and social factors, Kimangau possibly needs extra petrol allocation given its additional expense. Muthale and Mutomo need extra staff and different circuits to cover the population in greater depth.

Particularly disconcerting is the deliberate misinformation based on invalid contract assumptions. It is bad enough that project personnel do not know the available budgets. It is reprehensible to give the impression that funds will terminate six months before contracted project time.

Related to this is the issue of central management style which leaves Team Leaders essentially on their own. Most teams are very good but, there is reason to believe that one team needs both horizontal and top support. The Supervisors ill-health has contributed to this, no doubt, but the project should have generated backup resources. Given the RIGIDITIES OF THE DESIGN and the inability of the Consultant, Administrator and Supervisor, and CRS to ENCOURAGE REDESIGN during implementation,

[See more under Malaria, Immunization, Schools and Use of Nurse aides] in the words of a member of staff, "the project just copes."

Management can be improved by more unstructured discussion/learning horizontally across the teams than has taken place in past. Cross visits of teams would be very useful since nobody has a monopoly of talent for innovating.

Junior staff need to be more involved in decision making. The very best can thus be used to upgrade the others.

Central administration needs to visit the field more but since we did not analyse the Diocesan loads we cannot make specific proposals. We do, however, feel strongly that the project is under-administered and thus what is internally learned is not incorporated in innovations for the total project.

CHAPTER V. O U T P U T S / B E N E F I C I A R I E S.

Outputs : The Population Covered.

The population of Kitui District are indirect beneficiaries of the project whose impact spillover can be great as better health is a precondition for development. As shown in Annexe 1(p.95), CBS estimates that Kitui population was 576,602 in 1984. Of this, 77.2% are the direct beneficiaries of the project since they are in areas covered by the project teams. This is shown in Annexe 2(p.60) which breaks the project area population into the 4 sub-units. Muthale and Mutomo units, whose populations are just about equal, command just above 50% of the total district population.

One would then imagine that the project coverage should concentrate the activities in Muthale and Mutomo. Such a strategy would not be in the spirit of the project which specifically stated that "The program is (sic) directed to providing (sic) a primary health care delivery system to a population remote from existing government and mission medical services"! To the extent that the project has continued to press resources into the Nuu and Kimangau units, and the least populated areas of Muthale (towards Tana River to the West) and Mutomo (Yatta and Mutha areas) it is within the spirit of the proposal.

In the next Chapter, External Factors we will discuss the impact of drought on the demographics of the project area. All we want to point out here is that impressions we have gathered during field work suggest that the population in the project area was significantly mobile during the assessment period. As part and parcel of their traditional drought adjustment mechanism, they went out to work in other areas. They collapsed into the central Kitui hill massif which is outside the project area. They exited from the district into Machakos, Meru, Embu etc.

There are many references in project documents mentioning these migrations but no hard data. Other migrations were triggered by the plethora of feeding stations established. The OP has some data on this but it is still confidential.

We therefore suggest that in future Team Leaders be responsible for collecting data on feeding programs in their areas and on out migration. Such data is of great value for activity programming within the project. It can be used to service those areas in greatest food need for they are the most vulnerable to diseases.

The project can collect this data in conjunction with or from the CBS, which is in the process of setting up food risk statistical data to service the needs of districts.

To give credit where it is due, we noted earlier under management that clinic sites were changed when populations dwindled in some areas. However, we were not able to establish whether this related to migration patterns in a meaningful way. For example it would have been extremely imaginative to tie primary health care clinics to the large feeding centres by holding them in the same place even if not on the same day. That would have ensured a ready catchment. Perhaps the clear reductions in Ante-natal Clinic attendance in Table 1 and Children Immunisation in Table 2 and Curative in Table 4 reflects the fact that there was significant outmigration. There also was the pre-occupation of many in attending food distribution and food-for-work programs.

No data exists for time use patterns during the assessment period but many mothers explained to us that they could not attend clinics when they also had to queue for food and take part in food-for-work programs.

Outputs : Clinical Services.

Antenatal Clinics Attendance:

There was a significant drop in ante-natal clinic attendances as shown in Table I. For the whole project area this dropped from 37% to target population to 27.8% and finally 21.98% in six month intervals during the first eighteen months of the project. It is expected that it will pick up and be apparent, when the last six months data is tabulated.

Children Immunisations:

These dropped from 56.17% of target population for the whole area in the first six months of the assessment to 44.97% during the next 6 months and finally rose slightly to 47.17 in the last six.

There were increased attendances in the last three months of 1984 suggesting either parallel attendance - for immunization and curative assistance for children - or people returned to home areas as the rains broke.

Adult Immunizations.

These show similar pattern to children as shown in Table 2, particularly in Kimangau and Mutomo.

The deviant pattern in Nuu can be explained by the traditional movement where hardsmen at Syengo (stock camps) in the drier Eastern statelands collapse back to around Nuu Hill as the the drought bites. It this explanation is valid then the drop, as the rains return, reflects movement of people back out again. In total there were 10,727 adult immunisations.

We would urge the project to intensify immunisation of pregnant mothers with tetanus toxoid - 2 doses at an interval of one month - to avoid tetanus of the newborn.

Curative Services.

In a coherent primary health care program one would expect response to episodic diseases. Elsewhere we have touched on those handled in 1985. Aggregated data for the first 18 months, as shown in Table 4, shows increases as the drought bites and reductions towards the last months. 6,725 patients were attended to as shown in Table 4.

This curative activity is mainly confined to mothers and children. Under "Unplanned Effects" we discuss the implications of this restriction.

Malaria.

We believe that malaria should be central in any primary health care program in Kitui. Yet we did not find evidence of project personnel thinking and doing something about it. What would be needed is a generalised community reduction in plasmodium through prophylaxis and early treatment with management of infestation from without.

This calls for a different type of project activity which we were told was not possible since the program only sanctioned the monthly clinics.

Of course aggressive presentation to the donor of this issue by the central administration of the project might have led to redesign of the project during implementation. We recommend that DOK and the donors consider this during the next drought since many people are vulnerable to serious malaria (particularly cerebral) after loosing their immunity during drought. Since malaria hits at peak labour demand periods, its control would lead to fantastically high socio-economic benefits.

Health Education.

In Clinics.

There is little that is good about Health Education in the project. One team leader told us that a woman told her point blank that she did not want to hear the stuff anymore since she had heard it for so long.

We observed peculiar"rattling off" of facts by midwives who did not understand the local idiom. At another centre we saw a midwife and a local nurse aide talk almost simultaneously since the keeper of the "sacred knowledge" (midwife) was not fluent in the local language. At another centre women are forced to listen to the monologue by withholding the numbers tickets which entitle them to attend the child welfare clinic. This is supposed to be an innovation !

We saw terrible posters. Granted, the team leader said they were bad, but she had not drawn on the resources of another team which had better posters (although the colours were not positive in the cultural setting).

Above all we saw the worst of LECTURING AT people.

In extension work, particularly health education, the dialogic method is most efficacious. We understand one team uses it extensively.

Role playing is supposed to be used. We cannot comment on its quality since we did not see any.

We would urge the project to initiate serious dialogic method for the extension of the health knowledge. Good posters are cheap and easy to produce if the project teams work together with other resource people (painters etc.) in the region. The project staff could learn from other development projects designing similar materials both in Kitui and in adjoining districts.

In Schools.

Health education according to the project is also delivered to schools. The Semi Annual Reports for the period identify 79 school visits. We gather that these have been increased in 1985. Assuming that most talks are to the two top classes, the 'talks' could have theoretically reached 10,000 students from estimates in the reports. Any guess work on impact is without evaluation, folly compounded.

In Homes.

Health education is also supposed to be delivered to homes. A previous consultant said health education was viewed as a subsidiary activity in the project. From the Semi-Annual Reports we can only identify 1,470 visits. Thus we must concur with the previous consultant. Home visits are subsidiary activities undertaken "when there is time".

Everybody we talked to agrees that home visits are important but can only be done when clinics finish early (undesirable since the staff only reach those in proximity of clinics) and the one day weekly when there are no clinics. This of course simply means servicing families near the base. We are not sure that they are the neediest.

Among TBAs.

TBAs are in fashion. We agree they have a very important role to play since for the foreseeable future they will continue to handle more than 75% of all deliveries in Kenya. We cannot determine how many TBAs have been upgraded. However there have been 35 TBA/VHW courses. This is an improvement over the previous period.

We are encouraged that two teams have been pursuing this need of TBA's systematically. One team has even identified a "consultant" TBA who handles risk cases after reference from other TBAs. More of these individuals should be identified. Where a consultant TBA has been identified they should be used in 'training' the others.

Again the essence of 'training' should be dialogic and conducted in their home setting. The project should be seen to be outreaching to the community not bringing the TBAs to hospitals or Pastoral Conference Centre situations which essentially threaten them and are not conducive to contextualising the hygene and health problems they have to improve on. Young midwives are not likely to be particularly effective as their teachers as this violates deeply ingrained cultural practices.

We noted, with delight, that some of the TBA courses have been conducted in conjunction with the District Public Health Nurse. This type of coordination and programming should be encourage.

On a final note, TBA's selection for training methods should be tightened possibly using performance criteria ie. number of deliveries in recent past. One program used 5 for the previous month. This would quickly weed out the masqueraders. It would also keep out those referred to by some staff as "witchdoctors" when they meant waganga (awe). The word is perjorative and should not even be used in reports. In anycase until the project develops a public psychiatry program waganga have only a minor role of referring to hospitals those they cannot treat.

Herbalists.

We were struck by the fact that nowhere in the program do professional traditional herbalists feature. We only point this out and offer no solutions since the pharmaceutical problems they present in a primary health care system are phenomenal. Perhaps the teams can begin to think about their role particularly since it is informed opinion that there is unsatisfied curative demand in these remote areas.

Public Baraza's.

Public Barazas are not very effective information dissemination channels unless there is an emergency problem like an outbreak of cholera, or an effort at campaigning for project support. We are told by Team Leaders that they and their staff have attended many more than the 10 identified in the reports over the period. Such time should be better used elsewhere.

Health Committees.

Reportedly there are 17 Village Health Committees formed up to December 1984. More are being formed.

Recent extension thinking argues that community response is better if ALREADY EXISTING community institutions are utilised for many functions. The reason is simply that too many agencies and state departments are busy creating committees at the grassroots. These are hijacked by self-appointed leaders or formal leaders like chiefs who use them for their own ends and not to meet community needs.

Unfortunately identifying community leadership is a long process for which donors and implementing agencies or government departments do not have funding and/or time. If a community health program is to succeed there must be a careful process by means of which the community chooses the representatives. A simplified methodology of this follows.

The idea of the need and tasks and qualifications expected of the community organisation and representatives should be introduced to the localities formal leaders - government, ALL churches, harambee groups and clan leaders. Adequate time should be allowed for discussion of the health problem. There then should be public meetings where those proposing the service and the community discuss the project preferably under government aegis. The representatives of the community should be selected in public. Of course details will vary in each case. The public choices MUST BE HONOURED. Too many agencies keep to their personnel networks at fantastic cost to projects.

We only examined one community health committee in great detail and have communicated our findings to the Team Leader.

We are not convinced that greatest care has been taken in finding community institutions to deliver primary health care. This should be a priority issue during the rest of the project period.

Respiratory Tract Infection.

This appears in the reports as "coughs". It is thus difficult to assess its import in the project. However it raises the important issue of unsatisfied curative demand in postnatal care. Further documentation of this by the project to establish its saliency is needed.

ORT.

Inspite of the squabbles about ORT delivery information in rural areas we consider the extension of ORT, particularly with locally available materials and measures, (definitely not imported packages) important. It tends to be upstaged by bad nutrition teaching, a situation which should be reversed in the project.

We were struck by a case of an old lady (past 70) who knew how to prepare CRS. She arrived with the ingredients on a roadside scene when one of the team midwives was attending to her husband who was vomiting and had bad diarrhoea. Again coordination with public health and nutrition MOH staff would be useful.

Unsatisfied Curative Demand.

Populations of the remoter areas have a crying need for curative services which we believe has been triggered by the reliability of the visits of the clinics. Particularly important in this respect are adults, especially males, and school children. They are patently discriminated against in the clinics. This is a design problem of the project. The donor did not want to emphasize curative health. The project again was structured in such a way that it did not, as we would prefer, have personnel who are living in the communities as the main peoject delivery channels.

Simple curative services particularly of malaria and other fevers, diarrhoeas, worms and anti-tuberculosis immunisation (perhaps triggered by the project) should be tied to the program.

This has staff mix implications (community nurse or clinical officer rather than second midwife as is the case in many teams now and/or nurse aides in situ as village health workers) and transport cost implications. If slightly more curative care is offered and/or nurse aides/village health workers are put in situ there would be a big drop in unit transport cost. Such a saving could, in turn, be used to expand the project within the communities served.

Schools.

Two areas of special concern for the schools have been unanimously identified by all teams. These are upgrading immunisation and reproduction education for standard 8 (especially girls). We agree they are of importance and should be implemented as soon as possible. On immunisation we think the strategy should be to start with pre-school children and move up to the higher classes since it would take little time and there aren't major impediments.

Sex education is a little more problematic. The project should initiate discussion with the school supervision hierarchy to plan the best strategy and discuss how such information would dovetail into the newly introduced health education curriculum.

Environmental Health.

The project has not systematically thought much about this and drawn in those concerned.

We found that in one Team's area there are no toilets in 10 centres where the clinics take place. Another team has no toilets in 2 places they hold clinics. It is true that Mutomo, through the public health technician and harambee groups is doing some extension on toilets. All are not involved to as a great degree as current needs demand.

Sound toilets are central to a decent community health program. There are public health technicians in the minor towns/locations who could be encouraged by the project to do more extension work, to spread the knowledge on how to measure toilet holes, what wood from local trees does not rot from urine when used for the slab and above all maintainance of toilets.

The project can draw in the chiefs and sub-chiefs who have explicit orders from OP to ensure that toilets are not only built in every homestead but used. The project can thus act as a resource. It could catalyse communities to act independently.

Protecting water sources is another activity in which the project could act as a resource.

For these to take place, though, the project will have to break out of its female target population focus and become truly community oriented.

Reliability of Service.

The MOST DRAMATIC POSITIVE finding of the assessment is the fact tha ALL the planned clinics have taken place in the period under review. 1152 clinics were planned in all the four centres. Only 60 clinics ie. 5.2% were missed. Of the 60 missed clinics 39 (3.38%) were in Nuu; 17 (1.47%) were at Mutomo and 4 (0.34%) were at Muthale. Kimangau has the achievement of not having missed a single clinic.

It is a mark of how seriously vehicles and personnel are managed by the Team Leaders, Supervisor and Administrator that none of then were off the road to limit operations although in a few instances the project had to borrow a vehicle from other projects. Clinics were only missed because roads and bridges had been washed away.

Natural Family Planning.

The only evidence gleaned from the Semi-Annual Reports and interviews is that there are 3 tutors, one each at Nuu, Mutito and Mutomo. About 121 couples have been trained in Natural Family Planning from July 1983 - Dec. 1984. This includes the 12 teachers of the method and those actively practicing. Many more have attended a session here and there but are not active. Project staff confess that it is hard to find many couples committed to this method.

The method for training is to bring the individauals to a centre and hold a 2 day seminar. Some seminars for one week have been held for the teachers.

In summary, the impact of Natural Family Planning seems to be insignificant in terms of numbers reached by the program and the resource people to teach it. One centre report states another reason - perceived infertility - as the problem. To quote the Nuu KPHC Project Semi-Annual Report, July - Dec. 1983 :- "Efforts to promote family planning met with poor response. The problem of infertility is seen as greater than that of fertility by most families."

The curriculum of NFP depends on personal relationship particularly those of couples and their teachers.

On the wider issue of Family Planning (spacing and terminating reproduction), all project staff state emphatically that in Kitui it is not seen as a priority by the population. It will take along time to secure a meaningful output from this activity.

CHAPTER VI. EXTERNAL FACTORS.

Impact of Drought on the Project.

During the period under review there has not been a good crop in the District. In fact the last crop which partly met the subsistence needs of the people of Kitui was the long rains of 1983. This was during the period when the KPHC Project was being run with the remainder of the CODEL Grant. The subsequent short rains in 1983 and long and short rains of 1984 failed totally. 1985 long rains are good in the district with the exception of Southern(Mutomo) Division where it is estimated there will only be 25% food self-sufficiency

Since this evaluation is for the period April 1, 1983 to April 1985 the statement on lack of food is firm for the whole period.

As the January/June 1985 Semi-Annual Report is not complete, it is not possible to show the detailed impact of the drought up to the last half year. However, for the whole assessment period the district has been receiving 1500 metric tons of grain and 500 tons of DSM monthly. 90% of the population was at risk. This food support is continuing.

In 1984 Kitui was so badly hit that it is estimated that only 20% of the acreage usually planted during the short rains (October/November.) - which are the main crop rains in the district - was planted because seeds were not available. Maize seeds were Sh.20 a kg. and cowpeas Shs.60 in November 1984. Up to now (May 1985) the district is still under famine relief. Furthermore, whatever was planted in October/November 1984 was eaten by army worms. However, there was some replanting.

Ironically, after the army worm attacks of October/November 1984, the rains have persisted since then to now (May 1985) with good consequences for livestock. The famine reserve for the district is shoats and cattle. Their prices collapsed completely during 1984 so that Sh.10 could buy a shoat, Shs.2 a chicken and Shs.200 a full grown ox. Current (May 1985) prices are Shs.200 per shoat, Shs.50 for a chicken and Shs.3,000 per full grown ox. This simply reflects the fact that people want to rebuilt herds within the traditional drought adjustment patterns.

On the food side, subsistence self-sufficiency is expected at the end of current rains in general if rains persist for another month with the exception of Southern (Mutomo) Division where it is estimated there will only be 25% self sufficiency.

The drought led to transhumance which is a common drought adjustment mechanism particularly in the project areas covered by Mutomo, Nuu/Mutito and Kimangau.

This is widely reported in the project reports.

This migration makes nonsense of the statistical base of the project since nobody (even Provincial Administration) has solid data on where people moved to, how many and for what periods of time.

However, having said that, we can look at the project data and relate it to the drought.

The Ante-natal Attendances (T.1)show that in July/December 1983 period the project as a whole was reaching 37% of the target population. This dropped by ten percent to 27.87% in the January/June 1984 period. It was to drop by further 6% over the July/December 1984 period to 21.98%.

If one compares the specific centres the most dramatic drop over the 18 months period is Kimangau which in the first 6 months was reaching 43% of target population. It dropped to 35.6% and 29.30% over the next six months intervals. Mutomo has a 12% drop over the same period. Muthale has a 11% drop and Nuu 8% drop. Clearly then mothers were busy looking for food.

As shown in Child Immunisation(Table 2) there is a drop from 42,123, to 37,235 to 34,141. In percentage terms the overall drop is from 56% to 47% over the whole period. Looking at specific centres Mutomo shows the most dramatic fall. It dropped from 63% to only 37%. Kimangau dropped 12% points over the period.

These drops may be explained by the drop in births usually related to drought and/or the collapse of the economy with its attendant foraging, and immigration out of the area.

Mutomo shows the highest drop of 5,378 children. Significant numbers of families in Yatta, Mutha and Voo migrated out of the region in the period. Nuu's lower drops may be explained by the fact that those far out at the stock - camps came back to the Nuu, Mui, and Lundi area where there is water even in the worst droughts.

The adult immunisations Table 3 shows a slight increase in total numbers from 3,629 to 3,784 and then a slight drop to 3,314 over the three periods.

Similarly curative services show patterns which relate to drought. Table 4 on Curative Services shows children attendances as rising from 3,772, 3,751 and 4,717 in the three periods as the drought hits. On the other hand as more adults go foraging the figures drop. For the three periods they are 842, 2,036 and 2,008.

These clinic figures would have fallen to zero if the project had not fed attendants.

Having looked at the impact of the drought on the project one would like to pose this question : "What is the role of a primary health care project in drought ?"

First, it seems to us that the project should anticipate drought conditions by analysing its clinic data. It should be aware of the possible migration patterns and should adjust its project activities to handle more effectively drought derived stress and disease.

There were individual staff and team initiatives covering aspects of this response in Kitui but given the unimaginative design and administration at the project core (DOK and CRS/USAID) the project as a whole did not make coherent responses.

If it had, its delivery mixture would have changed eg. to giving general nutrition support including vitamins, relocating clinics more systematically to take advantage of feeding program centres, not worrying about the maternity deliveries drop at Mutomo Hospital, and moving into the curative and food clinics.

Such imaginative reprogramming during crises calls for a much more sure, astute and fast responding project management than the nervous "layback" style we have encountered. It calls for drawing on extra resources within and without DOK and specific proposals to the donor who, in this case, was involved in feeding and other drought related activities in the District.

Roads.

The donor, and project planners within CRS andDOK, and previous evaluators, do not seem to have been on top of the problem of road plans for their expansion and population shifts which accompany new communication networks. More importantly, the project could have played an advocative role in the district planning process to argue for some key roads to concentrations of populations eg. Lundi Valley at Nuu, thereby increasing the cost effectiveness of project transport. Many roads were being done under the food-for-work program. If all parties were attentive to the inter-relations of these factors much more flexibility would have been BUILT INTO PROJECT IMPLEMENTATION

Although we are aware that this might have called for much more social science input into project planning, and implementing methods/activities by people with more extensive district knowledge, the Diocese does not seem to have drawn deeply upon its personnel who have some of this knowledge but who were in other programs.

Again, it is a problem of the project being seen in narrow medical terms and being handled wholly be personnel so oriented. District GOK officials (especially DDO) would have been important sources of this planning information.

Specifically there are major road plans which have opened up the Yatta area for much more dense settlement than was apparent at project inception. This should be taken advantage of. Still in Southern Division, there are roads under construction in the Eastern extremity of the district which will be a factor in the demographics of the area. Road networks linking Tsavo with Northern Kitui in the Eastern statelands will stabilise some of the populations there and therefore create demand for health services. So will road proposals for opening the triangle of Mwingi, Thatha Hills and Tana River. Others proposals are for the Tana, Katse and Tsaikuru area. These are the remote areas upon which the project rationale is based.

Previous work in the district has established that Kitui population responds to communication systems expeditiously. This should always be incorporated in project design, implementation and monitoring and evaluation.

Cancellation of USAID Kitui Rural Health Project.

On August 20th 1984, the proposed Kitui Rural Health Project, which was to be funded by USAID, was formally cancelled although the de-obligation date was November 25th 1983. This was the project which the DOK expected would take up the responsibilities of its primary health care activities. We would like to go on record in support of the then proposed project.

Sometime this year, in January/February, USAID informally spread the word that it was not interested in refunding primary health care for CRS/DOK. This has been communicated to project staff and they are in panic particularly since other information suggests that the termination date is October 1985.

The USAID Kitui Rural Health Project was ostensibly cancelled because MOH did not get budget allocation for it formally. In the cancellation letter an opening was left for reprogramming the funds.

The USAID Health and Population Program has shifted in emphasis over the last two years to concentrate on population matters (including natural family planning). This is an opportunity which CRS/DOK could explore for possible future support. The net effect of the cancellation by USAID, and the program shift in CRS, is that personnel in the project are unsure of the future since they tell us they expect the project to end in October 1985 in spite of the fact that the project documents state that the Project Termination date is March 30th 1986.

We believe this confusion arose out of a cautionary letter from CRS about spending rates in 1983. However the project is currently underspending.!

USAID/CRS have responsibilities in clarifying this point to the staff. DOK has responsibilities for clarifying the employment situation to staff, particularly the nurse aides, and drivers. We are told that promises were made to midwives/ nurses but not any of the others.

Integration of DOK Planning/Implementation Processes.

Theoretically all development activities of the DOK are under the Development Coordinator who does not seem to have planning staff. This project was administered under the Health Office. It is not our business to tell DOK how to run its hierarchy but some pertinent issues impinging on the project under assessment need to be raised.

First, there was not systematic planning of the project. Secondly, there were too unrealistic demands from the donor accepted by the DOK on specific monitoring issues like demographics, mortality rates etc. which with proper planning inputs should not have been accepted since they COULD NOT in any way be achieved within the budget, personnel and time frames in the document.

Third, the internal planning and implementation coordination within the subunits of the DOK did not seem to be supportive of the project under assessment. True, resources (especially transport and maintenance knowledge) were borrowed but this is random activity.

Fourthly, and perhaps most importantly, DOK sub-units have many conflicting goals. Even within the project under assessment understanding of goals, and means to them, seems to depend on DOK sub-unit origins of the individual and their positions on some basic issues within the DOK.

Fifthly, given the political and medical push for static facilities within Kitui, it seems to us that this project with its pioneering thinking could form the basis of long-term meaningful development. This calls for a much more active role - in conjunction with GOK District Health Officials - which used to exist in the past. The cancellation by USAID of the KPHC Project seems to have rent all and sundry asunder.

It is, though, important that the project staff liase with GOK Health Officials on the clinic need patterns now that the following static health facilities are to start functioning;

Kaui, Miambani, Mwitika, Kanyangi, Kwamutonga, Nzawa, Kasala, Tiva, Kauma, Kaumu, Katyethoka, Winzie, Kisayani, Ilengi, Tyaa Kamuthale.

District Focus.

As is the case with many NGO's, CRS/DOK will have to adjust to the new District Focus for Rural Development which was introduced by GOK in July 1983 and whose impact on NGO activities is yet to be fully felt.

Central to District Focus is the idea that ALL PROJECTS will have to be INITIATED by local communities. They will have to be prioritized by LOCATIONAL DEVELOPMENT COMMITTEES and move up to DIVISIONAL DEVELOPMENT COMMITTEES and finally be prioritised for funding and implementation by the District DEVELOPMENT COMMITTEES.

The DOK does not do this with respect to this project. The point is simply that almost all feeding clinics could theoretically be closed now if challenged. The era when NGO's could initiate THEIR programs is over. We would be irresponsible if we did not point this out.

Rectification of this omission should be a priority IMMEDIATELY, for sins of omission are not acceptable defenses whether in law or politics. Any sub-chief, Chief, DO, and ultimately the DC, can close any of the project activities on the basis that they were not passed by communities. By the way, the fact that sub-chiefs, chiefs, DOs or even the DC or MP "knows",as project personnel told us, is immaterial. It must be the community, pure and simple. If it is to be general development it cannot be church only.

The new District Focus Training Framework also expects NGOs to fit into an overall district development training program which shows how skills of those employed are to be upgraded on the job. DOK should participate in this activity in Kitui.

We are informed that a District Health Committee is being planned as a sub-committee of the Executive Committee of the DDC. The project should seek representation in this.

CHAPTER VII. U N P L A N N E D E F F E C T S.

Sources of Nurses.

As a result of this project Mutomo Hospital became the source of project 'nurses'. Of course they are trained as midwives and not community nurses. We have not seen evidence that there were general attempts to find such community nurses who are the personnel most suited to this type of project.

Elsewhere we have pointed out that these midwives stay in the project on average six months. The project is a training ground in community health for midwives ! Perhaps this will be of use to some other projects later on. Midwives career advancement demands that they work in maternity wards delivering babies. Nobody should be surprised that they leave the project

Nurse Aides.

The project developed demand for nurse aides to handle the work-load in the clinics. Although the initial rationale was for non-technical activities like weighing, they have developed to be the main communicators of public health education. This has been so since many of them, unlike the midwives, are from the District, and, speak the local language. This gives them a communicating edge. The project never envisaged this and as a result they do not have maningful scheme of service. Many are apprehensive about their future if the project ends.

DOK assures us that something will be found for them. Since they have the project experience, they should form a useful pool of community health workers if somebody can plan their utilisation in local communities.

Unsatisfied Curative Demand.

The project is a female project run by females. An old man came to a clinic during our field work and since the only males he could see were the consultants, he gravitated to these 'doctors'. He talked at length about the unfairness of the project.

It is true that the only medical personnel seen in the remote environs are the female project personnel. Since most of the people cannot get any medical help locally, and, distances are too vast to travel, the curative demand triggered by the project's presence is unsatisfied.

The donor has of course stressed health education, training of TBAs, natural family planning, and de-emphasised curative. We believe that inclusion of a clinical officer/nurse in the project to handle simple curative issues would have been prudent. It should not have led to large cost variations.

For the future the donor, and primary health care project implementers, should be aware that any outreach into the really in-accessible areas is discriminatory unless it services some of the curative demand it generates.

Ironically needing curative services women, girls and children, can get into the clinics and be served or referred. It is the men and boys who cannot. The ante-natal and immunisation emphasis, together with the all female staffing means their presence is not tolerated. The simple curative care demand generated is for malaria, diarrhoeas, coughs, bites, and dressing of wounds.

Feeding Centres.

As discussed elsewhere Kitui District was hit by a serious drought during the period under assessment. Very many feeding centres were set up by GOK and NGOs. There was therefore some confusion in the public mind that the project clinics were feeding centres. Perhaps it was this which led to the pressure by DOK to CRS to get some food to use in the clinics for feeding. That however is not our main concern here.

Our concern is the fact that the clinics had some good data on children at risk. Given that those children were identified, it would have helped the GOK and other NGO feeding programs if the families of the children at risk were followed, identified and linked to the sub-locational famine relief committees. These were the committees handling the bulk of famine relief food.

No district-wide system existed during the drought for selecting mothers and children at risk and putting them and their families into the main GOK feeding programs. Since the project had been attending to many families, their data could have been used to feed into the selection of families at risk for three quarters of the district. In some basic sense it is counter-productive to give out food to children coming to clinics while the family is without food. The food gets shared as project people know.

A national famine relief risk family selection system is being designed. Its major concern, during future droughts, will be to merge all data on families under risk and to ensure that health and feeding program respond to FAMILIES and not INDIVIDUAL CHILDREN or MOTHERS. Perhaps the project can contribute to Kitui district thinking on this as it claims to handle 77% of the population.

CHAPTER VIII. L E S S O N S L E A R N E D.

USAID.

USAID intended to use the DOK/PHC project as the pilot for the more comprehensive Kitui Rural Health Program. This later program did not take off since GOK could not come up with the local component funds on time, or award contracts

A lesson learned out of this with respect to the project under assessment is that USAID should not have used an NGO pilot project as a planning base for a GOK program. If the GOK through DMOH Kitui had been involved in implementation of PHC project initially, perhaps the foward planning for MOH to include local contributions to Kitui Rural Health Program would have taken place.

USAID should be aware that feasibility of a project like this must be assessed having regard not only to the resources anticipated to be available, but to the time frame of the project, and also to the nature and strength of the impediments to success. The impediments in the KPHC project as well as distances, road conditions, floods, vehicle limitations also included beliefs, attitudes, knowledge and pre-program life-styles as well as poverty, and propensity to migration.

It is not easy to pilot a project through an NGO and then transfer it to GOK operations. Ideally the two sectors should work together on pilot projects.

CRS.

CRS got into KPHC as a result of terminating its feeding project which went on during the 1974 drought. Whereas a feeding project has few flow steps, mobile clinics have many flows and implementation problems. To begin with are issues of site selection. CRS should have got more planning into the location of the clinics. This would have enabled other resources, like personnel and transportation costs to be adjusted to the differing demands of the four sub-units. They should have insisted on flexibility in personnel and implementation methods.

It should be pointed out however that CRS sees itself as only a 'conduit' for the funds. Be that as it may, they should have given better planning and leadership of the project.

DOK.

It is useful at times to distinguish between soft and hard donors. The former are typified by the missionary boards who send money to implementers and rarely ever require continuous program accounting, monitoring and evaluation, other than in the most general way. USAID on the other side is a hard donor requiring detailed feasibility, planning and evaluation and monitoring processes. Such monitoring must be a built-in evaluative component of the project with a budgetary item and a defined minimum procedure. If sampling through home visiting is essential, this must be a component. The expertise needed for this component should be a consideration in project staffing.

Most of the DOK people in KPHC had never administered program funds from a hard donor like USAID. As a result there has been less than smooth handling of finances, collection of statistics and general accountability.

Significant proportions of DOK staff do not understand why monies do not flow smoothly. When we were in the field, one team leader was complaining she could not get replenished by the Administrator since CRS had not sent the money. On its part CRS, argued it had put claims to USAID more than a month before. On our part we do not understand the problem since there is a Shs.200,000 float based at DOK.

DOK staff are still bitter about the fact that between April and June 1983 they operated without DOK funds being replenished.

The basis of these complaints seem to us to fall on the filure to clearly think of an accountability, monitoring, data and money flow systems. If such systems were set up within reach of DOK resources, there would have been less misunderstanding.

The other key lesson in activity planning the DOK has learned out of this is the inadequacy of its central planning mechanism of only an Administrator and a Consultant. They are too busy with normal Diocese work to be expected to administer, and coordinate field activities. They have not been able to keep up with the required data reporting by the donor. This problematique of overworked core administrative staff being required by donors to report on the project in some measure explains the DOK hostility to evaluation. It also means that there cannot be systematic thought given to the redesign of the project during implementation.

Sustained direction of the project by persons having appropriate status and experience should have been a criterion for project authorisation and support.

Such project leaders must make an appropriate commitment but need the advice and support of a project steering committee which embodies not only appropriate expertise,

but also the wider view point of the bodies and agencies directly and indirectly involved. Direction must not be remote and sporadic and based only upon transmission of reports.

The DOK could have set up a cheap project data gathering system for the Teams. Such a system would have produced information for redesigning the project as well as the desired donor project information.

Such reports should embrace all key activities of the project and be presented largely in statistics of activities with the narrative component dealing with explanatory information.

Monitoring and evaluation information is most efficiently collected by implementers. It is a necessary procedure for hard donor funding. Implementers should, out of the feasibility studies, have done some baseline studies. Although these would not have been comprehensive, they could have focussed on a number of key indicators including changes in behaviour and enhanced capacity for self-care which can, despite constraints, be monitored at reasonable cost.

In a program with the goal of "the improvement of life in (underserved) rural areas" progress will largely depend on strengthening the capacity of the village community to help itself, so, strengthening existing local groups and where necessary encouraging the formation of new groups, strengthening leadership capacity, increasing health awareness - especially by a two - step process of leadership training - is likely to prove the most efficient approach to securing health improvement.

Health education "would be understood as planned efforts to secure beneficial behaviour change." It depends for success more upon establishing a relationship, that is upon "source credibility", than upon techniques derived from the methods of formal education. This different approach necessitates professionals assuming a new spectrum of roles as counsellors, advisers, co-workers, and friends of the community. Training is needed for these new roles and the transition may, in practice, not be made without difficulty by some professionals.

To derive a new and effective program partly from residual elements of a previous program with a different set of purposes may seem socially desirable and likely to bring economic advantages but may in fact be far more difficult to implement than is appreciated. A drastic rethinking, with reorientation of staff, is highly desirable.

Worthwhile projects are innovative and require of staff skills and capacities which usually have not been a part of their preparation or experience. Training and staff development, with career enrichment, should be pre-planned and continuously reviewed during the project.

CHAPTER IX. RECOMMENDATIONS

RECOMMENDATIONS

Preamble

Provision of health care for scattered populations living in remote areas without public transport is a problem confronting many third-world countries. Prescriptions for 'primary health care' have to be re-examined to fit the living patterns and constraints imposed. People living in marginal areas live, characteristically, close to the minimal subsistence level and have few resources. They are subject to especial hazards, in particular climatic fluctuations, and so residence patterns tend to be instable.

Designing services to meet these circumstances, especially on stringent health budgets, presents particular challenges. Continuously manned static health facilities will rarely be justifiable. The alternative approach, that is assisting the community to meet from its own resources as many as possible of its needs, is more feasible and adopted increasingly. The primary resort, then, must be to people and facilities within the community, especially to meet urgent needs arising, for instance, from fevers and accidents. Less urgent needs can be met, firstly, in the community and eventually with outside assistance.

Kitui Primary Health Care Program - Phase 3.

To be effective a primary health care program for rural Kitui should be aimed, firstly, at progressive development and expansion of local capacity for self-help in health. Secondly, it should aim to make provision for particular needs which it is apparent that local resources will continue to be unable to meet.

The present Kitui P.H.C. program needs, then, firstly, to be reinforced by development of the capacity for community self-care promotion. The second programme need is training of staff for the implementation of a scheme of comprehensive community health improvement.

Promotion of community self-care can best be undertaken through health education of the community, utilising both community wide meetings (barazas) and discussions with existing groups and their leaders. Discussion of health problems, and of their needs as seen by village people, provides the basis for adoption of proposals for community action. Responsibilities can be shared between those community groups who agree to work on environmental improvement and selected volunteers who will be responsible - after training - for individual and family care.

The initiation of the discussions and community education - playing an advisory and not an executive role - must be the responsibility of the Kitui P.H.C. staff, in co-operation with extension staff of the Ministry of Health (staff of the District Public Health Nurse, the District Public Health Officer, the District Health Education Officer, etc.), Ministry of Agriculture (the Nutrition and Extension Staff), Ministry of Culture and Social Services (the Social Welfare and Adult Literacy Staff), Ministry of Education (the school staffs), etc..

When the community has agreed the steps required, and identified those to be responsible for the program and those needing training, it then lists those items of tools and equipment required which cannot be secured using only community resources. When they are committed to the program communities will usually agree to provide labour for building a simple house if some of the materials can be provided. Provision of tools and materials, as well as of training, is the responsibility of the Kitui P.H.C. program, but in association with government extension staff and with assistance from local Development Committee resources. (Usually this will be the Locational Development Committee.)

The establishment of a community based primary health care program on sound foundations requires time and sustained effort. The steps taken in development of the program should each follow the decisions in support of the program made by those accepting responsibility. Each of the four Mobile Unit teams should select, for its first effort, one area - possibly a Sub-

Location) where local people meet and communicate at, for instance, a market. To secure collaboration spanning clan, religious and other group affiliations is often a slow process. The programme should be envisaged as progressive, remembering that ultimate sucess will depend upon continuing cohesion, community commitment to the scheme and resourcefulness. Results will reflect the strength of the foundations laid initially.

One community health volunteer is required for about twenty families. Training should be short; possibly only for one week at the first stage. But it should be followed by a series of one-day meetings of volunteers to discuss problems encountered and results obtained. Training should take place in a school, or community building, in one of the villages and, when appropriate, village elders should be invited to participate. It should be based upon community needs and confusions as these were disclosed in meetings and discussions, but further information should be gathered from community self-surveys conducted by groups, complemented by the survey efforts of the volunteers. The data compiled from these sources should provide base-line data for the program.

In training, demonstration, dialogue and discussions should be used; that is, methods very similar to those to be used by the volunteers in their work in the community. The local language should be the main vehicle of communication, and literacy should not be a requirement for selection for training. Use should be made of songs, story telling, role playing, and discussion pictures produced locally. Where they fit local interests, plays should be produced and slogans developed.

For each of the selected Sub-Locations, or areas, a resident Community Health Co-ordinator should be chosen. She could be one of the present Nurse Aides who has received further training for community work. The Mobile Unit team continues to provide services as at present but in collaboration with the CHC, and also provides support for the CHC in

simple drugs, for instance anti-malarials, and first-aid supplies. The CHC and the Mobile Unit staff should also participate in barazas and in some parts of the training programmes. The Kitui P.H.C. group should also, when necessary, be reinforced by Ministry of Health staff, including the Public Health Technician to promote environmental improvement, and the District Public Health Nurse assisting in her program to improve the performance of Traditional Birth Attendants.

The process of co-ordination and co-operation with District Staff should begin at the District Headquarters, Kitui, but should also be continued at the Locational and Divisional Development Committee levels. Centrally the project should be directed by a Steering Comitte meeting quarterly, with representatives of the Diocese of Kitui, the Ministries most involved, any other interested agencies, and project personnel. Inaugurating and sustaining the interaction centrally, and facilitating good relations at more basic levels, must be part of the responsibility of the Program Director.

The functions now to be undertaken in community health care by the Mobile Units, will require re-training of personnel and skilful direction and supervision. The impact of health education at present is limited by the social distance and communication gaps separating Mobile Unit Staffs and village people. This is exemplified by the lack of home visiting and by infrequent attendance at community and group meetings. But the impact gap is also widened by the lack of training of staff in methods suitable for the transmission of attitudes and skills calculated to secure behaviour change. The main responsibility for training to improve communication with village people must be carried by the Program Director. The person selected needs to have experience of group work, as the basis for community decision making, as well as capacity to assess progress made in community behaviour

The proposed program will require increased administrative support including a full-time Program Secretary. Innovations in staffing and service contracts - career opportunities must be made available -and in equipment, including educational aids, also in training procedures and program schedules and reports, will require more resources for central administration. A small specialised library for training, with films and visual aids may also be found to be useful.

Outline Program - September 1, 1985 to August 31, 1988.

Specific Requirements - additional to present program requirements.

1. Program Director - based in Kitui - office, vehicle and driver.
2. Program Secretary- Kitui - office equipment, teaching and training aids.
3. Four Community Health Co-ordinators - one attached to each Mobile Unit, village based, with community built house including a room for small group meetings, and storage of anti-malarials, O.R.T. packets, first-aid equipment, etc.

Program Schedule

Pre-program - agreement with administering agency..

September 1, 1985 to March 31, 1986.

Recruitment of Program Director, Program Secretary and Driver.

Purchase of vehicle, training aids and equipment.

Establishment of office, with telephone, etc.

Training of present staff in community based health care.

Selection and training of Community Health Co-ordinators.

Establishment of CHCs in villages.

Systematic collection of base-line data.

Inauguration in Kitui of Steering Committee with representatives of Diocese of Kitui, Ministries, administering agency and USAID.

Program Schedule (continued).

April 1, 1986 to March 31, 1987.

First half-year - extension of program to four Sub-Locations.

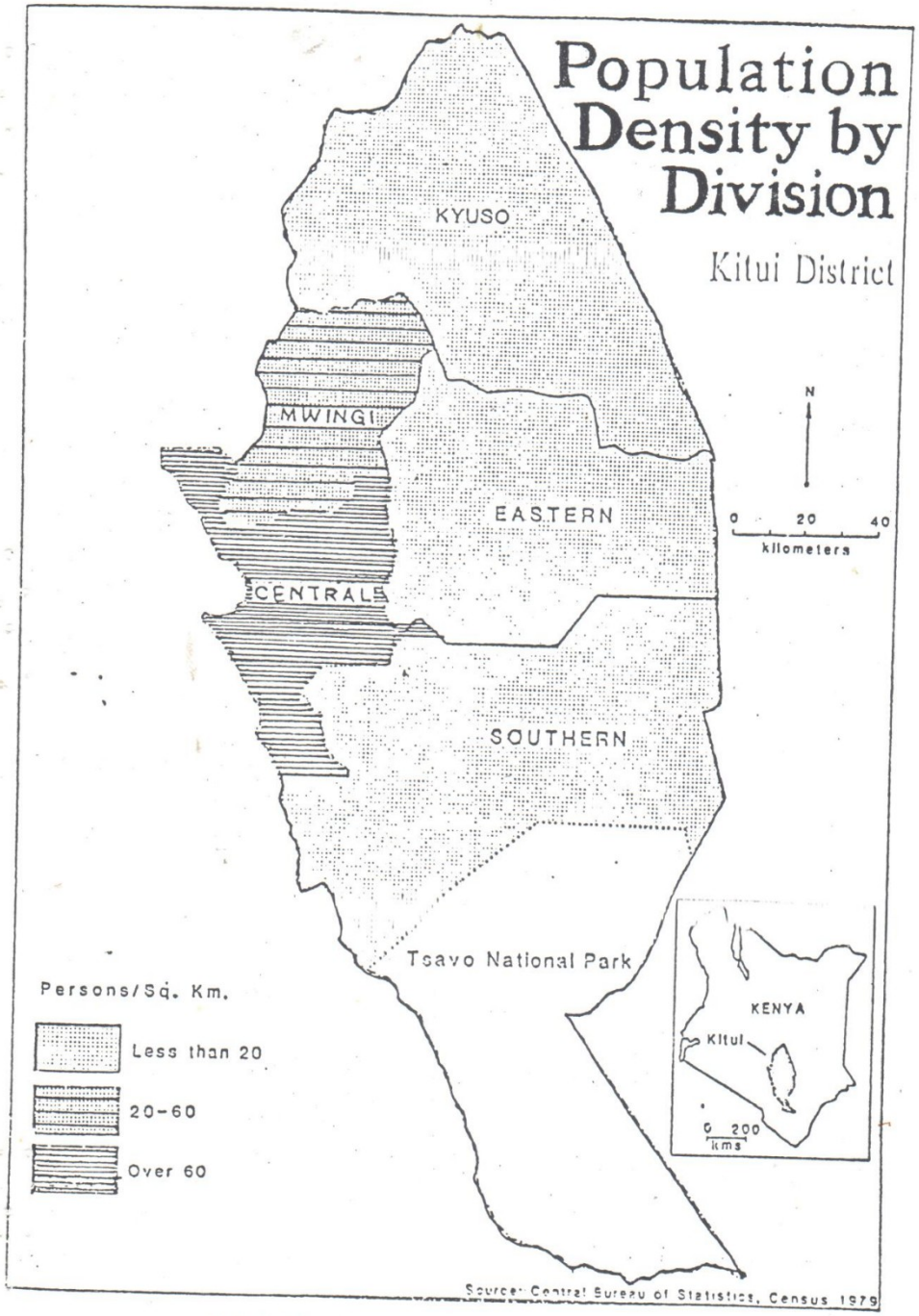
Second " " - extension of program to four Sub-Locations.

March 1987 - assessment of program achievements (mid-term).

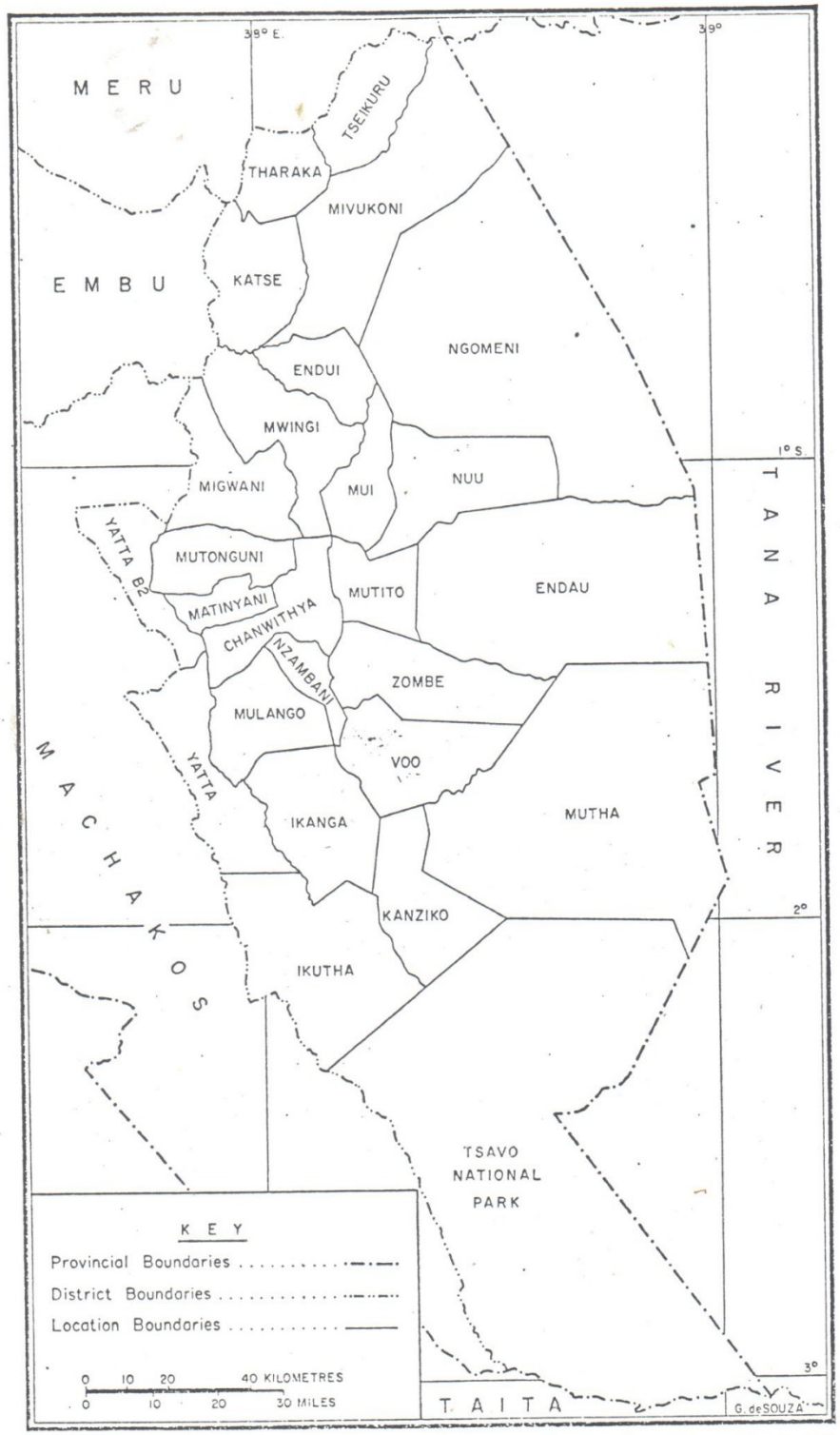
April 1, 1987 to August 31, 1988.

Extension of program to unserved Sub-Locations

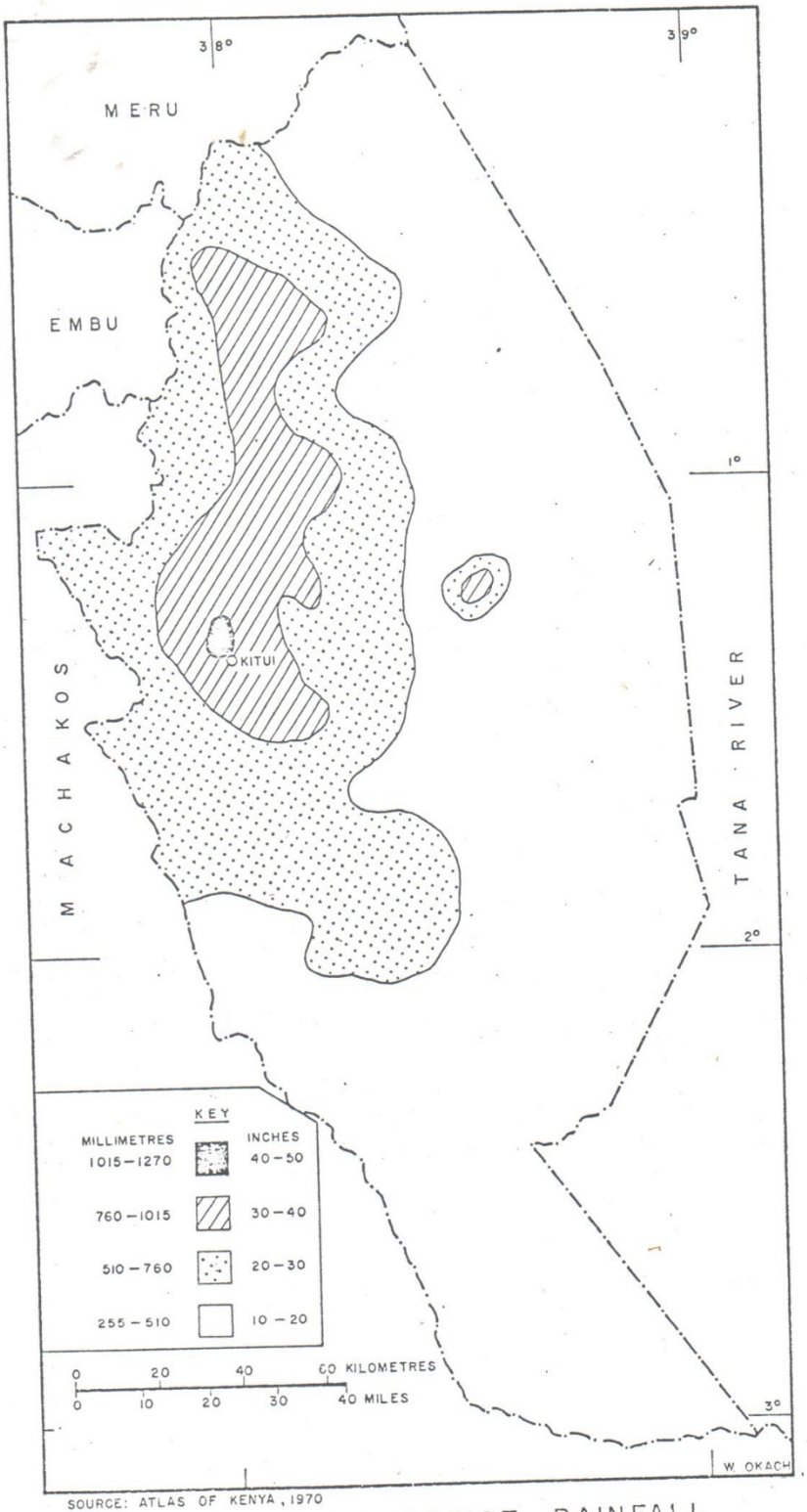
June 1988 - final assessment and Program Report.


Population Density by Division
Kitui District
KYUSO
MWINGI
EASTERN
CENTRAL
SOUTHERN
Tsavo National Park
N
0 20 40
kilometers
Persons/Sq. Km.
Less than 20
20-60
Over 60
KENYA
Kitui
0 200
kms
Source: Central Bureau of Statistics, Census 1979

MAP 1

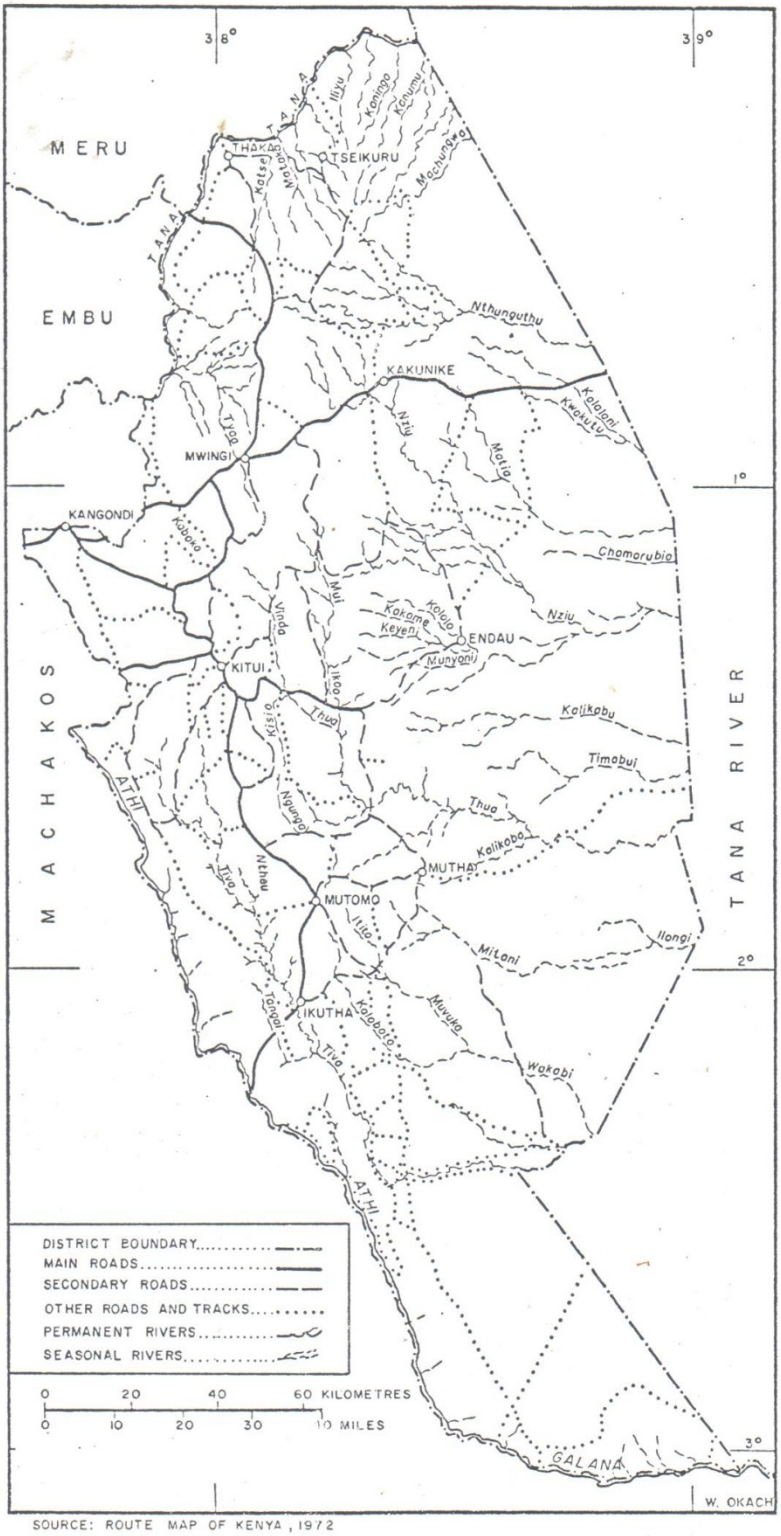


MAP 2. KITUI DISTRICT: ADMINISTRATIVE BOUNDARIES



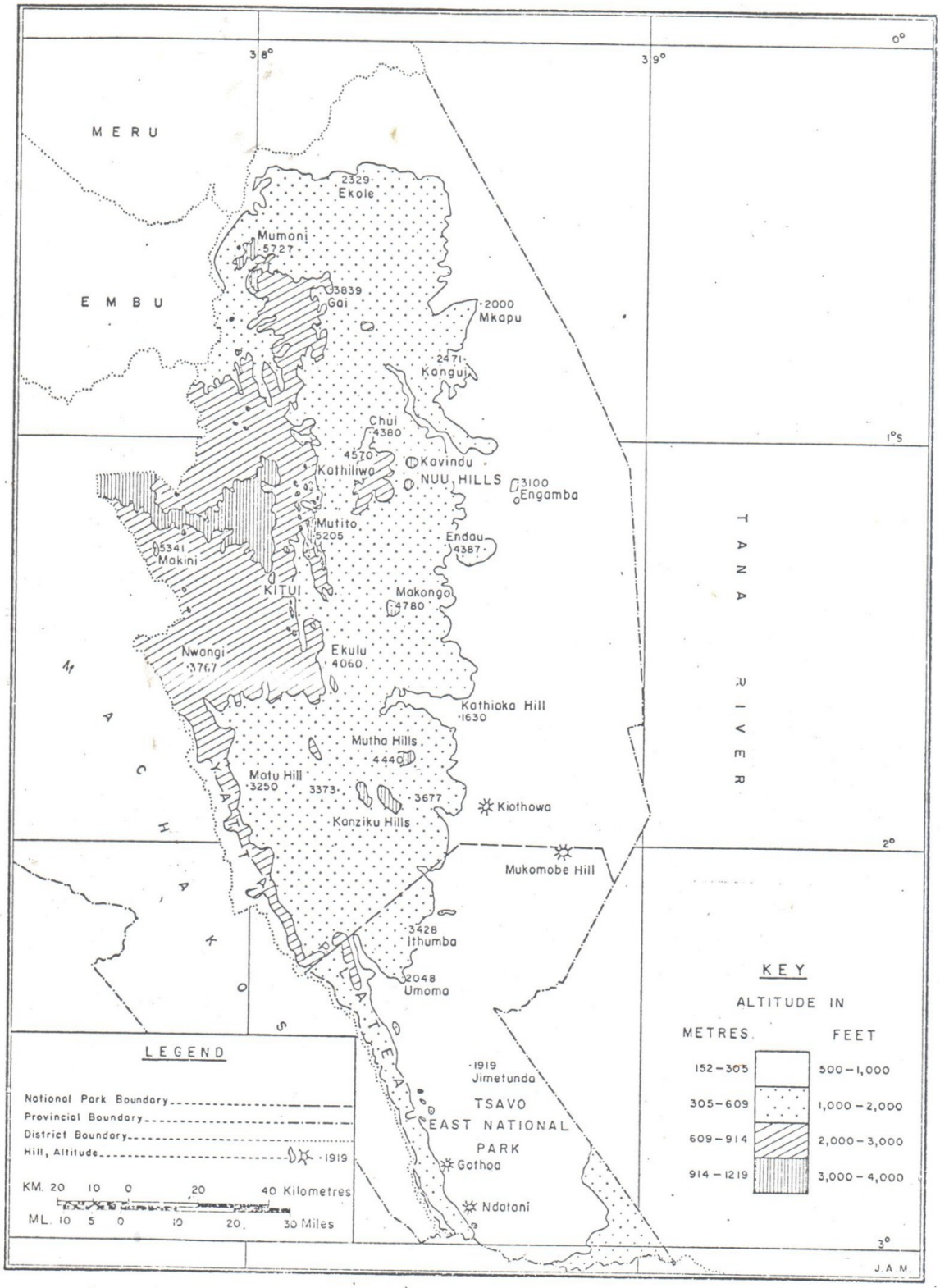
SOURCE: ATLAS OF KENYA, 1970

MAP 3: KITUI DISTRICT: RAINFALL



SOURCE: ROUTE MAP OF KENYA, 1972

MAP 4: KITUI DISTRICT: COMMUNICATIONS & DRAINAGE



MAP **5** KITUI DISTRICT : GENERAL

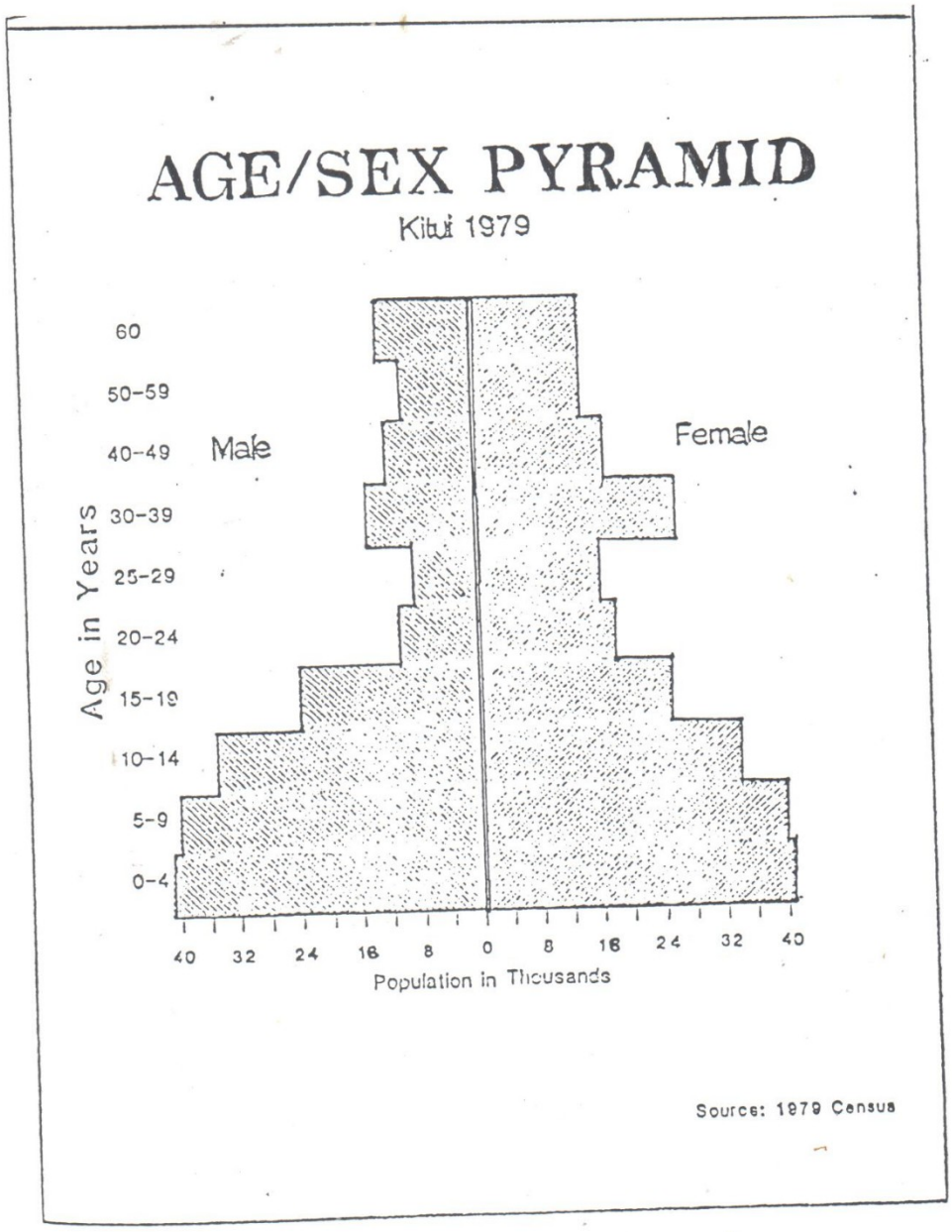

AGE/SEX PYRAMID
Kitui 1979
Male
Female
Age in Years
60
50-59
40-49
30-39
25-29
20-24
15-19
10-14
5-9
0-4
40 32 24 16 8 0 8 16 24 32 40
Population in Thousands
Source: 1979 Census

FIGURE 1

Annexe 1.

Kitui Demographics (CBS 1984)

1.	District	Project Area
1. Estimated Total Population	576,602	445,137
2. Estimated Population 0 - 5 years	107,247	82,795
3. No. of Deaths 0 - 1 year	1,604	1,238
4. No. of Deaths 0 - 5 years	2,713	2,094
5. No. of Pregnancies	16,658	12,860
6. No. of Live births	14,992	11,574

Annexe 2

Project Area Demographics by Centre 1984.

	Kimangau	Muthale	Mutomo	Nuu
1. Estimated Total Population	85,337	152,222	145,880	61,696
2. Estimated Population 0 - 5 years	15,873	28,313	27,133	11,475
3. Estimated No. of Deaths 0 - 1 years	237	424	406	172
4. Estimated No. of Deaths 0 - 5 years	402	716	687	290
5. Estimated No. of Pregnancies	2,465	4,398	4,214	1,782
6. Estimated No. of Live births	2,219	3,958	3,793	1,604

Annexe 3

KITUI PRIMARY HEALTH CARE PROJECT - MUTHALE SAFARIS 1985.

Clinic	Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Kikeani	Tue	11 Fri.	5	5	2	7	4	2	6	3	1	5	3
Kiseveni	Wed	2	6	6	3	8	5	3	7	4	2	6	4
Kivou	Thur	3	7	7	4	9	6	4	8	5	3	7	5
Kamuthulani	Fri	4	8	8	1 Mon.	10	7	5	9	6	4	8	6
Mutonga	Mon	7	11	11	12 Fri	13	10	8	12	9	7	11	9
Kanyaa	Tue	8	12	12	9	14	11	9	13	10	8	12	10
Kweluu	Wed	9	13	13	10	15	12	10	14	11	9	13	11
Thaananzau	Thur	10	14	14	11	16	13	11	15	12	10	14	13
Nzawa	Mon	14	18	18	15	20	17	15	19	16	14	18	16
Thitani	Tue	15	19	19	16	21	18	16	20	17	15	19	17
Kakumuti	Wed	16	20	20	17	22	19	17	21	18	16	20	18
Nzeluni	Thu	17	21	21	18	23	20	18	22	19	17	21	19
Mbondoni	Mon	21	25	25	22	27	24	22	26	23	21	25	23
Ngutani	Tue	22	26	26	23	28	25	23	27	24	22	26	31 St.
Kitutu	Wed	23	27	27	24	29	26	24	28	25	23	27	30 Mon.
Ithumbi	Thu	24	28	28	25	30	27	25	29	26	24	28	27 Fri.

Annexe 4

KITUI PRIMARY HEALTH CARE PROJECT - MUTOMO SAFARIS 1985.

Clinic	1st Week	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Katyethoka	Monday	DEC.* 31st	4th	4th	1st	6th	3rd	1st	5th	2nd	SEPT. 30th	4th	2nd
Kisauni	Tuesday	4th*	5th	5th	2nd	7th	4th	2nd	6th	3rd	1st	5th	3rd
Ndiini	Wednesday	2nd	6th	6th	3rd	8th	5th	3rd	7th	4th	2nd	6th	4th
Syomunyu	Thursday	3rd	7th	7th	4th	9th	6th	4th	8th	5th	3rd	7th	5th
	2nd Week.												
Kyamatu	Monday	7th	11th	11th	12th*	13th	10th	8th	12th	9th	7th	11th	9th
Voo	Tuesday	8th	12th	12th	9th	14th	11th	9th	13th	10th	8th	12th	10th
Mutha	Wednesday	9th	13th	13th	10th	15th	12th	10th	14th	11th	9th	13th	11th
Ikanga	Thursday	10th	14th	14th	11th	16th	13th	11th	15th	12th	10th	14th	13th*
	3rd Week												
Kinakoni	Monday	14th	18th	18th	15th	20th	17th	15th	19th	16th	14th	18th	16th
Kanziko	Tuesday	15th	19th	19th	16th	21st	18th	16th	20th	17th	15th	19th	17th
Kavisuni	Wednesday	16th	20th	20th	17th	22nd	19th	17th	21st	18th	16th	20th	18th
Kanyongonyo	Thursday	17th	21st	21st	18th	23rd	20th	18th	22nd	19th	17th	21st	19th
	4th Week												
Monguni	Monday	21st	25th	25th	22nd	27th	24th	22nd	26th	23rd	22nd*	25th	23rd
Kasaala	Wednesday	23rd	27th	27th	24th	29th	26th	24th	28th	25th	23rd	27th	24th*
Nzaini	Thursday	24th	28th	28th	25th	30th	27th	25th	29th	26th	24th	28th	20th*
Kisasi	Friday	25th	March 1st	29th	26th	31st	28th	26th	30th	27th	25th 1WK	29th	27th

Annexe 5

KITUI PRIMARY HEALTH CARE PROJECT - NUU SAFARIS 1985.

Clinic	1st Week	Jan.	Feb.	Mar.	Apr.	May.	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
Yatwa	Monday	7th	4th	4th	12th*	6th	3rd	8th	5th	2nd	30th	4th	2nd
Mutiangome	Tuesday	8th	5th	5th	9th	7th	4th	9th	6th	3rd	1st	5th	3rd
Mikuyuni	Wednesday	9th	6th	6th	10th	8th	5th	10th	7th	4th	2nd	6th	4th
Tuvaani	Thursday	10th	7th	7th	11th	9th	6th	11th	8th	5th	3rd	7th	5th
	2nd Week.												
Wingemi	Monday	14th	11th	11th	15th	13th	10th	15th	12th	9th	7th	11th	9th
Kalitini	Tuesday	15th	12th	12th	16th	14th	11th	16th	13th	10th	8th	12th	10th
Mwitika	Wednesday	16th	13th	13th	17th	15th	12th	17th	14th	11th	9th	13th	11th
Mui	Thursday	17th	14th	14th	18th	16th	13th	18th	15th	12th	10th	14th	* 13th
	3rd Week.												
Nyaani	Monday	21st	18th	18th	22nd	20th	17th	22nd	19th	16th	14th	18th	16th
Zombe	Tuesday	22nd	19th	19th	23rd	21st	18th	23rd	20th	17th	15th	19th	17th
Twambui	Wednesday	23rd	20th	20th	24th	22nd	19th	24th	21st	18th	16th	20th	18th
Endau	Thursday	24th	21st	21st	25th	23rd	20th	25th	22nd	19th	17th	21st	19th
	4th Week												
Makuka	Monday	28th	25th	25th	29th	27th	24th	29th	26th	23rd	21st	25th	20th*
Katumbi	Tuesday	29th	26th	26th	30th	28th	25th	30th	27th	24th	22nd	26th	21st*
Lawala	Wednesday	30th	27th	27th	1st	29th	26th	31st	28th	25th	23rd	27th	30th*
Lundi	Thursday	31st	28th	28th	2nd	30th	27th	1st	29th	26th	24th	28th	31st*
				*			*				*		

Annexe 6

KITUI PRIMARY HEALTH CARE PROJECT KIMANGAU SAFARIS 1985.

Clinic	Day	January	Feb.	March	April	May	June	July	Aug.	Sept	Oct.	Nov.	December.
Musavini	Monday	7.28	25		1:29	27		1:29	26		7:28	25	
Nthangani	Tuesday	8.29	26		2:30	28		1:30	27		1:29	26	
Masyungwa	Wednesday	2:30	27		3	15:29		3:31	28		2:30	27	
Tyaa-Muthale	Thursday	3:31	28		4	2:30		4	1:29		3	7:28	
Nguuku	Monday	14	4	4	15	6	3	8	5	2	14	4	2
Kaningo	Tuesday	15	5	5	9	7	4	9	6	3	8	5	3
Ukasi	Wednesday	9	6	6	10	8	5	10	7	4	9	6	4
Maseki	Thursday	10	7	7	11	9	6	11	8	5	10	14	5
Katse	Friday	11	8	8	12	10	7	12	9	6	11	8	6
Nduuni	Monday	21	11	11	22	13	10	15	12	9	21	11	9
Kamwongo	Tuesday	22	12	12	16	14	11	16	13	10	15	12	10
Kandwia	Wednesday	16	13	13	17	22	12	17	14	11	16	13	11
Ngungani	Thursday	17	14	14	18	16	13	18	15	12	17	21	13
Syambyu	Tuesday	25	19	19	23	21	18	23	20	17	22	19	17
Musosya	Wed.	23	20	20	24	20	19	24	21	18	23	20	18
Mitamisyi	Thursday	24	21	21	25	23	20	25	22	19	24	22	19

Annexe 7.

KITUI PRIMARY HEALTH CARE PROJECT: PHASE II

AID GRANT NO: 615 - 0219

QUARTERLY GRANT FINANCIAL REPORTS IN US DOLLARS.

Period: July 1 To September 30, 1983

Line Items	Grant/Budget Amounts Year 1 FX	Total Expenditure this period FX	Cumulative Expenditure Including this period FX	(Advance) Estimated Expenditure to be billed to AID next period FX
Salaries	-			
Vehicles	50,000			50,000
Transport	-			
Equipment	6,700			
Health Education and FP.	-			
Per diems	-			
Medical Supplies	11,400			
Evaluation	-			
Data Collection	6,400			
Overhead	18,800			14,100
Totals	93,300			64,100

Ctd.

Period January 1 to March 31, 1984.

Salaries	-	2,031.80	44,198.60	
Vehicles	50,000			
Transport	-			
Equipment	6,700			
Health Education and F.P.	-			
Per diems	-			
Medical Supplies	11,400			
Evaluation	-			
Data Collection	6,800			
Overhead	18,800		10,199.97	13,599.96
Totals	93,300	2,031.80	54,398.57	13,599.96

Ctd.

Period : October 1 to December 31, 1983.

Salaries	-	-		
Vehicles	50,000	42,166.80	42,166.80	7,833.20
Transport	-	-		
Equipment	6,700			
Health Education and F.P.	-			
Per diems	-			
Medical Supplies	11,400			
Evaluation	-			
Data Collection	6,800			
Overhead	18,800	10,199.97	10,199.97	8,600.03
Totals	93,300	52,366,77	52,366.77	16,433.23

Ctd.

Period : April 1 to June 30, 1984.

Salaries	-	-	-	-
Vehicles	-	-	=4,198.60	-
Transport	-	-	-	-
Equipment	5,000.00	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400.00	-	-	-
Evaluation	4,800.00	-	-	4,800.00
Data Collection	6,700.00	-	-	6,700.00
Overhead	13,400.00	13,599.96	=3,799.93	-
Totals	41,300.00	13,599.96	=7,998.53	11,500.00

Ctd.

Period July 1, to September 30, 1984

Salaries	-	-	-	-
Vehicles	-	-	-	-
Transport	-	-	44,198.60	-
Equipment	5,000.	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	-
Evaluation	4,800	-	-	-
Data Collection	6,700	-	-	-
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	-

Ctd.

Period : October 1, to December 31, 1984

Salaries	-	-	-	-
Vehicles	-	-	44,198.60	-
Transport	-	-	-	-
Equipment	5,000	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	4,800
Evaluation	4,800	-	-	6,700
Data Collection	6,700	-	-	
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	11,500

Ctd.

Period : January 1, to March 31, 1985

Salaries	-	-	-	-
Vehicles	-	-	44,198.60	-
Transport	-	-	-	-
Equipment	5,000	-	-	-
Health Education and F.P.	-	-	-	-
Per Diems	-	-	-	-
Medical Supplies	11,400	-	-	-
Evaluation	4,800	-	-	-
Data Collection	6,700	-	-	-
Overhead	13,400	-	23,799.93	-
Totals	41,300	-	67,998.53	-

Annexe 8.

KITUI PRIMARY HEALTH CARE PROJECT

PROJECTED BUDGET JULY 1983 TO JUNE, 1984 AID-615-0219

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May.	June	Cumulative Total
Salaries	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	3,400	40,800
Vehicles	-	-	50,000	-	-	-	-	-	-	-	-	-	50,000
Transport	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	5,617	67,400
Equipment	-	2,000	-	-	-	1,500	-	2,000	-	-	-	-	5,500
Education &FP	-	2,006	1,000	1,000	1,000	1,000	-	2,006	1,000	1,000	1,000	1,000	12,012
Per Diem	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
Medical Supplies	-	-	-	5,700	-	-	-	-	5,700	-	-	-	11,400
Evaluation	-	-	-	-	-	-	-	-	-	-	-	-	-
Data Collection	-	-	-	-	-	3,200	-	-	-	-	-	3,200	6,400
Overhead	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	1,566	18,792
Total	11,583	15,589	62,583	18,283	12,583	17,283	11,583	15,589	18,283	12,583	12,583	15,783	224,308

Annexe 9.

KITUI PRIMARY HEALTH CARE PROJECT

AID-615-0219

PROJECTED BUDGET APRIL 1984 TO MARCH 1985

Line Items	April	May	June	July	August	Sept	October	Nov.	Dec.	Jan.	Feb.	March	Cumulative Totals
Salaries	3,400	3,400	3,400	3,411	3,411	3,411	3,411	3,411	3,411	3,411	3,411	3,411	40,899.00
Vehecles	-	-	-	-	-	-	-	-	-	-	-	-	-
Transport	5,617	5,617	5,617	4,873	4,873	4,873	4,873	4,873	4,873	4.873	4,873	4.873	60,700.00
Equipment	-	-	-	-	-	2,000	-	-	3,000	-	-	-	5,000.00
Health Ed./FP.	1,000	1,000	1,000	4,400	-	-	4,400	-	-	4,400	-	-	16,200.00
Per Diem	875	875	875	875	875	875	875	875	875	875	875	875	10,500.00
Medical Supplies	950	950	950	950	950	950	950	950	950	950	950	950	11,400.00
Office and Housing	-	-	-	-	-	-	-	-	-	-	-	-	-
Evaluation	-	-	-	-	4,800	-	-	-	-	-	-	-	4,800.00
Data Collection	-	-	3,200	-	-	-	-	3,500	-	-	-	-	6,700.00
Overhead	13,599.96	-	-	-	-	-	-	-	-	-	-	-	13,599.96
	25,441.96	11,842	15,042	14,509	14,909	12,109	14,509	13,609	13,109	14,509	10,109	10,101	169,798.96

Annexe 10.

KITUI PRIMARY HEALTH CARE PROJECT

PROJECTED BUDGET APRIL 1985 - MARCH 1986

Line Items	April	May	June	July	Aug.	Sept	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Cumulative Total
Salaries	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	3900	46800
Vehicles	-	-	-	-	-	-	-	-	-	-	-	-	-
Transport	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	2800	33600
Equipment	-	-	-	-	-	2000	-	-	3000	-	-	-	5000
Health Ed./FP.	350	350	350	350	-	-	3500	-	-	4500	-	-	9400
Per Diem	550	550	550	550	550	550	550	550	550	550	550	550	6600
Medical Supplies	800	800	800	800	800	800	800	800	800	800	800	800	9600
Office and Housing	-	-	-	-	-	-	-	-	-	-	-	-	-
Evaluation	12800	-	-	-	-	-	-	-	-	-	-	-	12800
Data Collection	3500	-	-	-	-	-	-	-	-	-	-	-	3500
Overhead	7500	-	-	-	-	-	-	-	-	-	10100	-	17600
Totals	32200	8400	8400	8400	8050	10050	11550	8050	11050	12550	18150	8050	144900

Annexe 11.

BUDGET - KITUI PRIMARY HEALTH CARE PROGRAM PHASE 2.

US DOLLARS.

	Year 1			Year 2			Year 3		
	USAID	GOK	DOK	USAID	GOK	DOK	USAID	GOK	DOK
1. Salaries	42400	-	-	40900	-	-	2280C	-	-
2. Transport	120200	-	-	60700	-	-	3050C	-	-
3. Equipment	6700	-	-	5000	-	-	320C	-	-
4. Health Ed/FP.	12500	-	-	16200	-	-	1210C	-	-
5. Per Diems	11700	-	-	10500	-	-	480C	-	-
6. Medical Supplies	11400	147900	-	11400	148800	-	560C	73400	-
7. Office and Housing	-	-	13200	-	-	13300	-	-	6600
8. Evaluation	-	-	-	-	-	-	1280C	-	-
9. Data Collection	6200	-	-	6700	-	-	480C	-	-
0. Overhead CRS/NY 8.5%	18800	-	-	13400	-	-	860C	-	-
Totals	229900	147900	13200	164800	148800	13300	10520C	73400	6600

Three year Totals :	USAID	GOK	DOK	TOTALS
	499,900	370,100	33,100	903,100

Table 1

Ante-natal Clinic Attendances.

	July - Dec. 83		Jan - June 84		July - Dec. 84	
	No.	% Target	No.	% Target	No.	% Target
Kimangao	829	43	877	35.6	723	29.3
Muthale	1052	31	1022	23.2	871	19.8
Mutomo	1043	32	1229	29.2	852	20.2
Nuu	410	29.4	456	26.4	381	21.4
Total	3334	37%	3584	27.87%	2827	21.98%

Table 2

Children Immunisation

	July - Dec.83		Jan. - Jun. 84		July - Dec. 84			
	No.	%	No.	%	No	%	Total	%
Kimangao	8882	61.91	8772	55.26	7794	49.10	25448	55.21
Muthale	12796	50.03	11381	40.19	11323	39.99	35500	43.18
Mutomo	15553	63.45	12168	44.84	10175	37.50	37896	48.10
Nuu	4892	46.32	4914	42.82	4849	42.25	14655	43.73
Total	42123	56.17	37235	44.97	34141	41.23	113499	47.17

Table 3

Adult Immunisations.

	July - Dec. 83		Jan - June 84		July - Dec. 84		
	No.	%	No.	%	No.	%	Total	%
Kimangao	876		662		764		2302	
Muthale	1241		1441		1254		3936	
Mutomo	1177		1228		915		3320	
Nuu	335		453		381		1169	
Total	3629		3784		3314		10727	

Table 4

Curative Clinic Attendances.

	July - Dec. 83			Jan - Jun. 84			July - Dec. 84		
	Children	Adults	Total	Children	Adults	Total	Children	Adult	Total
Kimangao	1176	0	1176	1176	96	1273	508	1044	1552
Muthale	1571	647	2218	1784	506	2290	1695	N/A	1695
Mutomo	338	3378	3716	556	1081	1637	2179	784	2963
Nuu	687	817	1504	235	352	587	335	180	515
	3772	4842	8614	3751	2036	5787	4717	2008	6725

Table 5 Monthly Expenditures.

A. Mutomo.

	Salaries Per diems	Transport	Equipment	Health Education	Medical Supplies
April '83	10,028	-	-	-	-
May	9,608	6,681	350.	98.80	4,282.50
June	9,608	-	550.	-	-
July	19,445.	8,840	65.	-	-
Aug.	22,781	5,326	1,653.	413.	-
Sep.	13,701	4,187	830	2,232.	4,001.
Oct.	13,776	17,468	1,560.	3,090.	7,471.
Nov.	13,821	5,456	-	-	-
Dec.	14,591	4,256	95.	-	-
Sub-total	127,779	52,214	5,103	5,833.80	15,754.50
Jan '84	13,649	4,464	115.	20	1,057.
Feb.	459	22,390	3,353.	1,076	6,591.
Mar.	14,100	7,510	1,045	720.	-
April	14,017	4,477	-	2,680	10,904
May	14,757	5,613	550	-	-
June	11,560	11,654	1,752	1,600	-
July	11,814	8,642	720	4,676	-
Aug.	10,799	3,324	35	4,445	-
Sept.	10,244	2,000	50	161	-
Oct.	11,812	6,956	133	12,595	6,260
Nov.	11,179	10,781	130	-	-
Dec.	10,884	1,532	55	2,780	-

A. Mutomo ctd.

	Salaries Per Diems	Transport	Equipment	Health Education	Medical Supplies
Jan '85	12,614	18,864	3,172	3,190	-
Feb.	11,609	13,290	19	2,497	28.
March.	14,279	841	3,126	-	7,448
Sub-total	173,776	122,338	14,255	36,440	32,288

B. Muthale.

April '83	6,547	-	-	-	-
May	6,424	40	38	-	-
June	8,990	-	-	-	-
July	14,679	6,432	-	958	-
Aug.	10,682	2,975	142	197	6,605
Sep.	9,109	-	1,662	340	2,213
Oct.	11,275	14,172	578	525	-
Nov.	10,672	2,538	357	300	3,537
Dec.	12,992	8,431	421	-	-
	91,370	34,588	3,198	3,815	12,355

B. Muthale ctd.

	Salaries Per Diems	Transport	Equipment	Health Education	Medical Supplies
Jan '84	8,427	91	186	-	-
Feb.	11,600	1,309	1,719	300	-
March	10,784	12,683	465	-	5,465
April	11,973	2,491	197	847	3,208
May	12,042	7,814	484	24	3,731
June	12,262	4,088	311	210	-
July	12,605	3,474	239	-	5,719
Aug.	11,322	5,696	181	-	-
Sept.	10,570	-	364	-	-
Oct.	9,012	6,802	476	108	2,375
Nov.	13,954	3,870	312	404	-
Dec.	10,048	-	179	290	-
Sub-total	134,599	48,412	5,113	2,183	20,498
Jan '85	14,691	8,372	129	-	4,021
Feb.	9,606	2,317	125	225	-
March	14,219	6,780	133	202	4,135
Sub-total	38,516	17,469	387	427	8,156

C. Kimangau.

	Salaries Per Diems	Transport	Equipment	Health Ed/F.P.	Medical Supplies.
May '83	5,753	3,199	130	4	0
June	8,223	2,010	207	0	0
July	16,167	2,600	0	58	0
Aug.	9,797	4,538	260	0	1,645
Sept.	10,977	4,075	386	0	1,035
Oct.	6,574	3,084	0	0	0
Nov.	12,122	2,526	355	376	730
Dec.	10,388	3,767	1,320	189	1,345
Sub-total	80,001	25,799	2,658	627	4,755
Jan '84	9,714	110	1,089	446	1,072
Feb.	11,620	7,833	131	270	1,885
March	10,154	4,495	234	216	0
April	6,815	4,555	113	121	3,790
May	10,459	3,706	60	125	0
June	9,402	4,434	810	159	1,010
July	10,177	37,899	631	100	0
Aug.	10,061	3,306	248	25	2,195
Sept.	11,363	3,323	106	20	0
Oct.	10,287	1,638	80	1,435	0
Nov.	10,387	3,905	581	51	2,035
Dec.	10,608	4,969	143	70	200
Sub-total	121,047	80,173	4,226	3,038	12,187

J. EARLY WARNING: RESOURCE REQUIREMENTS FOR ALL REGIONS

J.1. TELECOMMUNICATIONS EQUIPMENT

Justification:
An efficient EWS depends upon the rapid transmission of data and information. As an extra layer is added to the administrative hierarchy under regionalisation, and most relief resources are still likely to be mobilised at national level, a strong communications network is critical. In some parts of the country, like Region 5, communications infrastructure is particularly weak.

Approach:
In regions where there is no functioning telephone system and no prospect that one will be put in place in the near future, the RRB at regional and at zonal levels should be equipped with a radio set. The RRB at regional level should also be equipped with a fax machine to facilitate communications with the RRC in Addis Ababa. Where there is no functioning telephone system at woreda level, the MOA or WDPPC should also be equipped with a radio set.

It may be necessary to carry out an assessment of existing telecommunications facilities first, in drought-prone woredas, zones and regions. In this case, technical assistance for six months, starting as early as possible in 1994, is recommended. A consultant should be employed to carry out the assessment and to develop a plan for the installation of telecommunications, including the integration of existing radio facilities. If the route of employing a consultant first, before investing in improved telecommunications, is chosen, this must not cause too many delays in setting up radio sets etc.

Indicative Budget:
Per region (without telephone system):

1) Regional RRB:	1 radio set	?
	1 fax machine	?
2) Zonal RRB:	1 radio set	?
3) Woreda MOA/WDPPC	1 radio set	?

Optional: 6 months consultancy

1) Salary/fees	US$ 60,000
2) Local boarding and travel costs	US$ 20,000
3) International travel	US$ 3,000
TOTAL	US 83,000

J.2. DATA ANALYSIS AND OTHER EQUIPMENT

Justification:
The EW unit within the regional RRB will have responsibility for analysing EW data for the region and for producing quarterly reports. They must be adequately resourced to do so. In regions like Region 5 where electricity supply is erratic and unreliable, the RRB must also be supplied with a small generator.

D. Nuu. ctd.

	Salaries Per Diems	Transport	Equipment	Health Ed/FP.	Medical Supplies
Jan '84	10,285	7,562	399	0	0
Feb.	10,135	3,243	698	1,554	0
March	10,842	3,457	607	100	4,816
April	9,562	6,678	5,195	97	6,044
May	9,240	3,835	470	816	0
June	9,240	6,199	280	406	0
July	9,083	1,272	0	461	0
Aug.	9,155	6,650	280	135	0
Sept.	9,235	6,777	694	130	0
Oct.	9,668	3,693	112	783	3,950
Nov.	9,385	4,960	419	355	0
Dec.	10,735	0	219	240	0
Sub-total	116,565	54,326	9,373	5,077	14,810
Jan. '85	9,021	8,644	725	205	8,208
Feb.	9,140	8,505	547	180	0
March	10,795	5,308	118	0	3,705
Sub-total	28,956	22,457	1,390	385	11,913

BIBLIOGRAPHY

Anonymous. A Monitoring and Evaluation Systems for Kitui Primary Health Care Program. Nairobi: USAID n.d

Anonymous. Kenya Kitui Rural Health Project. Project Paper 615-0206 Washington: USAID . January, 1982.

Anonymous Kitui Primary Health Care Programme - Phase 2 Nairobi: USAID. File No.1 - KEN-MD/J90-SPS n.d

Anonymous Kitui Rural Health Project Paper Nairobi:USAID. August, 1981.

Bennett, F.J. Evaluation of the Primary Health Care Project,Kitui Nairobi: USAID. November, 1980.

Chitere, P.A. Assessment of Existing Community Based Health Projects in Machakos and Kitui Districts. Nairobi: USAID. 1982

Consortium for International Development, et.al Kenya: Marginal and Semi - Arid Lands Pre-investment Inventory.

Nairobi: Min. of Agriculture. ASAL. 1978.

Diocese of Kitui. Kitui Primary Health Care Programme- Codel/USAID Proposal to Extend Project and Re-allocate Funds. Kitui: D.O.K. March. 1982.

District Clinical Officer, Public Health Officer, and Public Health Nurse Report on Training Birth Attendant's, Motivation and Training Kitui M.O.H. September, 1984

Dolan, Marian. Kitui Primary Health Care Programe Phase 2 Proposals. Nairobi:USAID. 1982

Gebreyesus, O. Salawu Evaluation of Vaccination Coverage in Kitui District of Eastern Province of Kenya Kitui: M.O.H. 1983.

Godiksen, Louis H. Social Analysis and Design Considerations for Kitui District Primary Health Care Project (Preliminary Draft)

Nairobi:USAID. n.d.

Kaseje, Dan. Mburugu, Edward K. Bloom, Gretchen. Kitui Primary Health Care Project. Final Evaluation. Nairobi: Codel/Catholic Diocese/USAID August - November 1982.

Kitui Feasibility Study Team. (Carlson Report) Kitui District Rural Health Services Feasibility Study. Nairobi. USAID. August, 1980

Mburugu, Edward K. Assessment of Potential Recipients to Support A Community Based Health System in Kitui District. Nairobi:USAID, 1982.

Morris, Rita and Smith, Sally. Midterm Evaluation of the Primary Health Care Project: Kitui District. Kenya. Nairobi: USAID August 1981

Appendix 1

Terms of Reference

Mid Term Evaluation Plan For

Kitui Primary Health Care Project Phase II.

A. Objectives.

To assess progress of project activities and to specifically determine progress since the evaluation of August - November, 1982 as follows :-

1. To determine extent the stated project purpose and outputs have been achieved, as defined by objective of verifiable indicators, and whether there have been unintended side effects.
2. To determine extent inputs have been appropriate to achievement of project outputs and purpose.
3. To determine status of past evaluation recommendations and their relationship to achievement of the project purpose.
4. To identify lessons learned to date.

B. Scope of Work.

1. Assessment of the project goal "The improvement of quality of life in rural areas through attainment of optimum level of health within the constraints of existing and developing economy and in line with the National Health Systems" in terms of the degree of achievement attained which will be determined by the use of the following indicators :
   a) Growth of community participation in work on priority health needs.
   b) Improvement in the health practices of the people (perception of health practices; education activities; latrines; immunization).
   c) Cost effectiveness and budget analysis (direct costs) of this project.
2. The extent to which the project purpose "The provision of a mobile primary health care services to rural areas of Kitui which lacked government/or mission medical services" has been achieved will be determined as follows :

a) Target population reached by the project.

b) Services provided by the mobile teams in terms of adequacy to meet the felt needs of the population served.

c) The extent to which joint planning with other services is carried out.

d) The extent of recognition of women leaders in community health work.

e) The extent of community support for the approaches used.

Include a summary of the attainment of the Project's purpose.

The examination of project reports, hospitals and clinic records will be made, and selected interviews conducted where necessary to elicit information.

3. The outputs targeted by the project are as follows :-

a) Mobile health delivery (services rendered, regularity of services, type of services delivered).

b) Maternal and child health care and disease prevention.

c) Preventive and curative services (balance between the two; promotional/educational activities).

d) Training and instruction for women's groups/community volunteers.

e) Promotion and instruction of natural family planning.

f) Community leaders trained in simple health remedies and techniques.

The above will be evaluated to determine the degree of success achieved, problems encountered and the solutions used. In the case of unrealistic goals, re-evaluation of project outputs will be made particularly in the light of project experience gained and minimum acceptable standards for quality health care.

Training and instructions for women's groups and community groups will be assessed in terms of numbers trained, type of curriculum used, and the kind of return provided by the trainees.

4. Project inputs will be examined to evaluate suitability to project performance for remainder of project and the proposed Phase II Project.

and where necessary additional resources or cutbacks will be recommended in the following :

a) Personnel.

b) Equipment.

c) Vehicle operation and maintenance.

d) Local resources.

e) USAID funding support.

This will serve more as a guide for future outside funding requirements in Phase III.

5. The cost of services (time to beneficiary is a cost,cost (bus fare), cost in time for travelling to centres) to project beneficiaries, including those support costs not covered by the project (MOH supplies vaccines, ORT from UNICEF) will be analysed and presented.

6. Review the Grant to assess compliance with its provisions.

7. A written report of the Evaluation will be submitted in the required (5) number of copies.