



GRANT NO. AID/615-0203

QUARTERLY REPORT

April, May, June, 1982

This is the ninth in a series of Quarterly Reports submitted to U.S.A.I.D. on the International Eye Foundation's Kenya Rural Blindness Prevention Project (Phase II), and outlines the activities and progress of the project.

I. General

The past quarter has seen some significant developments effecting the project's activities. In June, Ms. Lucy Nyaguthii finally joined the project staff as a counterpart for the Field Training Specialist. Ms. Nyaguthii, seconded by the Ministry of Health, was to have joined the project some months ago, but this was delayed. Initially, Ms. Nyaguthii will be working with the project two days per week, with the understanding that she will be available to participate fully in project-related educational activities.

Also during the quarter, Dr. J.J. Thuku, a Senior Deputy Director of Medical Services in the Ministry of Health, was appointed by the Ministry to act as Coordinator of Ophthalmic Programs. This is a significant step forward in the Ministry's efforts to coordinate its blindness prevention activities and those of the various NGO's involved, and will certainly boost the KRBP's institutionalization plans. Dr. Thuku has taken a strong interest in the project, and has provided full support and cooperation.

Significant progress was also made during the quarter in the project's efforts to involve the Rural Health Training Centres in blindness prevention and primary eye care education. Tutors from five of the six RHIC's gathered in June for a KRBP-sponsored workshop to draft a curriculum for use in teaching primary eye care/blindness prevention to rural health unit teams (RHUs). This will be discussed in some detail below.

II. Activities

A. Blindness Prevention Surveys: During the quarter under review, initial planning was done for the final survey, to be conducted in August. This survey will be held in Meru District, in the area first surveyed by the KRBPP in 1977. The value of this repeat survey will be primarily in providing an opportunity to confirm the results of the initial survey and a measure of the effects of physical development in the area on blindness prevalence (a road and piped water project have been completed since the initial survey was carried out).

B. Seminars: No further seminars were held at provincial or district level during the quarter under review. Consideration is currently being given to discontinuing the district and provincial level seminars as these don't seem to have much lasting value for the participants. It is probably a better investment of project time to concentrate on reaching the health worker training institutions, and this is probably the course that will be followed from now on.

In June, a workshop was held at Mosoriot RHTC for tutors from all six RHTCs. Five of the six RHTCs sent all of their tutors. Chulaimbo was unrepresented due to scheduling conflicts. The purpose of this four-day workshop was to demonstrate to the tutors how they could teach primary eye care/blindness prevention to the rural health unit teams (RHUTs), and to develop a curriculum and teaching aids for this purpose.

On the first day, participants took part in discussions and lectures on primary eye care and blindness prevention. This was to provide them with the information necessary to teach this subject. On the second day, participants took part in an open eye clinic at Kapsabet District Hospital. In the afternoon of the second day, and on the third day, the workshop broke up into small groups to draw up the basic curriculum and devise appropriate teaching aids. On the fourth day, the entire group reconvened to consolidate their draft curricula. The final draft of the curriculum is not yet complete, and will be attached to the next quarterly report, along with samples of the teaching aids devised.

The workshop was conducted by the project Field Training Specialist and counterpart, the Assistant Project Director, and Mr. Peter Godwin, of AMREF. Mr. Godwin has been involved in the training of RHTC tutors for some time, and his participation was invaluable.

Another workshop for senior ophthalmic clinical officers and those in charge of MEUs and RBPUs is now being planned, and will be held in September. Twenty six clinical officers have been invited to attend. Another workshop for the rest of the ophthalmic clinical officers will probably be held toward the end of this year.

C. Education: During the quarter under review, the Field Training Specialist continued her teaching activities at various facilities around the country. Teaching sessions were conducted for HUTs at Mosoriot (Rift Valley) and Tiwi (Coast) RHTCs, for nursing students at Muranga Nursing School, and for AMREF mobile health teams. Over 100 health workers were reached in these sessions.

III. Finances

Local expenditures for the just-completed quarter totalled K.Shs.346,900.95, or U.S.\$33,046.32, while expenditures from JFF/Bethesda totalled \$65,529.00. A financial summary for the quarter is attached.

IV. Project Vehicles

The main problem with project vehicles continues to be lack of spare parts. The Toyota Land Cruiser KQY371 was finally back on the road in May, after nearly ten months in the garage. However, at the end of May, Toyota Land Cruiser KQY372 entered the repair garage, and is still sitting due to lack of spares.

In June, the Ministry of Health gave its approval to the plan to turn over seven of the project vehicles to the Kenya Society for the Blind. This plan will proceed, with the KSB assuming administrative responsibility for the KRBPP-sponsored RBPUs within the next month or so.

V. Community-based Primary Eye Care Projects

During the quarter under review, the project Health Planner made a visit to the Saradidi Rural Health Project to inspect progress on the KRBPP-sponsored spring protection activities. Contrary to reports received from Saradidi, there has been little or not progress beyond digging one water catchment basin for one of the springs. The Health Planner therefore recommended against providing further funds until the first spring is actually completed. During a meeting with the Saradidi executive committee, a commitment was given for completion of the first spring within the next month or so. The Health Planner will visit Saradidi again during the next quarter to assess progress. If the commitment to complete at least one spring before his next visit is not fulfilled, the KRBPP will probably withdraw its offer to finance further spring protection activities.

Progress in the Meru community-based project has been rather limited during the past quarter. Because of time limitations, the Health Planner has not been able to visit the project site at Ithima with as much regularity as he might have liked. However, there has been a volunteer, Mr. Lund Cooper, at the site for several extended periods over the past few months. Mr. Cooper was an acquaintance for the former Health Planner, Mr. Ross-Degnan, who offered his services at Ithima to the KRBPP free of charge (other than expenses). A report prepared by Mr. Cooper about his activities at Ithima is attached. In spite of the numerous obstacles which he has faced, Mr. Cooper has managed to make some progress in organizing the community around the idea of a primary health/primary eye care project. The first group of community health workers will be trained in primary eye care/blindness prevention during the next quarter when the Field Training Specialist visits the project site. The Health Planner will be spending a large portion of his time during the next quarter at Ithima, which will hopefully result in significant progress toward establishing the viability of the Ithima project. His detailed report will be attached to the next quarterly report.

VI. Blindness Prevention and Health Education Activities

During the quarter under review, the RBPUs continued to shift the focus of their activities from the school screening program toward education of health workers in primary eye care/blindness prevention. All of the RBPUs have begun visiting health centres and dispensaries in their areas of operation, giving brief talks to clinical staff members. These talks have been well received by the health centres/dispensaries concerned, and regular follow-up visits will be scheduled. The RBPU at Nyeri visited nearly 75 health centres and dispensaries during the quarter and has covered almost all of these facilities in its area of operation. Exact figures for the other units are not available at the time of writing this report, but will be presented in the next quarterly report.

VII. Projected Activities

During the next quarter, a workshop will be conducted for senior ophthalmic clinical officers and all those involved in the operation of MEUs and RBPUs. The purpose of this workshop will be to develop the capabilities of these officers to conduct primary eye care/blindness prevention education activities in the course of their day-to-day work. The workshop will be held from 7-9 September at either the Nairobi or Nakuru MTC. Training sessions will also be organized at a number of health worker training facilities during the next quarter.

FINANCIAL STATEMENT

It will not be possible to attached a financial summary for the quarter under review since all the accounts materials are presently with the auditors for preparation of their annual audit of IEF accounts.

The statement for this quarter will be attached to the next quarterly report.



INTERNATIONAL EYE FOUNDATION kenya rural blindness prevention project

Notes on Project Work at Antuambul Sublock.,

Igembe Division, MERU

R. Cooper

As a result of talks between Dr. F.M. Mburu and members of the community at Antuambul, it was agreed that I should be dispatched to the area to continue the construction of water tanks started by Joe Mwangi of UNICEF, and sponsored by the IEF, last Aug-Sept. The rationale for this work is the recognition by the residents of Antuambul that water availability is a major health related problem; the goal is the transfer of the relatively simple skills and technology necessary to the construction of appropriate technology devices which are a potential benefit to many families. A further goal was the introduction of an on-location IEF presence, to both raise and monitor the level of community awareness of, and interest in, the project. What follows is a report on the work done during February and March, with some commentary on community attitudes toward the project, and speculation on possible future directions.

1 PAST WORK. Joe Mwangi was sent to the Sublocation in August/September 1981 to promote the building of roof-collection water tanks, one of his main activities with the UNICEF VTU in Nakuru. It should be noted here that his relationship to the community -- or at least to the members that spoke out about it with me -- was negative. I got many complaints: he was lazy, he was superior, he wanted to drink instead of work. These are perceptions of people in and around Kaelo, where Mwangi has discussed building a tank and then, apparently after minimal effort, abandoned the idea. Attitudes in Kyenkeetamo, where a tank was completed, may be quite different. Note also that Mwangi reciprocates the negative perceptions, and feels generally that community motivations, capability for mobilizing in a group project, etc., were not high enough to merit his services. People in the area, he has said, are lazy, superior, want to drink instead of work, etc. And too occupied with miraa. In any case, Mwangi departed after helping to complete one tank.

2 WORK OF FEB-MARCH. While I don't share (at all) Mwangi's personal reaction to people of Antuambul -- they have been mostly gracious and kind -- I did encounter a full range of difficulties in executing the work as planned. In January we'd agreed to work on three tanks: one by the new church at Kaorenene, near Kaelo; another at the primary school at Lukununu, and a third on the other side of Kaelo, toward KK, at a location whose name escapes me now. We agreed also to other conditions: that all the materials would be bought by the community and ready to go, save for the reinforcing chicken wire which Mburu would bring from Nairobi, and for which he would be reimbursed; that the clan head would pass information about the activity among members of their clans in order to insure a large turnout (one of Mwangi's problems was the unavailability of dedicated people who would return after the first few days); that housing with a family would be found for me.

Upon arriving in early February I found that only one of these conditions had been met: Mburu had brought the chicken wire. Chief Silas Murluki was not in Lare at the time (on vacation), but I learned from Sub-Chief Kamanja that no housing had been found: Beatrice K. thoni at the Lare HC was very kind in putting me up for a couple of days, after which I stayed in a hotel (the hotel) in Lare, at my own expense. This detail is important not as a personal grievance but as a symptom of the larger organizational problems. Cement had not been purchased. People had not been informed. Nothing had been done.

After a few days of organizing, and after moving in with the family of Stanley Matt, a primary school teacher in Kaorenene, I reluctantly decided to start work on the Kaorenene tank even though we had only a fraction of the materials necessary for completion. I want to say at the outset that there eventually evolved a small but dedicated group of individuals without whom we wouldn't have been able to do anything. Stanley Matt, Samuel Kobia, James Gichunge, Julius Njiru, M'Mwereria Mwereria, Isaac Mukaria: these were the people who invested much of their time and money, and faith. Many others spoke, praised and promised, but these acted. Often we spent much time chasing materials. If I had known how difficult this would be, I would have discouraged starting at all, would have waited until I could see everything stacked and ready. The pattern was this: overt facile assurance, covert passing of responsibility. In trying to organize things I worked with four potential agencies: 1 the Chief, Murluki, at Lare;

2 The sub-chief Kamanja, at Kaelo or wherever I could find him;
3 The clan heads; and 4 people at large (basic propaganda). What I found was sort of Catch-22: no one agency seemed willing to act without the prior action or support of at least one of the others. Each agency offered its own particular type of resistance. Appealing to "the people" directly is inefficient, like trying to bail out a boat with a paper cup. Clan heads were simply difficult for me to identify and track down; even if I succeeded in this they naturally wanted to see that the sub-chief was involved. Kamanja seems to me a quite ineffectual person; on several occasions he promised to visit the work-site and didn't, promised to send cement from Lare and didn't, then at one juncture casually and in a moment of apology gave Matl (who was probably the most insistent person involved) forty or sixty shillings, as a sort of penitence ploy I suppose. Kamanja seems a fearful man; often he balefully reminded us that by Presidential decree all Harambees had been postponed until June; often he said sadly, "Mimi ni mtu moja tu." I heard also that, in the month between our initial talks with Mburu and my subsequent arrival, he had wanted to phone the IEF in Nairobi and cancel the arrangements, as he was worried about being unable to meet the financial conditions involved. But whenever mentioned this to me a rumor only. When pressed to show his involvement in concrete terms -- literally -- he would defer to the chief, saying in effect, if the chief gets behind this, then people will see that it's serious and they will act.

I found the chief difficult to deal with, much more so than Kamanja whose resistance (in the form of incapability) is obvious; the chief is intelligent and reassuring, and gracious -- but he seemed to use these qualities to mask an unwillingness to get involved in the work. It's Kamanja's responsibility, Murluki would say, talk to Kamanja and the clan heads at Kaelo. On two or three occasions we were able to meet together with Kamanja and Murluki at Lare and each time, to my disappointment, the chief used the occasion publicly to berate the sub-chief, while reassuring me that "this is your man -- anything you want, see him." Why was the chief doing this? I'm not sure. People in Antuambul say that the chief wants development only in his own sublocation (Ntunene), and thus wants to sabotage work in Antuambul. This seemed to me extreme, and I don't believe it, yet there were times when it seemed that Murluki's voice was the one least in favor of continuing -- this after we had finished the first tank and were arranging for the start of the next -- and it was about at this time that I showed up for a meeting with him and found that

he'd summoned the two subchiefs from the other sublocations, both of whom entreated us to leave Antuanbul and work for them -- "We are ready, we have every thing waiting, we are eager..."

The last large meeting I had with Muriuki and Kamanja deserves some analysis, because it's typical of one of the major attitudinal obstacles to the type of involvement the IEF is proposing. The meeting took place in mid-March, shortly after completion of the first tank, and shortly before Mburu's scheduled visit. Several of the clan heads and project committee members were present. I wanted primarily to discuss two things: first, collection of funds for the purchase of materials to be used in the Lukununu tank, and second, reimbursement of individuals who had taken on the cost of materials for the first tank at Kaorenene (specifically, Stanley Matt and M'Mwerer a Mwereria; it should be noted that almost none of the materials used was paid for by clan/community/raised money). It was my opinion that beginning the tank at Lukununu would be premature before some action had been taken on these two points. We found, however, that the chief and sub-chief, and other present, had different priorities. The thing which concerned them most was the prospect of not having sufficient money in pocket to repay Mburu for his contribution toward the chicken wire. And he was coming that very weekend!! The Chief publicly commanded the subchief to raise this sum, about 750 Kshs, within three days -- from his own pocket if necessary. The other and greater monies for continuation of the project work were obviously considered secondary. Some people objected; one man pointed out that "Mburu is not a banker, he's not a moneylender", and that Mburu might be more disappointed by discontinuation of the work than by a delay in repayment of his money. I seconded this, but it didn't carry.

I go through all this point up a significant attitudinal problem which might be called the Red Carpet Syndrome. With the only contact between the IEF and the community being sporadic, brief visits from Nairobi, it is very tempting for the folks up there to concentrate on the frills of accommodation, the pleasantries of agreement and reassurance -- style, perhaps -- to make these contacts as hopeful-seeming as possible, even at detriment to substance. What you see and hear during a weekend visit is a highly decorated version of daily reality. For example, I recall walking from Kaelo to Lare on the morning of Mburu's visit; I was shocked to see on the roadside hill where barazas are held, several scores of people setting up chairs, long tables, harking away with pangas at grasses, setting up stools, all under the stern eye of the subchief, who was dressed in the outfit of his office. The chief was there also to welcome the visitor from Nairobi. All the clan heads were there,

the people on the project committee, others from Iare HC -- just the kind of meeting I'd been trying, without much success, to arrange for weeks. If I'd come just for the day I would have been impressed by the alacrity with which people and their officers had turned out.

The reality, of course, is more modest. I don't want to convey the sense of a whole community gripped by lethargy; teachers in particular were very eager to see what was being done, to participate, to use it as a learning exercise for their students. Yet on the day I went to talk to some of the classes at the large primary school near Kaelo, I was amazed to see behind the school a huge (thousands of gallons) concrete water tank built at great cost by the County Council some ten years ago, and it's never been used. The only things lacking are the gutters. It sits there partially filled with garbage, old bones of dead dogs... And there I was talking about how to build small water tanks out of mud... Another major problem is dissemination of information within the sublocation, which is large. The last week in March we began to work on the tank at the school in Iukununu, very close to subchief Karanja's home. With a minor struggle most of the materials had been raised, and there had been assurances of a good turnout for the first day. No one came. Walking back to Kaelo we passed a group of young men bundling miraa. Kobla, one of the men who worked very hard on the first tank, was with us and challenged these young guys -- they said they'd never heard of the project (well, one or two had heard of the Daktari wa Macho, vaguely), and hadn't been told about the water tank construction, even though it was in their veritable back yard. So it must be that the barazas at Kaelo do not succeed in spreading information over a sufficiently large portion of the population.

3 STATUS OF THE COMMUNITY HEALTH PROJECT

A. Present existing facilities. People of Antuanbul utilize three facilities: the Government Health Center at Iare, the mission clinic at Toumu, and the hospital at Muna. While the Iare Health Center is most convenient, there are several drawbacks, and many people do not most prefer the mission facilities. One problem at Iare is lack of drugs; it's not unusual to have very little available for one or two weeks out of the month. Problems most specific to this particular Health Center, however, are interpersonal. The center is staffed mostly by people from Imenti and it is the attitude of local Igembe people, rightly or wrongly, that the staff have a very superior and even uncaring attitude. People claim to have been abused there, and being told to sit in the hot sun all day only to be informed of the lack of dawn at the end of the day is considered normal treatment. Finally, rumors about the woman who gave birth unattended during the night in their maternity room, and died, abound. I asked about this case at the Health Center and they corroborated it; the fact that it's statistically insignificant doesn't seem to keep the people from going to

Maia for their child care whenever possible. And I have seen members of the staff act quite rudely, ordering patients to wash their feet and legs before entering, as it was cleaning day. The extension/field health care services available out of Iare Health Center are limited. There are two women, one specialising in Maternal Child Care, the other in Nutrition, but the first woman has been pregnant and busy with her own family, and the second is hampered by general unavailability of a vehicle. There is a government Ministry of Health vehicle usually at Iare, but I don't think it's often used by Esther or Ann (the two field workers) -- at least, according to Antuambui people who don't even know them, don't know what they do, have never seen them in Antuambui.

B. Progress on Project and Attitudes toward its Continuation: Very little has been done since the barazas of last summer and fall. It was decided by the community that a clinic was desirable, so money was raised toward the purchase of stone blocks for its construction; the site is just behind Kaelo market. All progress on this, however, halted with the postponement of Harambees; the plan is for action to resume after June. The blocks sit in a stack.

There seem to me several obstacles to implementation of the project as described in Dr. Mburu's Project Proposal ("Iare Community Health Scheme"). First is lack of awareness on the part of many people in Antuambui, especially those away from Kaelo; many people don't know that there is a project, or have heard only the difficult problem is that of passivity; the "experts from Nairobi" syndrome. Many people assume that this type of development will be funded and carried out by the people who seem to have initiated it: the III. And this passive attitude is closely tied to the largest problem, a general misconception of what the project is all about. Much of this is grounded in the widespread habit of seeing health care as curative only; preventive health care is a fairly alien concept; many people talked to are infatuated (for example) with injections, will even refuse pills and insist on injections when possible. The notion of a field health worker focussing on issues related to hygiene and nutrition, i.e., basic preventive measures, is not widely understood. Thus, despite informational barazas, the people of the community (those who are knowledgeable about the project) see it primarily as a way to obtain a clinic and dispensary of their own. (Two other problems I should mention. First is a reluctance to work together on projects which don't bear directly and immediately on individual well-being; thus the hesitation to work on a tank at a school, church etc., and the eagerness to do it on a private, individual basis. Second, the attitude of men toward women: the overwhelming majority of work done in home and field, especially the bringing of water, is done by women -- and I don't think it's a feminist simplification to suggest that husbands who have a relatively work-free, catered life are sometimes less eager than they might be to change the conditions of that life. Does this sound too heartless? A suggestion).

4 Possible Future Directions. Time is now short. Whatever is to be done must be done quickly. To disseminate information about the project, barazas should be held at locations throughout Antuambui other than Kaelo. It would be more effective if clan leaders would take this responsibility upon themselves capable of this. Also, further barazas should be held with the committee to stress the larger, preventive goals of the project. I know this may seem redundant and repetitive, in view of the many such meetings which have transpired in the past, but the message just hasn't gotten through. I think the major problem here is conceptual: the role the III

has chose is a delicate one, a catalytic role. "The community itself should evolve its own system through which the community can derive better health status." "The desirable community system is better organized and largely run by the community itself..." "...priorities identified by the community itself..." "...the scheme will take off largely in the direction the community prefers. The IFF will largely play the role of catalyst to development activities and change..." But a catalyst, of course, requires the presence of the essential chemistry in order for the desired reaction to occur; it's possible that if the IFF doesn't take a more forceful role, nothing will happen. After all, the project as stated in the proposal does have a goal, and that goal in reality is one of re-educating people into a preventive approach to health care. I would suggest that this has shown itself to be somewhat in conflict with the secondary goal, that of allowing the community to work out its own plans. The general reticence of the IFF is a basic conceptual problem which, given the constraints of time, will have to be remedied.

It's clear that the community intends to build a clinic, and for several reasons I -- though Mburu has somewhat different feelings about this -- would encourage this. First, because there is great support for it within the community. Part of this support springs from sub-locational loyalties: Antuanbul doesn't have its own clinic or dispensary (Lare does, Mutuall does), and many people feel that the people connected with these existing facilities are privately discouraging the Antuanbul project (especially Japhet, the fellow who runs the private clinic in Lare -- a very bad reputation) -- this of course makes the prospect of an Antuanbul clinic all the more attractive. The more important justification, however, is that all the community members who are aware of the IFF project see the clinic as a symbol of commitment, progress (actual work done), self-improvement. I mean the clinic itself, the actual building. It's natural for people to want to understand a concept in the most concrete terms possible. Thus, though the construction of a building is not crucial to the evolution of a program of community health education as the IFF sees it, it seems to me a worthy compromise, a bridge between health care as the residents currently understand it, and the greater and different possibilities opened up by the prospect of a group of village health workers. Frankly, I think residents would be very confused if they found themselves being discouraged from building a clinic. What, then, would the project consist of? The notion of a team of trained health care people operating out of their own homes, doing essentially preventive work (education), is not widely understood. So I think that the clinic would be an aid, not a detriment, to the project.

There is one danger, and that is that the clinic might come to be a mere dispensary similar to the Lare Health Center. This of course, would defeat the justification for its existence. I admit that many people in the community understand the clinic in these terms at present, but these preconceptions, given the right activities, are subject to change. Yes, the clinic could be used as a place where medicines are given out, but beyond this it could be the symbolic and functional base of operations for the field health workers. Clearly, the crucial thing is to find the right people. They must be capable of understanding, and then sufficiently dedicated to fulfill, the role of a field worker. I would look through the community for O- and A-level women (and men) -- I don't think you'll find many, if any, A-level women but this is not a conclusion based on anything statistical and begin training them immediately. To find these people it might be good to consult clan heads and teachers from the various primary schools, as well as the formal project committee keeping as many people as possible involved in the search and selection. It occurs to me that MBU has a list of prospective candidates.

The other main problem I see is the eventual transfer of responsibility for these village health workers (that is, their reimbursement) to the community itself. If training is paid for by the III, many people ultimately responsible for raising money (I'm thinking mostly of the clan heads) will allow themselves to agree with strenuously considering the final implications -- that they will have to be the ones collecting and putting out money on a regular basis for these workers. The first way around this problem is to seek community support (financially) for the training, but this would probably result in the least in inconvenient delays. The opposite option is to pay for the training and then try to get the MOH to take over the project from the III -- but this is something I know nothing about, I'm only speculating. In any case this would seem to contravert the stated goal of community responsibility. The third and most reasonable option is to train the workers while seeking throughout their training maximum community support for, and understanding of, their eventual activities within the community -- emphasizing and re-emphasizing the fact that these activities, if valued and desired, will have to be supported in real terms. It's a gamble -- there's a chance that the workers won't be appreciated, I suppose -- but the concept is fundamental to the project and so the gamble must be made. Again, to maximize chances of success -- carefully choose worthy candidates, involve the maximum number of people, in a meaningful way, in the selection process; press on with the reclarification of purpose and direction among the community.