



**Mid-Term Evaluation
of
AMREF's MCH/FP/Nutrition Project
(USAID OPG Family Planning Management and Research Project
Grant No. 615 - 0216)**

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TERMS OF REFERENCE

The terms of reference for this evaluation were to:

1. Review actual against planned inputs. Identify causes of delays and their effects on implementation progress. Specify courses of action to correct failures and/or delays.
2. Review actual against planned activities relating to the five outputs cited in the logical framework. Identify causes of any delays or problems in achieving outputs and specify action taken or to be taken to remedy problems. Review and confirm continued validity of assumptions relating to attainment of outputs.
3. Analyse AMREI's administrative and managerial resources to provide adequate support to the project.
4. Review experiences and results of major activities. Assess lessons learned during initial implementation phase of project which might be applied to subsequent phases.
5. Review and assess project expenditures to date and sufficiency of remaining project funds vis-a-vis remaining planned activities. If funding appears insufficient to complete remaining project activities, recommend project outputs which might be curtailed without comprising attainment of project purposes.
6. Assess costs of selected activities/outputs.
7. Review and confirm continuing validity of project strategies and implementation plans for the remaining project period. If indicated, recommend any alternative project strategies and implementation plans and explain rationales for recommendations.
8. Indicate, from mid-term perspective, overall progress toward achieving project purposes, and appropriateness of existing monitoring systems for measuring achievement of purposes. If progress is less than planned, identify reasons for inadequate implementation, e.g. delays in providing inputs, invalid output assumptions.
9. Produce a revised logical framework, if required.

OVERVIEW

The MCH/FP/Nutrition project of the African Medical and Research Foundation (AMREF) has initiated a unique approach to the population problem, through its use of community-based intervention activities to reduce the population growth. The project trains Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and shopkeepers as advocates and providers of family planning services. It also provides simple information about healthful living, nutrition, hygiene and sanitation.

The main function of the project is not to rapidly train cadres of community-based health workers but to explore suitable methods and contents of curricula for training these categories of health workers. The MCH/FP/Nutrition unit that has been established by the project appears to have gained enough experience to advise the Ministry of Health and non-governmental organizations, particularly on the training of TBAs and shopkeepers in the provision of family planning services.

The whole pilot project is based on a self-help approach, which appears acceptable to the community. The programme was launched in April 1984. It has already trained 32 TBAs, 40 CHWs and 32 shopkeepers.

The CHWs and shopkeepers are providing contraceptives such as condoms and foams. The CHWs are also recruiting clients for other methods of family planning and 29 clients are waiting for tubal ligation. This leads to the suggestion that the project needs to improve its family planning field facilities so that services, such as the insertion of Intra-Uterine Contraceptive Devices (IUCDs) and tubal ligations, can take place closer to the communities that are covered by the project.

It should be pointed out that considering the amount of work called for by the terms of reference of this evaluation, the time allocated for the evaluation (three weeks) was too short. Thus, it was not possible to conduct a thorough study of the activities of the projects. This fact is reflected in the conclusions and recommendations sections of the report. Where we make general statements regarding the future course of the project.

I INTRODUCTION

1.1 Project Background: Demographic and Economic Context

Over the past 15 years, i.e. between 1970 and 1984, the growth rate of Kenya's population increased from an estimate of 3.5 per cent per annum to a record figure of 4.0 per cent annually. Meanwhile, the average rate of increase of Kenya's Gross Domestic Product (GDP) fell from 6.6. per cent per annum to an annual rate of 3.1. per cent (Economic Survey 1985). In other words, over this period the growth rate of the Kenya population surpassed the growth rate of the goods and services which the population requires to satisfy its basic and other needs. This meant a fall in the standards of living in the country. In fact, over the past year - 1984, GDP grew by only 0.9 per cent. Since during that period, population grew by 4.0 per cent, the well-being of the average Kenyan (as measured by the per capital real GDP) actually fell by 3.1 per cent.

At the household level a deterioration in the standards of living precipitates or worsens conditions of illness, malnutrition, poverty, child morbidity and so on. Thus, it appears that the rapid growth rate of Kenya's population has had serious adverse effects on households' welfare. The prevalence of ill-health, malnutrition and poverty among sections of Kenyan households can be reduced by lowering the rate of population growth, increasing the growth rate of GDP or by pursuing both of these measures. Efforts to raise GDP growth rate in the face of a rapidly growing population are unlikely to succeed because of the urgent need to spend the available resources on consumption rather than on investment.

One of the promising methods of improving the standards of living in Kenya is to reduce the country's rate of population increase. This method is promising because the technology of population control, via Family Planning (FP), is well developed and is relatively inexpensive.

The problem is how to make this technology easily accessible to the majority of the population, especially in the rural areas where most people live, and how to create favourable attitudes towards it, both among its users and advocates.

The present evaluation is concerned with a pilot project that was started by the African Medical and Research Foundation (AMREF) in August 1983 in an effort to develop a replicable programme through which FP, Maternal and Child Health (MCH) and Nutrition services can be provided to different rural communities in Kenya in an integrated manner.

The project has a three year budget of US\$ 827,795 and was started with financial assistance from the United States Agency for International Development (USAID). On 11 August 1983 AMREF received a grant of US\$ 620,000 from USAID to implement and run the project. The grant covers 74.9 per cent of the project budget, the rest of the cost is being financed by AMREF. The life of the project is three years (August 1983 - August 1986).

The project has four interrelated components. These are: FP, MCH, nutrition and child survival. The objectives of the project are stated as follows:

1. To reduce the present rate of population growth in Kenya through creation of an effective demand for FP services and to improve the health and nutrition status of mothers and children.
2. To develop, implement and evaluate pilot interventions and, specifically, to explore alternative strategies in the delivery of MCH/FP/nutrition services to communities.
3. To develop MCH/FP/nutrition components for existing and new AMREF projects.
4. To assist, upon request, government and non-government agencies in formulating and evaluating MCH/FP/nutrition projects.

The activities required to achieve the above objectives are the responsibility of the newly established AMREF's MCH/FP/Nutrition Unit. The unit has been in existence now for about two years.

1.2 Scope of Work

The scope of work called for the review and assessment of the activities of the MCH/FP/nutrition project. It also called for an analysis of cost of implementing the interventions of the project, namely:

1. Training of Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) as FP advocates.
2. Provision of health education and FP services through rural shops.
3. Development of a programme for increased knowledge and favourable attitude in FP among health workers.
4. Provision of integrated services for child survival.
5. Improving and increasing ante-natal, obstetrics, post-natal and child care services.

1.3 Evaluation Methodology

The methodology which was used for the evaluation is primarily review of training materials and interviews of CHWs, TBAs and shopkeepers. In addition, an extensive discussion was carried out with the MCH/FP/Nutrition Unit staff. There were also consultations with other AMREF staff. No formally structured questionnaire was administered for the interviews. Thus, the findings are primarily based on the discussions carried out during the meetings.

1.3.1 Review of Training Materials

The MCH/FP/Nutrition Unit is collecting training materials. However, as the unit is newly established, and has its own innovative ideas, much of the

material resources are those which are already developed and being developed by the unit staff.

One of the training manuals - Traditional Birth Attendants Training Package - has been prepared by Ms J. Naisho, Senior Public Health Nurse. This training manual has been prepared thoughtfully. Its contents are based on the job to be performed and its ideas are explained one at a time. There might be a need to improve the method of presentation of the material in the manual so that participatory learning can take place.

The unit is collecting reference materials from different countries so as to establish a comprehensive library with relevant educational resources. It is also setting up a system for a microfiche library which will ease the need for a large space and also can be transported easily.

The audio-visual aids available in the MCH/FP/Nutrition Unit include films and slides. Although most training programmes are carried out by actual demonstrations, audio-visual aids have a role to play in provoking discussions, assimilating concepts, etc. Thus special attention needs to be paid to the provision of audio-visual aids.

As there is not enough time to mention all the reference materials being used, brief comments are given below on selected references.

1. Hosken, P.F.: The Universal Child Birth Picture Book, 1982

This monograph is a useful reference. It is simple and yet has all the essential information. However, the illustrations need to be revised and most appropriate ones selected. If funds are available, it would be more effective as a learning resource if it can be reproduced in colour.

2. IPPF: Family Life Education Curriculum Guidelines, Centre for African Family Studies (CAFS), 1984

This Curriculum Guide is well structured and useful in approach. However, it will be more practical and useful if the column on suggested teaching situations and learning experience can be divided. Teaching situations are the places where learning takes place and learning experience is what the learners gain during and after the learning period.

The contents (subject matter) may not be relevant to TBA training except on the population education (pages 79-82) and health and disease (pages 65-69). However, it is very relevant for youth training as it addresses itself to the youth and the project will have to enhance the activities of youth training in FP if it is to have a lasting effect.

3. Wood, E.: Community Health Workers Manual, AMREF 1982

This manual is comprehensive and covers most of the health problems in Kenya but its illustrations need improvement. The illustrations are prepared in sketches that appear to be more easily understood by the urban people than by the rural communities and may not communicate the intended messages to the rural people. The information on FP is not adequate: it needs to be rewritten in depth and updated.

4. Nyonyintono, R.M.N.: The Kenya National Population Programme - A Model of Explanation and Background Information, AMREF 1985
This document explains the rationale behind the population problem and presents a model of planned social change that might be useful in designing population control interventions.

1.3.2 Interviews at AMREF Headquarters

All the MCH/FP/Nutrition Unit professional staff, namely the Unit Leader, the Senior Public Health Nurse, the Sociologist/Anthropologist, the Nutritionist and the Trainers in FP of the private sectors were interviewed.

All the staff said that the MCH/FP/Nutrition Unit is doing the best it can to implement and carry out the planned interventions. They were aware of their responsibilities. However, a need was expressed for additional staff, especially in the areas of administration and support of field activities.

It is also the feeling of the staff that it is time for getting involved in other health and socio-economic development activities which are being carried out by other agencies so that the integration of the MCH/FP/Nutrition Unit with other development activities can be appropriately carried out.

Although this is a pilot project, the early establishment of the project with other agencies will be an essential base for replicating the project. For example, as a result of the unit's involvement and the active role in child feeding programmes, good working relations have been established with the Catholic Relief Services, Food and Agriculture Organization (FAO), Technoserve, etc. The unit has also established a close relationship with breast feeding groups. In addition, it is promoting and supporting breastfeeding practices; amongst other aspects, emphasis is put on lactation methods.

1.3.3 Field Visits

1. Kibwezi Health Scheme

Kibwezi Health scheme serves a population of about 120,000-150,000 in an area of 1,000 sq. km. in Kibwezi Division. The Health Centre in the scheme was built in 1979.

According to the Kibwezi Health Scheme Coordinator, Mr S. Muli, the services of the scheme comprise of:

- o preventive and curative medicine (with activities in MCH services);
- o outpatient and inpatient care;
- o immunization;
- o mobile clinic services.
- o water provision program

The centre also trains CHWs and TBAs. About 146 CHWs and 60 TBAs have been trained at Kibwezi Health Centre.

There are 14 beds for emergencies and 3 for maternity cases at the centre. There is also a laboratory for simple blood and urine analysis as well as a theatre. The centre has its own power for lighting.

The professional staff of the centre consist of a Project Coordinator, Clinical Health Officer, two Nurse/Midwives, two Nurses, Laboratory Technicians and a Community Nurse Nutritionist. A Nutrition Rehabilitation

Unit was added during the famine of 1984. This centre serves as a base for the MCH/FP training and nutrition education for TBAs and CHWs.

The Senior Nurse/Midwife was interviewed and strongly felt that the training programme for CHWs and TBAs, as well as the Mobile Clinics, should continue. Her justification being that it has instituted a demand for FP services at the centre. Further, the nutritional status of the children appears to be improving due to the services given by CHWs and TBAs.

It was suggested that a refresher course should be given on a regular basis so that the staff skill can be improved and the staff can be informed of new developments. A course of Training of Trainers (TOTs) and in maintenance of simple equipments was expressed as an immediate concern. She also suggested that she would like to follow-up the trainees, but lacked the time and the means to do so.

The need for continuous supplies, such as sterile gauze, gloves, etc., was also expressed. In general, the present system of delivering medical supplies, keeping records and maintaining equipment are not adequate.

The staff suggested that the integrated approach of service delivery should continue and more training opportunities should be provided for the staff. This is a valid suggestion as the health centre needs to be improved and kept up-to-date. If the health centre is updated, Intra-Uterine Contraceptive Devices (IUCDs) can be inserted there, and even tubal ligation can be performed by a visiting gynaecologist. Due to the efforts of the CHWs, there is a demand for such services but the clients are referred to Makindu and Machakos.

If these shortcomings are overcome by training the staff and by providing adequate medical supplies, Kibwezi Health Centre can be developed into one of the best models of a health facility that is supporting a Community Based Health Care (CBHC) programme. This improvement would increase the demand for IUCDs and tubal ligations (which are more safer methods of FP).

2. Makindu Sub-District Hospital

The team briefly visited Makindu Sub-District Hospital and interviewed the Community Nurse-Midwife there. She explained that there are good relations between TBAs and the Community Nurse-Midwives, especially since the training programme has been carried out at Kibwezi. TBAs refer complicated cases of delivery to the hospital and some even accompany their patients. They encourage the mothers to use modern methods of FP.

The TBAs come to the hospital with misconceptions about different methods of FP, i.e. they believe that if modern FP methods are used, an abnormal baby would be born. But when they are shown different contraceptives and advised how they are used, they overcome their fears.

The purpose of the brief visit to Makindu Sub-District Hospital was to determine the type of relationship that exists between the hospital and the AMREF-run project in Kibwezi division. There is a good relationship and a continuous interaction between AMREF project staff, CHWs and TBAs.

1.3.4 Observations

The project staff are dedicated to their work. There appears to be high morale and team spirit among them. Even the field staff at the Kibwezi Health Scheme identify themselves strongly with the project.

1.4 Evaluation Constraints

The major constraint in this evaluation has been the limited time allocated to the field work. Thus, it was not possible to interview all the field staff and also to give enough time for those present. With respect to the CHWs and TBAs, a group interview had to be applied which is not one of the best methods of obtaining information from individuals.

II THE MCH/FP/NUTRITION UNIT

2.1 Implementation

Project implementation follows a structured timetable of planned activities. The timetable is called a work plan and covers the period August 1983 - August 1986.

The project timetable or path is divided into discrete time periods called project phases. These phases are as follows:

- o August - December 1983;
- o January - June 1984;
- o July - December 1984;
- o January - June 1985;
- o July - December 1985;
- o January - June 1986;
- o July - August 1986.

The last project phase in the foregoing list is not explicit in the work plan. It follows from the fact that a full project phase covers a period of six months and also from the recognition that the current project funding expires in August 1986.

The six months allocated to each project phase are not based on the nature of planned activities: they are merely a reflection of the project accounting periods.* Thus, timely or untimely execution of project activities may not reflect the quality of project management.

Following is an account of project activities by project phase. The information presented below is drawn from progress reports of the AMREF Maternal and Child Health (MCH)/Family Planning (FP)/Nutrition Unit.

Project Phase I (August - December 1983)

The activities that were undertaken during this period are:

1. Recruitment of Staff

The post of Community Nurse was filled by Miss J. Naisho in September 1983. Miss Naisho is a Public Health Nurse with graduate training in health planning and a remarkable practical experience. She was appointed Acting Head of the MCH/FP/Nutrition Unit until the recruitment of the Head of the Unit.

The post of Sociologist/Anthropologist was offered to Dr (Ms) R. Nyonyintono, a Sociologist with extensive research and teaching experience at the university level. Efforts to locate other members of staff continued.

2. Formation of Working Committee

This committee consists of members drawn from within AMREF. Its function is to monitor project activities. The committee meets every three months.

* Project progress reports are produced twice annually. These reports give an account of the project activities over a period of six months. Project

financial statements are also produced every six months.

3. Nomination of Advisory Committee

The function of this committee is to assist the MCH/FP/Nutrition Unit in policy formulation. For example, in determining research priorities, in decisions regarding the activities to be discontinued or undertaken for the first time, and in the assessment of the unit's training methods, and so on. The committee meets twice a year and its membership is drawn from the following organizations:

- o Ministry of Health (MOH) headquarters;
- o Division of Family Health, MOH;
- o Ministry of Finance;
- o Ministry of Planning and National Development;
- o Division of Health Nutrition and Population, United States Agency for International Development (USAID);
- o African Medical and Research Foundation (AMREF).

4. Consultative Meetings with Government and Non-Government Agencies
These meetings were held with the MOH, the USAID Mission in Kenya and the International Planned Parenthood Federation (IPPF).

The purpose of these meetings was to familiarize the agencies just mentioned with the MCH/FP/Nutrition Unit's plans and to seek their collaboration in furthering its objectives. All the agencies consulted were willing to share the experiences they had gained in the provision of MCH/FP/nutrition services with the AMREF's new unit. Some agencies offered to lend the unit their audio-visual materials whenever it needed them for training purposes.

5. Workshop and Training Courses

- o Ms Naisho, the Unit's Acting Head at that time, participated in an evaluation workshop organized by the Family Planning Association of Kenya (FPAK). On a pilot basis, the FPAK had organized and trained Traditional Birth Attendants (TBAs) with the aim of using them as family planning (FP) advocates,
- o Ms Naisho and other AMREF staff held a two-day workshop for seven TBA trainers at Makindu Sub-District Hospital in Kibwezi. Later the TBA trainers with AMREF trainers conducted a five-day course for 11 TBAs who had come from different parts of Kibwezi. During the training, the Ms Naisho introduced the concept of FP.
- o Ms Naisho attended other courses and seminars that were relevant to the training programmes of the unit.

6. Ordering of Materials/Commodities

Office equipment and stationery were ordered and received. The project vehicle was also ordered.

The activities which were planned for this period but which did not take place are:

- o review of the literature relevant to the unit's work;
- o field visits to selected project areas;
- o recruitment of the Head of the Unit.

Comment:

The major problem that faced the project in its first phase was lack of staff. The post of the project leader proved extremely difficult to fill. The one

full-time member who was recruited during this period did a commendable job as the acting project leader. She set up the MCH/FP/Nutrition Unit and initiated a number of its activities.

Project Phase II (January - June 1984)

The following activities were implemented during this period.

1. Recruitment of Additional Staff
Dr R. Nyonyintono took up the post of Sociologist/Anthropologist which had been offered to her in the previous project period. A driver and a secretary were hired. The position of Medical Officer (the Head of the Unit) was offered to Dr H. Sandbladh.
2. Workshop on MCH/FP/Nutrition
This was held for Community Health Workers (CHWs), TBAs and Community Leaders in Kibwezi Division of Machakos District.
3. Course on Population and FP at Columbia University
This was attended by the unit's sociologist/anthropologist.
4. Review of MCH/FP/Nutrition Literature
This was started by the unit's sociologist. The purpose of the review was to produce a report which would familiarize the unit with the important factors that influence utilization of MCH/FP/nutrition services in a community.

The literature review was not planned to take place in the second phase of the project. It should have been done in the first phase but the unit did not have research staff at that time.

A baseline survey and a workshop for TBAs trainers in Kibwezi were planned for Phase II of the project but did not materialize due to staff shortage.

Comment:

Most of the activities scheduled for this period were implemented. However, staff shortage in the unit continued to be a problem.

Project Phase III (July - December 1984)

During this period the following activities took place.

1. Staff Recruitment
The Head of the Unit, Dr H. Sandbladh, took up his position with effect from July 1984. Instead of the planned position of a part-time Field Research Officer, a full-time Nutritionist, Mrs A. Ngesa, who has experience in working with communities, was hired in October 1984. This completed the hiring of project staff.
2. Committee Meetings
A working committee meeting was held in July. The committee discussed project progress among other matters.

The first advisory committee also met in July. All the invited members

attended the meeting. In this meeting, USAID suggested the introduction of a monthly project monitoring meetings between themselves and AMREF. This suggestion was agreed upon. Two such meetings were held.

3. Workshops, Seminars and Training Courses

A three-day seminar was conducted for 19 shopkeepers from Kibwezi Division in July. The shopkeepers agreed to assist in the promotion and distribution of contraceptives. A follow-up seminar planned for December did not take place due to cholera outbreak in Kibwezi.

4. Traditional Birth Attendants' Course

A two-day course was conducted for 14 TBAs from 30 July - 3 August 1984. During this course, instructional songs and plays were recorded for use in the training of TBAs trainers. The 14 TBAs were later invited for a one-day seminar in December where they related their successes in their work regarding MCH and FP. They reported satisfaction from Kibwezi Health Centre and Makindu Sub-District Hospital when they visited these facilities to participate in ante-natal and FP activities.

5. Research

The literature review that was begun in March 1984 was completed in November 1984. It was noted in the review that programmes in MCH were first undertaken in Kenya as a specific service to women of child-bearing age and children under five years of age, when a study with the help of the World Bank and the MOH revealed that these two sections of the population utilized health services most.

The FP component was added to the MCH during the 1974-79 population programme. The integration of MCH and FP reflect the widely held but incorrect belief that it is the responsibility of mothers alone to space children. Until 1981, FP in government clinics was restricted to married women of child-bearing age. The review also noted that nutrition programmes in Kenya have always been part of health education in MCH clinics.

This review provided the unit with information regarding the status of the MCH/FP/nutrition programmes in Kenya. In particular, the review made the unit staff aware of the high drop-out rate in FP programmes in Kenya. This awareness is probably one of the factors which influenced the unit to set up a system to monitor utilization of FP services at the shops. An MCH/FP/nutrition survey was conducted in Kibwezi Division. The purpose of the survey was to identify problem areas where appropriate low-cost MCH/FP/nutrition interventions could be undertaken.

Comment:

This phase was the most difficult period for the project. Cholera and famine struck the project area and some of the activities planned to take place there had to be postponed, e.g., FP courses for the MOH workers in Kibwezi had to be cancelled.

The project staff took off time from their MCH/FP/nutrition work to provide famine relief to the people in the drought-stricken areas. About 18 feeding centres were established in Kibwezi and 20,000 children were fed. The project staff hope to use some of these centres in their future MCH/FP/nutrition activities. A nutrition-rehabilitation unit was established at the health centre. The establishment and running of the unit was partly the work of Mrs

A. Ngesa, the project's nutritionist. This rehabilitation unit has proved to be more effective than other units in similar situations in the treatment and prevention of malnutrition. It seems that the unit's emphasis on teaching mothers about nutrition and ordinary public health care might be the reason for the superior effectiveness of the unit in dealing with cases of malnutrition. In parts the functions of the unit are replicable in ordinary as well as in famine situations.

Project Phase IV (January - June 1985)

The project activities were as follows:

1. Committee Meetings

On 1 January 1985 working committee meetings were held at AMREF headquarters. The committees discussed project implementation but their deliberations are not reported.

The advisory committee meetings did not take place as scheduled because members did not turn up for the meetings. In an attempt to resolve this problem, the committee membership was reconstituted in May 1985. The new committee has not yet met.

The monitoring committee meetings took place monthly and they turned out to be useful because they avoided delays in dealing with problems related to project implementation.

2. Workshops, Seminars and Training Courses

A seminar on MCH, FP and nutrition was held in Kibwezi in March for 14 health workers drawn from MOH facilities in Kibwezi, Makueni and Athi River. The seminar lasted three days. In addition to covering the topics of MCH, FP and nutrition, the participants discussed health workers attitudes towards FP and also dealt with issues related to population growth and development.

A one-week course for 16 TBAs was conducted in June 1985. The course covered family-life education, ante-natal care, delivery, nutrition education, post-natal care, child care and FP.

During the same month a four-day workshop was conducted for shopkeepers and CHWs. The topics covered included the use of drugs that the shopkeepers sell in their stores, population crisis, FP and techniques of distributing condoms and foaming tablets.

To facilitate monitoring of the distribution of contraceptives, the following forms were issued to the CHWs and the shopkeepers:

- o first stock supply forms;
- o reorder supply forms;
- o client information forms.

In addition, all CHWs and shopkeepers were each given four gross of condoms and 96 tubes of foaming tablets.

At the request of the CHWs and shopkeepers, one-day community talks were organized in different locations of Kibwezi Division. The talks were mainly on information regarding child spacing and use of contraceptives.

On 26 June 1985 a two-week workshop on breastfeeding was conducted by the Head of the MCH/FP/Nutrition Unit for senior management staff from all the provinces in Kenya. The workshop was organized in conjunction with the Division of Family Health, MOH.

3. Research

The MCH/FP/nutrition baseline survey was conducted in Kibwezi in January and February 1985. The data collected in these surveys are being analysed.

The analysis of the national sample of contraceptive acceptors was completed in April 1985. The main findings of the analysis were:

- o high drop-out rate among users;
- o contraceptive users were not being monitored.

4. Review and Acquisition of Reference and Training Materials

The unit continued collecting and reviewing materials for training Nurses, Clinical Officers, Midwives, CHWs and TBAs in FP. Also, in an attempt to develop a library with relevant materials for MCH, FP and nutrition, the unit has collected following:

- o comprehensive materials on training, supervision and evaluation of TBAs;
- o research papers on FP;
- o additional materials on nutrition and recent research papers on breastfeeding.

The unit is still continuing with the collection of the above materials.

5. Famine Relief Programme

With the food situation in Kibwezi having improved, the famine relief was terminated in May 1985.

6. Family Planning Education for AMREF Staff

The unit conducted three one-and-a-half hour family education talks for AMREF staff in Nairobi. An arrangement is also underway to provide individual FP counselling for AMREF staff.

7. Post-graduate Training

One AMREF staff member, Ms P. Ochola, completed a nine-month MCH degree course in health education at Harvard University. A second staff member, Mrs M. Memia, is at an advanced stage of a 15-month MCH degree course on population planning and family health at Columbia University.

8. Consultations

The unit was consulted by various agencies on appropriate training and materials in MCH/FP/nutrition. Some of the agencies and organizations that visited the unit for consultations on training matters are:

- o Division of Family Health, MOH;
- o Ministry of Finance;
- o FPAK;
- o IPPI;
- o Kenya National Council for Population and Development.

Comments:

There were no major constraints encountered during this phase of the project.

This was the most successful stage of the project. The unit undertook and completed virtually all the activities that were planned for this period. The activities which were not implemented during earlier periods were then carried out in this phase. As mentioned before, certain activities were postponed due to lack of staff, a cholera outbreak and famine in the project area. Two factors account for the remarkable achievements of the unit during this period. For the first time the project leader was in the unit throughout the project phase. Secondly, the staff appear to have learnt during the previous phases how to use existing AMREF infrastructure to carry out the activities of the unit both at headquarters and in the field.

From what the unit has done so far, it appears that it could easily train a large cadre of shopkeepers in the next project phase. The unit should move slowly in its shopkeeper training programme. This is because the unit's research work shows a high drop-out rate among contraceptive users in Kenya, and this is also a possibility in Kibwezi. In the next phase the unit should focus attention on monitoring the distribution and use of contraceptives. Mass training of shopkeepers in contraceptive distribution at this stage poses the risk of a large shop-based contraceptive distribution network that will remain heavily under-utilized. The training of CHWs and TBAs in FP can continue at the rate the unit can afford because even if the demand for contraceptives falls the CHWs and TBAs can remain as FP advocates. Their educational role in matters regarding FP should create demand for contraceptives in the community.

While monitoring the performance of shopkeepers in Kibwezi in their distribution of contraceptives, the unit should consider training a limited number of shopkeepers in FP and in the distribution of contraceptives in another area.

Project Phase V (July - December 1985)

The activities for this phase are in the process of implementation. The activities planned for this period are:

1. Courses/Workshops/Seminars:
 - o one five-day course for the third group of TBAs;
 - o evaluation workshop for TBAs and shopkeepers;
 - o workshop on FP curriculum.
2. Research:
 - o computerization and analysis of Kibwezi baseline survey;
 - o research reports;
 - o preparation of research proposal for:
 - i) follow-up of clinic drop-outs in conjunction with MOH;
 - ii) exploration of needs of out of school youth in conjunction with the National Council for Population Development (NCPD) and the Kenya Youth Association; closer collaboration with NCPD.
3. Nutrition:
 - o visits to wells and the well groups in Kibwezi with a view of selecting areas around the wells where vegetables and fruit growing can be ventured;
 - o train school children as nutrition volunteers (scouts) to pass nutrition messages to their parents and neighbours: the same children could be trained to monitor the nutritional status of pre-school children.

4. Advisory and Other Committee Meetings
5. Review and Acquisition of Training and Reference Materials

Comments:

The research activities proposed in third part of number 2 above should not distract the unit's attention from research on follow-up of any drop outs from the FP services at the shops.

In addition to its nutritional value, the first part of number 3 above is also an income generating activity. However, the following should be borne in mind with respect to this activity:

1. An initial capital expenditure will be required which the community (the well groups) might not be able to afford. This will be needed perhaps to modify the wells, fit them with simple irrigation facilities and purchase seeds and other inputs. The unit might have to extend some assistance to the well groups. The form of this assistance will depend on specific situations of the well groups.
2. If the fruit and vegetable project takes off successfully, the problem of marketing the produce might arise. If this problem is not resolved, the income generating component of the activity will collapse.

The second part of number 3 above appears to be a cost-effective method of nutritional surveillance among the pre-school children. The school children might also find it interesting.

Project Phases VI and VII (January - August 1986)

Some of the activities for these phases are not worked out yet. Those which are already stated are:

1. KAP studies in pilot intervention areas;
2. Collaboration with Government of Kenya and private voluntary organization agencies;
3. Development of new programme of interventions;
4. Development of re-funding for future unit activities;
5. Committee meetings;
6. Final analysis and documentation of project activities,
7. Final evaluation.

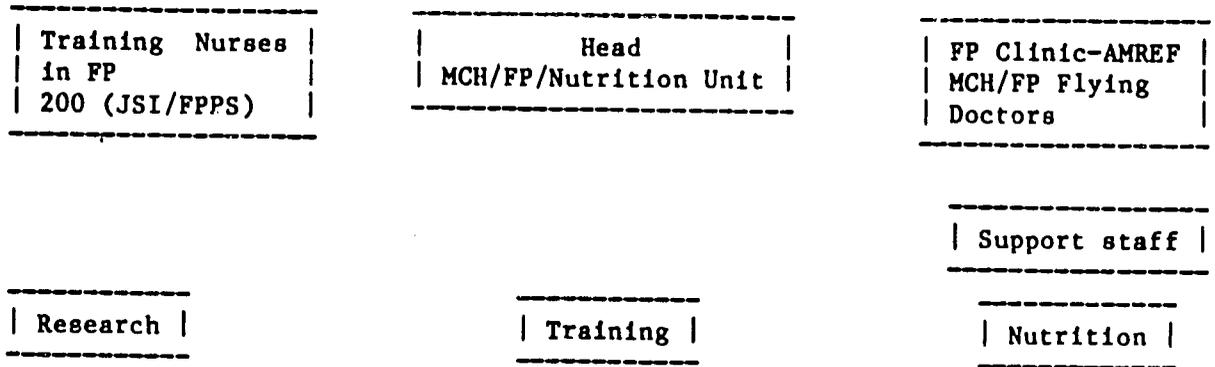
Comments:

It appears that in the last two phases of the project the unit will be concerned with: analysis and documentation of its previous activities, re-funding of its future plans and final evaluation of its performance. Operational activities of the project are likely to be quite limited if its re-funding concern is not settled early enough.

2.2 Organizational Structure

The organizational structure of the MCH/FP/Nutrition Unit is highly decentralized. The various positions in this structure are displayed in Figure 2.1 on the following page.

Figure 2.1: Organizational Chart for MCH/FP/Nutrition Unit



The positions in Figure 2.1 are occupied by persons who are highly qualified in their areas of specialization. The Head of the Unit has delegated tasks to his staff according to their fields of specialization.

For instance, the research section carries out the research functions of the unit. The training of CHWs, TBAs, shopkeepers and MOH personnel is done by the training section. The nutrition activities of the unit are the responsibility of the nutritionist. The Head of the Unit gives technical support to his staff (both in the field and at the headquarters) develops reference and teaching materials, formulates policy of the unit in consultation with his staff and other relevant AMREF staff, liaises with MOH and non-government organizations involved in MCH/FP/nutrition work in Kenya, and collects reference materials from outside the country.

At the moment, the research, training and nutrition sections shown in Figure 2.1 each have one staff member. Given the research and training workload in the unit, there appears to be a need for additional staff to assist in research, administrative and training activities.

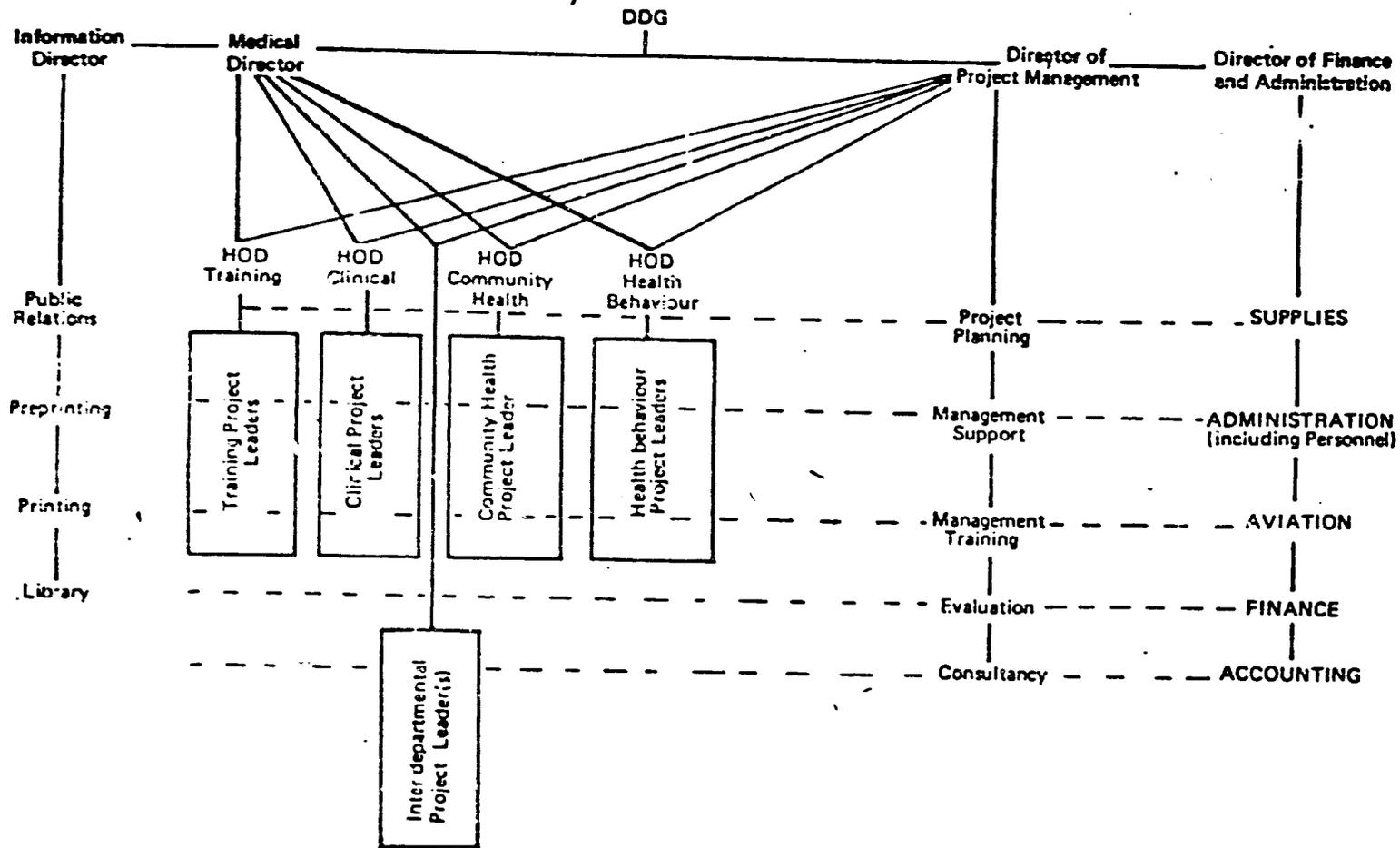
At this point, it appears appropriate to depict MCH/FP/Nutrition Unit in the context of AMREF's organizational structure.

In AMREF's organizational structure, the MCH/FP/Nutrition Unit falls under the Department of Community Health. This organizational relationship is depicted in Figure 2.2 (see page 17a).

From Figure 2.2 it can be seen that the various departmental heads in AMREF report to the Director of Project Management and the Medical Director. The Director of Project Management deals with project policy. The key functions of this director are management support to projects and planning, and monitoring and evaluation of projects. The main functions of the Medical Director are supervision of project implementation and development of technical/medical programmes (see Figure 2.4).

The Director of Project Management liaises between the project leaders in various departments and the project donors. The liaison work is the responsibility of the project officers in the Division of Project Management. Figure 2.3 on the following page shows the managerial relationship between a Project Officer, Director of Project Management, Medical Director, Head of the MCH/FP/Nutrition Unit and the Head of Department of Community Health.

Figure 2.2: AMREF's Organizational Chart



As can be seen from Figure 2.3, the Project Officer is the monitor of project activities in various departments. Through him, the Division of Project Management (and hence the donor) is in touch with project activities.

Figure 2.3: An Illustration of Coordination of Project Activities

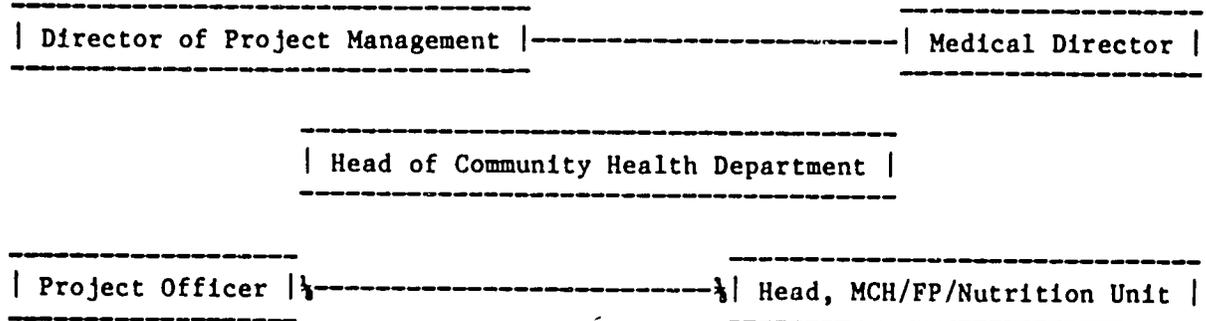
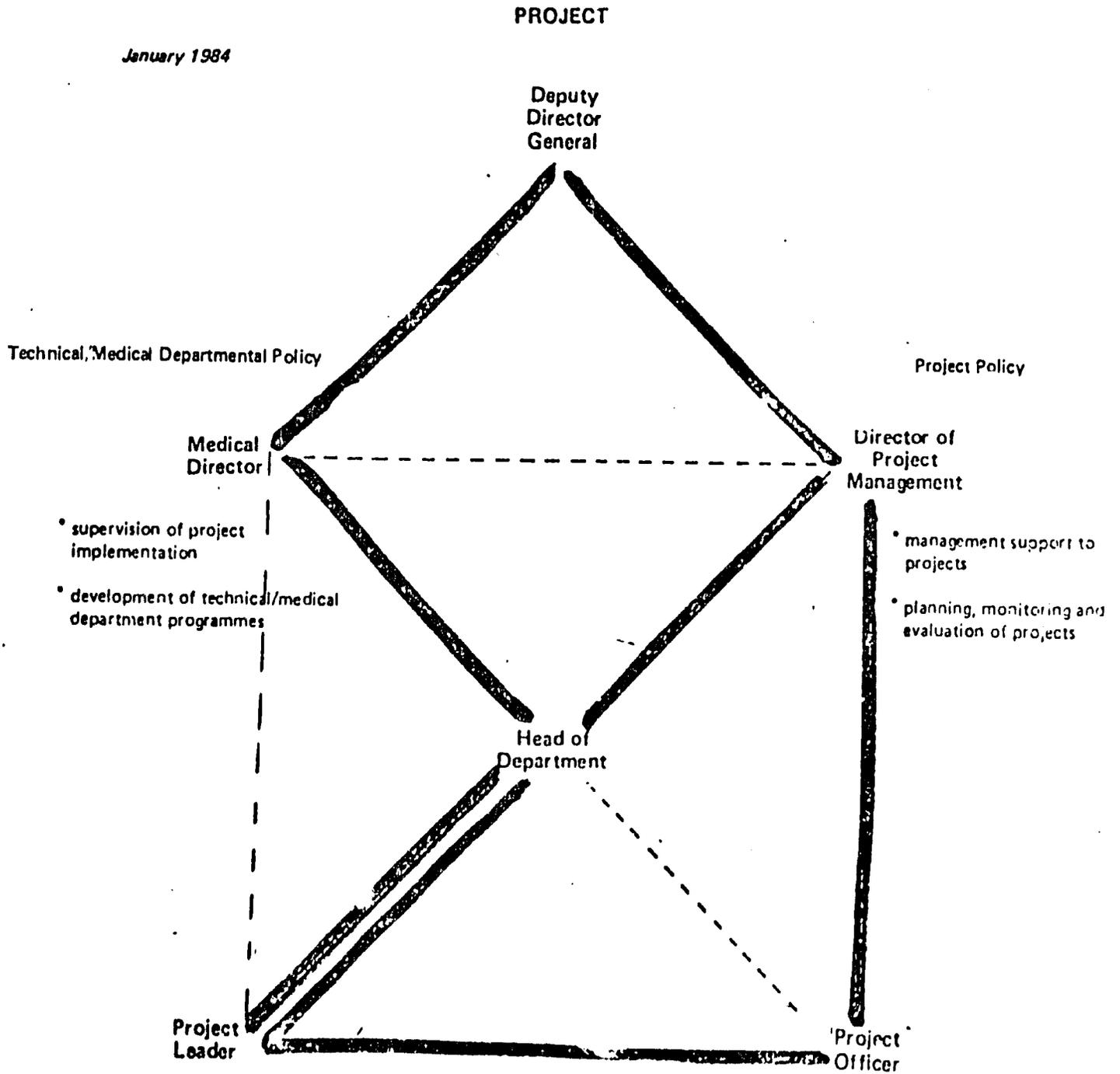


Figure 2.4 (see page 18a) depicts coordination of project activities in a wider AMREF's structure. The dotted lines in the figure show informal channels of communication within the organization. The solid lines show formal channels of interactions as established by job descriptions. Notice that the Project Officer interacts directly with project leaders and this makes it possible for the Division of Project Management (and the donors) to obtain timely information about project activities. Figures 2.2, 2.3 and 2.4 indicate that the MCH/FP/Nutrition Unit is well integrated into AMREF's organizational structure.

Figure 2.4: A Further Illustration of Project Monitoring and Management



III INTERVENTIONS

The following is a brief assessment of the interventions of MCH/FP/Nutrition Unit.

1. Family Planning (FP) Interventions:
 - o Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) as FP advocates;
 - o health education and FP supply through rural shops;
 - o developing and testing programmes for increased knowledge and favourable attitudes in the field of FP among health workers.
2. Interventions Related to FP Acceptance and Utilization:
 - o integrated project of child survival;
 - o ante-natal and obstetric care.

Notice that the interventions seem to play a double role, that of an objective and that of a methodology. In many ways, programmes of such nature have to have such a characteristic since a constant interaction of means and ends needs to take place.

Given the above characteristics of the interventions, it is necessary to examine whether these interventions are realistic, achievable and replicable with the available resources. If we take the training programme for the advocacy for FP with the retention, the actual cost is US\$ 44.18 per person per day which is equivalent to KShs 800 per day. This figure excludes the staff time and vehicle cost. The cost of the programme is one third of what the project document calls for. The budgeted cost of training ranges from US\$ 132-177 per day. AMREF should be credited for their prudence in expenditure. They have accomplished the intended output with about 33-34 per cent of the planned budget. Although, this cost appears high for the pilot interventions, it should decline dramatically if a large number of TBAs are trained and if scale economies exist in training.

Although there is no figure to quote, the ante-natal and obstetric care can be achieved and are being achieved at low cost especially since they are being performed by TBAs who are based in their own communities and who charge little, if at all, for their services.

In the areas of health education and provision of FP services through rural shops, it may be difficult to assess the health education part but the provision of contraceptives is an innovative idea which is achievable and replicable. (Table 5.2, Chapter V, shows the shopkeepers' activities; it indicates that a demand for FP services can easily be created without incurring high costs.)

The intervention of developing and testing a programme for knowledge and more favourable attitudes in the field of FP among health workers is a sound and realistic objective. It is also possible to achieve this goal without additional cost if the programme is designed in such a way that it thoroughly integrates with the actual training of health workers in which teaching of various subjects is possible.

The child survival part of the programme is the most crucial aspect of the interventions. The sensitivity regarding FP is related to this issue. There are psychological, social, cultural and religious issues involved in the minds of the families in this matter. To overcome these conflicts, the programme must be sound so that it can create confidence in the family and the community towards the FP programme. It will not be costly since it is community based but it will need a lot of patience and understanding on the part of the providers. It is an intervention with which the child's welfare can be demonstrated. It can convince the family to have confidence in FP since it assures them that the newborn has a better chance to grow. A good example here is the case of mothers in the nutrition feeding centres. One can observe an immediate change in their attitudes toward FP when they see an improvement in the health of their children.

In general, the interventions and the strategies for achieving them are well designed. In a short period there are noticeable outputs, e.g. 40 CHWs have been trained and are practicing what they learnt, and 30 TBAs and 32 shopkeepers have been trained. The shopkeepers seem to have begun training their family members too. The shopkeepers can be said to be practising their training (since they are distributing contraceptives as trained to do), but the extent to which the TBAs are practising their training is not known. A system to monitor the activities of TBAs after training needs to be set up.

IV PROJECT INPUTS

4.1 Staff

The Maternal and Child Health (MCH)/Family Planning (FP)/Nutrition Unit has the following staff:

Staff member	Date joined the unit
Ms J. Naisho (Public Health Nurse)	12 August 1983
Dr R. Nyonyintono (Sociologist)	1 March 1984
Mrs A. Ngesa (Nutritionist - initially a part-time Field Research Officer)	1 October 1984
Dr H. Sandbladh (Medical Officer - initially joined the project for three months in 1984)	1 January 1985
Ms R. Sempele (Secretary)	1 March 1984
Mr G. Kamau (Driver)	1 May 1984

4.2 Materials

1. Three offices at AMREF headquarters in Nairobi.
2. One station-wagon car. Other AMREF vehicles can also be used by the project when available.

4.3 An Analysis of Input Budget and Cost

The total budget for the inputs of the MCH/FP/Nutrition project described in the previous chapters is US\$ 827,795. The USAID's contribution to this budget is US\$ 620,000. This represents 74.9 per cent of the budget; AMREF is financing the remaining portion of the budget.

Table 4.1 below depicts a summary of the financial budget of the project inputs and the actual expenditures on those inputs for the period August 1983 - June 1985. The budget figures are those that were approved by Amendment No 3 dated 11 August 1985. This amendment allowed changes in the budgets for various inputs but did not alter the total amount of the funds budgeted for USAID inputs. The revised budget is referred to in the tables and in the text as 'Amendment No 3 Budget'.

**Table 4.1: A Summary of Amendment No 3 Budget
and Actual Expenditures on USAID Financed Inputs
for the Three-Year Period 8/83-8/86 in US Dollars**

Budget line item	Budget amount 8/83-8/86	Actual expenditure 8/83-8/86	Actual expenditure as % of budget
A. Technical Assistance	206,560.00	71,578.72	34.65
B. Training	98,938.82	52,554.81	53.12
C. Commodities	26,594.00	16,392.22	61.64
D. Other Costs	160,910.00	48,554.77	30.18
Total	493,002.82	189,080.52	38.35
Overheads (25.76 per cent)	126,997.52	48,707.14	38.35
Grand Total USAID Inputs	620,000.34	237,787.66	38.35
Unspent Balance		382,212.34	61.65

Since the project has been in existence for about two years, it should have spent approximately two-thirds of its budget, if its spending has been according to plans.*

It can be seen from Table 4.1 that, as of June 1985, the project had spent 38 per cent of its three-year budget, i.e. the proportion spent is slightly above one-half of what should have been spent. The table also shows that about 62 per cent of the training budget and 53 per cent of the budget on commodities have been spent. These are the budget proportions that one would expect to have been spent at this stage of the project. However, an explanation is required as to why the total budget and the budgets for the other line items shown in the table are underspent. To facilitate this explanation, all the line items in the Amendment No 3 Budget are displayed as in Table 4.2 on the following page.

* This is true, however, only if project costs are evenly distributed over the three year period.

**Table 4.2: Amendment No 3 Budget
and Actual Expenditures on USAID Financed Inputs
for the Three-Year Period 8/83-8/86 in US Dollars**

Budget line item	Budget amount 8/83-8/86	Actual expenditure 8/83-8/86	Actual expenditure as % of budget
A. TECHNICAL ASSISTANCE			
1. Long Term			
Medical Officer	52,735.00	11,590.66	21.97
Sociologist/Aanthropologist	45,350.00	18,009.93	39.71
Community Nurse	49,810.00	19,995.96	40.14
Nutritionist	18,675.00	3,214.69	17.21
Secretary	17,375.00	5,948.32	34.23
Driver	6,990.00	2,557.68	36.59
2. Short Term			
Consultants	10,415.00	1,243.75	11.94
Enumerators	5,210.00	9,017.73	173.08
Sub-total, Technical Assistance	206,560.00	71,578.72	34.65
B. TRAINING			
1. Ten one-week workshop for 15-20 participants			
	15,808.82	14,816.33	93.72
2. Development, production and distribution of teaching materials and training manuals			
	16,400.00	3.68	0.02
3. Participation in other relevant training courses as resource staff			
	1,735.00	0.00	0.00
4. Staff training (two MCH degree courses)			
	43,000.00	37,734.80	87.76
5. Three MCH/FP/nutrition workshops (incorporated into other AMREF training courses)			
	12,800.00	0.00	0.00
6. Incorporation of MCH/FP/nutrition component into distance teaching courses			
	9,195.00	0.00	0.00
Sub-total, Training	98,938.82	52,554.81	53.12
C. COMMODITIES			
1. Station-wagon vehicle			
	10,354.00	8,125.30	78.47
2. Teaching equipment			
	5,000.00	0.00	0.00
3. Office equipment			
	7,560.00	8,123.25	107.45
4. Supplemental FP supplies			
	3,000.00	0.00	0.00
5. Reference material			
	680.00	143.67	21.13
Sub-total, Commodities	26,594.00	16,392.22	61.64

Table 4.2 continued.

Budget line item	Budget amount 8/83-8/86	Actual expenditure 8/83-8/86	Actual expenditure as % of budget
D. OTHER COSTS			
1. External evaluations	13,975.00	0.00	0.00
2. Vehicle running expenses (\$0.45 x 25,000 km for FY2 & 3 and 19,000 km for FY1)	36,370.00	3,498.52	9.62
3. Staff travel expenses (\$40 per day x 200 person days)	27,780.00	20,548.55	73.96
4. Reports and technical papers	4,000.00	5,806.20	145.16
5. General expenses (contingency)	3,475.00	834.10	24.00
6. AMREF project-related liaison work with USAID Washington	17,365.00	17,867.40	102.89
7. Research data analysis (NFWC, FP, Family Life Education)	52,225.00	0.00	0.00
8. Office supplies	5,720.00	0.00	0.00
Sub-total, Other Costs	160,910.00	48,554.77	30.18
Total	493,002.82	189,080.52	38.35
Overheads (25.76 per cent)	126,997.52	48,707.14	38.35
Grand Total USAID Inputs	620,000.34	237,787.66	38.35
Unspent Balance		382,212.34	61.65

The following are comments on the budget line items shown in Table 4.2 that appear to require an explanation

Item A: All Lines

The budgets for these line items are under spent for two reasons:

- Decline in the value of the Kenya Shilling relative to US Dollars. In 1983, when the project budget was drawn, the exchange rate between the Kenya Shilling and the US Dollar was KShs 13.6 to US\$ 1. In June 1985 the exchange rate was about KShs 16.15 to US\$ 1. This means that the Dollar had appreciated by approximately 18.8 per cent relative to the Shilling. Since AMREF salaries are paid in Shillings, the amount of Dollars required to pay these salaries has continued to decline since 1983. Had the Shilling appreciated relative to the Dollar, the reverse would have happened, i.e. an increasing number of Dollars would have been required to pay a fixed-wage bill in Shillings and the budget proportions for line item A would have been much higher.
- Because of the AMREF's salary structure, the project staff are paid less than the salaries estimated for them in the project budget.

Item B2

The expenditure on this item is higher than is shown in the table. The actual expenditures on this item are reflected in item C3. This is why the budget for item C3 is overspent. Some of the expenditures which are shown under C3, but which actually belong to B2 are costs of audio-visual aids, plastic materials and stationery.

Item B3

AMREF staff participated in training courses organized by the Ministry of Health (MOH). The MOH was willing to meet the expenditures for these staff and therefore AMREF kept these funds for other purposes.

Items B5 and B6

These are new items created under the revised budget.

Item C2

This budget is already spent but it is not reflected in the account books.

Item C4

The MOH supplies FP materials to AMREF at no cost. So AMREF saved the funds that were allocated to cover the cost of these items for other purposes.

Item C5

AMREF is not charged for many of these materials because it is a non-profit organization, e.g. the International Development and Research Centre (IDRC) and Popline do not charge for the materials they supply to the unit.

Item D1

This budget is in the process of being spent.

Item D2

The spending of this budget is in accordance with plans. If the project moves to a new site, all the unspent funds in this budget will be needed.

Item D4

Some of the costs charged to this budget should have been charged to D7, but this line item did not exist before the amended budget.

Item D8

This is one of the new items created under the revised budget.

For the budget and expenditure patterns during the period August 1983 - June 1985, see Appendix 1. For the budget and expenditure patterns before Amendment No 3, see Appendix 2.

Comment:

Out of the grant of US\$ 620,000, US\$ 237,787.66 was spent by June 1985. The unspent balance is US\$ 382,212.34. This balance is adequate for the next project year. The activities planned for this period are described in detail in Chapter II (see Project Phases V-VII therein).

4.4 Efficiency and Cost Effectiveness

Due to time limitation it was not possible to gather data which would permit a quantitative assessment of the efficiency of the project and its cost effectiveness. Thus, only general statements about these aspects of the project are possible.

Efficiency

The issue here is whether, with the available resources and given the prevailing input prices and production technology, the measurable outputs of the project have been achieved at the lowest possible cost. The reference materials were obtained from the cheapest possible sources without any tradeoffs in their quality. The project leader has identified institutions from which he can get high quality reference materials at little or no cost. He is also actively involved in finding out the best way to apply new developments in the audio-visual technology in the training of TBAs. It appears that the project is carrying out its activities efficiently.

Cost Effectiveness

Some of the project outputs, e.g. favourable attitudes towards FP among health workers or the curricula for TBA training, are very difficult to measure. So an analysis of costs per unit of output cannot be made when judging the performance of the project in these fields. What is needed is to find out whether, for example, favourable attitudes towards FP have been created using the cheapest method possible. The community-based approach that the project is using in Kibwezi to change people's attitudes in favour of FP is cost effective since it is the cheapest method the project can use. The project is not paying the CHWs and TBAs for being advocates of FP. The CHWs (and also the TBAs to some extent) belong to the community.

V PROJECT OUTPUTS

5.1 Orientation Workshop

A two-day workshop was held in Kibwezi in April 1984. There were three major purposes in organizing this workshop:

1. Introduction of AMREF's newly established Maternal and Child Health (MCH)/Family Planning (FP)/Nutrition Unit;
2. Orientation of health, FP and nutrition activities to government and community representatives;
3. Identification of problems related to the above mentioned areas and findings possible solutions.

The key note addresses are related to FP, primary health care (PHC), nutrition, the spread of information on healthful living, such as simple measures of sanitation and personal hygiene, boiling drinking water and the protection of wells and springs, were given.

The participants were then divided into small groups for one-and-a-half days to identify solutions to problems encountered in the delivery of MCH/FP/nutrition services .

Full details of the one and half day group exercise can be found on appendix three on this report.

It should be noted here that this exercise has several important points; some of which are:

1. It enabled the groups to identify their needs and priorities in the delivery of MCH/FP/Nutrition services
2. It created an atmosphere where the groups were able to think of some possible steps that should be undertaken to solve the problems which they have identified.

In conclusion, since these problems and possible solutions are identified and expressed as felt needs by the community representatives, they should be used as guidelines for further development of the MCH/FP/Nutrition services delivery.

5.2 Training of Community Health Workers

There are about 146 Community Health Workers (CHWs) in Kibwezi Division. Of these 40 have attended courses on FP, nutrition and health education conducted by AMREF's MCH/FP/Nutrition Unit. All these courses were held at Kibwezi Health Centre. The evaluation team interviewed seven of the CHWs who had received training in the above subjects. This training was additional to the previous training which the CHWs had received from AMREF before the formation of MCH/FP/Nutrition Unit.

During the interview the CHWs said that from the courses offered by AMREF's MCH/FP/Nutrition Unit they gained knowledge about various methods of FP and about causes and prevention of communicable diseases. This knowledge appears useful in the activities of the CHWs. The CHWs said their duties in the villages are to:

1. Teach hygiene and sanitation. More specifically they advise families to drink clean or boiled water and to build and use latrines and they also advise families to clean utensils and to keep them in clean places.
2. Teach households or adult individuals about FP. In particular the CHWs inform people about the benefits of contraceptives, show them how they are used and where they can get safer methods of FP. An example of specialised FP service is tubal ligation which the CHWs said had been requested by 29 people.
3. Give contraceptives free of charge to adults who want to use them. The CHWs receive condoms and foaming tablets at no charge from the shopkeepers and from Kibwezi Health Centre.
4. Show families how to prepare Oral Rehydration Solution (ORS) and to advise parents to give this solution to children when they have diarrhoea.
5. Advise families about nutrition. For example, they advise mothers to breast feed their babies and discourage feeding babies with breastmilk substitutes.
6. Advise patients (when requested) how to use the medicines obtained from shops, dispensaries, health centres or hospitals.
7. Refer patients to health centres or hospitals. The CHWs said sometimes they use a lot of their own resources on patient referrals.
8. Teach families how to control infectious diseases. For example, when there was cholera outbreak in Kibwezi in 1984 the CHWs said they advised people to boil drinking water and to use latrines as measures of preventing the spread of cholera.

The CHWs have two ways of reaching the households: by visiting their homes and farms or through public places, such as barazas. Usually, several CHWs are present in a public gathering.

In such a meeting different health messages are transmitted to those attending the meeting by different CHWs. For example, one CHW might speak on FP while another might explain the use of ORS in the treatment of diarrhoeal diseases.

Between March and August 1984 the seven CHWs who had been interviewed distributed contraceptives to 444 people in Kibwezi District.*

* Between January and December 1984 there were 150 new acceptors of FP at Kibwezi Health Centre. Between February and August 1985 there were 50 new acceptors of FP. In January 1985 the centre closed down due to a cholera outbreak (see also Table 5.2).

Table 5.1 on this page displays contraceptive distribution by CHWs in Kibwezi Division.

There appeared to be a consensus among the CHWs that, in general, the communities they serve are willing to use contraceptives. At this stage of the programme it can be said that the CHWs have been successful in creating a sizeable demand for contraceptives in the project area.

Table 5.1: Contraceptive Distribution by Community Health Workers

Interview No of CHW	No of people issued with: Condoms	Foaming tablets	Total number	Period covered
1	140	155	295	March - August 1985
2	43	20	63	March - August 1985
3	5	4	9	March - August 1985
4	1	10	11	March - August 1985
5	1	2	3	June - August 1985
6	6	3	9	June - August 1985
7	28	28	54	March - August 1985
Total	244	220	444	March - August 1985

Source: Compiled from field data.

The success of the CHWs in this matter is due to two factors. The first and most important factor is their proximity to the population. The second factor is their active advocacy for FP. The CHWs said they spend a considerable amount of time at people's homes and farms informing them about modern methods of FP. Two of the CHWs spend 2-4 days a week on health work, with one day being spent on FP matters.

5.3 Training of Traditional Birth Attendants

Two courses were organized for Traditional Birth Attendants (TBAs) in MCH, FP and nutrition.* In particular TBAs were trained in:

- o oral rehydration;
- o ante-natal and post-natal care;
- o danger signs of labour;
- o balanced diet, especially for pregnant and lactating mothers and children;
- o safe and clean methods of delivery.
- o different methods of FP.

The course is organized on the basis of a job to be performed. The length of the course is five days with a monthly follow-up for four months.

* A two-day follow-up workshop was also carried out.

The training was conducted by the Community Nurse in charge of training in AMREP's MCH/FP/Nutrition Unit with participation of other professionals from Kibwezi Health Centre, Makindu Sub-District Hospital and Machakos Diocese.

The methods used for training are discussions, demonstrations, return demonstrations and use of some audio-visual aids.

Pre- and post-training tests were used for ante- and post-natal care, delivery and child care. According to the scores a reasonable knowledge has been gained (see Appendix 4).

The team interviewed TBAs who came from Makindu, Kisingo, Kai, Mtito Andei, Kainboydo and Kawinguni sub-locations, some individually and some in groups. A total of ten TBAs were interviewed. Nine of those were trained and one was not. The TBAs stated that they were performing the following activities since they received the training:

- o advising and demonstrating nutrition;
- o demonstrating oral rehydration;
- o explaining about the advantages of FP;
- o referring cases which they felt were unsafe to be delivered by them.

They gave other examples of post-training practices such as washing their hands before delivering, referring a pregnant woman if there is blood before delivery, and palpating the foetus while it is in the womb. They also stated they refer prolonged labour cases but the time limit was not explained.

The untrained TBA said that she knows how to help a mother deliver. She started with an emergency situation six years ago. She has delivered three babies since then. She does not know about FP, ante- or post-natal care, nutrition, or complicated deliveries. She wishes to be trained.

It was interesting to note that nine out of the ten who were interviewed have started to be TBAs due to a need of helping a woman to deliver. One said she had to deliver herself as there was no one to help her. A male TBA said his interest in becoming a TBA began after he helped a lady to deliver while in a bus.

It seems that these experiences have opened the minds of TBAs for the need of training in MCH which has become the link for seeking information on FP.

Most TBAs said that they are not paid for their services. One stated that she is paid KShs 20 per delivery. However, she does not demand to be paid if the family does not pay her. A number of them are paid in kind. Most of them stated they make a living on subsistence farming.

5.4 Training of Shopkeepers

Since March 1984 the MCH/FP/Nutrition Unit, using the training facilities at Kibwezi Health Centre has trained 32 shopkeepers. The shopkeepers have received education regarding the diseases that can be treated by non-prescription drugs that they keep in their shops and also about modern methods of FP. It was found during the training sessions that over 110 different types of drugs are being sold in a variety of shops in Kibwezi Division. The non-prescription drugs kept by the shopkeepers can be classified into four groups: painkillers, malaria tablets, worm killers and cough medicines. There is strong suspicion in Kibwezi (as is probably the case in other parts of Kenya) that some shopkeepers are selling antibiotics and other drugs which require a doctor's

prescription.

The shopkeepers who attended AMREF's FP/health education courses are encouraged to pass on health education messages to their customers. They are, for instance, asked to inform their customers how to use the drugs they buy and, whenever possible, to verify whether the drugs patients request are appropriate for the illnesses they believe they have. The shopkeepers are also given stocks of contraceptives to distribute to the population free of charge. The evaluation team visited a number of shopkeepers to assess their performance regarding the distribution of contraceptives and dissemination of health information. Eight shopkeepers were visited. Four of them had attended AMREF's shopkeepers' course and had received supplies of contraceptives. The other four had not been trained and, as a result, were not distributing contraceptives.

Tables 5.2 and 5.3 on the following page provide descriptions of the shopkeepers who had attended AMREF's course on FP (and those who had not) regarding provision of health information and distribution of contraceptives.

Table 5.2 shows that the shopkeepers managed to distribute the contraceptives to some of their customers. However, it is not possible to tell from the data displayed in the table whether the people who collected contraceptives from the shops actually used them. The shopkeepers described in table 2 said that they were willing to act as advocates of FP.

We found this information surprising because there are no economic incentives in the current method of distributing the contraceptives to motivate the shopkeepers to create demand for the contraceptives. As mentioned earlier, the shopkeepers distribute the contraceptives to their customers free of charge. When asked what they gained as businessmen from the time they spent convincing their customers to use contraceptives, the shopkeepers could not point to clear personal gains. They simply said they had volunteered themselves to be advocates of FP.

There appear to be two reasons for the shopkeepers' willingness to act as volunteer advocates of FP. The first reason is that the shopkeepers who are currently distributing the contraceptives were carefully selected, i.e. the selection criteria were biased in favour of the shopkeepers who would be willing to do voluntary work. In order for a person to qualify for AMREF's shopkeepers' course he had to have a shop in an area (village) in which a CHW lived and a stable or successful business. Note that these criteria led to the selection of the shopkeepers familiar with CHWs (who were already doing voluntary health work and who had established businesses in their communities.

A second conjecture for the shopkeepers' willingness to act as voluntary workers in the initial phase of the MCH/FP/nutrition project is that they expected some gain during future phases of the project as a consequence of their association with AMREF.

Some shopkeepers knew that contraceptives are being sold in some chemist shops in Nairobi; thus it is probable that their willingness to act as FP advocates was based on the hope that they would be in a position to distribute contraceptives on commercial basis in the future.

From the shopkeepers' records it was noted that virtually all of the people who had collected contraceptives from the shops came from the villages in the vicinity of the shops (five kilometres or less in most cases).

Table 5.2: A Description of Shopkeepers who had Attended AMREF's Course on Family Planning

Name of shopkeepers' market	Sex	No. of people issued with: Condoms	No. of people issued with: Foaming tablets	Period covered	Characteristics of most frequent customers	Any repeat visits	Does shopkeeper educate customers about drugs they stock	Benefits of attending a shopkeepers' course	Were contraceptives displayed conspicuously
Kambu	M	28	13	June - August 1985	Unmarried adult men	None	Yes	Gained knowledge about drugs and the diseases they treat; learnt how to use contraceptives	No
Mbui-Nza	M	7	10	March - August 1985	Adult women	None	Yes	No response	Yes
Kambu	M	8	7	March - August 1985	Married men with at least 3-4 children	Yes	Yes	Learnt that contraceptive use can prevent STIs	No
Kambu	F	-	5	June - August 1985	Married women	No	No	No response	No

M = Male; F = Female.

* Also provides nutrition education.

Table 5.3: A Description of Shopkeepers who had Not Attended AMREF's Course on Family Planning

Name of shopkeepers' market	Sex	Would he/she be willing to attend a shopkeepers' course	Does he/she educate customers about use of drugs kept in the shop	Would he/she be willing to advocate for FP if trained	Had she/he heard of AMREF's shopkeeper's course	Is he/she willing to distribute contraceptives if trained
Kambu	M	Yes	Yes	No	Yes	No
Kambu	F	Yes	No	Yes	No	Yes
Kwezi	M	Yes	Yes	Yes	Yes	Yes
Kwezi	F	Yes, with permission of husband	No	Not sure	Yes	Not sure

M = Male; F = Female.

Table 5.3 contains information about a random sample of four shopkeepers who had not attended AMREF's course on FP and who had therefore not been supplied with the contraceptives to distribute.

In comparison to Table 5.2, Table 5.3 displays informative results. This table shows that virtually all the shopkeepers would be willing to attend AMREF's course on FP. However, only half of them would be willing to distribute the contraceptives and/or act as FP advocates.

Two points are worth noting regarding the information displayed as Tables 5.2 and 5.3. Firstly, no statistical significance should be attached to the shopkeepers' responses displayed in the tables since the sample sizes are very small. Secondly, the results tabulated in the table depend on the criteria used to select the shopkeepers.

The discussion about the shopkeepers can be summarized as follows:

1. Distribution of contraceptives through rural shops would make contraceptives more accessible to the rural population. This should increase the demand for contraceptives.
2. At the moment there are no economic gains to be had by the shopkeepers as distributors of contraceptives since they give them to their customers free of charge. But in the long run they probably hope to reap these benefits having first created a demand for contraceptives and then distributing them commercially. (However, for this to happen, some barriers to this market should be imposed otherwise no shopkeeper would invest initially in creating demand for a product which would be available for sale by every one).
3. The shopkeepers would be willing to act as voluntary advocates of FP provided that they are carefully recruited. This aspect of the shopkeepers could be used in the initial phases of the FP project to create demand for contraceptives.
4. Health education with respect to use of over-the-counter drugs is possible through the shops but on a limited basis because there are no strong economic motives to drive the shopkeepers to provide it.

Other aspects of distribution of contraceptives through the shops

1. The shop owners who had been trained as contraceptives' distributors are not in the shop all the time. The people they leave as their deputies (wives or relatives) showed some knowledge of contraceptives. This is because, as mentioned earlier, the trained shopkeepers inform their family members about the contraceptives they distribute.
2. The shopkeepers felt they needed further training in the distribution of contraceptives.

5.5 Measurement of Final Output

The ultimate aim of this project is to develop replicable methods of lowering the population growth rate in Kenya. Thus, the ideal index of final output of the project is a reduction in the annual growth rate of Kenya's population by a certain percentage. Further, the extent of decline in this growth would represent the magnitude of the impact of the project.

However, in a practical evaluation of the impact of this project, alternative measures for its output are required. There are three main reasons for this.

1. This project life is too short for it to have noticeable influence on the growth of the population in the project area.
2. Because of the child survival component of the project, even if a noticeable change in the population growth occurs, this change is likely to be positive rather than negative.
3. There are other factors, such as migration flows, which are not being controlled in the project interventions.
4. Further improvements in the health services in the area

These considerations make changes in the population growth rate inappropriate as measures of the project impact.

The realistic measures to use in a practical assessment of the impact of this project are measures of changes in variables related to improvements in chances of child survival and indices of variables related to increased use of FP services. These impact measures are realistic because an enhancement in child survival should lead to an increase in the use of FP services among couples. (Assuming that the majority of new additions to the population are from married couples, the adoption of FP would eventually lead to a reduction in the rate of population increase.)

Practical measures of final output for this project should be a combination of some or all of the following:

- o number of contraceptives distributed during the project life;
- o number of people using contraceptives for a given period;
- o frequency of use of ORS for diarrhoea problems;
- o frequency of referrals of abnormal deliveries by TBAs;
- o frequency of nutritional advice by TBAs;
- o ante-natal visits to TBAs;
- o number of mothers no longer using breastmilk substitutes;
- o number of shops no longer selling breastmilk substitutes;
- o number of ante-natal visits to modern facilities;
- o extent to which the research papers of the project are read by people involved in population control interventions.

Other output measures can be constructed along the lines suggested above.

VI MONITORING

The monitoring system that is used by the MCH/FP/Nutrition project falls into the following areas:

1. Written or verbal report from the field, when the head of unit or staff visit the field (the project site) extensive discussions are carried out with the Kibwezi Health Scheme staff, the Community Health Worker, and Traditional Birth Attendants, in the areas of achievements, difficulties and possible steps to be taken to solve some of the difficulties. Some forms have been provided for the CHWs and TBAs to record the FP services they provide but they have not yet learned to accurately use them. A follow-up and proper training on record keeping should be considered.
2. MCH/FP/Nutrition Unit meetings and exchange of reports and comments:

This is an in-house meeting where the staff members of the unit inform other staff of their respective activities and plans. It is a useful exercise as it helps to coordinate the programme and also may supplement information from the field for project activities (e.g. nutrition, family planning supplies etc.)
3. Quarterly staff meetings with all AMREF staff who are concerned with the MCH/FP/Nutrition Unit project. During these meetings the concerned AMREF staff are informed of all the activities that were undertaken during the period. The achievements, constraints and the procedures to carry the activities and discussed in detail. This meeting is very important as it provides concrete ideas and suggestions on how to carry further the activities of the MCH/FP/Nutrition Unit.

These meetings, reports may be called an in-built monitoring and evaluation. They provide a base for further monitoring and evaluation and the continuity of this activity should be encouraged.

4. Monthly meetings -

A Monitoring Committee meeting has been established. The members are composed of USAID, FPPS and MCH/FP/Nutrition Unit. This committee reviews all activities that have been carried out during the month and suggests alternative steps to be taken on the areas of activities that may need a change and endorse the programmes that are running smoothly.

5. Advisory Committee meeting

This committee is composed of AMREF Representatives, Ministry of Health Representatives and other agency representatives. It is supposed to meet twice a year and advise the MCH/FP/Nutrition Unit on the development of the Unit's programme. So far it has been difficult to get the participation of the members outside the AMREF staff. A special effort should be taken to hold these meetings since they link the project with other agencies that are crucial for the replication of the activities of the project.

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VII SUMMARY AND CONCLUSIONS

7.1 Summary

The current growth rate of Kenya's population (4 per cent per annum) is a constraint on socio-economic development of the country. It makes it difficult for the Kenyan economy to provide adequately for the basic needs of this population.

In 1983 AMREF, with a financial grant of US\$ 620,000 from USAID, started a management and research project in an attempt to develop replicable means to reduce the present very high rate of population growth in Kenya. The project hopes to achieve its purpose by a strategy that enhances the chances of child survival and increases the use of contraceptives.

After a period of preparatory work during which AMREF set up a Maternal and Child Health (MCH)/Family Planning (FP)/Nutrition Unit at its headquarters in Nairobi, AMREF began field tests of the above strategy in Kibwezi Division of Machakos District in March 1984.

Since then cadres of Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and shopkeepers in Kibwezi area have been given courses in MCH, FP and nutrition education. So far 30 TBAs have been trained and are hopefully advising clients about the modern methods of FP in addition to their other MCH duties.

Forty CHWs have undergone courses in FP and have been given condoms and foaming tablets to distribute free of charge to the communities they serve. Of the CHWs interviewed, 7 had distributed these contraceptives to 444 people between March and August 1985. On average, each interviewed CHW distributed contraceptives to about 63 people during this period. Since 40 CHWs had been trained to distribute contraceptives, we estimate that the CHWs distributed contraceptives to about 2,520 people between March 1983 and August 1985. Over the same period the number of people who received contraceptives from the shopkeepers is 640. (Thirty-two shopkeepers had been trained and on the basis of those interviewed, each shopkeeper is estimated to have distributed contraceptives to 20 people).

In addition to training the community-based health workers in MCH, FP and nutrition, the MCH/FP/Nutrition Unit also gave the same training to the facility-based health workers in Kibwezi and in other areas of Machakos District.

An activity that the unit pursued with some success is the development of materials for training and teaching purposes. The collection and acquisition of these materials is inexpensive since AMREF, being a non-profit organization, is not charged for some of these materials. Some of the materials, especially recent research works, are being acquired from abroad. The Head of the Unit is in touch with overseas institutions which supply the unit with teaching materials or with information about them. The unit is also in good relationship with a number of organizations and institutions in Kenya. e.g. the Ministry of Health (MOH), the Family Planning Association of Kenya (FPAK), the International Development Research Centre (IDRC), and the University of Nairobi.

There were delays in project implementation in Phase I of the project because of staff shortage and in Phase III due to a severe famine and an outbreak of cholera in the project area. This appears to be one of the reasons why, as of June 1985, only 38 per cent of the project budget had been spent.

In regarding the conclusions and recommendations that follow, it should be borne in mind that due to the long term nature of the effects of this project, its evaluation was done too early. The interventions of the project are only 18-20 months old, and their effects are yet to fully work themselves out.

7.2 Conclusions

Two kinds of conclusions are presented in this section: Conclusions specific to the objectives of the project and general conclusions. In the case of the latter, each of the objectives of the project is listed separately, along with the conclusion(s) specific to it.

a) Conclusions specific to the objectives of the project

Objective One:

"To reduce the present rate of population growth in Kenya through creation of an effective demand for FP services and to improve the health and nutrition status of mothers and children".

Conclusions:

(i) The first part of this objective, i.e. reduction in the growth rate of Kenyan population is not achievable within the pilot interventions of the project. So far, the project interventions have been implemented only in one area in Kenya - Kibwezi Division in Machakos District. An additional area can be covered during the remaining life of the project. However, even if population growth rates decline in the project areas, no noticeable decrease would be observable in the average growth rate of the population in Kenya.

(ii) The second part of the above objective, i.e. improvement in the health status of mothers and children (in the project area) is achievable, but not in the current life of the project.

The project activities in MCH/FP, nutrition and in child survival in the project area (Kibwezi Division) should eventually lead to an improvement in the health status of mothers and children in the division. For example, the training of TBAs in safe delivery, ante-natal and post-natal care, and in diagnosis of delivery cases that require hospital referral, would, if practiced, lower maternal and child mortality. Some TBAs are already referring abnormal delivery cases to hospitals; but it is not clear the extent to which these referrals are due to the training given by the project staff. It will take more than one three-year period (i.e., more than one project life) to document the effect of training on the existing practices of TBAs; and hence on the effect of this training on the process of improving the health status of mothers and children. This process for instance, consists of an increase in the utilization of ante-

natal services; improved nutrition for expectant mothers (as a result of nutrition education by TBAs, and CHWs); and an increase in hospital referrals of abnormal pregnancies by TBAs.

Objective Two:

"To develop, implement and evaluate pilot interventions and, specifically to explore alternative strategies in the delivery of MCH/FP/Nutrition services to communities."

Conclusions:

(i) With regard to the development, implementation, and evaluation (monitoring) of pilot interventions, the project has been successful in developing and implementing a number of pilot interventions.

For example, the project has developed training materials, and has used them to train TBAs, shopkeepers and the CHWs in FP and in nutrition education. As a result of this training, the shopkeepers and the CHWs, are now distributing contraceptives (condoms and foam tablets). The trained TBAs are not distributing contraceptives, but they are reportedly involved in providing advice on oral rehydration, FP and nutrition.

The monitoring of the distribution of contraceptives by the CHWs and the shopkeepers, and also the follow-up of the activities of trained TBAs has just started. The research and training staff of the project have designed forms to monitor the distribution of contraceptives and provision of FP advice by TBAs. These forms have already been issued to the TBAs and the CHWs, but they have not yet been collected for analysis.

A good number of reference materials have been developed or purchased, but their utilization appears limited.

(ii) The project has succeeded in exploring alternative strategies of delivering MCH/FP/Nutrition services to communities. Shopkeepers, CHWs and TBAs are providing FP services and advice. However, although the project staff have trained the CHWs, shopkeepers and the TBAs to provide nutrition education, the extent to which this education is being provided is not known and needs further monitoring.

(iii) The project has plans to encourage the well-groups to start vegetable and fruit cultivation at the water sources. This proposal seems feasible, but the well groups might need assistance in form of seeds and irrigation facilities.

Objective Three:

"To develop MCH/FP/Nutrition components for existing and new AMREF projects."

Conclusion:

There was no time to investigate this aspect of the project in detail. So far, the project has developed a number of these components. The project staff have given several lectures to AMREF staff at the headquarters, and at Kibwezi Health scheme on Family Planning. Project staff also attend working committee meetings of other related and appropriate AMREF projects where they offer advice on their specialty areas. More importantly, the project has integrated FP services into

AMREF's Flying Doctors Services through its training of Flying Doctors nurses in FP, gynaecology and obstetrics; established a Nutrition Rehabilitation clinic at Kibwezi Health Scheme; and set up an MCH/FP clinic for AMREF staff in Nairobi. In addition to the above, the project has been consulted to integrate MCH/FP in Primary Health Care services in Lake Kenyatta Settlement and also has been asked to provide MCH/FP services for AMREF's projects in Southern Sudan. The project is planning to establish a second Nutrition Rehabilitation clinic in Magadi.

Objective Four:

"To assist upon request, government and non-government agencies in formulating and evaluating MCH/FP/Nutrition projects."

Conclusion:

It was not possible to obtain information which could be used to assess the performance of the project in achieving the above objective. However, we find that the project staff have provided advice to the government of Kenya, and non-governmental organizations on appropriate materials and methods in the training of health workers in the fields of MCH, FP and nutrition. So far, the project's MCH/FP/Nutrition Unit has been consulted by a number of agencies and institutions on appropriate training materials in areas of MCH, FP and nutrition. Some of these agencies are: The Division of Family Health, MCH; Family Planning Association of Kenya; and the Kenya National Council for Population and Development. Thus, the MCH/FP/Nutrition Unit that was set up by the project has succeeded in establishing itself as a source of advice on matters concerning training in MCH, FP and nutrition. The Unit also appears capable of assisting other institutions in the formulation of MCH/FP/Nutrition projects, but it does not yet have the necessary experience to assist in the evaluation of these projects, other than the design of evaluation survey and data collection instruments.

b) Summary of Specific Conclusions:

(i) The project's objective of reducing the rate of population growth in Kenya is not achievable even if only applied to the pilot intervention areas. The interventions of the project are trial in nature, and will necessarily have to be limited to a few areas in Kenya. Thus, their impact on the overall growth of the Kenyan population will be negligible. However, the project is capable of developing replicable methods of reducing the growth rate of population in Kenya which was probably the major purpose of that objective.

(ii) Through its training of community based health workers in the distribution of contraceptives, and in the provision of child survival services (.e.g. information about ORS and balanced diet), the project has initiated a process that should eventually lead to an improvement in the health status of mothers and children in project area. since this is a slow process, the documentation of it, and evaluation of its impact on health status, will require more than three years (i.e. a period longer than the life of the current project).

(iii) The project has explored several methods of providing MCH/FP/Nutrition services to communities.

Currently Rural shopkeepers, CHWs and TBAs are delivering MCH/FP/Nutrition services. The TBAs provide information about FP methods, but do not distribute contraceptives as is the case with shopkeepers and the CHWs. Both the shopkeepers and the CHWs are distributing contraceptives on a voluntary basis.

(iv) The project is developing MCH/FP/Nutrition components for existing and new AMREF projects as planned.

(v) The project has established an MCH/FP/Nutrition Unit that is now capable of advising the Kenya Ministry of Health and other institutions on matters related to the training of health workers in the fields of MCH, FP and nutrition. The project's original aim of developing a capability for assisting the Ministry of Health and other agencies in the formulation and evaluation of MCH/FP/Nutrition projects has not yet been fully realized.

(vi) Except for objective three and the first part of objective one, the project has made good progress towards the achievement of its objectives. Considering problems of staff shortage that the project experienced in its first two phases of its life, the progress of the project is as planned. The project may thus not modify its existing logical framework.

c) General Conclusions:

(i) The MCH/FP/Nutrition Unit at AMREF is now fully established and is functioning as planned.

(ii) AMREF's administrative and managerial resources are adequate to support the project. The MCH/FP/Nutrition Unit is well integrated in AMREF's organizational structure and the unit has access to the resources at AMREF to carry out its activities. The unit has highly qualified staff.

(iii) The project has integrated the activities of the community-based health workers, i.e. the CHWs, TBAs and shopkeepers, in the provision of MCH/FP/nutrition services. The CHWs obtain contraceptives from the shopkeepers when their supplies run short; the TBAs refer their clients who are willing to use contraceptives to the shopkeepers, CHWs or a health facility. Through its training programme the project has also strengthened the link between the community-based health workers, Kibwezi Health Centre and government health facilities in Kibwezi Division.

(iv) The shopkeepers are currently distributing contraceptives on a voluntary basis. At the moment there are no economic gains that accrue to them as distributors of contraceptives. However, some of the shopkeepers know that contraceptives are being sold in Nairobi and they probably expect to sell them in the future.

(v) As of June 1985 the project had spent about 38 per cent of its three-year budget. The remaining funds are sufficient to cover the cost of the activities planned for the final year of the project. The activities

planned for this period are also consistent with the objectives of the project.

(vi) The project's addition of the FP work to the existing duties of the CHWs has substantially increased the workload of the CHWs. Any additional work to them is likely to have an adverse effect on their performance, especially since they are not being paid.

VIII RECOMMENDATIONS

a) Recommendations specific to the objectives of the project

(1) As it stands, the first objective of this project is a composite objective, in the sense that it contains several objectives in itself. This makes it difficult to know which objective is intended to be achieved by a certain intervention of the project.

We recommend that this objective be split into several objectives, each of which should be less ambitious than the current one. Other objectives should also be re-examined to determine how they can be modified in the light of the experience gained so far in the attempts made to achieve them.

(2) Through its interventions, the MCH/FP/Nutrition project has initiated a process of change that should improve the health status of mothers and children. But this process is slow, and some time will be required before its health effects can be assessed. We recommend that USAID fund the project for another five years, to enable the project's Unit to monitor and evaluate the process it has already started, besides enabling it to complete the other interventions in the project plus undertake additional pilot interventions, particularly those identified jointly with the Ministry of Health. These conclude:

- (1) School health education in family planning and nutrition
- (2) Development of more FP and nutrition teaching and learning materials.
- (3) Research on distribution of contraceptives through the shops in different geographic areas in Kenya. Some of the research topics in this area might be:

Characteristics of the shopkeepers who are considered successful in distributing contraceptives; willingness to pay for the contraceptives kept at the shops; methods of informing people of the availability of contraceptives at the shops.

- (4) Nutrition activities in schools, particularly the teaching of nutrition education.
- (5) Training members of the well groups to extend nutrition education to communities.
- (6) Introduction of Family Life Education in schools.
- (7) Introduction of new MCH/FP card at MCH clinics in Health Centres and hospitals, first in Kibwezi, and then in a few other areas in Kenya.
- (8) Further training of mothers in nutrition at the rehabilitation clinics.

- (9) Improving MCH/FP/Nutrition services at Kibwezi Health Centre.
- (10) Training and retraining shopkeepers, TBAs and CHWs in Family Planning (FP).
- (11) Further research on dropouts from Family Planning services in the project area and in other areas in Kenya. The research work would for example concentrate on finding out the reasons why clients drop out of the FP Programme.
- (12) Spreading community based distribution of contraceptives more widely.
- (13) Basic Training in health care for mothers.
- (14) Upgrading the skills of the project staff in identification, and writing up of project proposals.
- (15) Improving the skills of the project staff in implementation, evaluation and monitoring of projects.
- (16) Project staff training in skills which would enable them to provide consultancy services to other organizations and agencies concerning project identification, implementation and evaluation, among others.
- (17) Further development of teaching materials including audio visual aids.
- (18) Further training of TBAs in ante-natal and post-natal care.
- (19) Mass training of TBAs, CHWs and Shopkeepers in other areas after enough experience has been gained on the training and utilization of these cadres as MCH/FP/Nutrition advocates
- (20) Improving ante-natal clinic services in selected areas in Kenya.
- (21) Testing the applicability of experience gained in Kibwezi in other areas
- (22) Monitoring of the existing project activities.

11. If the USAID accepts to extend the project for a period of five years, we suggest that they (USAID) inform AMREF early enough of their decision to re-fund the project so that AMREF may not unnecessarily spend time (which might have been allocated to project activities) looking for alternative ways of refunding the project.

(3) 1. The project's current strategy of distributing non-prescribed contraceptives through the shops and the CHWs, makes contraceptives accessible to more people than would have been the case if their distribution was through either the shops or the CHWs.

We recommend that this strategy of contraceptive distribution be

continued in the present project area.

11. At the moment, the TBAs are not distributing contraceptives. Some TBAs in the project area expressed willingness to distribute contraceptives. We suggest that the TBAs who are willing to distribute contraceptives be recruited to distribute them.

(4) Since the project's strategy of contraceptive distribution is intended for replication, we recommend that the strategy be tried in a new site in which AMREF's infrastructural support is not available. This would require additional training, either direct training of shopkeepers and TBAs, or training of trainers in courses for health centre staff or district teams to do the training themselves. We also suggest that the contraceptive distribution should be through the shops, and possibly through the TBAs. The CHWs should not be used in the new site because their recruitment, training or supervision is likely to be very costly in an area in which AMREF's infrastructure does not exist. More importantly, the project's remaining time and financial resources are unlikely to be adequate to permit exploration of different strategies of contraceptive distribution in a new site.

(5) Since the Government of Kenya supports Community Based Distribution of low dose oral contraceptives, strategies to distribute such contraceptives should be tested along the lines of the distribution of non-prescribed contraceptives. The TBAs, CHWs and the Shopkeepers can be used for this purpose.

(6) In order to promote its nutritional goals, the project has plans for initiating cultivation of vegetables and fruits at the water sources in Kibwezi Division. We support these plans. However, it should be borne in mind that the well-groups, who are the target for this activity will likely need project's assistance in the form of seeds, irrigation facilities, and probably markets for their produce.

(7) If practised, the TBAs' training in safe delivery, ante-natal and post-natal care, nutrition, and in oral rehydration methods, should improve the health status of mothers and children in the project area. The little evidence that is available to the effect that the TBAs are practising their training, is based mainly on TBAs' verbal accounts of what they do.

We recommend that a system to monitor the extent to which the TBAs use their training be established. The project staff should develop monitoring and supervision schedules and methods. The community nurses at Kibwezi Health Centre and at the dispensaries will then regularly supervise the TBAs according to the supervision programme drawn by the project staff. The project staff themselves will monitor the community nurses and also the TBAs from time to time.

b) General Recommendations

(1) There was no time to cost the intervention activities of the project. The costs of these activities (e.g. training of TBAs and shopkeepers; data collection and analysis; training materials; etc.) are needed in order to estimate the total cost of replicating these

interventions in other parts of Kenya.

We recommend that the costs of these interventions be determined prior to the final evaluation of the project. To facilitate the costing of intervention activities during the final evaluation, we suggest that for each future activity, the following costs be kept separately:

- o Petrol costs
- o Vehicle repair or maintenance costs
- o costs of books, stationery, magnetic tapes, etc.
- o Time costs (to be shown in number of days the staff spend on an activity. The activity might be a shopkeeper workshop, data analysis, data collection and so forth)
- o Costs of food/accommodation for the participants (the number of participants should be indicated)
- o Travel costs for participants/enumerators
- o Other cost items.

It is not necessary to integrate this activity cost reporting system with the main project accounting system. The above cost data can be collected (with the aid of appropriately designed reporting forms) from the project staff as they return from the field. The cost data can then be kept in form of journal entries (or in other convention forms) for each activity. It should be stressed that these cost data should be maintained for each distinct activity of the project. A first step in establishing this system of filing activity costs, is a clear understanding of the core activities of project interventions.

(2) In a period of less than two years, the research staff of the project have produced research papers and reports of very high quality. The research findings seem relevant to the project's work, (e.g. the finding of a high drop-out rate among contraceptive users in Kenya should warn the project staff of a similar problem in the project area).

It should have been a very good thing for the research activity, if this finding led to the existing system of monitoring the use of contraceptives distributed by the shopkeepers and CHWs in Kibwezi. some of the research work planned for the next project phase include:

- o Follow-up of clinic drop-outs in conjunction with the Ministry of Health
- o Exploration of needs of out of school youth with regard to FP services

We suggest that the following research agenda be considered in addition to the one listed above.

Pattern of utilization of FP services provided by the shops, CHWs and health facilities. An example of a research question here is: which source of FP services is most frequently chosen by the clients and why?

A comparison of costs of training TBAs or shopkeepers in FP using different training methods, e.g. a comparison of costs of training TBAs using audio visual aids vs a method without these aids. The next step

would be to compare the effectiveness of these methods in terms of the knowledge gained or retained by the TBAs or shopkeepers. An assessment of the effectiveness of various methods can be done through pre- and post-tests. The final step would be a comparison of total costs of different methods for a national programme of training a given number of TBAs or shopkeepers in FP. The differences between TBAs (shopkeepers) scores in pre- and post-tests would also be shown for each method.

Thus, a method of training TBAs or shopkeepers in FP in a nationwide programme would be chosen bearing in mind its cost and effectiveness relative to other methods that are available. This choice rule would promote economic efficiency in a training programme.

An exploration of a curriculum for training a new generation of TBAs. These are TBAs who can read and write. The current research budget is unlikely to be sufficient to support the proposed research activities. We recommend that requests for additional research funds for the above activities be granted whenever funds are available.

(3) Through various official reports, we know that the pregnancy rates among the school-age girls are high.

We recommend that the project extend its FP information services to the youth.

(4) Considering that there is a demand for other Family Planning (FP) methods which are more effective than condoms and foaming tablets, we recommend that Kibwezi Health Centre be up-graded to a level where Intra-Uterine Contraceptive Device (IUCD) insertions and tubal ligations can be performed. These services could be provided by a visiting gynaecologist.

(5) The nursing staff at Kibwezi Health Centre stated that they were experiencing a depreciation in their knowledge and they felt they should be given refresher courses so that they may not forget what they learnt during their training and also to keep up with the new developments in their fields and related areas. They also feel that they need training regarding supervision of TBAs and how best to interact with the CHWs and the Shopkeepers.

We concur with the views of the health centre staff and recommend that training and refresher courses be given as the need may be.

(6) During the visit to Kibwezi Health Centre we observed that some of the equipment, such as the sucking and weighing machine, were out of order. The nursing staff said they had reported this matter but no one repaired the equipment nor was a replacement made. It appears that a special course on equipment maintenance and repair is needed for the health centre staff to avoid unnecessary delays in repairing damaged equipment.

(7) As described in the text, the morale of the project staff is high. The estimated work load is 70-80 hours per week. Staff continuously search for innovative ideas to improve the performance of MCH/FP/Nutrition project. They have the commitment and interest which

contributes to strength of the Unit. The management should work out an incentive scheme to maintain the high morale of the project staff.

(8) Although the staff are innovative and have been preparing materials, including audio-visual aids for training purposes, there is still a need for additional staff in this area of the programme who will be responsible for designing training materials.

We recommend that a documentation officer be employed who can work under the direction of the project leader and staff of the unit in preparing training manuals and audio-visual aids.

(9) During the workshop held in April for needs assessment, the top priority was water. When the unit visited Kibwezi the need for water was also repeatedly expressed. One can also observe the scarcity of drinking water. People can spend KShs 10-15 for a gallon of water and some have to walk 6-15 kilometres to collect water from the main pipeline.

Health education activities, such as washing hands, hygiene and boiling water for drinking is based on the availability of water. Communicable disease control, which is based on cleanliness, needs an ample water supply. Thus, without the provision of water, effective community-based health programmes cannot be carried out.

Therefore, we strongly recommend that a programme for water provision be organized in conjunction with the concerned authorities and institutions.

(10) There is a shortage of secretarial services in the unit. We recommend that an additional secretary be employed to work for the unit.

(11) Since the activities of the unit are field based, i.e. training takes place at the community level service has to be provided in the village. Nutrition activities will have to be carried out within the community-based facilities and other areas. An additional driver and a car are needed to help facilitate the activities of the unit. At the moment the unit has one car and a driver. Additional research staff are also needed.

(12) As distributors of contraceptives, the Community Health Workers (CHWs) are rendering a useful service to the community and the project. Both benefit from the services of the CHWs. The CHWs reduce the community's cost of obtaining contraceptives. They are also advancing the project's experimental goals. The CHWs spend 2-3 days per week working for the community and the project.

We recommend that a CHW compensation scheme, supported both by the community and the project, be explored. This compensation should be through the community since it is the one that selects the CHWs. This routing of the CHWs compensation will avoid making CHWs dependent on AMREF.

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APPENDIX 1

Table A1: Amendment No 3 Budget
and Actual Expenditures on USAID Financed Inputs
for the Two-Year Period 1983-1985 in US Dollars

Budget line item	Budget amount	Actual expenditure	Actual expenditure budget
A. TECHNICAL ASSISTANCE			
1. Long Term			
Medical Officer	27,700.00	11,590.66	41.84
Sociologist/Aanthropologist	24,600.00	18,009.93	73.21
Community Nurse	29,360.00	19,995.96	68.11
Driver	3,240.00	2,557.68	78.94
2. Short Term			
Consultants	6,450.00	1,243.75	19.28
Enumerators	3,225.00	9,017.73	279.62
Sub-total, Technical Assistance	111,875.00	71,578.72	63.98
B. TRAINING			
1. Ten one-week workshop for 15-20 participants	6,617.64	14,816.33	223.89
2. Development, production and distribution of teaching materials and training manuals	7,500.00	3.68	0.05
3. Participation in other releant training courses as resource staff	1,075.00	0.00	0.00
4. Staff training (two MCH degree courses)	20,000.00	37,734.80	188.67
5. Three MCH/FP/nutrition workshops (incorporated into other AMREF training courses)	4,000.00	0.00	0.00
6. Incorporation of MCH/FP/nutrition component into distance teaching courses	4,195.00	0.00	0.00
Sub-total, Training	43,388.00	52,554.81	121.13
C. COMMODITIES			
1. Station-wagon vehicle	10,354.00	8,125.30	78.47
2. Teaching equipment	5,000.00	-	0.00
3. Office equipment	7,560.00	8,123.25	107.45
4. Supplemental FP supplies	1,500.00	-	0.00
5. Reference material	430.00	143.67	33.41
Sub-total Commodities	24,844.00	16,392.22	65.98

Table 4.2 continued.

Budget line item	Budget amount 8/83-8/85	Actual expenditure 8/83-8/85	Actual expenditure as % of budget
D. OTHER COSTS			
1. External evaluations	6,500.00	0.00	0.00
2. Vehicle running expenses (\$0.45 x 25,000 km for FY2 & 3 and 19,000 km for FY1	21,490.00	3,498.52	16.27
3. Staff travel expenses (\$40 per day X 200 person days)	17,200.00	20,548.55	119.46
4. Reports and technical papers	2,000.00	5,806.20	290.31
5. General expenses (contingency)	2,150.00	834.10	38.79
6. AMREF project-related liaison work with USAID Washington	10,750.00	17,867.40	166.21
7. Research data analysis (NFWC, FP, FLE)	29,155.00	0.00	0.00
8. Office supplies	3,375.00	0.00	0.00
Sub-total, Other Costs	92,620.00	48,554.77	52.42
Total	272,726.64	189,080.52	69.33
Overheads (25.76 per cent)	70,254.38	48,707.14	69.33
Grand Total USIAD Inputs	342,981.02	237,787.66	69.33

APPENDIX 2

Table A2: Amendment No 2 Budget
and Actual Expenditures on USAID Financed Inputs
for the Three-Year Period 8/83-8/86 in US Dollars

Budget line item	Budget amount 8/83-8/86	Actual expenditure 8/83-8/86	Actual expenditure as % of budget
A. TECHNICAL ASSISTANCE			
1. Long Term			
Medical Officer	107,010.00	11,590.66	10.83
Sociologist/Aanthropologist	89,175.00	18,009.93	20.20
Community Nurse	37,505.00	19,995.96	53.32
Nutritionist	13,025.00	3,214.69	24.68
Secretary	17,835.00	5,948.32	33.35
Driver	5,099.00	2,557.68	50.16
2. Short Term			
Consultants	10,415.00	1,243.75	11.94
Enumerators	5,210.00	9,017.73	173.08
Sub-total, Technical Assistance	285,274.00	71,578.72	25.09
B. TRAINING			
1. Ten one-week workshop for 15-20 participants			
	13,635.00	14,816.33	108.66
2. Development, production and distribution of teaching materials and training manuals			
	14,000.00	3.68	0.03
3. Participation in other relevant training courses as resource staff			
	1,735.00	0.00	0.00
4. Staff training (two MCH degree courses)			
	43,000.00	37,734.80	87.76
Sub-total, Training	72,370.00	52,554.81	72.62
C. COMMODITIES			
1. Station-wagon vehicle			
	17,354.00	8,125.30	46.82
2. Teaching equipment			
	5,000.00	0.00	0.00
3. Office equipment			
	6,360.00	8,123.25	127.72
4. Supplemental FP supplies			
	3,000.00	0.00	0.00
5. Reference material			
	680.00	143.67	21.13
Sub-total, Commodities	32,394.00	16,392.22	50.60

Table 4.2 continued.

Budget line item	Budget amount 8/83-8/86	Actual expenditure 8/83-8/86	Actual expenditure as % of budget
D. OTHER COSTS			
1. External evaluations	13,975.00	0.00	0.00
2. Vehicle running expenses (\$0.45 x 25,000 km for FY2 & 3 and 19,000 km for FY1)	36,370.00	3,498.52	9.62
3. Staff travel expenses (\$40 per day x 200 person days)	27,780.00	20,548.55	73.96
4. Reports and technical papers	4,000.00	5,806.20	145.16
5. General expenses (contingency)	3,475.00	834.10	24.00
6. AMREF project-related liaison work with USAID Washington	17,365.00	17,867.40	102.89
Sub-total, Other Costs	102,965.00	48,554.77	47.16
Total	493,003.00	189,080.52	38.35
Overheads (25.76 per cent)	126,997.57	48,707.14	38.35
Grand Total AID Inputs	620,000.57	237,787.66	38.35

APPENDIX 3

EXAMPLE OF PARTICIPANTS' SOLUTIONS TO PROBLEMS ENCOUNTERED IN MCH/FP/ NUTRITION DELIVERY

MCH/FP/Nutrition Workshop held at Kibwezi Health Centre
3-4 April 1984

1. FAMILY PLANNING:

1.1 Problem

F/P was first introduced to women without involving men and this contributes to the resistance on FP from men.

1.2 Solution

- a) The sub-chief of every sub-location to hold a "Baraza" where the men should be told the importance of FP: A male Health Worker should be the one to teach the men.
- b) Men should form groups through which information of FP could be given.
- c) Organize a seminar for men alone;
 - i) for teaching purposes
 - ii) apologise for the way FP was introduced i.e. not involving men.
- d) Any information concerning FP should be given to both husband and wife.
- e) Men should join those groups that deal with FP issues
- f) Couples should completely agree on when they are starting FP and go to the clinic together
- g) Posters should be developed which depict the problems of the men if they do not practice FP
- h) Recruit more male F.H.F.E. (Family Health Field Educators)

1.3 Problem

Traditional teaching on FP is no longer practised.

1.4 Solution

- a) Parents should start teaching the youth at home.
- b) Traditional ways of family life education should be revived.
- c) Family Life Education should be introduced in schools
- d) There should be counsellors to prepare those who are getting married on FP
- e) Parents should set up rules and regulations to be followed by the youth (boys and girls)
- f) Follow traditional teaching especially for the girls
- g) During school holidays the parents (mother) should teach girls family life education

1.5 Problem

FP clinics are far from the clients

1.6 Solutions

- a) Community Health Workers to be taught on proper information, and motivation on FP and be given condoms to distribute

NOTE

General dissatisfaction with condoms being distributed i.e. they are too small, they bust in action. Men do not like using condoms on their wives.

- b) Mobile clinics should be started
- c) Increase FP service delivery points in the Dispensaries and mobile clinics
- d) Distribution of contraceptives through village pharmacies built on harambee basis
- e) Build new dispensaries and health centres on harambee basis

1.7 Problem

Lack of FP information

1.8 Solution

- a) All the health workers should be given adequate information on FP.
- b) There is need to increase the number of Family Life Educators
- c) Family Planning information should be given in all the "Barazas" public meetings
- d) All local leaders should be involved to inform the community on the importance of FP.

1.9 Problem

Mis-information

1.10 Solution

- a) Those who are to give information on FP should be well informed about FP
- b) One village representative together with the sub-chief to be given more information or to be trained on FP so that they can impart this knowledge to the villagers.
- c) The community should be given proper information on what family planning is i.e. child spacing and not Birth Control.
- d) Health workers should have positive attitude on FP
- e) Health workers should have adequate information on FP
- f) Use of local language when giving FP information
- g) There should be uniformity all over the Republic on what is being taught about FP
- h) Improve health worker/client relationship.

1.11 Problem

Problem of giving information on family planning men

1.12 Solution

- a) More information relevant to men to be given in the radio
- b) Posters depicting advantages of FP for men should be used
- c) Organise meetings and seminars on FP for men only.

1.13 Problem

Shortage of family planning educators

1.14 Solution

- a) Identify a suitable person from community to be trained on FP education.
- b) F.N.F.E. to be trained through seminars and the majority should be men.
- c) Recruit more male F.H.F.E.
- d) Local leaders should be trained on FP using relevant visual aids for them to be able to impart the knowledge to the community

1.15 Problem

Lack of Family Life Education

1.16 Solution

- a) There should be family life educators at village level who can be called at any time to give education
- b) Families to be encouraged to listen to the Family Life Programme on the Radio.
- c) Seminars on Family Life Education should be organized for the Community
- d) Personnel from Ministries of Health, education and culture and social services should be educated on Family Planning.
- e) Parents should be encouraged to revive family life education teaching at home

1.17 Problem

Fear of modern methods of FP

1.18 Solutions

- a) Men should use condoms
- b) Couples should have two separate beds
- c) The couples should be taught about Natural Methods of FP

- d) Proper information with the use of visual aids on each of the methods should be given to the community in order to remove the fear of use of modern methods.
- e) The community should be taught about the advantages and the disadvantages of all the methods of FP

1.19 Problem

Social Problems

- i) Large families.
- ii) Unmarried mothers

1.20 Solutions

i. Large families

- a) Social workers should teach the community the need for use of FP
- b) Parents should teach their children the importance of planning their families
- c) Large families to be visited and be taught the need for FP

ii. Unmarried Mothers

- a) The unmarried mothers should be advised about FP and should adopt it.
- b) All parents should advice and correct all children where necessary irrespective of whether they are their own children or for the neighbours
- c) Girls should be discouraged from receiving money or presents from men. This can be achieved if the parents find out from their children where they got any new things that they bring home.
- d) Girls should be taught about FP methods and they should have an access to them

1.21 Problem

Poor interviewing technique

1.22 Solutions

- a) Health workers should be taught and practice good interpersonal relationship to the client.
- b) Health workers should be taught proper interviewing technique.
- c) There should be privacy when discussing FP issues with the clients.

1.23 Problem

Poor client reception

1.24 Solution

- a) Health workers should practice good Health worker/client relationship
- b) Health worker should be taught good human relationship
- c) Privacy should be availed both in the interviewing and in the service providing areas

2. MCH

2.1 Problem

Mothers doing very heavy work

2.2 Solution

- a) Pregnant mothers should be relieved of heavy work and the husbands relatives or employed workers should help
- b) Pregnant mothers should be informed of the dangers they are likely to face when they do strenuous work
- c) Men should help their wives in all home activities

2.3 Problems

Mothers do not get balanced diet

2.4 Solution

- a) Mothers should be advised on the importance of balanced diet using locally available foods
- b) Mothers should be taught the preparation of a balanced diet using locally available foods and any other relevant visual aids
- c) Mothers should be encouraged to have kitchen gardens, keep poultry, goats etc

2.5 Problem

Pregnant mothers do not attend ante-natal clinic

2.6 Solution

- a) Leaders and CHW should explain to the people the importance of ante-natal clinic
- b) Husbands should encourage and support their wives to attend the clinic and give financial support

2.7 Problem

Poor home management

2.8 Solution

- a) Husband and wife should plan their home activities together
- b) Men should be clearly informed of their role in home management and such can be explained during their clan meetings
- c) The community should be given information on home management

2.9 Problem

Lack of knowledge on the importance of MCH services

2.10 Solution

- a) Expectant mothers should be informed about the importance of attending ante-natal clinic as early as possible e.g. at 3 months
- b) There is need to increase the number of health workers who will educate the community on the importance of MCH services
- c) Leaders should inform the community the importance of MCH services
- d) Mothers should be informed about the importance of MCH services

2.11 Problem

MCH/FP clinics are far

2.12 Solutions

- a) Mobile clinics should be started where static clinics are not available
- b) Community should be encouraged to build new dispensaries on ha'ambee basis

2.13 Problems

Having more confidence on witch doctors

2.14 Solution

- a) Local leaders should educate the community on the need to discard useless taboos
- b) The community should be informed about the importance of modern medicine
- c) Community leaders should discourage witchcraft in their areas

2.15 Problem

Mothers who cannot meet community expectations find it difficult to attend clinics (ante-natal and child welfare)

2.16 Solution

- a) Mothers should be encouraged to the clinics no matter how they are dressed
- b) Health workers should accept and appreciate the clients irrespective of their physical or appearance or the way they are dressed
- c) Social workers should be involved to help the poor and needy
- e) Women groups should assist their members when in need

2.17 Problem

Shortage of water

2.18 Solution

- a) Encourage the community to dig wells and construct dams with the assistance of the staff from the Ministry of Water and other organizations
- b) The community to initiate self help water projects and seek help from the government where necessary
- c) Women groups to be encouraged to buy donkeys to carry water for sale and for their members
- d) The community should be encouraged to buy and install water tank to catch rain water-corrugated iron roofs
- e) Planting of trees should be encouraged

2.19 Problem

Lack of Financial and Transport Facilities

2.20 Solution

- a) Communities to start income generating activities e.g. Poultry, goat, horticultural farming etc.
- b) Mobile clinics should be taken to far off villages
- c) Communities to construct dispensaries on harambee basis

3. NUTRITION

3.1 Problem

Lack of Water

3.2 Solution

Lack of Nutrition Knowledge

- a) Community should be taught the importance of a balanced diet by using locally available foods
- b) Agricultural extension workers should teach the community how to grow and use a variety of foodstuffs.

3.2 Problem

Financial constraints

3.3 Solution

- a) As for Number "10" under "MCH"
- b) Communities to start income generating activities
- c) Couples to plan and budget together

3.4 Problem

Distance from clinic is far:

3.5 Solution

- a) Like number "6" under "MCH"

3.6 Problem

Lack of protein foods

3.7 Solution

- a) Veterinary officers to advice the community on proper animal husbandry

- b) Community to be taught alternative sources of protein foods e.g. beans, pigeon peas.
- c) Agricultural extension workers to teach the community on modern farming methods

3.8 Problem

Famine due to drought

3.9 Solution

- a) The community should be taught on good storage facilities especially when there is a good harvest
- b) Irrigation facilities where possible, should be utilized
- c) Prevent soil erosion
- d) Famine stricken areas should be provided with famine relief

3.10 Problem

Taboos

3.11 Solution

- a) The community should be encouraged to abandon bad food habits and adopt the good ones, e.g. barazas

4.0 Group E only:

4.1 Problem

Lack of qualified personnel:

4.2 Solution

- a) The few trained personnel should educate the community and the community should take action in achieving the health goal
- b) The government should train more personnel

4.3 Problem

Equipment

4.4 Solution

- a) The few equipment we have in the country should be handled

properly to ensure they remain in good functioning order for a long time.

- b) Properly trained technicians should maintain the few equipment available
- c) Properly trained personnel should be stationed in central medical stores, who understands the urgency of some of the equipment required in hospitals
- d) Central medical stores should order equipments before the old stock is completely finished.

4.5 Problem

Space

4.6 Solution

The community should seek political assistance to expand the health institutions

4.7 Problem

Transport/fuel for outreach clinics

4.8 Solution

- a) Involve the community to fuel the vehicles of the out reach clinic where fuel is the problem
- b) Start static services where space is available
- c) Emphasize on the importance of regular supply of fuel to the health institutions

4.9 Problem

Teaching aids relevant to local situations

4.10 Solution

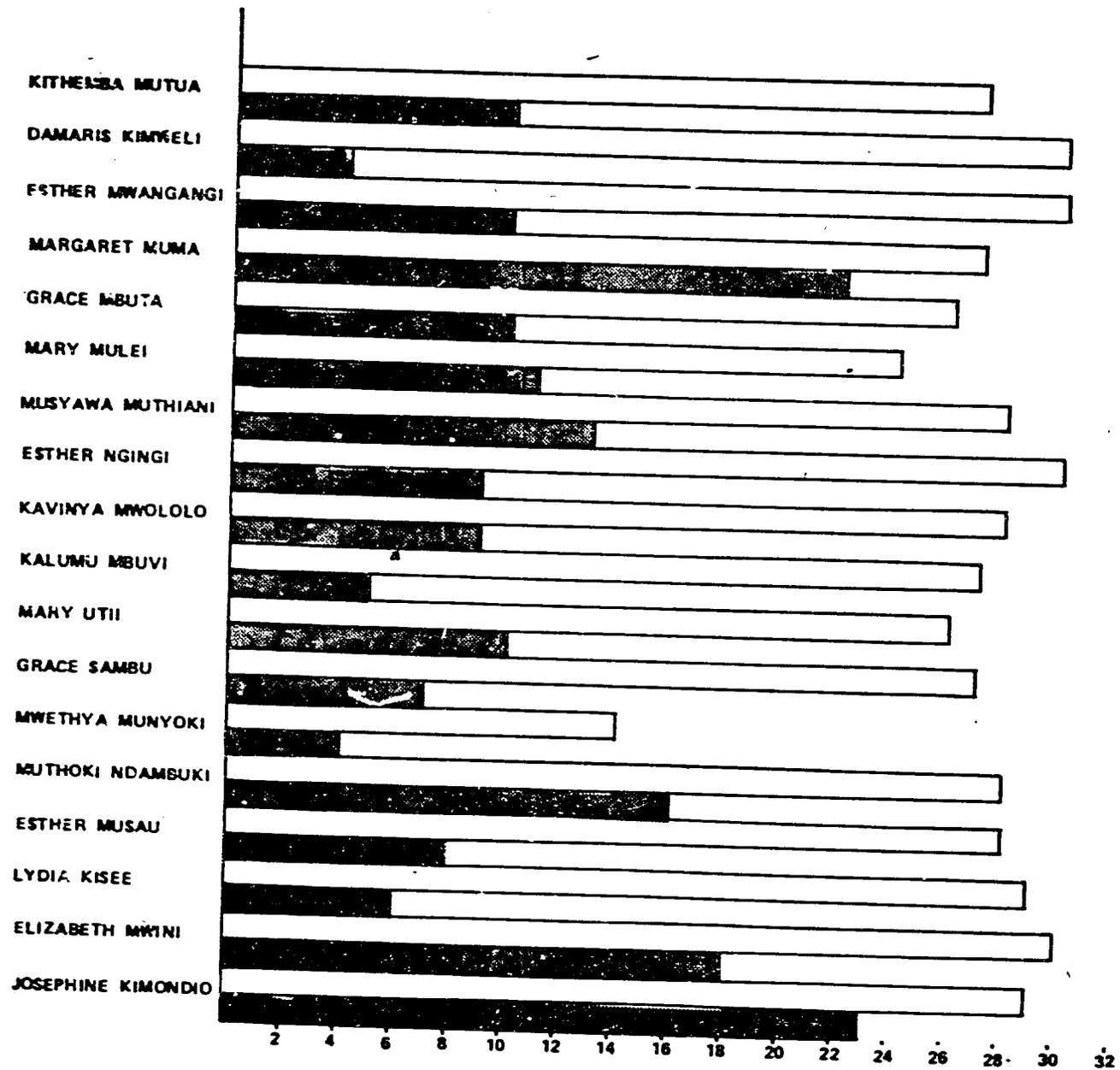
The Ministry of Health should follow up the printing of relevant posters to each specific community

4.11 Problem

Poor interpersonal relationship between health workers and community

4.12 Solution

Health workers should be educated on human relations.



KEY
■ PRE-TEST
□ POST-TEST

TRADITIONAL BIRTH ATTENDANT'S KNOWLEDGE BEFORE AND AFTER COURSE

APPENDIX 4

APPENDIX 5

AMREF MCH/FP/Nutrition Project USAID OPG Family Planning Management and Research

Scope of Work for Mid-Term Evaluation

Introduction

The overall objective of the project is to develop means to reduce the present very high rate of population growth by creating a demand for family planning (FP) services, especially in the rural areas. FP is addressed together with efforts to improve health and nutrition status of mothers and children, especially pregnant women, lactating mothers and children under five years of age. The project enables AMREF to establish and operate an MCH/FP/Nutrition Unit.

In collaboration with government and relevant non-governmental organizations (NGOs), the unit addresses various issues of major concern. During the initial period priorities have been given to the five key intervention areas, as indicated in the project document, namely:

1. FP interventions:
 - o Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) as FP advocates;
 - o health education and FP supply distribution through rural shops;
 - o developing and testing a programme for increased knowledge and more favourable attitudes in FP among health workers;
2. Interventions related to FP acceptance and utilization:
 - o integrated project of child survival;
 - o antenatal and obstetric care.

The aim is to change attitudes and practices related to child spacing and family size, to increase child survival rates and to improve nutrition in low income households. Improved self care concerning common childhood diseases in the household is one objective which also includes use of oral rehydration. Still another objective is to improve ante-natal and delivery services in the formal and the traditional sectors and to address breastfeeding/weaning practices.

At the end of the three-year project the AMREF unit will have gained operational skills and experience in the above mentioned areas. The staff will be able to identify, start, carry out and evaluate other appropriate MCH/FP/nutrition programmes and assist the Ministry of Health (MOH) and other NGOs.

The USAID grant of US\$ 620,000 covers 74.9 per cent of total project costs. AMREF is financing the remainder. The detailed terms of the grant are described in the project documents.

Objective of the Evaluation

The terms of the USAID grant call for a mid-term evaluation project mid-point. In actual fact the evaluation is now scheduled after completion of two out of three years of the present grant period.

The main objectives of the evaluation are:

1. . Review actual against planned inputs. Identify causes of delays and their effects on implementation progress. Specify courses of action in correct failures and/or delays.
2. Review actual against planned activities relating to the five outputs cited in the logical framework. Identify causes of any delays or problems in achieving outputs and specify action taken or to be taken to remedy problems. Review and confirm continued validity of assumptions relating to attainment of outputs.
3. Analyse AMREF's administrative and managerial resources to provide adequate support to the project.
4. Review experiences and results of major activities. Assess lessons learnt during initial implementation phase of project which might be applied to subsequent phases.
5. Review and assess project expenditures to date and sufficiency of remaining project funds vis-a-vis remaining planned activities. If funding appears insufficient to complete remaining project activities, recommend project outputs which might be curtailed without attainment of project purposes.
6. Assess costs of selected activities/outputs.
7. Review and confirm continuing validity of project strategies and implementations plans for remaining period. If indicated, recommend any alternative project strategies and implementation plans and explain rationales for recommendations.
8. From mid-term perspective, indicate overall progress toward achieving project purposes, and appropriateness of existing monitoring systems for measuring achievement of purposes. If progress is less than planned, identify reasons for inadequate implementation, e.g. delays in providing inputs, invalid output assumptions.
9. If required, produce a revised framework.

Methodology and Timing (Headquarters Office)

Two independent evaluators will be engaged as consultants to carry out this evaluation with assistance from the project team and the project officer. The two consultants, Ms A. Wolderufael and Dr G. Mwabu, will be covering the following specific areas of evaluation:

1. Ms Wolderufael (Nurse Tutor, MCH/FP Specialist):
 - o CnWs and TBAs as FP advocates;
 - o Increase knowledge and change attitudes regarding FP among rural health workers;
 - o Integrated project for child survival;
 - o Ante-natal and obstetric care.
2. Dr Mwabu (Health Economist):
 - o Health education and FP supply distribution through rural shops;
 - o Development and establishment of MCH/FP/Nutrition Unit at AMREF;
 - o Economic and financial analysis of all actual and planned strategies;
 - o Assembling and editing final report.

Methods of evaluation will include documentary analysis, interviews, field visits and participant observation.

The evaluation will take three weeks. Week 1 is to be spent primarily in Nairobi reviewing the framework and tools for evaluation, analysing reports and documents, and interviewing AMREF headquarters and USAID staff. Week 2 will be spent at the project's key field site, Kibwezi Division in Machakos District. Reports will be written and presented during Week 3.

Budget (in Kenya Shillings)

36 person/days consultant @ 1,500	54,000
1,500 km road travel @ 5	7,500
12 days per diem @ 600	7,200
Supplies, printing	15,000
Miscellaneous and contingency	15,000

Total	98,700

1. Specific areas for evaluation for Ms Wolderufael:
 - o to review and assess the relevance of reference material on training TBAs, shopkeepers and health staff to obtain stated outputs;
 - o to review and assess teaching material and training methods of TBAs and shopkeepers;
 - o to review and assess activities and strategies related to improved child survival;
 - o to review and assess activities and strategies related to improved overall MCH/FP/Nutrition services;
 - o to review and assess research findings and actual or potential utilization of completed research for intervention design and implementation;
 - o to review and assess the need of improving/upgrading the MCH/FP/nutrition activities to other field sites.
2. Specific areas for evaluation for Dr Mwabu:
 - o to review and assess inputs and activities health education and FP supply distribution through local shops;
 - o to review underlying assumptions of these interventions with regard to project purpose;

- o to review and assess project expenditures to date and sufficiency of remaining project funds vis-a-vis remaining planned activities;
- o to assess costs of selected activities/output;
- o to review progress toward fully establishing the MCH/FP/Nutrition Unit and toward strengthening the MCH, FP and nutrition components of other AMREF projects as a result of the unit's work;
- o to review the present use of project sites and assess the need for developing/using sites additional to Kibwezi;
- o to review information and monitoring systems of the unit which serve for continuing evaluation and provide a basis of eventual impact evaluation.

Appendix 6

PLAN OF ACTIVITIES CHART
MCH/FP/NUTRITION PROJECT (C209)

- Reduced rate of population growth
- Improved socioeconomic status of certain target groups

- Reduced fertility through child spacing
- Reduced family size
- Improved child survival
- Improved health and nutritional status of mothers and children

- Increased awareness and demand for family planning/childspacing
- Increased knowledge on nutrition requirements
- Improved antenatal, delivery and MCH service at all levels
- Improved self care of childhood diseases in the household
- Improved breastfeeding/weaning practices

- Studies carried out for developing five acceptable, low cost, effective interventions in areas of FP(3), Nutrition (1) and Maternal & Child Health (1)
- Five interventions developed, implementation started and resulting success and failures evaluated
- Related learning materials/teaching modules developed through training courses & incorporated in appropriate, ongoing AMREF training activities
- Findings disseminated at workshops and utilized in project training activities
- MCH/FP/Nut. Unit established at AMREF with the capacity & capability to continue to carry out stated activities & serve as a resource to Government and NCOs in MCH/FP/Nutrition activities

<ul style="list-style-type: none"> - TBAs/CMBs as MCH/FP/Nut. advocates & FP supply distributors - Identify at risk prog/deliv. - Refer approp. patients. - Improved integration with established health care system 	<ul style="list-style-type: none"> - Shopkeepers as health educators & FP advocates - Distribution of contraceptives - Increased utilization of contraceptions in households 	<ul style="list-style-type: none"> - Program for increased knowledge & more favourable attitudes in FP amongst health workers 	<ul style="list-style-type: none"> - Integrated child survival 	<ul style="list-style-type: none"> - Antenatal and obstetric care, interventions at all health care levels in project areas 	<ul style="list-style-type: none"> - Capable MCH/FP/Nutrition Unit 	<ul style="list-style-type: none"> - Other projects/intervention - Famine relief activities - Integrating flying Doctor's in MCH/FP services - JSI/FPPS training project of Nurses/COs in FP - Halper restocking scheme - MCH lactation courses - Establish AMREF FP clinic - Advise on contraceptives to (Mini pills)
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<ul style="list-style-type: none"> o Trained TBAs/CHWs in: - FP advocates/contracept (TBA) distribution - Antenatal care - Safe deliveries - Post natal care - ID of at risk preg./del and refer. - Nutrition advisors - Environmental health (CHWs) 	<ul style="list-style-type: none"> o Trained shopkeepers in: - Health educ./comm. - Drug supply service - Contraception knowledge & distri. of contraceptives - Promotion of ORS 	<ul style="list-style-type: none"> o Trained/educated health workers in: - Greater willingness to give time & effort to promote FP: - To get a positive attitude to FP (at all levels) - Increased technical knowledge in FP 	<ul style="list-style-type: none"> o Trained Community & Health Workers to achieve: - Decreases prevalence of diseases: - Nutritional improvement in target groups - Disease Prevention: - Self care of diseases (childhood diseases (esp.)) 	<ul style="list-style-type: none"> o Trained TBAs/CHWs & health workers to: - Improve quality of service - Increase coverage of service - Reduce complications rates during pregnancy, deliveries, postpartum - Reduce perinatal/maternal mortality /morbidity - Increase basic FP information - Increase the referrals - Improved delivery technique 	<ul style="list-style-type: none"> o Trained, capable staff - To assist/formulate/evaluate governmental/NGOs activities & project - To analyse & strengthen institutional capability - To have capacity to implement project - To train health workers & TBAs in FP/MCH/Nutr. - To carry out consultancies - Develop new projects - To keep an up to date international/national knowledge in MCH/FP/Nutrition - To carry out studies/research 	<ul style="list-style-type: none"> o Obtain relevant reference materials: - Research/studies in: - MCH/FP/Nutrition - Contraceptives - Breast feeding - Community Health Based Care - Utilization/training of TBAs/CHWs and shopkeepers and communities in MCH/FP Nutrition Services
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<ul style="list-style-type: none"> -Review of experiences in other projects -Review of TBA/CHW attitudes and practices regarding FP/breastfeeding/weaning -Run training program for TBA, CHW (10 courses) -Recommendations -Dissemination of findings 	<ul style="list-style-type: none"> -Exploration of attitudes and willingness to participate as health educators/FP advocates/distributors of contraceptives -Give advice on long term basis how to find supp. -Supervision of sales/utilization 	<ul style="list-style-type: none"> -FP related IAP -Eval. of existing teaching material/methods & Curriculum for health courses -Develop teaching materials -Develop teaching methods -Develop curriculum -Run 4 one wk courses for Disp/N/C Hosp. staff -Evaluation of impact of training courses 	<ul style="list-style-type: none"> -Development & rest of nutr. progr. -Dev. & test dise. prevention progr. for village and household level -Dev. & test self care progr. of common illness, including diarr. -Education at village/household level to identify diseases 	<ul style="list-style-type: none"> -Training in self care during progr. -Proper & training of TBAs, CHWs and Health workers -ID of risk prog. and at risk deliveries -Test ways to improve management of complicated prog. deliv. postnatal care & all levels -Develop and test learning materials -Recommendations 	<ul style="list-style-type: none"> -Assign, train & upgrade unit staff -Training of nurses, CHWs, in FP -Support encourage clinical FP services -Inform, train MCH/FP staff in MCH/FP/Nutri. -Communicate about integrated MCH/FP/Nutr. activities of Government and NGOs. -Integrate & utilise MCH/FP staff knowledge in relevant fields -Do MCH training courses 	<ul style="list-style-type: none"> -To do research/studies - Model for FP services - 1985 FP/Contracept. users -Kibuzi sur. on MCH/FP/Nutrition -They should lead into further interventions and research/studies
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MIDTERM EVALUATION
OF
AMREF'S MCH/FP/NUTRITION PROJECT (USAID OGP FAMILY PLANNING
MANAGEMENT AND RESEARCH PROJECT, GRANT NO. 615-0216)

BY
Germano M. Mwabu
and
Abeba Wolderufael

AMENDMENTS

- 1) The inconsistent parts of the report
 - a. The first objective of the project (p.4 and p. 39) was originally stated as follows:

"To reduce the present rate of population growth in Kenya through creation of an effective demand for FP services and to improve the health status of mothers and children." This was the overall objective of the project.
 - b. On p. 42 of the report, it is concluded that the first part of the above objective is not achievable within the life of the project even if only applied to pilot intervention areas.
 - c. On p. 45 of the report, we recommend that the first objective of the project be simplified by splitting it into several objectives. We further require that the new objectives be feasible, i.e., be attainable given the time and resources allocated to the project.
 - d. On p.43, we conclude that the project management may not change their logical framework even if they decide to alter objective one as recommended in (c) above.

The AMREF project team, and also the USAID officials concerned with this project, have correctly pointed out to us that (d) and (c) above are incompatible. In what follows, we indicate the changes in the logical framework (in this case, the flow chart of project activities in appendix 6 pp. 73-74) that are implied by the changes in objective one. First we state explicitly how the overall objective should be split up. The suggested (sub) objectives are as indicated in the next page.

AMENDMENT 1

- a. To develop and test (in the field) new approaches for reducing population growth in Kenya.
- b. To improve the health status of mothers and children in the project area (i.e. the area in which the new strategies will be tried out)
- c. To create "effective demand*" for FP services in the project area.

* "Effective demand" in this project means willingness to use FP services that is backed by ability to use the services. Ability to use an FP service includes knowledge of location of service, information on how the service is used, accessibility to the service and an ability to acquire it.

AMENDMENT II

Decomposition of the overall objective of the project as indicated in Amendment I implies the following changes in the logical framework (the flow chart of project activities).*

- a. Blocks 1-3 in the flowchart (The blocks are not numbered)

In their present form, these blocks contain statements of the outcomes of the project. Since the outcomes of the project, as expressed in the flow chart, are very difficult to assess given the short period of the project (3 years), the outcomes stated in the blocks should be turned into statements of objectives e.g., "Reduced rate of population growth" should be re-stated as: To develop and field test new approaches for controlling population growth in Kenya. The second statement in block 1 should be rephrased as: improve the socioeconomic status of certain target groups

This objective should be moved from block 1 to block 2. All the expressions in block 2 should be re-expressed as sub-objectives e.g., the first statement in block 2 should be changed to read: To reduce fertility through child spacing*. The other statements in this block, and those in block 3 should be changed similarly.

- b. The statements contained in block 4 may not be changed. The block contains categories of interventions for achieving the overall objective of the project (or the sub-objectives). Some of these interventions have already been implemented.
- c. Block 5 mainly represents specific intervention activities. The phrase "MCH/FP/Nutrition Unit" (in the 6th section of the block 5) should be shifted from block 5 to block 4.
- d. The statements in block 6 are elaborations of and/or additions to the intervention activities in block 5. The terms "trained/educated in the first row of this block should be changed to read: train/educate.

* In a formal sense, the chart shown in appendix 6, pp. 73-74 is not a logical framework for this project. It is merely a sequence of project activities that are needed to achieve the overall objective of the project. "A logical framework (also known as a logframe) represents a preliminary plan for action. It identifies very clearly the goals and objectives of the project, the required resources and the expected outcomes, and how those relate to objectives. The one thing it lacks is a description of the overall process by which inputs are linked to outputs." S.N. Blumenfeld. Operations Research Methods:

A General Approach in Primary Health Care, PRICOR monograph series, 1 May, 1985, p. 45.

* The Original statement is: "Reduced Fertility through Child Spacing"