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**MID-TERM EVALUATION  
USAID MATCHING GRANT TO AMREF**

**COOPERATIVE AGREEMENT  
NO. FAO-0158-A-00-2052-00**

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# **EXECUTIVE SUMMARY**

## **EXECUTIVE SUMMARY**

Since October, 1992 the African Medical and Research Foundation (AMREF) with funding from an A.I.D. Matching Grant has been implementing a program to strengthen the efficiency, quality, and accessibility of health services delivery systems in Kenya and Uganda. This three year grant which will total \$600,000 is matched by AMREF and administered by AMREF headquarters in Nairobi, Kenya.

AMREF was established in 1957 and originally called the "East African Flying Doctors Service". In its early years it became well-known for using light aircraft to bring medical services to isolated people in rural east Africa. Over the years AMREF has evolved into a major health sector development organization and the largest African NGO with a budget of over \$11 million and more than 650 staff members.

AMREF is headquartered in Nairobi and it has country offices in Uganda and Tanzania. During this evaluation a decision was made to establish a country office in Kenya. In addition to these programs there are ten national offices operating with discrete Boards of Directors in ten "northern" countries including the U.S. AMREF/US in New York is the recipient of the Matching Grant.

AMREF's overall goal is to assist in the achievement of sustainable and equitable improvement in the health and well-being of selected target populations in Africa. AMREF assists by following a policy of complementing and supplementing government, international agency, NGO and community efforts. Unlike most NGOs operating in east Africa, AMREF works with, and often along side, Ministry of Health officials, assisting them by upgrading technical and management skills.

The goal of the program supported by the Matching Grant is to increase the effectiveness, quality and sustainability of health care delivery systems in the two countries. AMREF's methodology to achieve the goals and objectives of the project has been to provide management training and systems development using both direct and distance learning approaches. District Management Boards, District Health Teams, mid-level management, and operational level management have been singled out for management training. Rural health workers, most of them in remote, resource-deprived areas were singled out for distance learning. Women comprise a large portion of these target groups. Management training activities are the responsibility of AMREF's Health Policy and Management Department and distance learning is managed by AMREF's Distance Education Unit. Health policy and delivery of health services in Kenya and Uganda is being decentralized and Ministries of Health in both countries as well as AMREF see management training as a key in the decentralization process.

The purpose of this mid term evaluation is to provide AID/BHR/PVC and AMREF with an assessment of AMREF's progress in undertaking activities under the Matching Grant. The evaluation was carried out November 5th - 22nd, 1994 by an independent consultant with various AMREF staff participating various segments of field visits.

*The evaluation revealed that AMREF is on track to meet the goals and objectives of the Matching Grant.* Training, management and planning assistance, and systems development provided through AMREF's Health Policy and Management Department is highly regarded by Ministry of Health Officials involved in areas corresponding to grant activities and by recipient structures within the health delivery systems. Distance Education, which is providing continuing education for thousands of health workers through self-contained correspondence courses and educational radio programs, is likewise highly regarded. In both instances host governments and the recipient health structures indicate a desire for more assistance from AMREF.

Institutional assessments of this kind are challenging because there is no broadly accepted, easily measurable standard of what constitutes institutional effectiveness. This is particularly true in the case of AMREF where its grant activities are tied to the complexities of government policy implementation including decentralization activities where it appears that each level within the health delivery system overestimated the capacity of the next to carry out new responsibilities. Because of the lack of standard measures of effectiveness in these areas, AMREF has logically tried to define effectiveness as meeting the goals that it set for itself at the beginning of the grant period. Because the situations have changed and certain realities about decentralization have not been realized not all of these measures are necessarily as valid now as they appeared at the beginning of the grant period.

This evaluation recommends that in order for AMREF to continue to be effective, it should follow two courses of action. First, AMREF should formally acknowledge that circumstances have changed since the beginning of the Matching Grant and some course correction, including expanding AMREF's management training role is probably in order. AMREF and corresponding health agencies should review progress to date and plan out future activities. Second, it is recommended that AMREF design revised indicators of success and incorporate them into a monitoring system to provide more information from which better, more informed decisions can be made. Under the current system AMREF and corresponding health agencies appear to be tying grant program success to meeting input and deliverable schedules. More critical indicators are needed not only to measure impact but to better justify and support AMREF's chosen approaches of management training and distance learning.

# **ABBREVIATIONS AND ACRONYMS**

## **ABBREVIATIONS AND ACRONYMS**

<b>AMREF</b>	<b>African Medical and Research Foundation</b>
<b>BHR/PVC</b>	<b>Bureau of Humanitarian Response/Office of Private and Voluntary Cooperation</b>
<b>CIDA</b>	<b>Canadian International Development Agency</b>
<b>DE</b>	<b>Distance Education</b>
<b>DEU</b>	<b>Distance Education Unit</b>
<b>DHMB(s)</b>	<b>District Health Management Board (s)</b>
<b>DHMT (s)</b>	<b>District Health Management Team (s)</b>
<b>DMO</b>	<b>District Medical Officer</b>
<b>GOK</b>	<b>Government of Kenya</b>
<b>GOU</b>	<b>Government of Uganda</b>
<b>HCFS</b>	<b>Health Care Financing Secretariat</b>
<b>HIS</b>	<b>Health Information System</b>
<b>HPMD</b>	<b>Health Policy and Management Department</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>NHIF</b>	<b>National Health Insurance Fund</b>
<b>SIDA</b>	<b>Swedish International Development Agency</b>
<b>USAID</b>	<b>United States Agency for International Development</b>

# **INTRODUCTION**

## **I. INTRODUCTION**

### **Organizational Background**

Established in 1957, the African Medical and Research Foundation (AMREF) was originally called the East African Flying Doctors Service. In its early years it became well-known for using light aircraft to bring medical services to isolated people in rural east Africa. Over the years AMREF evolved into a major health sector development organization and the largest African NGO with an annual budget of over \$11 million and more than 650 staff.

AMREF is headquartered in Nairobi and it has country offices in Uganda and Tanzania. In addition to these programs there are ten national offices operating with discrete Boards of Directors in Austria, Canada, Denmark, Germany, France, Italy, The Netherlands, Sweden, the United Kingdom and the United States. The role of these national offices is primarily advisory and fundraising. A decision to establish a country office in Kenya was made during the course of this evaluation.

AMREF's overall goal is to assist in the achievement of sustainable and equitable improvement in the health and well-being of selected target populations in Africa. AMREF assists by following a policy of complementing and supplementing government, international agency, NGO and community efforts. The focus is on developing methods and systems which are appropriate, relevant, affordable and effective.

Central to AMREF's philosophy is bringing health services to the people. This includes strengthening the skills and knowledge of health managers at regional and sub-regional administrative levels as well as health workers in underserved areas. AMREF is committed to primary health care.

Priority target groups for AMREF are those people who have limited or difficult access to the first levels of health services. These include vulnerable groups, such as women and children. More specifically, women of child-bearing age and children under two are targeted. Also included are people in remote areas who have low economic potential and who are in need of development. Health management teams at district levels and rural health workers are targets for AMREF training and support. In addition to programs supported under the Matching Grant AMREF still has the "Flying Doctor Service", trains health workers from all over Africa, and has programs in Tanzania, Ethiopia, Rwanda and Sudan.

### **Current Cooperative Agreement**

The current Matching Grant builds on the historic experience of AMREF and a preceding Matching Grant (1986-1989). The current grant, Cooperative Agreement No. FAO-0158-A-00-2052-00 was awarded October 1, 1992 and is scheduled for completion September 29, 1995. The total award is \$600,000. AMREF is to provide a match of \$635,000.

**AMREF has had other grant relationships with FHA (now BHR)/PVC and USAID missions in East Africa. These have included child survival grants and support for a Program Management and Development Project in Kenya, the Southern Sudan Rural Health Project, a continuing education project for health workers in Tanzania, the Family Planning and Nutrition Project in Kenya, and a Primary Health Care project in Somalia.**

**The goal of the Matching Grant is to strengthen the efficiency, quality, and accessibility of health services delivery in Uganda and Kenya. Although the grant builds on the preceding Matching Grant, the current grant as implemented was scaled down approximately 70% from AMREF's original grant request to USAID/BHR/PVC. This original request was for five years and included Tanzania. AMREF interpreted this reduction as resulting mostly from financial limitations in PVC and not as a reflection on AMREF's performance in prior grants or on AMREF's institutional capacity.**

**To meet the overall goal AMREF should:**

- 1. Strengthen the capability of Health Management Teams in Kenya and Uganda in health delivery systems management.**
- 2. Improve the efficiency of the health service delivery systems in Kenya and Uganda through improvement of the health information system for the management of user fees.**
- 3. Produce health plans for selected districts in Uganda.**
- 4. Strengthen the MOH's capability of providing continuing education through distance teaching in Kenya and Uganda, and;**
- 5. Develop monitoring and evaluation systems for distance education.**

**Management responsibilities for the Matching Grant are divided between AMREF's Health Policy and Management Department which deals with policy and management training issues and the Distance Education Unit which manages distance training programs for (rural) health workers. These activities, or parts of them, are also supported by other donors, the major ones being CIDA and SIDA.**

## **Evaluation Methodology**

**The purpose of this mid-term evaluation is to provide both USAID/BHR/PVC and AMREF with an assessment of AMREF's progress in undertaking activities specified in the grant agreement. The Scope of Work for this evaluation is included in this report as Appendix I.**

**The evaluation was carried during the period from November 5th to 22nd by John Zarafonetis, Independent Consultant. Prior to the field work a one day briefing was held at AMREF/US in New York on October 25th. Another briefing and review of documents was held at AMREF headquarters in Nairobi and field visits were made in Kenya and Uganda. In Kenya, Mr. Joseph Ngugi of AMREF's Health Policy and Management Department participated in the field evaluation. In Uganda, Zarafonetis was joined by Dr. Muthoni Magu-Kariuki, Director of the Health Policy and Management Department and Mr. Amos Nzabanita, Senior Health Planner from the same department. Mr. David Puckett, Technical Advisor for Child Survival for USAID/Uganda also participated in the Uganda field visits as did Mrs. Clare Semwanga, an AMREF health planner attached to the GOU's Health Planning Unit. An itinerary is included as Appendix II.**

**The evaluation is based on interviews with participants in training and management activities, officials from Ministries of Health in Kenya and Uganda, AMREF headquarters and country staff, and USAID staff in the two countries. In a couple of instances, interviews with rural health workers were conducted through interpreters who were from either AMREF or the District Health Team under review. Grant agreements, monitoring and evaluation reports, training materials, project proposals, and internal studies were also reviewed as part of this assessment. A list of people contacted for this study is included as Appendix III and a list of documents consulted as Appendix IV.**

## **II. Summary of Evaluation Findings**

The following is a summary of major evaluation findings:

**-AMREF is on course to meet and in some cases, exceed the specific objectives outlined in the Cooperative Agreement.**

**-AMREF is widely known and enjoys a strong reputation within the East African region. It is particularly respected by Host government officials who see it as an "African" NGO (as opposed to northern) Its with highly skilled staff and access to necessary resources allow it to carry out its mission and support initiatives of those government agencies it is working to assist.**

**-Unlike many PVOs, AMREF enjoys easy access to high health policy-making levels of the Ugandan and Kenyan governments. These host governments tend to look at AMREF personnel as an extension of their own staff. In Uganda, an AMREF staffer, in fact, is housed in the MOH Health Planning Unit and others are assigned to a District Training Center.**

**-AMREF appears to be one of very few NGOs in Africa working in the area of policy. Although potential for mid or long-term impact is rather great, working at the policy level leaves AMREF susceptible to shortcomings within host government's policy-making and implementation systems. Moreover, new government policies tend to be overambitious as well as inadequately resourced, and overestimate the capacity of those charged with policy implementation. In both Uganda and Kenya there has also been staff turnover at the corresponding health ministries, especially at the target levels.**

**-Although AMREF is headquartered in Nairobi there is no formal AMREF/Kenya country program and each department or, in some cases, unit conducts its business on its own. Because of AMREF's large size and many program interests in Kenya, this has led to perceptions of communication and coordination problems. Outside agencies, including USAID/Kenya, are not always sure with whom they should discuss business. This is not the case in Uganda, where AMREF has a discrete country program with a country director, making lines for reporting and follow-up clearer.**

**-At the time of this evaluation, AMREF was beginning to consider a reorganization. One step of this reorganization was establishment of a Kenya country office.**

**-The benefits of the above-mentioned reorganization, beyond establishing a Kenya country office, are unclear to some AMREF staff and need to be thoroughly reviewed before proceeding.**

**-Although the final evaluation report of the previous cooperative agreement recommended merging of the Health Planning Department and the Distance Education Unit so that both training functions supported by that matching grant could fall under the same office, it did not appear that this offered any advantage to either program. Apart from being essentially training activities, they are separate and designed to impact on different target groups. Coordination appears to be needed only in determining how Matching Grant resources are to be divided to adequately support each of the initiatives of the Health Planning and Management Department and the Distance Education program.**

**-Changing priorities within the Ministries of Health in both Kenya and Uganda, as well as other economic and political realities in those countries, point to a need to re-examine and probably re-direct certain activities in the remaining part of the Cooperative Agreement. While these activities probably were appropriate when the current grant began some have been reinterpreted or have stalled. Issues to be reviewed include how AMREF can best impact on policies of decentralization and cost-sharing for medical services.**

**-AMREF is behind schedule in obligating Matching Grant funds. This appears to be due in various parts to a delay in receiving initial grant funds at start up, some lag in negotiating and planning the Uganda program, and changes in policy and delays in implementing health care user fees in Kenya.**

**-As is the case with many NGOs, AMREF better needs to define program success. Current indicators used by the Health Policy and Management Department and the Distance Education Unit more resemble input measurements than true indicators of impact. Because it is basically ticking off inputs and deliverables (i.e. number of people attending workshops, number of workshops held, number of people enrolled in distance education programs), AMREF is having difficulty not only in describing the impact of the programs which appear to be something desirable, but also in taking advantage of available information from which (better) program management decisions can be made.**

### **III. Summary of Major Evaluation Recommendations**

This assessment shows that AMREF is on course to meet the goals and objectives of the Matching Grant. Consequently only a few major recommendations are offered. They are summarized below:

- 1. It is recommended that AMREF meet with corresponding health ministry officials in order to formally review progress to date and discuss and work out future action. AMREF and the MOHs in Uganda and Kenya acknowledge that circumstances have changed since the beginning of the Matching Grant and that some course corrective measures including an expanded role for AMREF are necessary to better impact on improving efficiency, quality and access of health care systems. This is particularly necessary in Kenya where the government admits that there have been problems as it has pursued its policy of de-centralizing health care systems including resistance to, and varying and inconsistent interpretations of, the user-fee policy and problems in structure and effectiveness of district health management boards.**
- 2. It is recommended that AMREF design indicators of success and incorporate them into a monitoring system designed to provide both AMREF and the corresponding health ministry with more information from which program decisions can be made. Under the present system both AMREF and the corresponding ministries appear to be tying success to inputs and meeting deliverable schedules. This is not unusual for an NGO and some important information can be gleaned from data on, for example, the number of NHIF workshops held or the number of district level baseline studies conducted over the period of the grant. After so many years of involvement in large management training efforts, however, AMREF should be able to provide harder information to support its belief that training activities in the areas of health systems development lead to improvements in effectiveness, quality and sustainability. More information on the impact of these activities is needed not only to define success, but also to provide better information to make project decisions. After years of training experience AMREF should be providing it. In the case of health policy and management AMREF needs to strive to better measure increases in competency and improved capacity of those which it is training, i.e. DHMTs, DHMBs, hospital secretaries, hospital clerks. To do this, indicators that are more critical need to be developed.**
- 3. Similar to #2, indicators for the Distance Education programs should be revised to better measure impact of the program rather than measure inputs. As noted above some of the information being collected is important, but relying on current indicators such as student drop-out and retention rates, although helpful, do not fairly provide compelling rationale for the program nor do they provide enough information to make better (more informed) program decisions. Program indicators again need to be more critical and be designed to at least measure knowledge gained by training recipients and tie it to increased capacity or competency. In the case of the Distance Education Program monitoring needs to better focus on improved competency of those targeted by the program. This group is composed of local, rural health workers and should be competency based.**

4. It is recommended that AMREF revise its financial tracking system to provide breakdowns of specific grant activities by country. As it stands now it is difficult to determine the cost effectiveness of the grant activities. Tracking by activity would make this easier as well as provide important information relating to issues of replicability, project budgeting and possibly, fundraising.

#### **IV. Evaluation Issues**

Institutional assessments are challenging because there is no broadly accepted easily measurable standard of what constitutes institutional effectiveness. This is particularly true with respect to the non-profit sector since the success or failure of philanthropic endeavors cannot be measured by a simple "bottom-line" formula, as it can in the case of profit making entities. For this reason, non-profits are obliged to spend considerable time and effort defining what constitutes effectiveness in their particular case. Because of the lack of a standard measure, evaluators are frequently forced to conclude that the only fair measure of institutional effectiveness is the demonstrated capacity of the organization to achieve the goals that it has set for itself. The difficulty with this logical but circular line of reasoning is that it does not add to or enrich our understanding of what constitutes a healthy, viable development assistance organization. In the final analysis it is true that non-profits can only be fairly judged against the goals they set for themselves. At the same time, there are certain indicators or attributes which appear to enhance the likelihood that an organization will be successful in that endeavor. For the purpose of this study a list was developed of several cross-cutting issues of an institutional and organizational nature and considers them of importance in assessing the performance of AMREF. This section considers:

1. Project methodology
2. Culture, values and style of AMREF
3. Organization and management.
4. Staffing
5. Headquarters/Field relations
6. Policy formulation and planning
7. Implications of growth
8. Financial Management

## **1. Project Methodology**

### **A. General Issues**

**As stated the emphasis of the grant has been on health systems development. In particular this has meant manpower development and health systems management.**

**Similar to most aspects of development assistance, obstacles to health development efforts in eastern Africa are multifaceted and cannot be solved overnight. Health development is hampered by a number of factors. High among them are inefficient and ineffective management of scarce health services and other sectors in planning, failure to focus intersectoral development efforts at the districts and communities, and inadequate technical knowledge, skills and attitudes towards responsibilities. To address these deficiencies AMREF established the Health Planning and Management Department (HPMD) and the Distance Training Unit (DTU).**

**The overall aim of this direct and distance training approach has been to strengthen the management practices and clinical skills of middle level health managers, local health management teams and managers and clinical workers of hospitals, health centers, training institutions, and other organizations involved in health service delivery in the Kenya and Uganda.**

**Under the first Matching Grant (1986-89) a Health Policy and Management Unit was established at AMREF. Under the current grant this unit has been upgraded to departmental status. The Health Policy and Management Department has been active in strengthening supervisory, management and services delivery skills of health care professionals at multiple levels in the Ministries of Health and health sector NGOs in Kenya and Uganda. In addition to working at the national level, AMREF, under the current grant, continues to use distance education to work with health workers at the periphery of the health care system who have little or no access to any other form of continuing education. Through this remote health management training, the program has been able to strengthen its focus on management improvement initiatives at the district and local levels.**

**In recent years, AMREF has worked closely with the host governments and NGOs to strengthen training of health workers in technical skills and management. Unlike most NGOs operating in Kenya and Uganda, AMREF works with, and often along side Ministry of Health offices to strengthen training of health workers in technical skills and management. Several bilateral donors have been assisting including SIDA, CIDA, and A.I.D.**

**There are many advantages in working with governments in upgrading technical and management skills. Governments make policies that guide health developments and they provide, although far from adequate, the bulk of health services. Governments also provide the flow of trained health workers to NGOs. These workers bring the skills with them when they transfer. Additionally, governments have invested in increasing human and financial resources in health services development which need proper management for maximum benefit to prospective communities.**

**Under the cooperative agreement, AMREF has been implementing a program of strengthening the efficiency, quality, and accessibility of health delivery systems in Kenya and Uganda at a budget of \$600,000 matched approximately by AMREF. The program is administered by AMREF headquarters through the country office in Uganda and MOH counterparts in Kenya.**

**The goal of the program is to increase the effectiveness, quality and sustainability of health care delivery systems in Kenya and Uganda. As in the previous Matching Grant AMREF's methodology to achieve the goals and objectives of the project has been to adopt management training and systems development using both direct and distance training approaches. District Health Management Boards and District Health Management Teams, Mid-level management and operation level management were singled out for management training.**

**The purposes of this project:**

- 1) To strengthen the capability of Health Management Teams in two countries in health delivery systems management.**
- 2) To improve the efficiency of health service delivery systems in the two countries through improvement of the health information system for the management of user fees.**
- 3) To produce health plans for selected districts in Uganda.**
- 4) To strengthen the MOH's capability to provide continuing education through distance teaching in Kenya and Uganda, and**
- 5) To develop monitoring and evaluation systems for distance education.**

**Summary of objectives:**

- 1) To carry out management training through workshops, distance education and support supervision;**
- 2) To train AMREF and health personnel on impact evaluation;**
- 3) To carry out Distance Education evaluation;**
- 4) To organize and coordinate two meetings for the East African Regional Health Planners and trainers once a year in each country.**
- 5) To establish management databases;**
- 6) To assist selected districts in Uganda to carry out baseline surveys to help them develop district health plans;**
- 7) To orient District Health Management Boards (DHMBs) in Kenya;**
- 8) To hold National Hospital Insurance Fund (NHIF) workshops;**
- 9) To collaborate with selected districts in the development of Health Information Systems;**
- 10) To organize DE materials development and writers workshops.**

The methodology to achieve the above objectives is to adopt management training and systems development using both direct and distance training approaches. DHMBs, DHMTs, Mid-level Management and Operational Level Management have been singled out for such management training. As women comprise the majority of rural health workers and according to AMREF compose at least one-fourth of DHMTs and DHMBs, they are involved as participants. This same strategy involves women (and their children) as ultimately the majority beneficiaries of improved health care services.

## B. Achievements

At the time of the evaluation, AMREF had achieved the following in comparison to the proposed targets:

**Table 1**

OUTPUT	PLANNED	ACCOMPLISHED	GAP +/-ve
AMREF and MOH training on impact evaluation	1	1	0
DE Evaluation	1	1	0
DE Review Workshop	2	1	1
DE Material Development Workshop	1	1	0
Follow-ups on DE Material Development	1	1	0
East African Regional Planners and trainers meeting	2	0	2
Database/Review of management activities	2	0	2
Management Workshop	2	0	2
Management workshops	3	2	1
DHMB Training	13	13	0
NHIF workshops	3	0	3
Follow-ups (NHIF)	2	0	2
AMREF Staff training (short courses)	2	0	2
Steering Committee	4	1	3
Final Evaluation	1	0	1
HIS (MRA curriculum)	1	1	0

In addition to being able to claim achieving the above outputs AMREF gets high marks from those MOH officials with whom AMREF is collaborating. Interviews with MOH officials in Kenya and Uganda revealed support for AMREF and a belief that by necessity training was the strategy of choice in strengthening management of district level health centers.

For example, Mr. I.M. Hussein, Head of the Health Care Financing Secretariat (Kenya) indicated that "AMREF's help is needed to make up for the lack of capacity of an understaffed HCFS". Mr. Francis Mworira, Chief Hospital Secretary (Kenya) said that because his ministry lacked the resources to train hospital secretaries who often lacked administrative skills, "it was left to AMREF to provide training in administration, planning, financial administration and health service management...and AMREF is best suited among NGOs in Kenya to train." Another Kenyan MOH official described AMREF as "unique among NGOs. A good number of them (AMREF staff) came from the MOH and they have sufficient information of how systems work here and find it easy to participate in discussions. There is no other NGO in Kenya that could do this."

Not surprisingly, these same MOH officials express a desire for AMREF to do even more to support their policies. As stated by one, "There is no way that the HCFS can cover all 50 districts in Kenya. AMREF has the personnel and resources to provide more support." According to another, "Decentralization is an ongoing process and we have made mistakes that need to be remedied. Training should also be on-going. So far AMREF has limited itself to working through the DHMBs. More training of this type is needed at other levels and for other groups and we would like AMREF to provide some of it."

This last statement is significant and merits exploration.

In Kenya, the MOH, like most of the government, is decentralizing its services. This has meant increased authority and responsibility for district level workers, including DHMTs, hospital secretaries, hospital clerks, and supervisors of rural health facilities. The introduction of a cost-sharing policy to government facilities has also led to the creation of DHMBs, a board of local citizens most of whom have little or no training or experience in managing health services and who now have responsibility for budgeting and priority setting for local health facilities. With the introduction of cost-sharing, government hospitals are required to file reimbursement claims with the National Health Insurance Fund (NHIF) and these hospitals have had little experience in filing such claims.

Over the life of the grant thus far the decentralization process as it effects health services has been problematic. According to the HCFS, of the 39 constituted DHMBs, 13 are not operating at all, and 13 others are considered ineffective. Moreover, the HCFS reports that district hospitals are taking cost-sharing "lightly". Nine district hospitals have made 0% of cost-sharing target, nine others are at 1% of targets.

Although the issue is complex, part of the problem appears to be frequent re-deployment of health care personnel. Another part, however, is lack of continuous training for the District Teams and Boards and for hospital personnel in the claims process. According to the HCFS, some of these problems were due to the selection ("gazetting") of unqualified or uninterested people as members of DHMBs. If more careful criteria had been devised for selection of DHMB members, the HCFS implied that many of the systems short-comings including board inactivity or ineffectiveness probably would have been averted.

Whether this is true or not, AMREF DHMB training gets very favorable reviews from not only the HCFS, but from the DHMBs themselves. While it is hazardous to place too much importance on two short visits with two DHMBs, these visits (Embu and Nyeri) seemed to justify the belief that the Boards can work effectively if they have continuous and substantial training from AMREF such as in the case of Embu. This DHMB by all accounts is active and working effectively and members described their training experience with AMREF as "very fruitful" their only disappointment being that there wasn't more training.

The Nyeri DHMB had not received any AMREF training outside of a MOH-sponsored two day orientation which AMREF helped organize. Although it viewed itself as fully functioning, it in fact is one of those classified by the HCFS as operating far below potential. Rather than leveraging cost sharing funds, it was actually overdrawn on its account.

Embu's interest in more training is of interest and might have a bearing on future activities. The Embu DHMB desires more training from AMREF because it has found that as it has become more capable, the management and planning issues and attendant options have become more complex. The Board feels a need for more assistance and requested specific training for its various DHMB sub-committees and in NHIF claiming for hospital clerks.

Although the Kenya MOH's assessment of DHMB effectiveness is based primarily on statistics on district cost share recovery figures and anecdotes on district management, it believes that it has enough information to begin to revise its approach. As a key player in both of these activities, it would appear that AMREF needs to be involved in strategies for course correction. Despite routine contact and easy access, AMREF had not been involved in any *formal* discussions with the MOH on revising its approach. It would appear that the coincidence of the MOH's conclusions on the need for some strategy revisions, internal AMREF dialogue further promoted by the timing of this mid-term evaluation of the Matching Grant, and discussions and planning relating to any new matching grant proposal make this an opportune time for joint discussions. *This constitutes the first recommendation of this evaluation. It is recommended that AMREF/HPMD meet with the MOHs in Kenya and Uganda with the purpose of reviewing progress to date and determining future collaboration. It is further recommended that role of AMREF in district management training be re-examined so as to more explicitly involve AMREF in the design of health policy implementation measures and expanding its training role to include other key participants in district health delivery systems such District Medical Officers, hospital secretaries, DHMTs, rural health workers, and hospital clerks.*

If anything, de-centralization is even more extreme in Uganda than Kenya. A combination of factors appear to have enabled AMREF to stay in step with the government's policy--a late start in implementing the Matching Grant which allowed for AMREF to get a sense of the government's health services decentralization policy, a discrete country program with a Country Director responsible for all negotiations with the GOU and for ensuring that projects are implemented, and a decision to focus initially on a single district. This district, Soroti, is a resource-deprived district in which AMREF is one of the few NGOs operating. It is likely not only that Soroti offers AMREF a laboratory to further develop measures to best impact on health management issues in rural and newly decentralized Uganda but also that such work will lead to opportunities for replication in other districts.

Utilizing support from the grant, AMREF is providing support to the Soroti DHMT which expressed appreciation for, and satisfaction with, AMREF's assistance in management and particularly, planning. Specific activities carried out so far have been a baseline study, the development of quarterly and annual plans, training of the DHMT in HIS, continuous education for district community health workers, and follow up training (support supervision) and installation of a district health management system.

It is too early to assess the significance of these interventions. The members of the Soroti DHMT, however, related that while initially they were frustrated by the slowness in undertaking such activities as the baseline study, they now understand and appreciate the process. They are confident in their planning capacity and find that the "slow-going" in the beginning has given them "a lot of information on which we can base planning." Hopefully this will be relevant and useful especially since recently there has been interest on the part of other NGOs and multi-lateral agencies in Soroti making planning and coordination increasingly critical.

However small AMREF's Matching Grant activities have been in Uganda, the flexibility demonstrated in revising its Uganda grant-supported activities is impressive. While there are any number of reasons for this responsiveness, one element making this possible probably is the presence of a country director who, as pointed out above, oversees program negotiations, planning, implementation and coordination. Based on this experience, AMREF's decision to establish a Country Program in Kenya with a Country Director is a good one.

One issue confronting both country programs has been a proliferation in the number of training programs, seminars, stages and workshops offered by donor agencies and NGOs. This has led to a cadre of "professional seminar goers" who may be benefitting from training opportunities, but these same opportunities take them from their jobs. Honoraria and per diem for these sessions alone often are substantially more than government salaries and there is a tendency among officials to want to attend themselves and not send a more appropriate representative who might better benefit or contribute. Instances where District Medical Officers in Uganda being away at training workshops and conferences more than 50% of the time were reported matter of factly during the evaluation. Moreover, the proliferation of multi-lateral-sponsored training has significantly driven up the "going-rate" of per diem so much as to almost put agencies and NGOs in a bidding war over participants. This is an issue for AMREF which in Uganda pays about half the per diem rate of organizations such as UNICEF.

**After viewing AMREF's headquarters and field operations it is clear that the above purpose and objectives are consistent with AMREF's articulated goal of improving delivery of health services in the region. This consistency is so apparent that at the operational levels it is difficult to determine where the matching grant starts and stops and how it differs from business as usual. When asked to describe accomplishments under the grant both the Director General and the Head of the HPMD offered that the Matching Grant has enabled AMREF to strengthen its institutional capacity and specifically it has done the following:**

**-Supported the District Health Management Board Training workshops in Kenya**

**-Supported the East African Regional Health Planners and Trainers conference**

**-Supported Impact Evaluation training for MOH Kenya, MOH Uganda, and AMREF personnel**

**-Facilitated the training of MOH personnel on National Hospital Insurance Fund Claiming process in Kenya**

**-Supported management training, a PHC baseline survey, Support Supervision and District Three Year Plan Development in the Soroti District of Uganda**

**Supported appraisal of management training in MOH's in Kenya and Uganda**

**Supported Distance Education activities in Kenya and Uganda.**

### **C. Health Policy and Management**

**AMREF has worked with Ministries of Health and NGOs in several countries in East Africa in carrying out management courses, designing and teaching courses and workshops on project formulation, planning, implementation and evaluation. Other courses include seminars and workshops designed to develop planning and management systems at central, district and health facility levels in the countries of the region. The creation of the HPMD was to facilitate the consolidation of the vast experience AMREF had gained in the area of planning and management of health services and, above all extend training in planning and management throughout the region.**

**A major constraint on the effective and efficient delivery of health services in Africa is the weakness, and sometimes the complete absence of appropriate management and support systems. Many deficiencies can be traced to lack of competence and material resources. There is a pressing need among ministries of health and nongovernmental organizations to improve their planning and management abilities. Such abilities would maximize the benefits of efficient health services delivery system.**

Typical management problems which need to be addressed by MOHs include cumbersome administrative procedures and structures, information systems, staff and skills orientation and development, linkages between budgeting planning and program implementation.

The objective of the HPMD therefore is to increase health management competence among district health management boards, district health management teams, and NGOs providing primary health care in rural areas so that resources are more effectively used.

#### **D. Distance Education**

As discussed, Matching Grant funds also support AMREF's Distance Education Program in Kenya and Uganda. The program is designed to reach health professionals delivering services in rural areas who do not have access to continuing education through other mechanisms. AMREF's approach has evolved over the years to where it presently offers Distance Education through two methods:

1) Provision of self-contained correspondence courses which utilize printed course material and sometimes audio tapes. Students participating in these courses are field health workers. They receive lessons from a regional center or by mail which include text and study guides, reference materials and assignments which upon completion are returned to AMREF's Distance Education Unit in Kenya or the Continuing Education Center in Uganda where they are graded and returned with comments. More than 5,000 Kenyan and 1,600 Ugandan rural health workers have enrolled in at least course in the two countries. Over the course of the current Matching Grant the number of self-contained courses has grown from four basic courses to nine in Kenya and to eight in Uganda. The courses are listed below:

- |                |                                            |
|----------------|--------------------------------------------|
| <b>Kenya:</b>  | <b>Communicable Diseases</b>               |
|                | <b>Child Health</b>                        |
|                | <b>Community Health</b>                    |
|                | <b>Family Planning</b>                     |
|                | <b>Breastfeeding</b>                       |
|                | <b>Environmental Health</b>                |
|                | <b>Obstetrics and Gynecology</b>           |
|                | <b>Non-communicable diseases</b>           |
|                | <b>Mental Health</b>                       |
| <b>Uganda:</b> | <b>Community Health</b>                    |
|                | <b>Communicable diseases</b>               |
|                | <b>Child Health</b>                        |
|                | <b>Immunization</b>                        |
|                | <b>Environmental Health</b>                |
|                | <b>Management of Essential Drugs</b>       |
|                | <b>Management of rural Health Facility</b> |
|                | <b>Mental Health</b>                       |

**2. Weekly Radio Broadcasts aimed at rural health workers. These broadcasts which last 15 minutes also target rural health care workers and are designed as a group learning activity to which the audience is encouraged to react and correspond with the Distance Education Unit.**

**AMREF's Distance Education Program has been evaluated three times over the last five years including an external impact evaluation conducted in November 1993. Each evaluation has given AMREF high marks for project implementation and the findings have been consistent. This evaluation likewise found that the Distance Education Unit is on course to meet the specific objectives spelled out in the grant agreement.**

**All of these studies to some extent indicate that despite reaching a level of success the DE program has been hampered by the failure of corresponding MOH's to entirely recognize the value of continuing education. During the course of this evaluation it appeared that there is a general sense that DE is good and worthwhile, especially since no one could come up with an alternative way of reaching rural health care workers. This sense emanated not only from MOH officials but from AMREF leadership.**

**There does seem to be ample evidence in support of the program. AMREF commissioned surveys of health workers participating in the correspondence courses show that they are positive and enthusiastic about the DE courses. Almost anyone interviewed who had taken a correspondence course indicated that the course had impacted on his/her knowledge and skills and sometimes, confidence. Other studies of the radio programs show that where broadcast reception is good in remote rural areas, listenership is high. Any practical follow-up to the courses offered by AMREF or the MOHs has been extremely popular. AMREF's DE Unit in Nairobi and the Continuing Education Center in MBale Uganda are flooded with requests for information. Everyone interviewed as part of this assessment felt that the potential for Distance Education was very high. One figure often cited was the fact that there are more than 33,000 district or sub-district level health workers in Kenya alone of which 5,000 were enrolled in a DE course. It was felt by many that the decentralization policies underway in Kenya and Uganda validated both the need and approach of DE.**

**The satisfaction and enthusiasm reported by participants and implementers is, however, not matched by government policy. This is despite many improvements in the design and implementation of DE since its inception in 1980 (Kenya) and anecdotal reports of success. During interviews for this evaluation, health ministry officials were quick to salute Distance Education as the only known way to reach a large number of rural health workers. They all acknowledged that conventional teaching methods could not work because of lack of government resources to reach thousands of health workers and also they acknowledged that conventional teaching would disrupt health services delivery.**

However, there has been little movement since the inception of distance education for rural health workers in Kenya or Uganda to formally recognize distance education and provide career incentives for those health workers who participate in the program. As it stands now, a health worker in the field can complete the entire distance learning curricula and not be rewarded with a promotion, salary increase, or any government recognition. This student receives only a certificate from AMREF and whatever knowledge and self-satisfaction derived from completing the course(s).

The situation for the radio programs is analogous. Despite recognition from health ministry officials that the broadcasts are "valuable, especially to those health workers in remote areas", program air times in both countries have been routinely bounced around to the extent that the broadcasts are aired at undesirable listening times i.e. too late at night, and have shifted times so much that no one knows the when a health program is scheduled. In the words of one health worker in Uganda, "one tunes in by accident."

AMREF attributes the inability to link distance education to formal recognition and supporting health policy to lack of documentation.

Over the years it has tried to provide more information including the three aforementioned evaluations one of which was an impact evaluation conducted as recently as 1993 (Nyonyintono and Mungai). While all of these evaluations have provided useful management information, they basically have provided demographic information on those participating in distance education and participants' and trainers' views of the programs. There is a substantial body of information on number of participants, number of courses taken, drop-out/completion rates, ratings of course usefulness, etc. It would appear however, that more information on DE impact would be necessary to offer hard information on the utility of DE. What appears to be missing from the way AMREF evaluates DE are ways to measure how participation in DE courses improves performance (competency) of rural health workers.

*It is recommended therefore, that AMREF devise a monitoring system to measure increased competency of rural health workers participating in Distance Education courses.*

While this may seem to be a large task, it should be remembered that AMREF has many years of experience as a training organization and has employed methods of measuring skill and knowledge transfer before. Additionally there are a number of publications that could be of assistance in designing a system to capture competency training such as the evaluation series from the Center for the Study of Evaluation at UCLA (1987, Sage Publications). AMREF's own publications including manuals for community health workers and *Community Health* might be especially helpful in developing critical indicators.

The benefits of providing more information on how Distance Education is improving the skills and competency of rural health workers are important and would seem to make the case for improved monitoring compelling. First, harder information on how DE impacts on the health worker can be used to make a better case for formal recognition from the MOHs. Desired ends here would include government certificates upon course completion, incentives for participation including promotion and salary increases, and incorporation of DE into national health policy. Second, by collecting base-line data and measuring competency of program participants, AMREF would have more information from which it could either revise shortcomings in current programs or design new programs. For example, until recently the AMREF course was teaching sterilization using a sterilizer requiring gas fuel. As most rural health centers lack funds to pay for gas, they rely on coal or wood fuel and certain sterilizers are not appropriate. Only after a time it was realized that the training course had to be modified to gear down to more practical sterilization practices. Third, the information provided through monitoring impact would encourage needed dialogue between rural health workers and DHMTs and AMREF and the MOH in Kenya and Uganda.

## **2. Culture, Values and Style**

AMREF's most singular institutional characteristic may be its clear and consistent conception of its mission and the compatibility between that mission and AMREF's own internal organization. Its community-based efforts since the early 1970's have emphasized integrated approaches to health development. AMREF was one of the first NGOs to broadly define health as inclusive of nutrition, water, sanitation and income generation for health promotion. More recently the development of health systems through training has enabled AMREF to assist national and local governments, rural health providers and managers, other NGOs, and rural communities.

AMREF's strong and unifying value structure and its set of shared beliefs about health service delivery reflect a composite of influences including a non-political reputation that enables it to work where governments cannot, a long history as a training institution, and the fact that it is a regional NGO with a predominantly African staff. It is preserved through rigorous screening of new employees and a formula and well organized structure of policy directives.

Although a strong value base is not unusual for an NGO, what is striking to an outsider in AMREF's case is the clarity, and strength of broadly shared convictions regarding development and the role of health systems development and health manpower training in development.

AMREF staff are conscious and appear proud of their strong "institutional" culture and shared values and beliefs. As stated by the Chairman of the AMREF Board:

"AMREF is an NGO that enjoys a unique position in this part of the world. It is one of the few international NGOs headquartered in Africa. It has been a strong supporter of regional development and has promoted pan-African health programs in recent years. AMREF has been an active partner to both the communities and donors. And as an NGO, it has always advocated a close working relationship with African Governments."

**The common language and shared values appears to be the basis for several important institutional attributes:**

**-A marked absence of overt internal conflict. While there are differences of opinion with regard to the future direction of the organization the degree of difference appears manageable and resolvable and the nature of the debate appears healthy.**

**-An unusual degree of programmatic focus and consistency. AMREF has demonstrated an exceptional inclination to do what it knows how to do and "stick to its knitting."**

**-An unusual capacity to collect and organize a body of knowledge about health services delivery. Consistency of focus has provided AMREF with an opportunity to increasingly act as a research laboratory for health services delivery.**

**-A sense of being special and a pride in being distinctively different from other NGOs. AMREF staff place considerable emphasis on setting themselves apart from other NGOs not only with respect to what they do but how they do it.**

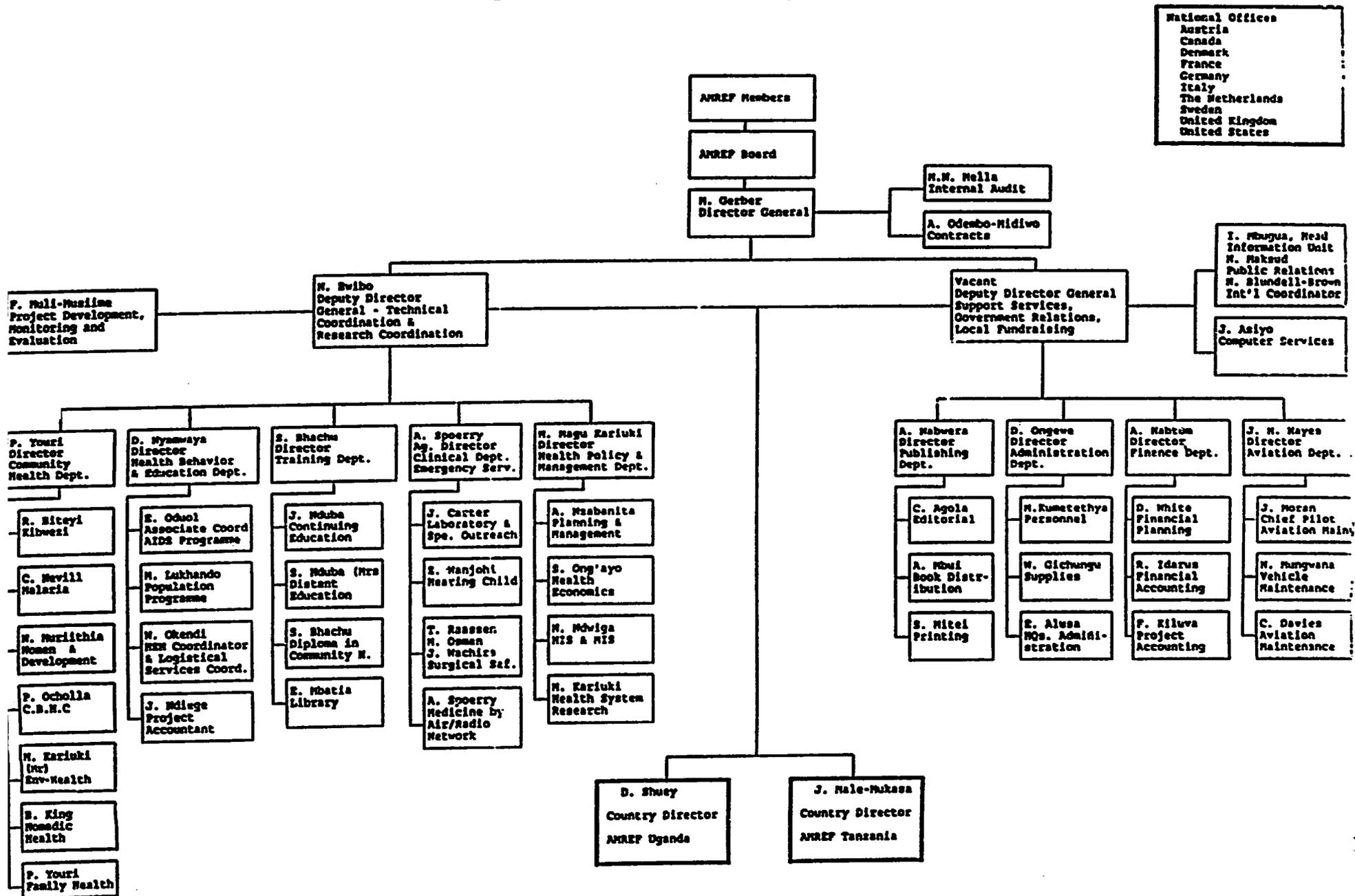
**This strong sense of identity and shared values are institutional attributes that are normally of significant benefit to an organization and in the case of AMREF are characteristics that may set it apart from most other PVOs. At the same time, these strengths have some potentially negative side effects including difficulty in identifying new opportunities, new approaches, and adjusting to change i.e. the ability to focus becomes confused with what is focused on. Also there may be an increasing tendency to further regiment decision making in order to protect established doctrine from invasion.**

### **3. Organization and Management**

**AMREF employs a management structure which appears to have grown out of a traditional, hierarchical central decision-making process that was later combined with a need for a decentralized system capable of managing a number of discrete projects. Currently there are five program-related departments including the Health Policy and Management Department, Clinical and Emergency Services Department, Health Behavior and Education Department, Community Health Department, and the Training Department which includes the Distance Education Unit. In addition to these there are four primarily administrative departments including Publishing, Finance, Administration, and Aviation. Each of the eight departments reports to one of two Deputy Directors (one of which is vacant) who report to the Director General who reports to the AMREF Board. (See Table 2.)**

Table 2

AMREF Management Structure and Organizational Chart



AMREF utilizes a fairly standardized set of reporting, monitoring and program and project approval documents that are mapped out in a policy manual. The management style strikes an outsider as being professional, businesslike, tightly structured, slightly formal, hierarchical and moderately centralized. In general there is a consistency and complementarity between the substance of what AMREF does and the way it does it. As mentioned earlier, AMREF's rapid growth and the nature of funding contributed to some "practical" management responses. While appropriate for the short term, many staff believe that the result has been an inherent weakness in internal coordination and communication. This was a major issue discussed in a senior staff retreat on the proposed reorganization of AMREF which took place during this evaluation.

The Director General of AMREF is clearly the "orchestra leader" in terms of substance and style. In a deliberately low profile way he plays a role in all significant policy decisions, the planning process, and in all major program initiatives. His influence is palpable and is due to his consistency of purpose and his cognizance of AMREF's position as a "regional NGO with a predominantly African staff."

#### **4. Staffing**

AMREF devotes considerable time and effort to key staffing decisions. Hiring practices are thorough and intense. One newer staffer described the process as being "put through the wringer". This exhaustive process reflects a recognition of the importance of finding people who are not only highly qualified, but who will fit the culture and style of the organization.

Within AMREF, morale appears to be generally good. The working atmosphere is serious and professional, there is strong sense of loyalty to the organization, pride in its accomplishments, and commitment to its purposes and methodology. Salaries, benefits, and overall working conditions appear to be good. While there may be disagreement with respect to ways that AMREF could improve, there is virtual staff consensus that AMREF is better at health development in East Africa than other NGOs.

The level of professional competence both at headquarters and in the field appears high both in terms of experience and training. Staff turnover, conversely is low. AMREF's claim that is the only NGO in Africa that combines the ability to make available a wide range of relevant technical expertise with its own large, operational public health program. Its complement of qualified African professionals, whose experience includes both the provision of technical assistance and the management of active field projects places AMREF in a better position than most organizations to provide technical assistance.

## **5. Headquarter/Field/Mission Relations**

**While it is hazardous and not necessarily relevant to draw conclusions on the basis of a visit to two countries, the following impressions emerged:**

**-The level of tension between headquarters and field is within the range of normality. As would be expected, older, more mature country programs i.e. Uganda desire a greater degree of operating autonomy than would proposed new start-up efforts i.e. South Africa.**

**-To an outsider it is confusing that there is no Kenya country program. As described in this report, Kenya programs and projects are implemented and administered through the MOH by the corresponding or designated AMREF department. To some within AMREF this arrangement has caused confusion with regard to coordination of AMREF resources and communication in-house. Moreover there appears to be a institutional fear of redundancy. To some outside AMREF (including USAID/Nairobi) it is sometimes unclear who the appropriate contact within AMREF is. This would appear to set the stage for not only inappropriate staffers making decisions on issues that they should not have the lead/final decision but also lead to missed opportunities for collaboration and even, funding.**

**-Few complaints were made regarding the level and quality of technical backstopping and support from Nairobi.**

**-To a degree AMREF is decentralizing. Decision making on programmatic issues in Uganda, is the responsibility of the Uganda Country office. This should continue if AMREF is to take seriously its policy of encouraging its field programs to work more independently.**

**-Field staff appear content with current reporting requirements.**

**-AMREF/US likewise indicated that is was satisfied with the level and quality of reporting from Nairobi.**

**-Policy guidance disseminates efficiently down through the organization and appears to effectively influence program design. As stressed elsewhere, AMREF is characterized by policy cohesiveness. Language and approach are similar in AMREF/Uganda and AMREF/Kenya with most differences being situational.**

**-Some headquarters and field staff indicated some concern that they were inadequately involved in the central process, expressing the occasional view that these directives were "passed down from on high". In response in part to these concerns AMREF made an effort to bring staff together at a retreat to discuss reorganization issues during the time of this evaluation.**

**Relations between AMREF Nairobi and AMREF/New York also appear to be basically smooth. The role of the New York office is largely fund raising and procurement. As Matching Grant funds can only be awarded to a registered U.S. PVO, this Cooperative Agreement is signed with AMREF/US. All Matching Grant funds pass through New York even though all project activities are carried out through AMREF's headquarters in Nairobi.**

**All reporting emanates from Nairobi. Reports are sent to New York and passed on to BHR/PVC. Turnaround time for communications between Nairobi and New York is short and these communications are done primarily through fax and international couriers. According to AMREF there have been no delays in financial reporting on the Matching Grant.**

**It should be noted that during the course of writing this report the AMREF/US President left AMREF. The significance of this is unknown to the evaluator.**

**Both AMREF and the USAID missions expressed a need for more routine and regular communications between the two organizations. One USAID project officer described her relationship with AMREF as being in "information lock". AMREF's Director General indicated that for year relations between AMREF and USAID as excellent but they had shifted down in Kenya due to turnover at the USAID and he being extra - and probably unnecessarily - sensitive to the fact that he was AMREF's first American Director and wanted to be sure that he was regarded as AMREF's DO first, rather than as American. For their parts, some AMREF staff were unsure who among them should be liaising with USAID. Similarly, it appears that USAID officers were not always sure with whom within AMREF they should be discussing business. The unfortunate results include some tension and more importantly lost opportunities for possible collaboration or at least sharing of information.**

**It would seem that AMREF's decision to establish a Kenya country office with a Country Director will help address these issues. The participation of a USAID/Kamala Project Officer in the Uganda portion of this evaluation should likewise make communications between the mission and AMREF easier in that country.**

## **6. Policy Formulation and Planning**

**Policy formulation and planning constitute the guidance or "Gyroscope" function within an organization. As organizations grow in size and complexity and relations become more impersonal and bureaucratic, the ability to hold or deliberately alter a desired course becomes increasingly difficult and the policy and planning functions grow in importance.**

**Policy and planning must deal with three interlocking sets of concerns:**

- Institutional strategy. (Where is AMREF going; what is its comparative advantage.)**
- Program content. (What is it doing well, not well and what should be changed?)**
- Implementation. (How does AMREF translate policy goals into practice through e.g. the budget process or the project selection process.)**

**These policy/planning concerns can be consolidated centrally within an organization or they can be located separately. What is important is that the policy/planning function be treated as a discrete and critically important package of responsibilities and that its various elements be consciously placed in appropriate locations with the organization.**

**AMREF has various mechanisms for formulating and reformulating policy including:**

- Internal Policy manuals;**
- A five-year Strategic Planning process;**
- Weekly senior staff meetings;**
- Periodic policy guidance memos from the President;**
- The annual budget process;**
- Various procedural guidelines;**
- Ad hoc studies and efforts such as the Distance Education evaluation.**

**It was agreed by all interviewed as part of this evaluation that planning and policy making are becoming increasingly important because AMREF is larger and more complex, because there are several critical institutional choices that soon will have to be faced, and because AMREF's training approaches will need to be constantly adjusted and updated. Although there was a strong central commitment to long range institutional planning and to the creation of a mechanism for thrashing out policy issues, this commitment is not felt equally throughout all parts of the organization. Policy formulation and planning tends to be handled at the center and passed down to the Departments and the field programs. This approach may have worked fairly well until AMREF became too large to allow two-way flow of communication and because the country programs were still in a formative stage.**

**Due to increases in size and complexity the policy making and planning processes will need to be decentralized. Greater decentralization will mean at least two things: First it will mean that country programs such as Uganda will need to participate more fully in the policy making process and secondly, country programs, departments and units within AMREF will have to formulate their own strategic plans in conformance with the themes and strategies contained in the Headquarters Strategic Planning Document.**

Organizationally, it appears that AMREF lacks an institutional mechanism for translating plans and policies into the programs and budgets of its field programs. Given the relatively few number of country programs and the apparent close geographic distances this has not been a problem. At a larger size and as programs are designed to meet country and regional strategies, it might be.

Finally and as mentioned elsewhere in this report, there is a growing need for increased policy analysis in at least three areas:

- The development of replicable models;
- Clearer guidance and methodology with regard to the largely, uncharted area of NGO-Government policy dialogue and policy implementation;
- The formulation of an AMREF growth model that would set forth characteristics and conditions associated with the growth, maturity and independence of country programs.

## **7. Implications of Growth**

By any measure AMREF is a successful organization, growing at an impressive rate while maintaining focus and concentration. For AMREF the most important question is not whether growth will continue, but what shape it will take.

Besides major programs in Kenya, Tanzania, Uganda, and Somalia, AMREF is also working in Ethiopia, Sudan, South Africa, and Namibia. Health workers from many other African countries will continue to be trained by AMREF. AMREF's credibility as a regional NGO in Eastern Africa is unmatched. Its potential for impacting other parts of the continent, including Southern Africa, is growing. A number of factors contribute to AMREF's regional and Africa-wide network:

- A non-political reputation that allows AMREF, as an NGO, in ways which governments cannot. AMREF will continue to serve as a facilitator in promoting regional Eastern African initiatives.
- An African headquarters able to provide management, technical and administrative expertise to support its work on the continent.
- Country offices concentrating on program development and implementation of AMREF's technical programs. De-centralization of many functions to the country offices will continue.
- National offices in the U.S., Canada and Europe concentrating on fund-raising and marketing of AMREF's technical programs.
- A network of collaborating agencies--in particular the MOH's NGOs, training institutions and international organizations working in health sector development in Eastern Africa.

**Growth will involve several structural and functional changes some of which have been previously discussed. These include:**

**-Gradual decentralization of decision making and increased delegation to the field (including Kenya.)**

**-A strengthened capacity to do policy research, formulate policy guidance and impose and monitor policy guidance. This capacity will need to be housed somewhere, presumably in the Coordination and Policy Research Division, the Project Development, Monitoring and Evaluation Office or a new Policy and Planning Office, reporting directly to the Director General.**

**-A strengthened and institutionalized budgetary process that more clearly relates policy objectives to funding decisions than is now the case.**

**-A strengthened planning process involving preparation of long range strategic plans at the country and department levels as well as for the organization as a whole with this function housed either in the Project Development, Monitoring and Evaluation or within a new Policy/Planning Office.**

## **8. Budgeting and Financial Management**

**AMREF has several funders and this holds true for activities corresponding to those funded under the Matching Grant. The HPMD also receives major funding from SIDA and CIDA and during the evaluation was informed that a substantial grant from the Aga Khan Foundation had been awarded. The DTU also has donor support from CIDA and SIDA in addition to the Matching Grant.**

**A thorough review of financial management system and procedures is beyond the scope of this study. In broad terms financial affairs seem to be managed with care and professionalism. However, two important issues are of concern:**

**1) At the time of the evaluation, AMREF was far behind in grant obligations. Over the first two years of the matching grant \$282,893 had been expended of an obligation of \$400,000. (See Table 3) This lag in obligation appears to be due to two factors.**

**1) Differences between AMREF's original request to BHR/PVC and what was approved. The current grant represents about 30% of what was requested in AMREF's original submission. The duration of the grant was changed from five to three years, a Tanzania country program was dropped, and the overall size and scope of the program was scaled back significantly. Because of these changes, AMREF needed to not only revise its plans both at the headquarters and field levels, it needed to re-negotiate and re-plan activities with host governments and MOH counterparts. This took time and in fact, two proposal revisions were necessary before BHR/PVC approved the program in January 1993.**

**Table 3**

**AFRICAN MEDICAL AND RESEARCH FOUNDATION**

**FINANCIAL STATUS REPORT  
 USAID GRANT No. FAO-0158-A-00-2052-00  
 SEPTEMBER 24, 1992 TO SEPTEMBER 30, 1994**

USA17: USA COST	30 JUNE 199	JUL-SEPT	EXPENDED	OBLIGATED	AVAILABLE	ADJUSTMEN <sup>10/93-6/94</sup>	JULY	AUGUST	SEPTEMBER	TOTAL
SALARIES/EXPENSES	6,891	1,534	8,425	27,600	19,175	807	166	115	445	1,534
TRAVEL	2,528		2,528		(2,528)					
OTHER DIRECT COSTS	2,367		2,367		(2,367)					
INDIRECT COSTS	3,122	406	3,529	7,300	3,771	214	44	31	118	406
EVALUATION										
<b>TOTAL USA COST</b>	<b>14,909</b>	<b>1,940</b>	<b>16,849</b>	<b>34,900</b>	<b>18,051</b>	<b>1,020</b>	<b>210</b>	<b>148</b>	<b>563</b>	<b>1,940</b>
<b>USA17: AFRICA COST</b>	<b>30 JUNE 199</b>	<b>JULY-SEPT</b>	<b>EXPENDED</b>	<b>OBLIGATED</b>	<b>AVAILABLE</b>	<b>ADJUSTMEN</b>	<b>JULY</b>	<b>AUGUST</b>	<b>SEPTEMBER</b>	<b>TOTAL</b>
SALARIES/EXPENSES	68,482	18,453	86,935	128,900	41,965		4,630	5,796	8,027	18,453
TRAVEL	25,369	11,501	36,870	24,600	(12,270)		1,700	800	9,001	11,501
OTHER DIRECT COSTS	65,269	21,253	86,522	135,200	48,678		2,200	700	18,353	21,253
EVALUATION										
INDIRECT COSTS	42,152	13,565	55,717	76,400	20,683		2,260	1,933	9,372	13,565
<b>TOTAL AFRICA COST</b>	<b>201,272</b>	<b>64,772</b>	<b>266,044</b>	<b>365,100</b>	<b>99,056</b>		<b>10,790</b>	<b>9,229</b>	<b>44,753</b>	<b>64,772</b>
<b>USA17: COMBINED COST</b>	<b>30 JUNE 199</b>	<b>JULY-SEPT</b>	<b>EXPENDED</b>	<b>OBLIGATED</b>	<b>AVAILABLE</b>	<b>ADJUSTMEN</b>	<b>JULY</b>	<b>AUGUST</b>	<b>SEPTEMBER</b>	<b>TOTAL</b>
SALARIES/EXPENSES	75,373	19,987	95,360	156,500	61,140	807	4,796	5,911	8,472	19,987
TRAVEL	27,897	11,501	39,398	24,600	(14,798)		1,700	800	9,001	11,501
OTHER DIRECT COSTS	67,636	21,253	88,889	135,200	48,311		2,200	700	18,353	21,253
EVALUATION										
INDIRECT COSTS	45,274	13,971	59,245	83,700	24,455	214	2,304	1,963	9,490	13,971
<b>TOTAL</b>	<b>216,181</b>	<b>66,712</b>	<b>282,893</b>	<b>400,000</b>	<b>117,107</b>	<b>1,020</b>	<b>11,000</b>	<b>9,375</b>	<b>45,317</b>	<b>66,711</b>

of

**2) In both Kenya and Uganda changing governmental priorities resulted in delays in implementing the grant program and consequently, delays in grant expenditures. In Kenya there were delays in constituting the DHMBs. Additionally, implementation of the national health insurance fund, an activity slated to be an important part of AMREF's support to the MOH in Kenya has been problematic and is on hold. In Uganda, it was necessary for AMREF to revise its country plan to meet revisions in the overall Uganda health plan and then conduct an up-front base-line assessment in the target district.**

**It appears that these two factors sufficiently rationalize the AMREF's delay in grant expenditures but point to two obvious conclusions. First, *at the anticipated rate of expenditure, AMREF will need to request a no-cost extension from BHR/PVC.* Second, it appears evident that because of problems associated with implementing and interpreting policy as well as obvious shortcomings in resources and capacity at the government levels, it is unlikely that AMREF and the corresponding MOH's will ever be in sync. This appears to be an issue whenever working in the policy area and one which distinguishes this AMREF's activities from those of other NGOs working in grassroots development where because of the collaborative and backstopping nature of the program, AMREF must work especially collaboratively leaving it more susceptible to its partners meeting their own schedules.**

**2) A USAID/Nairobi Project Officer expressed concern that AMREF had experienced difficulty in meeting its matching responsibilities. AMREF responded that in the course of the grant there had been no problems in making the match, most of which comes from SIDA. It is unclear whether there is an issues here or not. At the time of the evaluation, there was no matching problem. It may be that the issue raised by the USAID officer, whether real or perceived, is related to problems in communications between AMREF and the mission and to AMREF's Kenya structure which are discussed elsewhere in this report.**

**Administration and financial management appears to be pretty clear. Both the heads of the HPMD and the DE Unit are involved in budget planning and work with the accounts department in determining how matching grant resources are used. Country workplans are also used to determine how resources are to be allocated, however, tracking grant resources by country activity appears to be difficult. Although this study did not explore how this system worked, it would seem on the surface that this arrangement may cause problems in overall reporting and could result in taking certain financial decisions away from the Department, Unit or Country Director. It would seem at least that there might be a risk of making financial decisions without the benefit of some important information. *Therefore, it is recommended that the system for tracking expenditures of the HPMD and the DTU by country be expanded to track specific activities by line item.***

**APPENDIX I**  
**STATEMENT OF WORK**

**PROPOSED TERMS OF REFERENCE**

**FOR**

**SEPTEMBER 1994 MATCHING GRANT MID-TERM EVALUATION**

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**Health Policy and Management Department  
African Medical and Research Foundation  
P O Box 30125  
NAIROBI, Kenya**

**July, 1994**

# AMREF MATCHING GRANT MID-TERM EVALUATION

## Terms of Reference

### A. Scope of Work

#### Purpose

To assess the accomplishment of activities in Kenya and Uganda funded under the USAID Matching Grant and examine AMREF's Headquarters performance in providing oversight and support to field activities. Project performance will be used to direct the activities to be carried out in the remaining period of the project.

#### Objectives

1. To assess AMREF's progress in the implementation of the activities as spelt out in the grant, which are aimed at enhancing management skills of health care professionals;
2. To review and assess the effectiveness of AMREF's headquarters in providing technical, financial, policy and programmatic oversight and support to field activities in all focus countries. Particular attention should be given to the programmatic implication resulting from the communication between AMREF's headquarters in Nairobi and USAID in New York.
3. To assess AMREF's problems and constraints <sup>confront AMREF</sup> ~~hindering them~~ from reaching the goals and objectives outlined in the Cooperative Agreement.
4. To develop specific recommendations for AMREF regarding field backstopping, monitoring and evaluation and administrative procedures.
5. To assess whether activities complement health programmes in the two countries and USAID policies.
6. Examine what steps are being taken to institutionalize projects in order to assure the sustainability of the benefits.
7. To assess the potential of the projects being replicated and to recommend actions that could encourage such replication.
8. To examine how gender concerns are being addressed and recommend how these concerns can be strengthened during the remaining period of the project.

## **B. Evaluation Outputs**

**The mid-term evaluation team leader will be responsible for preparing and delivering ten copies of the report to USAID. Prior to this, the team leader will provide a copy of the draft report concurrently to AMREF and USAID for their review and comments.**

**The report should provide the following:**

- 1. Assessment of AMREF's progress towards achieving the goals set out in the Grant Agreement.**
- 2. An assessment of AMREF's performance in focus countries, as well as the problems and constraints that are influencing progress towards the set goals.**
- 3. Recommendations to AMREF for actions to support their future progress.**

**The body of the report should also contain the following:**

- **Table of contents**
- **Executive Summary**
- **Purpose of the mid-term evaluation**
- **Key findings and recommendations**
- **Team composition and study methods**
- **Separate analyses of DE program and Health Management and planning program**
- **Annexes**
  - **Scope of work**
  - **List of documents consulted**
  - **List of individuals/organizations consulted**

### **C. Background**

In 1990 AMREF submitted a proposal requesting AID assistance of \$3113.6 for a 5-year Matching Grant which AMREF would match with equal funds. Only a few of the proposed programs were accepted for funding in 1992. These were to be implemented by the Health Policy and management Department [HPMD] and the Distance Education Unit [DEU] of AMREF.

#### **Health Policy and Management Department**

This department was established in AMREF headquarters in Nairobi in order to provide management assistance to health professionals in Eastern Africa employed by NGOs as well as Ministry of Health staff at the local, district, regional and national levels. Management activities were to be conducted in Kenya and Uganda and would address such topics as health planning, health management, HIS, support supervision and evaluation. The department benefitted from a three-year AID grant [1986-89] which had started some of the above interventions

#### **Distance Education Unit:**

AMREF was provided funding to improve and expand its Distance Training program which earlier on also benefitted from the AID Matching Grant. In distance teaching students learn at their own pace through radio, publications and written assignments [which they return to an instructor for comments before proceeding to the next lesson]. The program is intended to reach health professionals delivering services in rural areas who have no access to Continuing Education through other mechanisms. Improvements through this project were to include evaluation mechanisms both in Ministries and AMREF, writing skills and distance education material development.

### **D. Methodology**

The evaluators will conduct their assessment using the following:

1. AMREF Matching Grant Agreement
2. Project reports [annual]
3. Other relevant documents
4. Interview with AMREF staff, course participants, host country counterparts, USAID Missions and other individuals considered relevant.

#### **Schedule**

It is anticipated that the fieldwork will take <sup>TWO</sup> ~~three~~ weeks starting with briefing of Team Leader in New York, headquarters evaluation and team planning in Nairobi, fieldwork in Uganda and Kenya.

**Tentative Dates:**

*Sept 5 - 18 days*

Briefing in New York - Week of August 29, 1994

Planning in Nairobi and field work - 5th and 12 Sept 1994

Report Writing - week of September 19, 1994

*REPORT DRAFT DUE SEPT 30, 1994*

**B. Evaluation questions and Issues**

The following are questions and issues that the evaluators will have to develop to direct them during the course of the mid-term evaluation. Some questions are more relevant for the field than headquarters, and vice-versa. The team should use these as a guide; it will not be expected that each will be separately addressed in the final report.

1. **Ability of project design and implementation procedures to meet project objectives**
  - Are AMREF's program activities consistent with the focus of the grant agreement?
  - Is there evidence that the project beneficiaries have benefitted from AMREF's involvement in subject communities?
  - What strategies has the project management taken to improve health training programs? Do they seem appropriate?
  - Do field guidance, training materials and promotional materials reflect state-of-the-art health knowledge and sensitivity to cultural constraints?
  - Has training and education been targeted to particular groups? If so, do groups seem appropriate/ Has targeting been effective?
  - How appropriate are training materials for countries and participants? How has training been tailored to meet specific needs of trainees? How effective are materials used in Distance teaching program?
  - How many training programs are successfully functioning? And how many health professionals have participated in AMREF's program under this cooperative agreement?
  
2. **Institutional Development in the field**
  - At each level, does the field staff have the training and skills necessary to perform project functions?
  - How does AMREF identify trainers and consultants? Has any type of training been provided to teaching staff?
  - If the training has taken place, do staff feel it was appropriate and have they incorporated skills into their job responsibilities?

- Has technical staff been sensitive to local abilities to absorb new information?
  - Have training materials been field tested? If so, how and by whom?
3. Relationship with host governments, community and other organizations in the country
- What has been the involvement of the MOH and local institutions or other NGOs in terms of project design, financial support or project implementation?
  - How successful are partnerships with local partner organizations? Are counterparts assuming ownership of the projects?
  - Do projects complement policies and programs of host governments and AID?
4. Monitoring of the program
- What type of system has each project activity developed to monitor and measure costs, progress of activities? What are the indicators of progress in program activities?
  - Who is responsible for data collection and analysis? Do these individuals have the training and skills necessary to do the job?
  - Does AMREF keep track of course participants once training is completed?
  - How is feedback provided to project staff, counterpart organizations, trainees and community?
5. Sustainability
- What financial and organizational strategies have been implemented to promote project's sustainability?
  - Do communities and/or local institutions believe that the project meets their health needs?
  - Do host governments demonstrate commitment/ability to sustain project benefits once AMREF's support ceases?
6. Relationship between field and headquarters
- How does headquarters [New York and Nairobi] offices support field efforts? What role does the NY office play in project management and monitoring?
  - What is the turn-around time between field request for information, technical assistance, etc and responses from headquarters?

- **How many trips have headquarters staff made to field sites? What has of the visits (i.e. to provide technical assistance, monitor status of proj).**
- **Is technical assistance from headquarters to the field typically initiated at headquarters, field or either?**
- **Does headquarters tend to employ technical staff, or to hire consultants as needed?**

**7. Financial Management**

- **What is the turn-around time between the field expenditure requests and money sent from headquarters?**
- **Is there typically enough cash to meet the requests from the field?**
- **Is there an implementation plan or time line that relates activities to expected expenses? If so, how far into the future does it calculate?**
- **How do planned and actual expenditures relate?**

**APPENDIX II**  
**FIELD ITINERARY**

## MEMO

**TO:** AMREF Director General  
AMREF USA  
DDG[T]  
Dr Dean Shuey, AMREF Uganda  
S Nduba

**FROM:** Dr Muthoni Kariuki

**DATE:** 12th October, 1994

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### Matching Grant Evaluation Schedule

The mid-term evaluation is scheduled to run from 7th to 21st November, 1994. The following is the proposed schedule for the evaluator. A more detailed time-table will be drawn when Mr Zarafonetis gets here. He arrives in Nairobi on the 6th November, 1994.

<b>Monday 7.11.94</b>	Meet with Project staff, DDG[T] and Director General at AMREF Nairobi
<b>Tuesday 8.11.94</b>	Meet with USAID, Ministry of Health and Health Care Financing Secretariat officials
<b>Wednesday 9.11.94</b>	Travel to Embu District in Kenya
<b>Thursday</b>	Meet with Embu District Health Management Board [DHMB] and travels to Nyeri District later that evening.
<b>Friday 11.11.94</b>	Meet with Nyeri District Health Management Team then travel back to Nairobi
<b>Saturday 12.11.94</b>	Report writing
<b>Sunday 13.11.94</b>	Travel to Entebbe, Uganda
<b>Monday 14.11.94</b>	Meet with AMREF Uganda, USAID officials and MOH officials at Entebbe and Kampala
<b>Tuesday 15.11.94</b>	Travel to Soroti in Uganda
<b>Wednesday 16.11.94</b>	Meet Soroti District Health Management Team [DHMT]
<b>Thur 17.11.94</b>	Travel to Mbale and meet the Distance Education Team

**Fri 18.11.94**

**Travel to Nairobi**

**Weekend 19-20.11.94**

**Prepare draft report for AMREF**

**Monday 21.11.94**

**Discuss report with AMREF, debrief USAID and AMREF  
Director General.**

**Leave for USA in the evening.**

**APPENDIX II**  
**FIELD ITINERARY**

## **PEOPLE CONTACTED FOR THIS EVALUATION**

### **AMREF/USA**

**Lewis Heyman, President**

### **AMREF/Nairobi**

**Dr. Michael Gerber, Director General**

**Dr. Muthoni Magu-Kariuki, Director HPMD**

**Samual Ong'ayo, Health Economist**

**N.K. Ndwiga, Health Information Specialist**

**Amos Nzabanita, Planning and Management**

**Prof. Nimrod Bwibo, Dep. Director General**

**Dr. F. Muli-Musime, Director Project Development, Monitoring and Evaluation**

**J. N'gogi, Hospital administrator and Planner**

**T. Omuria, Data Management Spec.**

**Stephanie NDuba, Head, DEU**

**Joan Mutero, DEU**

**Peter Mwarago, DEU**

**Charles Omondi, DEU**

**Lucy Muriuki, Project Accountant**

### **MOH Kenya**

**I.M. Hussein, Head HCFS**

**Dr. Francis Mworira, Chief Hospital Secretary**

**Sam Munga, HCFS**

### **USAID/Nairobi**

**Ms Kate Colson, Project Officer (by telephone)**

### **EMBU DHMB**

**Dr. S.K Mantii, DMO**

**Dr. J.N. Njage, Medical Superintendent**

**Dr. S.K. Muttinji, Public Health Officer**

**R.G. Ngogo,**

**Cosmos N.E. Kathngu, Chairman**

**C.M. Kagath, Hosp. Secretary**

**J.W. Kimanda, member**

**K.W. Mwaniki, member**

**Eva Muai, member**

**Fr. Vincent Ileri, member**

Mrs. E. Muturi, member  
John N Nderi, member

**Nyeri DHMB**

J.W. Githuku, Chairman  
Mrs. Charles Mwangi, member  
W.O. Wanganga, Representative of DC.  
Aboli Awach, DHO  
Mrs. J.M. Wamyoiki, hospital matron  
Mr. Njukia, Hospital Secretary  
S.N. Wamondo, Hospital Secretary  
Dr. R Kamau, MON  
Rev. Charles Wahome Kimari

**AMREF UGANDA**

Dr. Dean Shuey, Country Director  
Mrs. Clare Semwangu, Health Planner (Entebbe)  
Peter NGabic, AMREF Project Leader, Uganda Health Training and Planning Program (MBale)  
Ruth Maginoh, Coordinator DE Program (MBale)

**MOH**

Dr. Abongomere, Acting Head, Health Planning Unit

**USAID Kampala**

David Puckett, Technical Advisor Child Survival

**DHMT Soroti**

Dr. Nicholas Okwana  
Enos Osire  
J.C. Odatum  
S.E. Etoh  
Sr. Janet Ebietu Erivania  
E.R. Wangu

**Asamuk Dispensary**

Jane Atengoit, In-charge  
Peter Ecayu

**Amuria Health Center**

Peter Esamu, In-charge

**Other**

Mrs. Emugo-AKel, District Executive Secretary

**APPENDIX IV**  
**DOCUMENTS CONSULTED**

## **DOCUMENTS CONSULTED FOR THIS STUDY**

1. Cooperative Agreement FAO 0158-A-00-2052-00.
2. Final Evaluation Report, AID Matching Grant, 1990, Carolyn Brye and Martin Gorosh.
3. FY 1992 Matching Grant Proposal, "Strengthening the Efficiency, Quality, and Accessibility of Health Services Delivery Systems in Eastern Africa" August, 1992 AMREF.
4. Revised Matching Grant Applications, November 1992, AMREF
5. Memo: Future Matching Grant Opportunities, Dr. Pat Youri to Lewis Heyman, AMREF, September 1994.
6. Report on "NHIF Claiming Workshop", Sept. 1994, MOH Kenya and AMREF.
7. Report on "District Health Management Boards", October, 1992, HCFS and AMREF.
8. Support Supervision Supervising Checklist, Not dated, MOH/Uganda and AMREF.
9. Report on "Uganda Community Based Health Care Secretariat TOT IV Workshop", May 1994, MOH and AMREF.
10. Technical Support Supervision Report, Uganda, May 1994, AMREF.
11. Health Policy and Management Programme, Annual Reports, 1991,1992, 1993, AMREF.
12. Soroti District Health Care Baseline Survey Report, October, 1993, Soroti DHMT and AMREF..
13. Soroti District Three Year Health Plan 1993-1995, Soroti DHMT and AMREF.
13. Survey "Facts About Health Radio Programme Listenership"  
May, 1994, HMDC and AMREF.
14. Report on Sensitization Review Workshop for District Health Teams, October, 1993, MOH and AMREF.
15. Distance Education Curricula-Five Self-contained Units, Kenya, AMREF
16. Mid-term Evaluation of AMREF Health Planning and Management and Distance Teaching in East Africa, F. M. Mburu and J.B. Mukasa, 1989.
17. Report on DHMB Orientation Workshop, Aug. 1993, MOH and AMREF.
18. Reports on Nairobi/Embu DHMB Workshops, June, 1994, MOH and AMREF.
19. Report on Support Supervision, April, 1994, AMREF/Uganda.
20. Report on Soroti District Health Management, Sept. 1993, AMREF/Uganda.
21. AMREF's Strategic Plan "Towards the 21st Century: Meeting Africa's Health Challenges", January 1994, AMREF.
22. Report on DHMBs Supervision Workshops for Vihiga, Migori and Homa Bay Districts, May 1994, MOH and AMREF.
23. Report on "Review of Soroti District Health Plan Workshop", March, 1994, AMREF/Uganda.
24. Facility Improvement Fund Supervision Manual, February 1994, MOH/HCFS.
25. Report: Interim Evaluation of PAC Project Phase II, 1993, AMREF and External Consultants.
26. "Health Project Management Guide," Part I Project Planning, 1992, AMREF.
27. Report: "Factors Influencing Prioritisation of District Health Needs in Kenya, Oct. 1994, AMREF, MOH/Kenya and WHO/HSR.
28. "Facing the Challenge of Africa's Diseases" AMREF Annual Report, 1993.
29. Report on DE Review Workshop by Uganda's DE Coordinators and Part-time Tutors, 1994,

**AMREF.**

**30. Report on Writers' Workshop On Writing and Editing Distance Education Materials for Health Workers, July and August, 1994. AMREF.**

**31. Report on NHIF Claiming Workshop for Rift Valley, Western and Nyanza Provinces, Sept. 1994, MOH/HCFSS and AMREF.**

**32. "DEH News" (Distance Education in Health) Newsletters, Dec. 1992, June 1993, and July 1994, AMREF.**