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**A MID-TERM EVALUATION OF THE MIHV CHILD SURVIVAL PROJECT
in Dagoretti, Nairobi Province, Kenya**

POPULATION COMMUNICATION AFRICA
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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AMREF	African Medical Research Foundation
ARI	Acute Respiratory Infection
CBD	Community Based Distributor
CBHC	Community Based Health Care
CDD	Control of Diarrhoeal Disease
CHAK	Christian Health Association of Kenya
CHW	Community Health Worker
DGIS	Directorate General International Cooperation (Royal Netherlands Government)
DIP	Detailed Implementation Plan
DPT	Diphtheria Polio Tetanus
EPI	Expanded Program on Immunization
FP	Family Planning
FPPS	Family Planning Private Sector
GTZ	German Development Cooperation Agency
HIS	Health Information System
HIV	Human Immuno-Deficiency Virus
JICA	Japanese International Cooperation Agency
JSI	John Snow International
KRN	Kenya Registered Nurse
MC	Maternal Card
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	Non-Governmental Organisation
OPD	Out-Patient Department
OR	Oral Rehydration
ORT	Oral Rehydration Therapy
PCA	Population Communication Africa
PHC	Primary Health Care
PMO	Provincial Medical Officer
PWAs	People With AIDS
STD	Sexually Transmitted Disease
TT	Tetanus Toxoid
TBAs	Traditional Birth Attendants
TOT	Trainer of Trainers
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development

Executive Summary

The evaluation team, comprising staff of Population Communication Africa and Consultant (Dr. Rae), operated in participatory fashion with project staff in the undertaking of the present mid-term evaluation. A total of 42 person days were devoted to this exercise. The major activities involved in this evaluation were:

- a) desk top research of the relevant project documents, reports and related records, made available to evaluation team by the MIHV project management,
- b) the organization and implementation of a small community survey to update indicators of progress and provide a quantitative assessment of project impact, and
- c) the undertaking of participant observations of the health centre and community-based activities including field visits and protracted staff discussions (volunteers, health centre and project staff).

The major accomplishments of this project, for which there are measurable outcomes, are very sound key indicators of improved child survival: better nutritional practices, enhanced control of diarrhoeal and respiratory infections, increased child immunization rates, and much improved health provision coverage for mothers, including improved rates of adoption of family planning practices. General environmental health indicators also show improvement. The quantity and quality of health programming revealed by the survey are indicative of steadily improving chances of child survival.

The key recommendations made by the mid-term evaluation relate, firstly, to the immediate activities that should be undertaken to complete DIP requirements: short-term staff replacements and consultants to advise upon HIS and volunteer incentive programming. And, secondly, to the initiation of three strategies which might improve the retention of volunteers, increase the managerial involvement of community leadership, and identify and establish other short-term sponsors with a view to eventual transfer of the CBHC programme to the community. It is proposed to disseminate these evaluation results through project management and staff to all partners presently involved and, discretionally, to prospective sponsors.

The authors of this mid-term evaluation were Dr. Tony Johnston (Executive Director, PCA) and staff of PCA. Our thanks to Craig Reeves (Project Director) and of his staff for their invaluable assistance. USAID has funded a child survival project in Dagoretti, Kenya, which in many respects have achieved results beyond original expectations due to the efforts of community and a highly competent and dedicated NGO. The final project report should be of considerable strategic interest to other initiatives in this field, particularly those in Sub-Saharan Africa.

Introduction

Dagoretti community lies in the extreme Western Division of the City of Nairobi. Originally an area of aggregated rural villages with a Kikuyu population engaged primarily in subsistence agriculture and petty trading, it has more recently become a focus for squatter immigrants. The presence of ten slaughterhouses in Dagoretti Market, which employ over 600 persons, as well as other, sometimes perceived, economic opportunities, and Dagoretti Market's large size and its busy matatu stage, have resulted in rapid community growth. The population of the area now numbers over 60,000. In the project area it is estimated that 30% of the total population are long-term residents, while 70% have moved into the community from other areas. Indeed, the area's demographics are characterized, amongst others, by a rapid population growth above the norm for Kenya, which has exerted increasing pressure upon the basic resources of land, housing, water and electricity supply. This, in turn, has generated under-nutrition, poor sanitation and low levels of environmental health.

The MIHV Child Survival Project, for which the initial groundwork was undertaken in 1987 by the MIHV team, has two component parts: a Health Centre which provides primary health care services, and an outreach community-based health component which primarily serves three locations (Waithaka, Mutuini and Ruthimitu). The project draws a clientele from the wider Dagoretti community. The Health Centre was established in 1990/1991 as a consequence of community demand to remediate the sparse provision of primary health care within this community.

Accomplishments

The MIHV Child Survival Project has been in operation since August 1988, and is currently in its third cycle of implementation. Since its inception, a period of eight years has elapsed and time expended during the third cycle - from August 1994 to the present - amounts to 25 months. Funding support by USAID for the current, and final, cycle is planned to terminate in August 1997.

The objectives outlined in the current Development Implementation Plan (DIP-1994) and couched in strategic terms were as follows.

As an over-arching goal:

"To maintain the community expertise and infrastructure which has been established to

reduce morbidity and mortality of women of childbearing age, and reduce morbidity and mortality of children under five (with the main focus on children under the age of two)".

As sub-goals, the following:

- "(a) to deliver child survival interventions to the target group through the mechanism of training community health volunteers, and through the operation of a health center integrating maternal and child health with curative care and a traditional outpatient department (OPD),*
- (b) to develop and institutionalize a community-endorsed and implemented revenue-generating system that can finance the project's operation beyond the initial funding term, and*
- (c) to develop the administrative and technical expertise necessary to manage the project activities after the departure of the expatriate staff".*

Inputs and Outputs

The measurable inputs of this project in its Phase III operations, relate to staff and volunteer training, meetings held, equipment obtained and materials acquired for dissemination.

Training

a) Staff Training

Over this immediate reporting period, a total of 18 project and MOH-staff members have received short course training in health administration, ARI, technical skills training for curative health care, family planning, AIDS prevention, counseling and community motivation and mobilization in 28 separate courses held locally and in other Sub-Saharan countries. All 18 staff are presently in post and functional.

b) Community-based Training

A total of seven groups of CHWs have been trained since project inception, and 33 in this last phase. They have all undergone the programme indicated in the course summary and have graduated as field operatives. A further group of 16 are presently attending classes and will complete their training within the coming two months.

Over this reporting/evaluation period 24 CBDs, and a further 43 TBAs have been trained, graduated and placed in position.

Both groups add significantly to community health personnel in operation. The consequences of their attachment is apparent in survey findings to be discussed in a subsequent section.

Meetings

Regular monthly meetings have been held with CHWs and TBAs to discuss progress, exchange experiences, and to examine the issues of working conditions and incentives. Meetings of the Project's Area Health Committees and the Joint Health Committee have been attended by project staff, who have reviewed recent activities and discussed steps undertaken in preparation for project "completion and transition".

At community level, regular meetings have been held with group leaders (market workers), slaughter house employees and teachers. The purpose of these meetings, undertaken primarily by CBHC and AIDS staff, has been to motivate community groups into greater involvement in peer counseling, and the organization of a school counseling programme.

Barazas (large community gatherings) have been organized by the project to educate residents. These are usually held monthly and primary themes for discussion are STDs/HIV/AIDS, water safety and sanitation. Attendance has averaged between 200-300 people. Also, as part of project activities, Folk Media Festivals are held every six months. They include puppetry, dancing, and plays, and have a usual attendance of approximately 1,000 persons. Most of these Festivals have STDs/HIV/AIDS awareness and prevention as their main themes.

Equipment and Materials

In this phase, equipment has been received from the FPPS programme, necessary to the establishment of a mini-operating theatre within the health centre complex. Program materials, in the form of pamphlets, posters, brochures and auxiliary medical supplies, have been received from the Ministry of Health, the AIDS Consortium, Innovative Communication Systems and from various private donors. A total of 2,800 items and 19,000 condoms have been distributed (12,000 condoms remain in stock).

The measurable outputs from the project, apart from standard health centre services rendered, emerge from the community based activities organized and implemented. These relate to counseling, home visits, health education sessions, referrals made and public health sanitary improvements effected. If, by way of example, we take only the three month period December 1995 to February 1996 (for which there is compiled data) we find the following activities to have been undertaken.

1)	<u>Home Visits</u>	
	Pregnant mothers visited and advised	56
	Post natal mothers visited and advised	43
	Malnourished children visited/mothers advised	11
	Children with diarrhoea visited and mothers advised	21
	Group health discussions held	52
2)	<u>Health Education</u>	
	Sessions held about Family Planning	66
	Sessions held on child care/breastfeeding	64
	Sessions held on immunization	54
	Sessions held on nutrition	66
3)	<u>TBA Activities</u>	
	Deliveries conducted	10
	Referrals made	6
4)	<u>Referrals to Health Units</u>	
	High risk pregnancies referred	8
	Cases of birth complications referred	21
	Clients referred for family planning	27
5)	<u>Sanitation Improvements</u>	
	Latrines constructed	24
	Dish racks constructed	20
	Maendeleo jikos installed	8
	Kitchen gardens established	41

The above outputs are indicative of the activities undertaken, but their quantity and range characterize the overall programme. This project has the capacity to lift volunteer activity rates in spite of minimal incentives to CHWs, a plus, which few other projects achieve.

Outputs and Objectives

This section seeks to examine project outputs against the specific indicators adopted by this project to evaluate the attainment of its child survival objectives. As will be noted, the findings are generally supportive of the notion that good progress has been made and sound incremental gains have been made in the attainment of objectives. (See data tables, Appendix A which summarize key indicators surveyed in 1989, 1991, 1994, to which we have added averages for 1996.)

Survey results demonstrate that:

- 1) survey demographics remain essentially similar. There is however a slight increase in both the age of mother interviewed and that of her index child.
- 2) nutritional indicators regarding the initiation and persistence of breastfeeding show reasonable gains. While the latter may be a function of more older children in the sample, the data suggest that the virtues of early and prolonged breastfeeding have been assimilated within this community, and that the coverage sought in these areas by the project have been attained.
- 3) in respect to the control of diarrhoeal and upper respiratory infections, a sound level of maintenance and some improvement in practices has been attained. ORT usage has increased significantly. It may be that this is a function not only of project education, but also of free provision of OR salts by MIHV. Whatever the situation, our view is that the outreach programme has had a contributory effect upon practice. We are of the opinion that the pneumonia findings are in fact in range - and that the slight decrease in medical referral may be a function of increased maternal confidence in home treatment.
- 4) immunization rates appear to be holding up well, and we interpret the 1996 findings to be an indication of maintenance at a consistently high level. There is nothing in the findings to suggest any decline in acceptance or coverage, despite the fact that in some urban areas of Nairobi immunization rates are known to be in decline, a reflection of overconfidence due to the decreasing incidence of epidemic outbreak. We sincerely doubt whether the present coverage rates can be exceeded and are of the view that an excellent level of provision has already been achieved and the objective attained.

- 5) the Maternal Health indicators mostly show positive findings, especially in respect to card possession and TT coverage rates. We are convinced from both health centre data and from observation, that health centre antenatal visits have increased, and that adoption of family planning methods is becoming more widespread within the Dagoretti community. We are similarly persuaded that much of this is due to the outreach programme and to CHW action on the first part, and CBD activities on the second part. The objectives set by the project in both respects are now within reach.
- 6) Environmental Health indicators are generally congruent with past surveys, and we construe the information gathered to mean that progress reported in the 1994 survey has been maintained. The average 80 percent level of attainment sought by the project for adequate access to safe health latrines and proper garbage disposal appears to have been achieved.

Taking all matters into consideration - and adopting a trend viewpoint for 1996 survey data - the evaluation team are satisfied. Firstly, this project remains on track (and is seriously addressing key indicators). Secondly, in what we construe to be key issues, the project has attained or is about to attain its major objectives - minor deficiencies apart. Thirdly, that considering other comparative Nairobi City data, this project has achieved well beyond expectation.

Relevance to Development

Dagoretti community is located on the outskirts of Nairobi. Its population is keeping pace with the rapidly increasing population of Nairobi city. Many of the inhabitants are newcomers with little access to land and wages. The community lies within the purview of the Nairobi City Council (NCC) which lacks the financial resources to either maintain or extend community infrastructure. NCC has health centres within the urban heart of Nairobi, and also a health centre within Dagoretti (Waithaka) which is frequently understaffed, short of essential drug supplies and other equipment. The nearest hospital to the Dagoretti community is operated by the Presbyterian Church and possesses no programme of outreach which touches this community. There are, however, within its confines, a number of private medical practitioners who offer curative services but mostly to a minority middle-class who can afford the fees. Other NGO supported health services are notable by their absence.

MIHV, working initially on a community basis within Dagoretti, managed to gain the support of

the Chandaria Foundation, a private, Kenya based charity. With the assistance of community leaders, MIHV persuaded the Foundation to fund construction of the Chandaria-MIHV Health Centre on land leased from the Nairobi City Council. Construction of the unit was begun in 1990 and completed in 1991. More recently the Chandaria Foundation has undertaken to add 6 more rooms to the Health Centre to expand both quantity and quality of health service. Building is expected to commence within 1996.

Prior to the acquisition of the Chandaria-MIHV Health Centre, MIHV obtained agreement from the Ministry of Health to staff this facility. This is a unique arrangement for Kenya, for it represents one of the first effective cooperative efforts between private and public health sectors. The staffing provided by MOH via a secondment system consists of:

- nine nurses (KRN and KCHN),
- two nutritionists,
- one clinical officer,
- three laboratory technicians, and
- one registration clerk.

This staff of 16 is employed by the Ministry and is self supervised and monitored by agreement with the Kenya Provincial Medical Officer (PMO). Medical, administrative, and technical assistance is supplied by MIHV.

While the Chandaria Foundation does not presently support the Health Centre financially, it is represented on the Board of Management (BOM) and does engage in community activities. The Foundation has reconfirmed its commitment to operate the Health Centre after August 1997, to the year 2000 by covering any short-fall in basic cost of operation. This is three years beyond the prospective termination of Phase III support by USAID. MIHV and Chandaria Foundation are now in the process of identifying possible partners for the future after the end of funding in August 1997.

Community leaders and groups have played a significant role in supporting the Health Centre and in initiating, undertaking and contributing to its community outreach activities. Village health committees in the 3 project locations formed an association termed "Dagoretti Community Health Services". This body has taken a keen interest in community health and is both represented on the project's BOM and active in recruiting volunteers for the outreach community health worker (CHW) and traditional birth attendant (TBA) programmes, organized by the MIHV's community-based Child Survival Project.

In its development, the project has received valued assistance from other organizations and, in particular, other Non-Governmental Organizations (NGOs). For example,

- * The University of Nairobi, through its Community Health Department, has conducted research surveys in the project area.
- * The African Medical Research Foundation (AMREF) has provided training for health centre-attached laboratory technicians.
- * The Family Planning Private Sector programme (FPPS), operated by John Snow International (JSI), has donated health centre equipment (most recently for a mini-operating theatre) and family planning products and educational materials for health centre and outreach use, as well as contributing to the training programme for community-based operatives.

While there are many other relationship examples which have contributed to the development of this project and the broader community, three issues are clear. MIHV's Child Survival project has played a key role in the development of health centre and community-based health interventions within the Dagoretti area. In so doing, the project has managed to negotiate sound developmental partnerships with organizations and institutions including the Chandaria Foundation, the Government of Kenya (MOH), community groups and other support organizations. Such partnerships are fundamental to project development and transition to sustainability. It is already apparent that health centre services have continuity beyond the present proposed term of the project and that ongoing interaction with community groups and other organizations (not excluding the community health department of the University of Nairobi), may offer pathways to ongoing assistance for community-based health care operations.

Design and Implementation

Management and Use of Data

The quantitative and qualitative data which is collected by the project falls into two categories: that collected from the Health Centre and that obtained through the CBHC.

For the Health Centre

- Curative-based outpatient department clinical diagnostics

- Laboratory-based diagnostics

The curative outpatient data formats, completed on a daily basis, do not presently contain information on age, sex and client location. This deficiency creates difficulties in patient follow-up and data analysis by gender and location. The laboratory-based diagnostics possess identical deficiencies and also do not include a medical history.

The health centre also furnishes information from its Child Welfare Clinic (child survival programme) about preventive and promotive health activities. Data relating to child immunization, growth monitoring and maternal welfare (particularly family planning), is routinely collected via the supply of maternal and child health cards to mothers. The health centre maintains records of all curative patients seen along with diagnosis. These are tabulated each month and compiled with the MOH records. Records are also available for use in health centre-based disease surveillance in the project area.

For the Community

- Non-project-based information
- Project-based information

The non-project-based data collected by civil authorities relates to births, deaths and, infrequently, the incidence of infectious disease and is supplied to the Ministry of Health through the PMO. This data is available to the project on request.

Project-based information is collected from a series of formats completed by community health volunteers. For example,

- * Community Health Worker reports. This form consists of a record of visits undertaken and referrals made on the health status of families within the community. Such reports also contain information about health status such as incidence of diarrhoea, measles and ARI among children.
- * Community Health Worker referral slips. These slips record referrals made to the health centre for specific treatment or counselling beyond the level of competency of the CHW.
- * Community Health Worker supervisors report. This form records the observation of supervisors in respect to the performance of the community health workers, particularly in

very infrequently are the results of information collected shared with data collectors, project staff, counterparts and community members. An exception to this is the Provincial Medical Officer who receives copies of the epidemiological data. Additionally, the project uses information on the activity levels of Community-Based Health Workers, as a tracking device for the additional training of Community Health Workers.

Given this context, it is of note that the project has undertaken on several occasions (1991, 1994 and more recently 1996) a community-based survey to assess and evaluate project impact upon a number of clearly defined indicators of attainment and impact. It is clear that a more effective and efficient health management information system may have provided interim formative evaluations that would have allowed the project to better assess ongoing performance.

Human Resources for Child Survival

As of 1st September 1996, the following project personnel were attached to this project:

Project Staff CBHC

Project Director
Deputy Director (Programmes)
Assistant Project Officer (Training)
Assistant Project Officer (PHT)
AIDS Programme Assistant
Health Centre Manager
Administrative Assistant
Accountant
Administrator/Personnel Officer

Health Centre Staff

Medical Director
Medical Coordinator
Cashier
Guards (4)
Cleaners (2)
Driver (1)

MOH Staff

Clinical Officer
Nurses (9)
Nutritionists (2)
Laboratory Technicians (3)
Registration Clerk

Community Volunteers

Community Health Workers (294)
Traditional Birth Attendants (43)
Community-Based Distributors (28)
Training Facilitators (8)
HIV/AIDS Counsellors (9)
Community Leaders on BOM (3)

See Transition Plan in Sustainability section for anticipated project staffing after August, 1997.

Project staff are funded from USAID grant money, while the health centre pays salaries of its

family counselling health activities.

- * TBA monthly report form. This form records births and delivery details by age and parity of mother.
- * CBD monthly monitoring form. This form devised by the Family Planning Private Sector programme seeks primary data on adoption of family planning and methods used.
- * Well inspection report. The project's community health-based team regularly inspects wells and bores throughout the community in order to ensure water quality.

There are a number of other examples but these are sufficient to give an indication of the type of information collected at community level. However, most of these forms are seldom compiled on a monthly or annual basis and subjected to analysis and feedback to the community.

From a human resources view point, there is the same division of data collection - that obtained from health centre and community. At a clinical level, medical practitioners and clinical officers make diagnoses and tally epidemiological information. This is done in a purely statistical way and generates neither analysis nor follow-up. A similar situation prevails with testing procedures undertaken by the laboratory. Procedures are categorized and tallied and filed for subsequent reference. The consequence is that health centre and laboratory staff, while they may discuss overall patterns, are neither cognizant of the need to feed back such information into the project, nor are they aware of the assets of computerization to facilitate this process.

There are also preventive and promotive activities carried out by nursing staff attached to the health centre. This information typically relates to child vaccinations, adoption of family planning, health education counselling, STDs, and the nutritional status of mothers and babies. Data is collected in a tally format and is seldom subject to analysis which might better inform health centre staff about ways of improving service provision.

In a community context a special survey is undertaken among CHWs in order to assess their level of activity and their frequency of reporting.

The data collected appears to have little impact upon decision making. For this to happen, prior analysis and interpretation are basic to this process. Presently there is no designated officer on project staff who carries responsibility for the management and maintenance of the HIS. Only

own staff from the fees that it levies. The salaries and other remunerations of the MOH attached staff are supplied by the Ministry of Health.

In the view of the evaluation team, project administration staff are under considerable pressure. The project has recently lost 3 officers who have not been replaced and the burden of their work has inevitably fallen upon those remaining. Health centre staff numbers are generally adequate (within the limits of public service - MOH - requirements) to meet present patient loadings. Nursing staff, however, are not uniformly experienced in patient counselling techniques and quality tends to vary by personality rather than by training (see recommendations). The mid-term evaluation team have discussed the above staffing issues with administrative personnel and are of the following opinion: that the short time span between the present and prospective transition date of the project (August 1997) tends to diminish the possibility for obtaining replacement professional staff. In the view of the evaluation team, the best prospects for fulfilling the obligations of the present DIP in the immediate term lie in the appointment and attachment of local (Kenyan) short-term advisers on a part-time or ad hoc basis.

In regard to community volunteers the project has made sound progress towards the targets proposed in the current DIP as indicated in the table below.

Volunteer Category	In Training	Trained/ in Place	DIP Target
Community Health Workers	71	294	411
Training Facilitators	15	8	60
HIV/AIDS Counsellors	0	9	30
Traditional Birth Attendants	9	43	45
Community-Based Distributors	0	28	40

With approximately a year to go, the above table suggests that in most instances volunteer training is on track and that DIP targets will be within reasonable reach of attainment.

In respect to volunteer activity by intervention, the table titles largely describe the situation, with two exceptions.

1. Some 20 CHWs have been trained by Population Services International (PSI) as Trust condom distributors - as part of an income generating activity - and, accordingly, might be

better included under the volunteer community-based distributors (family planning).

2. 47 CHWs involved in rotational refresher training have completed and 13 are currently in process of training (to attain a DIP target of 60). These CHWs also receive exposure to courses in STDs/HIV/AIDS. The 47 trained thus operate also in the AIDS programme, both in raising community awareness and, less frequently, in primary counselling for referral.

All community-based volunteers are intended to have a role in community maternal health and child survival information, education, and communication (IEC) activities, while TBAs and CBDs provide direct service: TBAs in the area of obstetrics and CHWs in the area of family planning.

The workload of community volunteers varies by functional category and the evaluation team are of the impression that the volunteer training facilitators are probably under the heaviest load. While CHWs and CBDs can tailor-make their working day, TBAs do not have this luxury. In theory, volunteer workload is based on a ratio of volunteers to households (for example, one TBA to every 90/100 households, one CHW for every 30/40 households and so on). In effect, theory does not appear to work out quite so neatly in practice. (CHWs are not so evenly distributed).

Compensation or incentives for volunteer health workers is an issue which is consistently debated and for which no easy resolution has been found. For some community health workers, volunteerism is a strong motivating factor for their work in outreach into the community. For other individuals, the costs of volunteerism in the form of time, effort and, on occasion, money, outweigh the motivation of contributing to the community. In this case, the non-availability of a monetary incentive/reward in a cash poor society tends to generate inactivity or what is often referred to as "turnover" and "drop out". The project operates on a notional "drop out" rate of 20 percent and compensates for drop out by recruiting and training additional CHWs.

In all, 26 courses are provided by the project for volunteers by way of orientation training. These are itemized in the table below by course type (topics), duration and methodology. Additionally:

- a) the majority of training interventions are of short duration (average three hours) but are developed in cumulative fashion so that all CHWs are exposed to a course series which includes topics clustered in the following categories: Maternal and Child Health (FP and AIDS), Childhood Disease, and Nutrition. In all, CHWs, TBAs and CBDs receive a total of

more than 40 hours of orientation¹,

- b) multiple course interventions, spread over time, have the asset of retaining participant interest and increasing incremental involvement in the project,
- c) the training methodologies adopted, while presentation focussed (didactic), do provide opportunity for interactive learning, particularly through case study presentations, simulation gaming, group discussions and debates,
- d) the tabled data above on methodologies tends to understate practicums (home visits) undertaken in the field, which enliven the training programme. This on-the-job component (observed by the evaluation team) is a highly valuable and relevant aspect of training provided, and as will be noted, is a device used in fellow monitoring and supervision.

In assessing the pre- and post-formative evaluations, the evaluation team has been impressed with the knowledge gains reported, and by the facilitator process of evaluating results in order to inform and change course content and methodology, and enhance training effectiveness and efficiency.

The evaluation team is persuaded that the project has obtained a body of volunteer community workers who, whatever their level of activity, are a significant residual resource with capacity and ability to inform, educate, motivate and mobilize the community in support of maternal and child survival activities.

An improved strategy needs to be devised to retain this cadre of volunteers and to increase their level of activity in order to ensure ongoing community involvement, increased rates of health centre referral, and improved prospects for continuity and self-sustainability.

¹ It is a notable feature of MIHV outreach training, that participants are invited to attend as many courses as they feel appropriate. The vast majority opt for all!

Child Survival Training Programme Summary

Type of Training	Topic Areas	Topic Hours	Training Methods
Block 1: 3 weeks	<ul style="list-style-type: none"> - Introduction - Concept of Primary Health Care (PHC) - Personal Hygiene - Cleanliness of the Environment - Latrines - Diarrhoea, Worms, Vomiting & ORS 	Each Topic Takes 3 Hours	<ul style="list-style-type: none"> - Question & Answer - Group Discussions - Role Plays - Demonstrations & Plan of Action - Home Visits
Block 2: 3 weeks	<ul style="list-style-type: none"> - Food & Nutrition - Budget - Breastfeeding and Weaning Food - Anaemia and Malnutrition - Growth & Development - Road to Health 	Each Topic Takes 3 Hours	<ul style="list-style-type: none"> - Question & Answer - Group Discussions - Role Plays - Demonstrations & Plan of Action - Home Visits
Block 3: 3 weeks	<ul style="list-style-type: none"> - Mother/Child Health & Family Planning - Ante-natal Care and Childbirth - Vaccinations - Venereal Disease, HIV/AIDS - Mental Health - Pneumonia - Alcoholism / Drug Abuse - Home Accidents 	Each Topic Takes 3 Hours	<ul style="list-style-type: none"> - Question & Answer - Group Discussions - Role Plays - Demonstrations & Plan of Action - Home Visits
Further Discussions	<ul style="list-style-type: none"> Role of a CHW - CHW activities - Group Teaching / Home Visits - Development of Good Codes - Stories of Good Code / Lesson Starters 		<ul style="list-style-type: none"> - Question & Answer - Group Discussions and Role Plays - Demonstrations & Plan of Action - Home Visits
Final (verbal) test 1 week (2 half days per week in the village)			<ul style="list-style-type: none"> Home Visits - (Approach and Advice)

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Supervision and Monitoring

The monitoring of health centre MOH staff is organized on an internal basis. The Medical Coordinator interfaces daily with all health centre staff, making the ratio of supervision within the health centre 1:10. Additionally, the nurses in charge regularly monitor and supervise the nursing staff, while the laboratory in charge supervises the laboratory technicians. The nutritionists are internally monitored by the MOH Clinical Officer. In all cases where there are difficulties or problems the assistance of the Medical Coordinator-in-charge is enlisted.

The Provincial Medical Officer (PMO), who is extremely supportive of the programme and continues to supply whatever technical assistance is requested, is content with the present internal monitoring and supervision procedures.

On the CBHC side, the facilitators play a key role in the monitoring and supervision of CHWs, CBDs and TBAs. During training, volunteers undertake scheduled home visits accompanied by a facilitator who thus monitors their progress. Following training, volunteer staff are also scheduled for weekly home visits which are supervised in several ways: by the facilitator and by what is termed a community-based CHW representative. Some 50 such representatives exist and operate upon the ratio of approximately one representative to five CHWs.

Once a month these representatives meet to discuss the quality of CHW activities and the performance of individual volunteers. In terms of the distribution of time given to various supervision and monitoring activities, the evaluation team assess that counseling and support occupy about 50 percent of supervisory time, performance evaluation 10 percent, and on-the-job education 15 percent, leaving five percent of time allocated to housekeeping matters.

The basic methodology utilized in supervision is the observed home visit and subsequent discussion between the monitor and the health worker about problems relating to quality of health care. In the view of the evaluation team, the supervision at each level of health worker activity has been more than adequate. While set formats or tools do not reflect the project's informal type of approach, it needs to be strongly stressed that the informality achieved by the

project and the strong cooperative interaction between staff as equals, in our view, reconfirms the positive nature of supervisory interaction. It is the opinion of the evaluation team that the monitoring and supervision procedures presently in place will adequately sustain this project through to its conclusion and through transfer to sustainability.

Regional and Headquarters Support

Administrative monitoring and technical support is provided through the MIHV home office. Currently, there are two technical staff in the home office: the Director of Programs and a Program Officer. Support provided through the home office has included assistance in meeting reporting requirements, recruitment of volunteers, procurement of supplies and computer equipment, consultation in technical areas of child survival and sustainability, periodic site visits, and fundraising for the PVO matching requirement. The relationship between home office and field personnel is one of partnership. Some of the questions which the project has had to wrestle with have had no easy answers, e.g., how to sustain a program, what benefits need to be sustained and which let go, how to deal with issues of sustainability amidst the overwhelming needs of an impoverished community/country, and how to maintain the interest and involvement of volunteers. These are the types of issues with which the partnership of expertise and experience between home office and field staff are best applied.

Constraints faced by the project in receiving adequate monitoring and support come mainly from logistics such as challenges with communication and related constraints in ability to react/respond quickly to needs.

MIHV currently has three Child Survival projects, one each in Kenya, Uganda, and Nicaragua (mission funded). These projects are backstopped by the Director of Programs and the Program Officer.

PVO's Use of Technical Support

The Child Survival Project at Dagoretti requires ongoing technical assistance in four areas in

order to complete its commitment to the current DIP.

1. Technical support from the short-term attachments of local advisors with competencies in organization and management, particularly in outreach activities, information dissemination and office administration.
2. Short-term technical assistance of a programmer who can assist in assessing the range and type of health related data which most requires computer input and retrieval.
3. Assistance of an HIS consultant to complete the development of an effective and efficient health information system.
4. Recruitment of a short-term consultant experienced in the provision of incentives for volunteer workers (and in the ongoing income generating activities now underway) who might advise upon alternative and practical ways of supporting the community-based health programmes.

The types and sources of external assistance received by the project to date cover a broad range of activity. In this most recent cycle of implementation, the following technical assistance has been provided:

- * an accountant firm (Deloitte and Touche) has performed an assessment of project accounting practices and methods,
- * Family Planning Private Sector personnel assisted in the training of community health workers in the operation of campaign barazas to stimulate community understanding of the local AIDS situation,
- * Innovative Communication Systems and Population Communication Africa have provided both assessment and advice on the development of the AIDS component of the community-based health programme,

- * Dr. Rae, a consultant, reported extensively on ways to improve the existing health information system.

External assistance as already indicated has been provided:

- a) as part of partnership and referral relationships
- b) as part of donor assistance (either in the form of direct funding grants or in the provision of equipment),
- c) as part of ongoing management such as the technical advice and assistance provided by volunteer community leadership to the health centre board of management.

The technical support needs of the future are unlikely to be of similar kind to those discussed above. It is clear that organizational and managerial assistance in particular will be required to administer the community health programme. The shape and type of such assistance will be largely dependent upon the ways in which this component is transferred to other ownership and the capacity of that ownership to administer and organize.

Assessment of Counterpart Relationship

In the view of the mid-term evaluation team, the variety and strength of counterpart relationships are a significant asset of the Dagoretti Child Survival Project. Relationships between MIHV, the Chandaria Foundation, Ministry of Health, the University of Nairobi and other NGOs have already been discussed. However, to further indicate the range of collaborative activities, it is necessary to begin at an international level and end within the local community.

The Chandaria Foundation will be constructing 6 additional rooms for the Health Center to provide more space for health centre services. The Foundation will also support the Health Center after August 1997 until the year 2000.

The United Nations Children Fund (UNICEF), recognizing the contribution both the health

centre and the community-based health programme make to child welfare in the Dagoretti community, has donated kits for Traditional Birth Attendants and a one time supply of essential drugs. Most recently, the Dagoretti-based project was involved as a partner to UNICEF and the Ministry of Health in a polio vaccination campaign with quite outstanding results: over a one week period 1,000 children were vaccinated by Chandaria-MIHV Health Center staff.

The Overseas AID Divisions of the Royal Netherlands Government (DGIS) and Government of Japan have been instrumental in the provision of equipment and supplies - Japan in the form of funding of the AIDS component in the community-based programme and the Netherlands in the provision of a health centre-based ambulance.

Marie Stopes International (MSI) and CARE International, each world-wide welfare agencies, have materially assisted the Child Survival Project. MSI provides a monthly surgical contraception service, supplied at no cost through the project; while CARE has offered the project two free training places in AIDS seminars designed to educate community workers in the use of drama and theatre to motivate and mobilize Kenyan communities.

Other local NGOs, such as Innovative Communication Systems and the Christian Health Association of Kenya (CHAK), have provided educational materials for distribution among community youth and for use in training. CHAK has also supplied training places for two community-based staff in AIDS counseling, as has the Kenyan AIDS Consortium NGO.

Nairobi Round Table Dental Services has provided visiting dental staff to treat children under age 17 within the project area.

Reciprocity in counterpart relationships also exists: both AMREF and the University of Nairobi's community health programme have utilized project facilities as a research and demonstration base for both professional staff and students.

All of the counterparts described above possess strong and viable relationships with the communities they serve, and communication between these organizations and MIHV is friendly

and supportive. This partnership network provides a variety of entry points into organizations which have their own donor linkages. For example, most of the above counterparts have:

- * resources and experience in the operation of community-based health programmes (particularly the University of Nairobi's department of community health),
- * a capacity building interest in child survival activities (especially UNICEF),
- * a specific donor function and hence the ability to find funding for at least components of a community-based health project (particularly in the case of Rotary).

In short, it is the opinion of the mid-term evaluation team that strong counterpart relationships are initial building blocks in the process of functional transfer and, ultimately, self-sustainability.

Referral Relationships

A complex of relational networks has been established by the MIHV Dagoretti Child Survival Project to ensure that a complete range of quality health services can be provided to health centre clientele and that community-based programming is supported.

The following referral network is in place for the Chandaria-MIHV Health Centre clientele:

- * Patients requiring minor surgery or emergency hospitalization are referred to the Kikuyu Hospital which lies four kilometers from Dagoretti. (A health centre ambulance is available for such transfers).
- * For female patients requiring cervical pap smears, an agreement exists between the Health Centre and Dr. Taylor (a local medical practitioner/pathologist) to process slides and return reports. The turn-around time is minimal and this service appears to function effectively.
- * For cases requiring advanced blood pathology (for resistant strains of STDs and for HIV

testing), blood samples are taken and sent to the University of Nairobi. Turn-around time is typically less than 5 days.

- * As indicated, a special referral type of relationship exists between MSI and the Health Centre in the provision of surgical contraception. Although less formalized, the community-based programme has on occasion referred PWAs who lack financial support to PWAK (People with AIDS Kenya) or, in the case of orphaned children, has facilitated placement with relatives or institutional care through the Don Bosco "Children with AIDS project" sponsored by the local Catholic Diocese and supported financially by CARITAS. People living in abject poverty who are in need of medical care are often treated free of charge by the Health Centre but for ongoing financial assistance, are referred to either the Church of the Province of Kenya or the local branch of the Kenya Red Cross Association.

The mid-term evaluation team, in discussing referral relationships with both project staff and selected referral partners, has been impressed with the quality of interaction. The readiness to accept referrals from the Chandaria-MIHV Health Centre appears to be very much related to its perceived status and standing not only within the Dagoretti community but throughout Kenya. As the DIP notes and the evaluation team confirm "the project has gained recognition from the MOH as being a model for community health centres and its user-fee system is a model for replication for other MOH health centres".

Our assessment of relationship quality strongly suggests a willingness to continue and strengthen present arrangements, which we construe as a sound indicator of continued viability. Presently the project is attempting to strengthen community-based referrals in the AIDS field with support organizations, particularly in the case of AIDS orphans.

The key question relates to the maintenance of this referral system as the project goes through transition. The evaluation team see no reason why the present referral system should change in any major way, given the now guaranteed continuity of the health centre by the Chandaria Foundation and the assurance of ongoing staffing from the Ministry of Health. Moreover, as we

perceive transition and sustainability issues relating to the community-based component of the project, we are of the view that the referral systems established by this programme will continue into the future.

Budget Management

Current rate of expenditures compare favorable with the project budget. Expenditures in most areas of the budget are in line with budget guidelines. One shift which should be noted is in the area of procurement, specifically supplies/equipment. As is evidenced in the attached pipeline, the USAID portion of this budget remains largely unspent, while the PVO side is well over budget. This is due to the one-time receipt of matching funds for the purchase of specific items from in-country funders. Over the remainder of the grant, we anticipate spending down the remainder of the funds allotted to procurement. The project will meet its objectives with the remaining funding. At this time, it is unlikely that the budget will be underspent at the conclusion of the project.

Sustainability and Transition

In the view of the evaluation team, child survival activities in Dagoretti will continue to be implemented both in the short-term and into the future.

There is a written agreement between MIHV and the Chandaria Foundation that Health Centre will be financially supported by the Foundation into the next century (see Appendix B). There is a reasonable likelihood that the Foundation will provide administrative resources for oversight of the community-based health care programme.

There is a clear understanding that the Ministry of Health will continue to provide ongoing staffing, supplies and equipment as available.

In planning for the sustainability and transition of the project in August of 1997. Several

measures are being undertaken or explored.

1. The initiation by present project administration of an incentive programme which will hold community-based health workers in place and increase activity rates. Activities include:
 - a) A plan where health centre care is provided at subsidized cost or, at no cost, dependent upon the level of activity attained by the Community Health Worker. Such a scheme of rewards has already been proposed for this project and is under consideration by the board of management.
 - b) A plan for Community Health Workers to become health product distributors and generate personal income (sufficient to defray expenses) via the sale and profit made on items such as contraceptive products (condoms), toiletries, and non-prescription pharmaceuticals. Pioneered by FPPS (and highly successful in Tanzania), this is in process of adoption with selected active project CHWs.
 - c) An additional possibility is a plan for TBAs and CBDs to collect a modest fee for services rendered in order to cover expenses. This may be difficult to institute but a beginning may be made by a request for a "programme donation" (5 to 10 KSh.)
2. Transition to community management of the outreach CBHC programme. These are transitional steps intended to increase opportunities for community management and eventual ownership of the outreach programme.
 - a) Seek within the community retired personnel with a background in public or private enterprise management, who may in return for a modest salary be prepared to undertake some of the tasks involved in outreach management. It should be possible to find from a minor donor seed money (1,000-2,000 USD) which would maintain two such personnel in place.
 - b) Reconvene the leadership of village health committees and other leaders within

the community to discuss the possibility of creating a committee which would oversee the creation of mini harambees to raise funds via a daily rental of market space or via a charge on attendance for festival events. Such levies might contribute to a revolving fund that would subsidize the CHW vendor scheme.

- c) Have the Deputy Director devote a minimum 20 percent of her time to the supervision of community-based leadership cadres. The purpose of this is to enhance and support the management of the different programme components (AIDS education, CHW and TBA management and, the activities in environmental health) with a view to better coordination.
3. Search for donor assistance. Ongoing activity of project senior staff. There are several groupings of prospective supporters. The objective is to seek longer term (3-5 year) commitment from multiple donors.

Present Partners

Further discussions should be undertaken with present partners who have an interest and investment in utilizing a community-based programme and health centre for research or training purposes. These include the University of Nairobi (Schools of Community Health, Nursing, and Public Health), AMREF, and the Nairobi Hospital.

The John Snow International Family Planning Private Sector Programme should also be approached in terms of support for ongoing CBD/CHW/TBA training, as should UNICEF in terms of a small annual grant in aid. The local Chapter of Rotary International which was instrumental in initial assistance to the Chandaria-MIHV Health Centre warrants additional follow-up.

Donors

There are a series of donor organizations with an interest or mandate in the field of

community health and development. Principal among these are CARE International, World Vision and Concern (UK and Ireland). In this cluster also are a wide range of bilateral agencies, mostly Northern European, who have previously shown interest in local health care issues. The Governments of Sweden, Norway, Denmark, Finland, the Netherlands, and Belgium in particular, have overseas aid divisions which are interested in health and development. These embassies will also provide information regarding national private sector donors, and occasionally religious bodies, which will also support specific community-based interventions, for example in the fields of AIDS control or in support of environmental health matters. There is considerable value in initiating discussions with GTZ (Germany) and their Family Health Division in Nairobi which operate a significant number of community-based health projects within Kenya.

In this cluster also are a number of organizations, most notably the Ford Foundation and Rockefeller Foundation, which have a health or community development mandate and are also worth approaching.

There are a number of multi-national companies which act as occasional benefactors to community development activities (3M, ESSO, CBA) and others who are involved in the production of pharmaceuticals (such as Johnson and Johnson, Glaxo-Wellcome and Ely) who are recognized supporters of health programming.

4. Equip present staff with a wider range of marketable skills. This is already being implemented by the project administration.

Staff facing prospective reengineering have been provided with opportunities to undertake computer classes and courses in areas such as project management and community health management. Two senior staff have undergone British Council organized courses in communication and report writing. It is the intention of project management to also offer an in-house workshop seminar on CV preparation and personal presentation skills.

The evaluation team are persuaded that the first clear steps in achieving project sustainability have been taken. The ongoing continuity of the Chandaria-MIHV Health Centre has been assured in the intermediate term. The community-based health care programme continues to make steady progress. Actions on the part of present administration offer opportunities for both continuity and transferability prior to the proposed conclusion of this project in August 1997. Ultimate sustainability of this component lies in the hands of the community and steps need to be taken to steadily increase the involvement of community leadership and village health committees in the process of management leading to final ownership.

Transition Plan

The following is the MIHV Transition Plan for the Chandaria-MIHV Health Centre and CBHC project which details the sequence of events in the coming months and hopefully provides a smooth transition for the project and allows for its continuation into the next century.

The long-term goal of this USAID funded MIHV-Kenya Child Survival Project is to create a health centre and community based health care (CBHC) project that will continue after the conclusion of the current cooperative agreement with USAID in August, 1997. MIHV operates the Chandaria-MIHV Health Centre and a Child Survival project in 3 locations in Dagoretti Division in Nairobi Province. The Chandaria Foundation is committed to serve the poorer communities in Kenya. The Chandaria Foundation has served the Dagoretti community through the construction of the Chandaria-MIHV Health Centre.

MIHV has implemented systems and identified resources which have enabled the Chandaria-MIHV Health Centre to attain some level of sustainability. This has included local and international, private and public donors, Health Centre user fees, seconded staff, in-kind donations, and other sources of support.

Mechanisms for sustaining CBHC programs are under continuous exploration. Incentives have been developed to sustain volunteers on an on-going basis. These include income generating activities, non monetary rewards, training, credentialing/ certification, and other incentives.

These and other types of incentives have been tried but due to the economic reality of the community these may not be able to sustain CBHC activity after the end of funding in August 1997.

More detailed phase-over plans are still in the process of discussion with project staff, MIHV-USA headquarters, Chandaria Foundation, MOH, and key partners in the local management of the Health Centre. Therefore, the outline below is tentative and still evolving.

Transition Timeline

Year	Phaseover event
1995	
*	New Kenyan accountant hired and trained
*	New Kenyan health centre manager hired and trained
*	Recruitment of Kenyan Medical Coordinator
*	Identify and create a relationship with potential donors/partners
1996	
	January
*	Project Director, Medical Director, Deputy Director identify new areas for future projects in Kenya and potential donors
*	Continued training of project and health centre staff in anticipation of transition
	February
*	Visiting new MIHV-USA Executive Director meets with potential donors/partners
*	Hire National medical coordinator
*	HIS Consultant hired
	April
*	Meeting with PS of Health, obtained letters of introduction for site visit to western Kenya
	May
*	Site visit to Kakamega, Busia, Bungoma (western Kenya) by MIHV team
*	Meeting with World Vision and Aga Khan Health Foundation
*	Project Director establishes cooperative discussions with local agencies regarding health centre program integration with agency programs
	July
*	Draft Transition Plan developed for phaseover
*	Meeting with USAID-Kenya to discuss HIS consultancy
	September
*	Initiate mid-term evaluation/transition report
*	Meeting with Nairobi Hospital Administrator
*	Meeting with Chandaria Foundation re: support for HC until year 2000 and administrative support
	October
*	Draft mid-term report to MIHV-USA for review
*	Meeting with DMS: agreed to write letter of support for Busia/ Bungoma proposal
*	Busia/Bungoma concept proposal to USAID-Kenya
*	Meeting with Aga Khan Health Services
*	MIHV-Kenya Deputy Director attends USAID meeting in Bungoma
*	Midterm/transition report due to USAID-US

- * MIHV-Kenya staff meeting to finalize transition plan
- * Draft MIHV-Kenya CBHC report due
- November**
- * Meeting with World Vision Director
- * Transition proposal to Chandaria for review and discussion. Written response to MIHV by Nov 30
- * Travel to Busia/ Bungoma
- * Hire local development consultant/ continue to explore local funding options
- * Identify funding guidelines and timeframe for proposals for identified organizations (ongoing)
- * Prepare timeline for proposals due/deadlines for funding options for CBHC
- December**
- * Child Survival proposal due to USAID (U.S. and Kenya)
- * Contacts made with FINNIDA, CIDA, DANIDA, Japanese Emb: Project Director
- * Contacts made with AMREF, University of Nairobi, UNICEF, Glaxo, J&J, other: Medical Director

1997

January

- * Continued tracking of proposals/submission deadlines for identified organizations
- * Health Center transition document: Medical Director

February

- * Departure of expatriate Medical Director
- * Continued tracking of proposals/submission deadlines for identified organizations

March

- * Continued discussions with Chandaria Foundation and preparation for transition of Health Centre
- * Continued tracking of proposals/submission deadlines for identified organizations

May

- * Finalize details for phaseover of Health Centre to Chandaria Foundation/NGO
- * Finalize detailed transition plans for CBHC project
- * Continued tracking of proposals/submission deadlines for identified organizations

June

- * Continued tracking of proposals/submission for identified organizations

July

- * Continued tracking of proposals/submission for identified organizations
- * Final Audit

August

- * Final transition of Health Centre to Chandaria or other NGO
- * Transition of CBHC activities
- * Transfer business accounts
- * Final KPC survey
- * Final Evaluation report

The plan being pursued for the continuation of the Chandaria-MIHV Health Centre and Community Based Health Care project is as follows:

I. CHANDARIA-MIHV HEALTH CENTRE

The following has been discussed with the Chandaria Foundation and key partners:

1. The Chandaria Foundation (CF) has agreed to fund the Chandaria-MIHV Health Centre after MIHV withdraws for an additional period up to December 31, 1999.
2. If CF is not able to find funding or another partner then they will hand over the health centre to Nairobi City Council on January 1, 2000.
3. Chandaria Foundation will provide administrative and financial support to the health centre. The Foundation has also encouraged MIHV to identify and establish a relationship with an interested NGO who may take over from MIHV after August 1997. Several possible donors/partners (Aga Khan Health Services, World Vision, Nairobi Hospital) have already been contacted who may be interested in assisting with administration at the Health Centre.
4. The Chandaria Foundation has stated that if MIHV is not able to find another NGO to take over the project by March 30, 1997, then MIHV needs to advise CF of this and CF will start the search for another NGO by networking with its contacts and advertizing in local news publications.
5. CF has agreed to the continued use of the upstairs portion of the facility for community based health care activities, at no cost to the community project. They are willing to consider contributing a portion of the personnel costs to one or two staff persons who would have a double function in working for the health centre and the project, for example, an accountant. They have requested a specific proposal for review by November 30, 1996. Any funds generated for continuation of CBHC activities after August 1997 will be administered through CF.

6. MOH has confirmed that they will continue the secondment of staff and provision of drugs and medical supplies at current levels. CF plans to continue this relationship. Currently, administrative and management duties for the health centre are shared among several people. There is considerable overlap with the project, making it hard to assess the level of support needed for the health centre as a stand alone operation.
7. The Medical Director has been working to build the capacity of the MOH and Kenyan staff so that it operates successfully apart from the NGO project. The amount of administrative support required depends upon the level of efficiency expected from the health centre in the areas of cost recovery, administrative controls, quality of care, and capacity building via relationships with outside institutions. It is anticipated that a health centre administrator will be hired, in addition to the accountant, to provide the necessary level of support. This person will be selected in conjunction with the Chandaria Foundation, does not require a lot of medical background, and, according to CF, cannot be a national.

The health centre currently has an expatriate Medical Director and Kenyan Medical Coordinator who are sharing duties in anticipation of the departure of the Medical Director in February 1997. The Medical Coordinator is being trained to take over administrative, supervisory and other duties currently performed by the expatriate Medical Director. However, as indicated above, it is unlikely CF will continue with this, unless someone was identified who could provide the necessary oversight to assure compliance with financial controls. The Kenyan Medical Coordinator is a trained Clinical Officer with six years in the medical field.

8. The existing Board of Management (BOM) consisting of partner and community representatives will continue to direct the operation of the Health Centre.

II. COMMUNITY BASED HEALTH CARE PROJECT

- A. The Project Director and Medical Director have contacted other Kenyan NGOs in the health field and potential donors and partners to brief them on the possibility of funding and/or creating

a partnership with MIHV to continue operating the CBHC project. We anticipate that a donor/partner for the takeover of the CBHC project will be finalized by July 1997.

The Chandaria Foundation is not interested in funding the community based health care (CBHC) program after the end of the USAID project.

Given current international economic conditions, donor fatigue, and the fact that MIHV is in its 3rd cycle of USAID funding for the Dagoretti project, MIHV anticipates that funding from USAID-USA will not be available. As stated earlier in the report our most viable option at this time appears to be the procurement of funding from local donors for the continued operation of the CBHC project in Dagoretti.

B. FINANCIAL (Ksh 56 = 1USD): Estimated Budget for Ongoing CBHC Activities

	Cost per month (Shillings)
Project Manager	30,000
2 Assistant Project Officers	50,000
Petrol	7,000
Telephone/FAX/DHL	4,000
Vehicle maintenance	4,000
Insurance: Vehicle	3,000
Travel	1,000
Incentives for CHW's	1,500
Office supplies	5,000
CHW/TBA Training	20,000
Contingencies (10%)	12,550
TOTAL: CBHC	138,050

1. Since we will be reducing activities at the end of the USAID funds, regardless of future funding, current positions with MIHV need to be eliminated or combined with other positions. All positions will be held by Kenyans.
2. Driver, clerk, cashier, guards, cleaners, are currently being funded by the health centre.
3. One vehicle (4 wheel drive) will be utilized in the CBHC project.
4. Chandaria Foundation has agreed to meet some joint administration costs and will allow the CBHC project to use the present office space for staff and training.
5. As funding will not be on the same scale activities will be reduced and focus on the following primary areas: STDs/AIDS/HIV awareness, water point protection, Maternal and Child Health Care, and income generation.
6. Given that there will be reduced project activities, staffing will be reduced to a operational minimum. The project manager will supervise the 2 project officers and direct their activities on a regular basis. Activities will focus on refresher training of existing CHWs and TBAs and follow-up in the project area. The project manager will also be responsible for the proper documentation of all project disbursements and vehicle use. Project staff will be required to have good computer skills and an excellent driving record.
7. Funding guidelines require oversight of project activities and finances from a recognized source which will require that MIHV have a person in place to do these activities on a regular basis. MIHV is exploring funding for another Child Survival project in Western Kenya.
8. Funding will be sought from a variety of donors. The funding will be small grants from several donors; UNICEF, USAID, European, and Japan, and will be sought with assistance from a consultant experienced in fundraising. The Medical Director will be responsible for contact with drug companies (Glaxo-Wellcome, Johnson & Johnson, others), AMREF, University of Nairobi, Nairobi Hospital and UNICEF. The Project Director will be responsible for contacts to USAID, Government of Japan, European Community (FINNIDA, DANIDA, CIDA, SIDA, others) and other UN agencies. All contacts will be completed by Dec. 20, 1996, with follow-ups on a regular basis. All meetings will be documented (contact names/addresses, summary, follow-up, dates) with copies to MIHV-USA.

Recommendations

There are two clusters of recommendations which the evaluation team wish to propose. Firstly, those recommendations that are necessary to fulfill the requirements of the current Development Implementation Plan. And secondly, those that are felt necessary in order to facilitate transition and eventual sustainability.

A) In relation to the present DIP the evaluation team recommend that:

- * project management assist health centre nursing staff in the provision of short refresher course (TOT) on patient counseling techniques,
- * project management proceed to the attachment of three short-term advisors (Kenyan) who will undertake the administrative responsibilities of those recently departed, and thus provide continuity of management through to August 1997,
- * project administration hire a consultant accountancy/audit firm to undertake final preparation of accounts,
- * project administration seek the assistance of a part-time consultant programmer who, in association with and HIS consultant, will develop a resume of basic statistics foundational to the transfer of health centre and the CBHC programme,
- * project administration acquire the services of a short-term consultant to advise on the viability of proposed incentive programming for community-based volunteers and on the relevance and applicability of income generating activities on an individual or group basis,
- * project management establish (via the reorganization of the Deputy Director's schedule of activities) a more rigorous system of in-field monitoring and supervision, to ensure co-ordination between leadership cadres in the implementation of CBHC programmes.

B) In relation to transition and sustainability that project management give increased attention to:

- * initiation of a programme of individual incentives for CBHC volunteers to enhance retention and increasing activity rates,

- * initiation of a strategy, or strategies, that would increase the involvement of community leadership (village health committees) in the organization and management of CBHC activities.
- * identify prospective donors for the CBHC programme with a view to gaining support (administrative and financial) and carry through transition to full community ownership of the CBHC project.

APPENDIX A

Survey Report

Methodology

The Questionnaire

The evaluation team adopted a rapid assessment technique of data collection. A simple interview-based questionnaire was devised to provide answers to a range of questions related to each of the seven project intervention areas. The questionnaire contains thirty questions and was designed by the evaluation team.

Selection of the Sample

The sample consisted of 228 women with children between the ages of 12 and 24 months residing in the three sub-locations of Dagoretti Division-Waithaka, Mutuini, and Ruthimitu. The sample of mothers was randomly selected using an index child number.

Training of the Interviewers

Twenty interviewers were selected and trained to carry out the interviews for this rapid-assessment. Training took place over a five-day period and covered research methodologies and protocols for interviewing, and participatory exercises such as in-house role plays to simulate interviews and pretest the questionnaire.

Conduct of the Interviews

The survey was conducted on September 19th and 20th, 1996 using the three page questionnaire. Twenty interviewers, under the supervision of PCA and project staff, interviewed a random sample of 228 respondents. Approximately eight teams consisting of two to three interviewers conducted the survey.

Analysis of Data

Once collected, data was analyzed and tabulated into tables for comparison. Quantitative data was supplemented by qualitative data to enrich the information obtained.

	SURVEY DEMOGRAPHICS	1989		1991		1994		1996
		RESULT		RESULT		RESULT		RESULT
		N or N/D	Mean (%)	N or N/D	Mean (%)	N or N/D	Mean (%)	
1	Mother's Mean Age in Years	662	26.8	223	24.3	212	24.3	25.7
2	Mother's Education: Literacy	NA	NA	<u>198</u> 224	(88.4)	<u>270</u> 295	(91.5)	92.3
	School Education	<u>624</u> 698	(89.4)*	<u>213</u> 224	(95.1)*	<u>276</u> 295	(93.6)*	96.1
3	Average size of Household	698	5.0		N/A	278	4.6	4.2
4	Mother's Income Generating Activity	N/A	N/A	<u>48</u> 224	(21.4)	<u>56</u> 296	(18.9)	25.9
5	Employment Status of Head of Household (excludes mother)	<u>649</u> 698	(93.0)*	<u>162</u> 178	(91.0)*	<u>189</u> 266	(71.1)*	90.6
6	Child's Mean Age in Months	N/A	N/A	223	11.5	293	10.3	16.2
7	Death of Child within Last Three Years	N/A	N/A	N/A	N/A	<u>22</u> 295	(7.5)	7.8

	NUTRITIONAL INDICATORS							
8	<u>NUT: Initiation of Breastfeeding</u> - Percent of infants/children (less than 24 months) who were breastfed within the first eight hours after birth	-----	N/A	-----	N/A	<u>257</u> 293	87.7	97.3
9	<u>NUT: Persistence of Breastfeeding</u> - Percent of children between 20 and 24 months, who are still breastfeeding and being given solid or semi-solid foods.	-----	N/A	<u>10</u> 35	28.6	<u>13</u> 38	34.2	53.1
	CONTROL OF DIARRHOEAL DISEASE INDICATORS							
10	<u>CDD: Incidence of Diarrhoeal Illness</u> - Percent of children with diarrhoea within the last two weeks	<u>79</u> 415	19.0*	<u>39</u> 224	17.4*	<u>76</u> 296	25.7*	25.0

11	<u>CDD: Continued Fluids</u> - Percent of infants/children (less than 24 months) with diarrhoea in the past two weeks who were given the same amount or more fluids other than breastmilk.	-----	N/A	<u>29</u> 37	78.4	<u>49</u> 73	67.1	84.4
12	<u>CDD: Continued Foods</u> - Percent of infants/children (less than 24 months) with diarrhoea in the past two weeks who were given the same amount or more food.	-----	N/A	<u>11</u> 38	28.9	<u>36</u> 71	50.7*	56.3
13	<u>CDD: ORT Usage</u> - Percent of infants/children (less than 24 months) with diarrhoea in the past two weeks who were treated with ORT.	-----	N/A	-----	N/A	<u>27</u> 76	35.5	84.4
	RESPIRATORY ILLNESS AND PNEUMONIA CONTROL							

14	<u>Pneumonia Control: Medical Treatment</u> - Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.	-----	N/A	-----	N/A	<u>55</u> 72	76.4	69.3
	EXPANDED PROGRAM ON IMMUNIZATION							
15	<u>EPI: Access</u> - Percent of children 12 to 23 months who received DPT1	-----	N/A	<u>80</u> 92	87.0*	<u>114</u> 119	95.8*	94.5
16	<u>EPI: Coverage</u> - Percent of children 12 to 23 months who received DPT3.	-----	N/A	<u>78</u> 92	84.8*	<u>112</u> 119	94.1*	95.5
17	<u>EPI: Measles Coverage</u> - Percent of children 12 to 23 months who received Measles vaccine.	-----	N/A	<u>67</u> 92	72.8*	<u>102</u> 119	85.7*	93.7
	MATERNAL HEALTH INDICATORS							

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18	<u>MC: Maternal Card</u> - Percent of mothers with a maternal card.	----	N/A	----	N/A	<u>168</u> 294	57.1	78.1
19	<u>MC: Tetanus Toxoid Coverage (Card)</u> - Percent of mothers who received two doses of tetanus toxoid vaccine (card).	----	N/A	----	N/A	<u>99</u> 294	33.7	97.0
20	<u>MC: Importance of Tetanus Vaccination</u>	----	N/A	----	N/A	<u>118</u> 296	39.9	73.4
21	<u>MC: Ante-Natal Visits (Card)</u> - Percent of mothers who had at least one ante-natal visit prior to the birth of the child (card).	----	N/A	----	N/A	<u>162</u> 294	55.7	74.0
22	<u>MC: Delivery of Health Professionals</u>	<u>309</u> 392	78.8*	<u>190</u> 222	85.6*	<u>225</u> 295	76.3*	81.3
23	<u>MC: Birth Spacing</u> - Percent of mothers not desiring children within the next three years.	----	N/A	<u>179</u> 223	80.3	<u>224</u> 281	79.7	66.4

24	<u>MC: Modern Contraceptive Usage</u> - Percent of mothers who desire no more children in the next three years, or are not sure, who are using a modern contraceptive method.	-----	N/A	-----	N/A	<u>143</u> 232	61.6	70.6
	STD/AIDS INDICATOR							
25	STD Control: Knowledge of two or more means to prevent an STD (abstinence, using condoms, keeping one partner, screening blood)					<u>25</u> 296	8.4	8.6
	ENVIRONMENTAL HEALTH INDICATORS							
26	<u>ENV: Household with access to a (pit) Latrine in good condition</u> - Percent of mothers with access to a (pit) latrine in good condition.	<u>542</u> 698	77.7	<u>73</u> 213	34.3	<u>243</u> 279	87.1	82.8

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27	<u>ENV: Household with access to proper garbage disposal</u> - Percent of mothers with access to an individual or community pit for garbage disposal.	-----	N/A	-----	N/A	<u>205</u> 290	70.7	80.6
28	<u>ENV: Protection of child from burns</u> - Percent of mothers with children who have had a burn in the last two weeks.	-----	N/A	<u>22</u> 221	10.0*	<u>15</u> 284	5.3*	5.5

* Significant difference ($p < 0.05$)

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APPENDIX B

MINISTRY OF HEALTH, GOVERNMENT OF KENYA
AND
MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS
IN COLLABORATION WITH THE CHANDARIA SUPPLEMENTARY FOUNDATION

THE MINISTRY of the Government of Kenya, hereinafter referred to
as the Ministry of Health, in collaboration with the Minnesota International Health Volunteers

- Recognizing the importance of Intersectoral Cooperation in the field of better health and prosperity of Kenyans;
- And in accordance with the prevailing laws, regulations, procedures and policies of the Government of Kenya concerning international technical cooperation;
- Considering that MIHV's efforts in the Dagoretti Area of Nairobi Province have culminated in the construction and equipping of a Health Centre to offer both Curative and Preventive-Promotive health care services to Kenyans;
- Recognizing that the Nairobi District Development Committee has endorsed the project;
- Considering that the site of the Health Centre (Plot 277 Dagoretti) has been leased to MIHV for a period of ten (10) years with the expressed proviso that MIHV may transfer the lease into the sole name of THE CHANDARIA SUPPLEMENTARY FOUNDATION REGISTERED TRUSTEES after a period of five (5) years

Have agreed as follows:-

ARTICLE I

The Ministry, through the Provincial Medical Officer, Nairobi, will extend technical support to MIHV with technical guidance, monitoring and evaluation of health care services offered at the Health Centre and the surrounding community.

ARTICLE II

MIHV will provide and continue to update a concise summary of general project objectives and activities in a PROTOCOL which will receive the mutual approval of the Ministry and MIHV.

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ARTICLE III

MIHV will:

1. Continue to maintain the Health Centre buildings (and the furniture and equipment in it) and the compound.
2. Employ and remunerate, as far as is feasible when income generated by the Health Centre is adequate, the staff to work at this Health Centre and its environs.
3. Provide preventive-promotive maternal and child health care services in the similar function and under the umbrella of the various Kenya's Government Child Survival and Development Programmes. These services to be offered at both the Health Centre and at the Community level.
4. Provide the preventive-promotive services stated above free of charge or at a reasonable user charge.
5. Provide Curative Services as offered in Government Health Centres. Establish, too, a reasonable fee for services provided.
6. Provide, as far as is feasible, drugs and dressings to be used at the Curative Services Section of the Health Centre.
7. Obey all laws of the Government of Kenya in the running of this project.
8. In collaboration with Dagoretti local communities, Ministry of Health and relevant bodies such as the University of Nairobi, the Provincial Administration etc, organize and maintain a Health Centre Management Board.
9. Institute a system of management, administration and financing of the Health Centre.

ARTICLE IV

The Ministry will:

1. Routinely visit, supervise and advise on the quality assurance of both Curative and Promotive-Preventive health care.
2. Provide technical support in the training of trainers (T.O.T.s) and/or training of Community Health Workers in

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line with the Primary Health Care Strategy.

3. Provide, as far as is feasible, supplies and materials for MCHS such as vaccines, contraceptives, oral rehydration salts (ORS).
4. In accordance with KEPI's principles and practices in force at a given point, provide (if feasible) some items of the cold chain system such as vaccine carriers, ice-packs, cold boxes, refrigerator etc.
5. Provide available items of Health Education materials (posters, handouts, booklets etc.) and Health Information System-all types of record keeping forms for Outpatients and MCHS.
6. Facilitate, by writing to the Customs Department, to obtain waivers of any Customs Duty, Sales Tax, V.A.T etc on equipment and/or supplies purchased directly for the project.
7. Screen, recommend and approve the applications of MIHV staff wishing to work at the project within the laid down Kenya laws.

FOR MINNESOTA INTERNATIONAL
HEALTH VOLUNTEERS (MIHV)

FOR THE GOVERNMENT OF
KENYA
MINISTRY OF HEALTH

Virginia L. Balanda
Kenya Project Director, MIHV

Date: 6.6.91

[Signature]
Permanent Secretary

Date: 6/6/1991

FOR THE CHANDARIA SUPPLEMENTARY
FOUNDATION

[Signature]

Trustee

Date: 6.6.91

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APPENDIX C

1996 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET X

		Total Agreement Budget		Actual Expenditures to Date		Projected Expenditures Against Remaining Obligated Funds		Projected Unobligated Funds at End of Project	
		090194	083197	090194	to 083197	090194	of 083197	(/ /)	(/ /)
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
I. DIRECT COSTS									
A. PERSONNEL (salaries, wages, fringes)									
	1. Headquarters - salaries/wages	42,990		52,320		(9,330)			
	2. Field, Technical Personnel - salaries/wages								
	3. Field, Other Personnel - salaries/wages								
	4. Fringes- Headquarters + Field	10,750		10,466		284			
	SUBTOTAL- PERSONNEL	53,740		62,786		(9,046)			
B. TRAVEL/PER DIEM									
	1. Headquarters-Domestic (USA)	6,310				6,310			
	2. Headquarters-International	12,460	13,240	9,885		2,575	13,240		
	3. Field-In country								
	4. Field-International	18,770	13,240	9,885		8,885	13,240		
	SUBTOTAL- TRAVEL / PER DIEM	28,540	26,480	19,770		17,770	26,480		
C. CONSULTANCIES									
	1. Evaluation Consultants- Fees								
	2. Other Consultants- Fees	11,830		6,363		5,467			
	3. Consultant travel / per diem								
	SUBTOTAL- CONSULTANCIES	11,830		6,363		5,467			
D. PROCUREMENT (provide justification/ explanation in narrative)									
	1. Supplies								
	a. Headquarters	2,220				2,220			
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)								
	c. Field - Other								
	2. Equipment								
	a. Headquarters								
	b. Field								
	3. Training								
	a. Headquarters	1,890				1,890			
	b. Field								
	SUBTOTAL- PROCUREMENT	4,110				4,110			
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)									
	1. Communications								
	a. Headquarters	11,350		4,991		6,359			
	b. Field								
	2. Facilities								
	a. Headquarters	15,760		9,763		5,997			
	b. Field								
	3. Other								
	a. Headquarters	2,340		1,052		1,288			
	b. Field								
	SUBTOTAL- OTHER DIRECT	29,450		15,806		13,644			
TOTAL - DIRECT COSTS		117,900	13,240	94,840		23,060	13,240		
II. INDIRECT COSTS									
A. INDIRECT COSTS									
	1. Headquarters	22,715	2,400	14,776		7,939	2,400		
	2. Field (if applicable)								
TOTAL - INDIRECT COSTS		22,715	2,400	14,776		7,939	2,400		
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		140,615	15,640	109,616		30,999	15,640		

1996 PIPELINE ANALYSIS: PART B - COUNTRY BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET XX

		Total Agreement Budget		Actual Expenditures to Date		Projected Expenditures Against		Projected Unobligated Funds	
		090194 to 083197		090194 to 083197		Remaining Obligated Funds		at End of Project	
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
I. DIRECT COSTS									
A. PERSONNEL (salaries, wages, fringes)									
	1. Headquarters-salaries/wages								
	2. Field, Technical Personnel-salaries/wages	155,600	42,540	90,392	42,540	65,208			
	3. Field, Other Personnel-salaries/wages	60,700	48,670	4,722	48,670	55,978			
	4. Fringes-Headquarters + Field	64,770		46,769	26,969	18,001	(26,969)		
	SUBTOTAL-PERSONNEL	281,070	91,210	141,883	118,179	139,187	(26,969)		
B. TRAVEL/PER DIEM									
	1. Headquarters-Domestic (USA)								
	2. Headquarters-International								
	3. Field-In country	50,040		33,744		16,296			
	4. Field-International	30,250		14,372		15,878			
	SUBTOTAL-TRAVEL / PER DIEM	80,290		48,116		32,174			
C. CONSULTANCIES									
	1. Evaluation Consultants-Fees	8,500		776		7,724			
	2. Other Consultants-Fees	38,400	3,780	27,711		10,689	3,780		
	3. Consultant travel / per diem	5,500				5,500			
	SUBTOTAL-CONSULTANCIES	52,400	3,780	28,487		23,913	3,780		
D. PROCUREMENT (provide justification/ explanation in narrative)									
	1. Supplies								
	a. Headquarters								
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)		120,390		38,932		81,458		
	c. Field-Other	72,270	40,260		32,544	72,270	7,716		
	2. Equipment								
	a. Headquarters								
	b. Field		11,400		5,868		5,532		
	3. Training								
	a. Headquarters	1,820				1,820			
	b. Field								
	SUBTOTAL-PROCUREMENT	74,090	172,050		77,344	74,090	94,706		
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)									
	1. Communications								
	a. Headquarters	25,480		11,108		14,372			
	b. Field								
	2. Facilities								
	a. Headquarters								
	b. Field	10,980		6,785		4,195			
	3. Other								
	a. Headquarters								
	b. Field	147,148	33,865	63,060	41,099	84,098			
	SUBTOTAL-OTHER DIRECT	183,608	33,865	80,953	41,099	102,655	(7,234)		
TOTAL - DIRECT COSTS		671,458	300,905	299,439	236,622	372,019	64,283		

II. INDIRECT COSTS									
A. INDIRECT COSTS									
	1. Headquarters								
	2. Field (if applicable)	125,235	21,570	46,654	36,866	78,581	(15,296)		
TOTAL - INDIRECT COSTS		125,235	21,570	46,654	36,866	78,581	(15,296)		

GRAND TOTAL (DIRECT AND INDIRECT COSTS)		796,693	322,475	346,093	273,488	450,600	48,987		
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1996 PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET X

		Total Agreement Budget		Actual Expenditures to Date		Project Expenditures Against		Projected Unobligated Funds	
		090194 to 083197		090194 to 083197		090194 to 083197		at End of Project	
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
I. DIRECT COSTS									
A. PERSONNEL (salaries, wages, fringes)									
1. Headquarters-salaries/wages		42,990		52,320		(9,330)			
2. Field, Technical Personnel-salaries/wages		155,600	42,540	90,392	42,540	65,208			
3. Field, Other Personnel-salaries/wages		60,700	48,670	4,722	48,670	55,978			
4. Fringes-Headquarters + Field		75,520		57,235	26,969	18,285	(26,969)		
SUBTOTAL- PERSONNEL		334,810	91,210	204,669	118,179	130,141	(26,969)		
B. TRAVEL/PER DIEM									
1. Headquarters-Domestic (USA)		6,310				6,310			
2. Headquarters-International		12,460	13,240	9,885		2,575	13,240		
3. Field-In country		50,040		33,744		16,296			
4. Field-International		30,250		14,372		15,878			
SUBTOTAL- TRAVEL / PER DIEM		99,060	13,240	58,001		41,059	13,240		
C. CONSULTANCIES									
1. Evaluation Consultants- Fees		8,500		776		7,724			
2. Other Consultants- Fees		50,230	3,780	34,074		16,156	3,780		
3. Consultant travel / per diem		5,500				5,500			
SUBTOTAL- CONSULTANCIES		64,230	3,780	34,850		29,380	3,780		
D. PROCUREMENT (provide justification/ explanation in narrative)									
1. Supplies		2,220				2,220			
a. Headquarters									
b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)			120,390		38,932		81,458		
c. Field- Other		72,270	40,266		32,544	72,270	7,716		
2. Equipment									
a. Headquarters									
b. Field			11,400		5,868		5,532		
3. Training									
a. Headquarters		1,890				1,890			
b. Field		1,820				1,820			
SUBTOTAL- PROCUREMENT		78,200	172,050		77,344	78,200	94,706		
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)									
1. Communications									
a. Headquarters		11,350		4,991		6,359			
b. Field		25,480		11,108		14,372			
2. Facilities									
a. Headquarters		15,760		9,763		5,997	7		
b. Field		10,980		6,785		4,195			
3. Other									
a. Headquarters		2,340		1,052		1,288			
b. Field		147,148	33,865	63,060	41,099	84,088	(7,234)		
SUBTOTAL- OTHER DIRECT		213,058	33,865	96,759	41,099	116,299	(7,234)		
TOTAL - DIRECT COSTS		789,358	314,145	394,279	236,622	395,079	77,523		

II. INDIRECT COSTS									
A. INDIRECT COSTS									
1. Headquarters		22,715	2,400	14,776		7,939	2,400		
2. Field (if applicable)		125,235	21,570	46,654	36,866	78,581	(15,295)		
TOTAL - INDIRECT COSTS		147,950	23,970	61,430	36,866	86,520	(12,896)		

GRAND TOTAL (DIRECT AND INDIRECT COSTS)		937,308	338,115	455,709	273,488	481,599	64,627		
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