THE MIHV DAGORETTI CHILD SURVIVAL PROJECT

MID-TERM EVALUATION REPORT

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LIST OF ACRONYMS

AIDS		Acquired Immune Deficiency Syndrome
AMREF	–	African Medical and Research Foundation
ANC		Ante-Natal Care
CBHC		Communi ty Based Heal th Care
CHWs	–	Cmmuni ty Heal th Workers
CBD	–	Ccmnuni ty Based Di stri butors
cs		Chi ld Survival
FC		Functional Cmni ty
FPPS	–	Family Planning Private Sector
IGAs	–	Income Generating Activities
JHC	–	Joint Health Commi ttees
KAP		Knowledge, Attitude, Practice
LHC		Local Health Committee
MOH	–	Ministry of Health
MCH		Maternal and Chi 1 d Health
MIHV	–	Minnesota International Health Vol unteers
NCC		Nai robi City Commi ssi on
NGOs		Non-Governmental Organizations
OPD	–	Out Patient Department
ORS	–	Oral Rehydration Solution
CRT	–	Oral Rehydration Therapy
PHC	–	Primary Health Care
PMO	–	Provincial Medical Officer
TOTs	–	Trai ni ng of Trainers
UNICEF		United Nations Children's Fund
USAID		United States Agency for International Development
WVIK		World Vision International Kenya

PREFACE

The MIHV child survival and development project is located in the Dagoretti Division, in the western part of the city of Nairobi; namely in Mutuini, Ruthimitu and Waithaka locations. These communities are pet-i-urban and they are low income areas. It was possible to visit only selected communities which provided a sample data to complete the mid-term qualitative evaluation.

The evaluation team consisted of the following:-

Dr. Alemu Mammo, Director of Technical Support Services/ Health/Nutrition, WV1 Kenya office External evaluator (Team Leader)

- Mr. Jaime Henriguez, USAID Project Gfficer
- Mrs. Lois Miano, Deputy Project Director of MIHV Child Survival Project, Nai robi, Kenya
- Ms. Kate Rardin, Project Officer, MIHV, Minneapolis, MN, USA

Support was received from:

- Mrs. Loyce Jones, Administrator of MIHV/Chandaria HC
- Kate Colson, USAID, Local Mission, Nairobi, Kenya
- Other project and health center staff

Community representatives who were interviewed and contributed significantly to enable us complete the evaluation exercise comprised:-

- six community health workers, selected from MIHV trained CHWs
- three mothers from the corrmunity, within the target area
- two members of joint health commi ttee (JHC)
- two members of the board of management that oversees the MIHV child survival activities.
- two health center 1 staff from MIHV/Chandaria HC (in addition to deputy project di rector)
- one from Provincial Medical Office - the matron
- two doctors from Nai robi City Counci 1, health department
- Director of Medical Services MIHV/Chandaria HC
- Administrator of MIHV/Chandaria HC

During the enti re exercise, the team was great1 y assi sted by both the MIHV/Chandaria HC and child survival project staff. They provided essential information regarding project activities, constraints and opportunities they have experienced in the process of implementing the project activities.

The team wishes to express gratitude for the support and advice given by the MIHV/Chandaria HC and project staff and the community representatives. Special thanks go to those who were interviewed, but whose names have not been mentioned in the document and the residents of the communities visited and for the support which had been generously given to the team.

1. INTRODUCTION

The Minnesota International Health Volunteer (MIHV) had received its f i rst funding from the USAID in August 1988 to carry out its first phase child survival and development interventions between October 1, 1988 and September 30, 1991 in the Dagoretti Division, Western part of Nairobi, Kenya's capital.

The second phase of the chi ld survival grant was approved by USAID for consol i dati on of the gai ns made duri ng the f i rst phase of CSP and implementation of a few additional interventions in the three locations (Mutuini, Ruthimutu and Waithaka), Dagoretti Division, with an estimated population of 54,346 in 1991.

1.1 Purpose of this Evaluation:

To assess the impact, potential for sustainability, to strengthen the project and make appropriate recommendations to strengthen the evaluation findings.

2. BACKGROUND

The MIHV with its second phase funding focused on the following interventions:-

2.1 The Nexus of Interventions at Second Phase

1.1 Increase awareness of:

a) Prevention and treatment of diarrhoea disease
b) Transmission of HIV/AIDS and other sexually transmitted diseases (STD's)
c) Proper child nutrition and weaning practices
d) Proper fami 1 y planning and birth spacing

1.2 Sustain current irrmunization rates and increase measles coverage rate

1.3 Reduce incidence of environment-related illness and injuries, and

1.4 Reduce acute respiratory illnesses in children was based on a joint effort with PATH which did not receive funding and was subsequently dropped .

These interventions were desi gnated to be achieved through communi ty based health care (CBHC) promotion carried out through the community volunteers facilitation (i.e. CHWs, TBAs, training of trainers (TOTs), joint health committee (JHC), and community based distributors (CBDs). In addition to the group mentioned herein, the project also uti 1 izes three area health committees that send representatives to the JHC, and CHW representatives, who are responsible for assisting, supporting, and overseei ng the CHW 's activities.

In addition to CBHC activities, the MIHV has a large clinic which opened in April 1991 providing curative services along with CBHC services through clinic based training on the promotive and preventive cares using the community volunteers as the key facilitator in collaboration with the health center staff.

2.2 Baseline Data

The MIHV had carried out a baseline survey in conjunction with the final evaluation at the end of the first phase and commencement of the second phase of chi ld survival interventions; this survey establ ished the baseline data to measure the second phase child survival intervention accomplishment impact.

This Mid-term Evaluation focused on the qualitative or descriptive assessment of the project's accomplishment to date. Jaime Henriquez, Project Officer at USAID, approved MIHV's request to forego a quantitative survey at this time, thus limiting quantitative data available for deriving authoritative conclusions. However, through interviews with the key staff, community representatives, CHWs, joint health committee members, and others as indicated in the preface, it was possible to gather relevant information which has enabled the team to make appropriate comments about the project's accomplishment to date and potential for future sustai nabi1 i ty .

3. BACKGROUND INFORMATION TO THIS EVALUATION

This phase of chi ld survival interventions was started on September -1, 1991 and ends on August 31, 1994. Unfortunately, during this evaluation exercise, the Project Director, Dr. Michael Graf was involved in a motor vehicle accident and was severely injured. This has caused a gap in some areas, especially our comments regarding budget have been negatively affected by his absence. It was somewhat al arming to learn that the medical director was, too, involved in motor vehicle accident a few days after the commencement of the evaluation exercise. With such unique events affecting two senior members of the project, the evaluation team worked with the remaining staff to complete the exercise. The medical director as a result of relatively minor injuries he had sustained, was able to make himself accessible to the team and his contribution was greatly valued.

4. STRENGTH OF THE PROJECT

4.1 Health Center

1.1 The MIHV/Chandaria health center has introduced effective and efficient cost recovery mechanism. This has made the health center almost a model to both P.M.O. (with 35 health institutions in the city of Nairobi) and NCC, (with 25 institutions) and it continues to attract more patients, which will be a key factor for the future sustainabi 1 ity of the clinical service (see figure 1), which indicates the flow of patients and kind of major illnesses treated at the MIHV/Chandaria health center.

1.2 The PMO has already provided clinical staff consisting of: 7 communi ty nurses, 1 senior nurse-in-charge, 1 clinical officer, 3 1 aboratory technicians , 1 nutritionist, and a pharmaceutical technologist. In addition to working in the health center, the nurses have been participating in the outreach program, going into the community with TOT's and CHWs, which is a unique program bringing the health center and CBHC into complementary roles. The PMO's willingness to keep the staff committed to the health center and the MIHV's abi 1 ity to 1 ink the health center staff with the CBHC

component are a good sign for the future sustainabi 1 i ty. The messages being promoted from the health center seem to have a positive impact on: family planning/birth spacing, EPI coverage, breast feeding and reducing prevalence of moderate malnutrition.

1.3 The commitment made by the Chandaria Foundation in writing to the MIHV and confirmation of that commitment to this team to take over the health center when the MIHV phases out, gives an assurance that the health center service continues beyond current USAID/MIHV funding period.

1.4 The audio-visual facility at the health center followed up by volunteer CHWs and at times, by the nurses, provides essential information to the outpatients concerning preventive and promotive services.

4.2 <u>The CBHC Activities</u>:

2.1 FPPS willingness to fund FP/birth spacing component of the project shows that the MIHV has done effective networking and is able to market selected project components locally to convince other NGOs to contribute to the child survival interventions.

2.2 The combined CBHC and clinical efforts have a positive impact on reducing moderate malnutrition, control of diarrhoea diseases (COD), and increased treatment of common illnesses and raising the immunization coverage of measles.

2.3 As it can be gleaned from the health center clinical records, diarrhoea and moderate malnutrition are declining, while malaria, upper respiratory infections (URIs) - particularly pneumonia - and skin infections have been recognized as major causes of morbidity and mortal i ty (Figure 1) , which indicates a need for the future intervention, if the project is to be extended. Furthermore, the distribution of service delivery at MIHV/Chandaria Health Center shows that patients seeking curative services continues to be constant1 y on the upward trend (Figure 2), whi le antenatal services though increased compared to 1991 level, nevertheless, between 1992 and 1993 remain static. From the health center data it can be seen (in Figure 3) that ear infection, skin disease, and malaria rank as major causes of morbidity making them possible candidates for re-prioritized interventions during the remaining phase of the child survival project.

2.4 Training of CHWs, TBAs, TOTs and CBDs continues to be carried out through the CBHC activities. This was evident by the existence of: 237 active CHWs, 13 TBAs and 5 TOTs and 6 CBDs, and 60 communi ty health worker representatives (CHWRs), who are voluntarily carrying out the CBHC activities.

2.5 Collaboration seems to be on the right course as the project staff continues to co1 laborate with University of Nai robi, departments of community health, obstetrics and gynecology, pediatrics, internal medicine in condom research; FPPs in family planning and birth spacing; PMO staff secondment and essential drug kit provision; NCC

in the referral and the community in voluntary services (i.e. CHWs, TOTs).

5. MANAGEMENT SYSTEM

1. The MIHV seems to have put together the management system. It has a computer and some of the staff members are literate in using the cmputer software essential for recording, analysis, and documentation of the child survival project intervention impact. Furthermore, the willingness of the JHC, BOM, and local area health committees representing the 3 communities of Mutuini, Ruthimitu, and Waithaka, are further indication that the community is willing to participate in implementing and sustaining the child survival project both during and subsequent to MIHV involvement.

   The natural 1 inkage that al ready exists between the health center (HC) activities and the activities of CBHC, is a further evidence of cmplementary roles of the two components of the project. This is a good indication, given an appropriate planning and coordination, when the CBHC components of the child survival phases out, the health center can incorporate the CBHC activities as a part of the outreach program.

6. WEAKNESS OF THE PROJECT

6.1 Health Information System (HIS)

In implementing a child survival and development project, it is important to ensure there exists appropriate HIS. This enables the project staff to implement consistent monitoring and evaluation precess. The existing documentation and reporting format do not constitute adequate measurable HIS, as they are more in the essay format.

Follow-UP Comments from MIHV

The current HIS does track and report achievement of project objectives through quantitative and qualitative measures. The monthly report format incorporates monthly numbers in essay format, but the reporting format does not invalidate the quantitative measure. In fact, the essay format provides a ready mechanism for explaining anomalies in the numbers from month to month which would not be possible in spreadsheet format.

6.2 Community Based Supervision

We learned that the number of CHWs is increasing and when added, TBAs, trainer of trainers (TOTs), community based distributors (CBDs) and Joint Health Committee and Area Health Committees, one supervisor was unable to provide adequate supervision. Current1 y, responsible person for supervision seems to be stretched too thin to cover al 1 the project areas.

Follow-up Comments from MIHV

The CBHC program has a hierarchical supervisory structure. The community health worker representatives (CHWRs) are the first tier of supervision, each responsible for assisting, supporti ng, monitoring the work of three CHWs. The CHWRs are supervised by the

two CBHC staff: Leonida Atieno and Lois Miano; the original plan in the DIP cal led for each staff person to supervise 10 - 15 CHWRs. Although at the time of the Mid-term Evaluation, it is true that Lois Miano was serving as Acting Project Di rector in the wake of Michael Graf's accident, her normal role is to work as the director for the CBHC with Leonia Atieno as her Assistant.

6.3 Budget

The general field staff, including the deputy project director lacked basic information about the project budget. They know how much they spend per month or quarter, but they had no access to actual budget and they are not sure whether they are overspending or underspend i ng . This is important as it can have a significant imp1 ication on the project activities. Unfortunate1 y , the project director as a result of a severe motor vehicle accident, was unable to participate in the evaluation exercise to clarify the issue of budget.

6.4 Sustainability of Community Based Health Care (CBHC)

Current1 y, there are 237 CHWs, 13 TBAs, and 5 TOTs along with 60 joint health commi ttee members. Al 1 of these are supervised by a single supervisor, who is a former CHW. As indicated above, it is not possible to provide adequate supervision, as d i stance, transportation and time limit her capacity to provide adequate supervision.

Sustaining the CBHC activities beyond MIHV/child survival grant has not been adequately addressed. Though commitment to sustai nabi 1 i ty had been impressively addressed in the detailed implementation plan (DIP), nonetheless, as of mid-term evaluation, there was no clear-cut strategy to carry on CBHC activities beyond current funding period.

Follow-up Comments from MIHV

As explained above, the super-vi sory structure also includes 60 CHWRs who are each responsible for three CHWs and one additional staff person, Lois Miano, who normal 1 y serves as the Di rector of the CBHC program. The supervisory role of CHWRs includes: 1) making at least one home visit a month with each CHW assigned to them; 2) distributing, reporting, and reviewing for significance, the monthly reports received from each CHW; 3) reporting of difficult cases to the local area health commi ttees and to the health center: 4) consulting with the two CBHC staff regardng diffcult cases, needs, and accomplishments; and 5) recommending local CHWs for awards.

The strategy out1 ined in the DIP to sustain the CBHC beyond the current funding period is being implemented, although it has not progressed as far as we would like. Michael Jordan, a Peace Corps Volunteer, has been assigned to the project to work with the CHWs and area health cctrmittees, who have all registered as self-help groups, in developing income-generating projects. He is advising and instructing them on establishing bank accounts, accounting for income and expenses, developing simple business plans, and determining whether or not an idea has the possi bi 1 ity of generating income. A small loan program has been established to provide the

necessary capital needed by a CHW self-help group in implementing their idea, once it has been determined to have the potential of a viable business.

In addition, Mr. Jordan is working with Manu Chandaria and the community in the development of a sanitary market for Dagoretti . (The jua kali which was originally included in the DIP seems to have been temporarily dropped in order to focus community activity on the sanitary market.) Spaces in the sanitary market would be made available to CHWs for selling their products. Progress has been delayed due to difficulties in obtaining a plot of land properly leased to the project or a self-help group. Mr. Chandaria remains committed to the project effort in spite of these delays.

Grassroots community development is by its very nature a slow and laborious process. In addition to earning a living and taking care of their families, the CHWs are volunteering their time to do outreach for the CBHC program and work together as a group to develop a small business. If the income-generating project is to be truly their own, it must be developed by them--and not by an outsider who needs to meet some externally-imposed deadline.

These project efforts to develop income-generating activities will help sustain the interest and participation of CHWs in the CBHC after grant moneys end. (Participation in the loan program, for example is reserved for CHW self-help groups.) In the DIP, it was envisioned that additional rental income could be generated from the jua kali and sanitary market to sustain additional CBHC expenses, such as the salaries of CBHC staff. At this time, there is some question whether sufficient rental income could be generated to support the CBHC and still be affordable to the community.

6.5 Trai ni ng

The lesson plan, contents, approach, impact and appropriateness has not been updated. Psychosocial method training curriculum, like any others needed to be updated. New ideas and approaches being developed by different organizations and agencies to improve the training quality, appropriateness and impact can al so be used. It is evident that the MIHV-CBHC trai ni ng approaches, contents and curriculum are in need of being streamlined to provide optimum benefits to the trainees.

Follow-up Comments from MIHV

The current training program is very much drvien by the CHWs themselves: lessons are taught based on wht questions the CHWs are asking in their classes and their monthly meetings.

6.6 The Project Staff

It is not yet known what happens to the CBHC staff when the USAID/MIHV funding phases out. This is essential that if true sustainability is to be achieved, there should exist:-

6.1 Continuity of the major components of the existing activities and local counterparts to fill in the gap currently held by paid staff and expatriate volunteers.

6.2 If this is not attainable, there should be a clear plan to phase-out the staff and phase-in the CBHC activities into existing community institutions, including health center, outreach program, other NGOs or the institutions of local government. The health center has a potential to be sustained with the Chandaria Foundation willingness to step in when the MIHV phases out and fee for service mechani sm is in place. However, there is a very weak 1 ink between the health center and CBHC components. The team was unable to observe any written evidence such as joint planning, strategy of common plan of action (POA), with a commitment to 1 ink up CBHC components with health center. It appeared to the evaluation team that the health center operated as an independent institution, instead of complementary to or with CBHC components. Al though meetings were held, there is no documented evidence which indicates joint planning and strategy formulation to ensure the child survival project benefitted from both HC and CBHC activities. Although outreach program has been recent1 y introduced, however, it sti 11 needs strengthening and integration. The exi sti ng weakness appears to dichotomize the project and weaken internal collaboration and co-operation.

Follow-up Comments from MIHV

It is unfortunate that the evaluation team was not able to observe this because there are multiple examples of this linkage. First, the DIP was written with input of senior staff for both the CBHC and the cl init. Weekly senior staff meetings include both CBHC staff and clinic staff. The Director for the CBHC program and the clinic administrator attend and report to al 1 Board of Management meetings. Both CBHC and clinic staff attend meetings of the joint health commi ttee once a month. CHWs make presentations to patients in the clinic's waiting rocm regularly and answer questions generated by the educational videos which are shown. As a resul t of a recent agreement with the Nursing School at the University of Nai robi, nurisng students are assigned to the health center to work with the CBHC program. Mobile clinics have been organized in which nurses frm the health center travel to mot-e remote project areas to weigh babies, irrrnunize, and see sick people; CHWs work with health center staff in these outreach efforts.

These efforts have been taken to strengthen the linkage between the health center and the CBHC. Although, the referral rate from the community health nurses at the health center to CHWs in the community remains relatively negligible at this time, the project staff remain committed to further fostering and facilitating this interaction. The involvement of the community health nurses in the CBHC activities has made considerable progress since the clinic f i rst opened. This interaction and participation include: 1) weekly community outreach rotated throughout the project area which began in April 1993; 2) counseling, referral , and assistance in the monthly voluntary surgical sterilization (VSC) performed at the clinic provided by Marie Stopes Clinic; 3) lectures on various health topics (CDD and KEPI) to CHWs participating in the Folk Media workshop held in September 1993 (planning of this workshop began prior to Dr. Mammo's visit) ; 4) extensive participation in the training of 13 TBAs (each TBA spent 4 days with the nurse providing

antenatal care); and 5) periodic teaching or demonstrations in initial and follow-up training of CHWs on specialty topics (e.g., antenatal care, KEPI, and CDD).

6.7 Income Generatinq Activities (IGAs)

Other than the health center cost sharing mechanism, the commitment to implement an IGA scheme has not yet been materialized. The one being introduced is at the rudimentary stage and its success is dependent on the number of factors. Such factors include:- training on accounting, management, cooperate ventures and short and long term loan schemes. As it is, the existing IGA approach does not meet these criteria and a process to strengthen may run out of time unless a rapid restructuring of the process is put in place with outside consultants with local expertise and field based experience to link HC with CBHC.

Follow-up Comments frcm MIHV

Michael Graf , Kenya Project Di rector for the last two years, has repeatedly emphasized to the community that MIHV will not support any communi ty income-generating efforts which do not directly support the project. Income-generating at best can serve -to maintain the interest and participation of CHWs and community volunteers on the area health commi ttees and joint health commi ttee if participation in income-generating is made contingent on continued involvement in the CBHC program; other revenue streams need to be identified if that is the goal.

Sustainability of income-generating activities depends on basic training of community participants in the skills and expertise needed to run a simple business. This training needs to be hands-on and experience-based. Michael Jordan, a Peace Corps Volunteer assigned to the project, is currently facilitating basic training in accounting, small business development, personal and small business financial managment skills, and small loan financing. We recognize that the development of these skills may take considerable time. At the same time, we are committed to the role of facilitation of proposals which originate from the community itself, rather than trying to i mpose outs i de i deas which frequent 1 y generate considerable controversy or are not sustainable in the long-term.

Prior to the Mid-term Evaluation, Michael Jordan had met with the Undugu Society and they expressed thei r wi 11 i ngness to al low some of our staff to participate in their workshops as they arise. We are currently exploring whether the Undugu Society can more actively participate in the inccme-generating strategies in the project area. In addition, we are currently investigating obtaining assistance in IGA development from other organizations such as Technoserve, and the USAID Office on Small Enterprise Development.

6.8 Resistance to Link HC with CBHC

Resistance by the Chandaria Foundation to 1 ink the health center with the CBHC outreach is going to be an obstacle to the sustainability process. Unless the MIHV, PMO and the communi ty convince the Chandaria Foundation, it is going to be a real bottleneck to the CBHC activities after current CS funding phases-

out. Without the support by the health center, at least to hire two supervisors to trai n , follow-up and continue to encourage the community volunteers (i.e. CHWs, CBDs, T O Ts a n d TBAs, J H C a n d functional committee), it i s not possi bl e to assume that the community will take care of itself.

6.9 DIP Interventions

The MIHV should have revised the DIP interventions a bit earlier as immunization, CDDs, incidence of moderate malnutrition have been managed by the MIHV staff al ong with community volunteer mobi 1 ization. Lack of effective and efficient health information system (HIS), the project was unable to monitor a shift in the priority order of the interventions.

Follow-up Comments from MIHV

The project has been successful at implementing the interventions originally identified in the DIP. The remaining period of the project needs to focus on solidifying those gains through improved data collection and reporting, testing mothers on lessons taught, and continued enhancement of the supervisory system through further integration with existing community organizations.

The project staff has some grave concerns about testing CHWs' knowledge. In particular, since this testing has not been built into the program from the beginning, the project staff feel that testing at this time may actually discourage CHW participation if they do not perform we1 1. Even the added pressure of examinations may disocurage participation. CHWs who are not 1 iterate may further be discouraged. At this point, project staff feel that we should be t-r-or-e interested in assessing household knowledge. If the messages are not getting through, we can conduct follow-up and refresher trainings of CHWs in areas where need is indicated. We can al so incorporate CHW testing in the training of new CHWs in the future.

Some reprioritization of program goals to focus more on HIV/AIDS prevention and family planning programs may be appropriate at this time. For this reason, we are exploring possibilities for expansion of our existing programs and also for submitting an extension grant which wi 11 focus more speci f i call y on these areas. However, we remain committed to maintaining and consolidating the progress the CBHC program has made especially in KEPI and CDD.

6.10 Lack of joint reporting mechanism

Though both the health center and CBHC activities are part of the child survival project, nonetheless, there was no joint reporting of accomplishments, limitation and unique activities. This has limited the project from sharing some significant achievements it has scored at the HC, as those achievements had not been regularly documented and related to overal 1 operation.

Follow-up Comments from MIHV

Joint reporting has always existed for the project. The senior staff meetings include representatives of both the CBHC and the cl init. The month1 y reports include both project components.

Interaction of the CBHC and the health center has long been a goal of project staff, and continuous efforts have been made to achieve that end.

7. RECOMMENDATIONS

7.1 Strengthen the HIS through strengthening the monthly, quarterly and annual reporting mechanism. In these reports, develop categorized out1 ine reporting format comprising: - introduction, major accomplishment, regular activities, unique events, recommendations for management attention, objective for the subsequent month/quarter/year and plan of action.

Ensure that the narrative report has quantitative report component as a part of overal 1 report and quantify accompl ishrrents when and where possi ble.

7.2 Develop a joint plan of action for both the HC and CBHC activities. Then, develop a master POA which will be monitored by the project d i rector. The POA should be developed for each month/quarter and has to be revi sed as a need arises .

Follow-up Comments from MIHV

The DIP is a joint plan of action which incorporates both the Health Center and the CBHC. Weekly senior staff meetings include both CBHC staff and clinic staff to discuss program issues and develop solutions. Both CBHC and clinic staff attend meetings of the joint health ccwmittee once a month to report on project progress and obtain community input and feedback. Monthly reports are prepared for the home office which document progress against key indicators, describe project achievements, and out1 ine challenges to be resolved for both the clinic and the CBHC.

7.3 Ensure access to the senior project staff of the budget information to enable them to relate the project activities and particular budget i tems to avoid operati ng based on guess or just depend i ng on headquarters instruction.

7.4 Revise, update, evaluate and adjust the training lesson plan, content, approach and appropriateness to ensure its relevance and impact on the trainees.

7.5 Reorgani ze the interventions in the following priority, if possible:-

- Prevention of HIV/AIDS/STD
- Family planning/birth spacing
- Prevention of URI as a part of (improvement of environmental sanitation)
- Strengthening and consolidation of CBHC activities

Follow-up Comments from MIHV

URI is not a current project intervention and it would be inappropriate to add it to project objectives at this time.

7.6 Seek professional advice from organizations like Undugu society on how to strengthen IGAs as they have expertise in implementing small IGA enterprise and are successful in the urban low income community.

7.7 Increase the number of supervisors, since it is not practical for one person to supervise 237 CHWs, 13 TBAs, 5 TOTs and other volunteers .

Follow-up Comments from MIHV

The supervisory system of the CBHC program has not been accurately described in this report (see MIHV comments to items 6.2 Community Based Supervision, and 6.6 The Project Staff. Sustainabi 1 i ty of a supervisory system which is dependent on paid staff is very difficult. Senior staff is considering other alternatives to strengthen the superv i sory structure which have a greater probability of sustainability.

7.8 The target population is estimated to be 62,000 in 1993. The estimate is based on pre-1989 census, which has not been officially released, estimate of 7% per annum population increase, irrnigration of those opportunity seekers, who go to city in search of job opportunity and their dependents who fol low them. This calls for increasing the number of supervisors.

7.9 Strengthen referral sys tern through appropriate follow-up, (collaboration with the NCC clinics/health centers) and follow-up of the CHWs.

7.10 Register the address of the out-patients to determine percent of the population coming outside targeted area. (Statistical ly unconf i rmed report indicates that patients are coming f t-cm as far as Kenyatta airport area, but due to the lack of appropriate documentation of the addresses of the patients, it was difficult to determine the exact percentage).

7.11 Register under five morbidity and mortal i ty as recorded at the HC to ensure the common causes and to implement appropriate interventions, based on the data.

7.12 Focuson linkage between awareness creation and behavioral change to prevent and control HIV/AIDs/STDs (the major problem is not lack of knowledge, but inability to link knowledge with behavioral change).

APPENDICES

FIGURES (l-3) SAMPLE DATA FROM THE MIHV/CHANDARIA HC MEDICAL RECORDS

FIGURE 4 - SAMPLE OF REGULAR MONTHLY/QUARTERLY/ANNUAL REPORTING FORMAT

FIGURE 5 - SAMPLE OF QUANTITATIVE REPORT

MAP OF NAIROBI SHOWING DAGORETTI DIVISION

COMPARISON OF CAUSES OF MORBIDITY FROM START OF 2ND PHASE TO MT

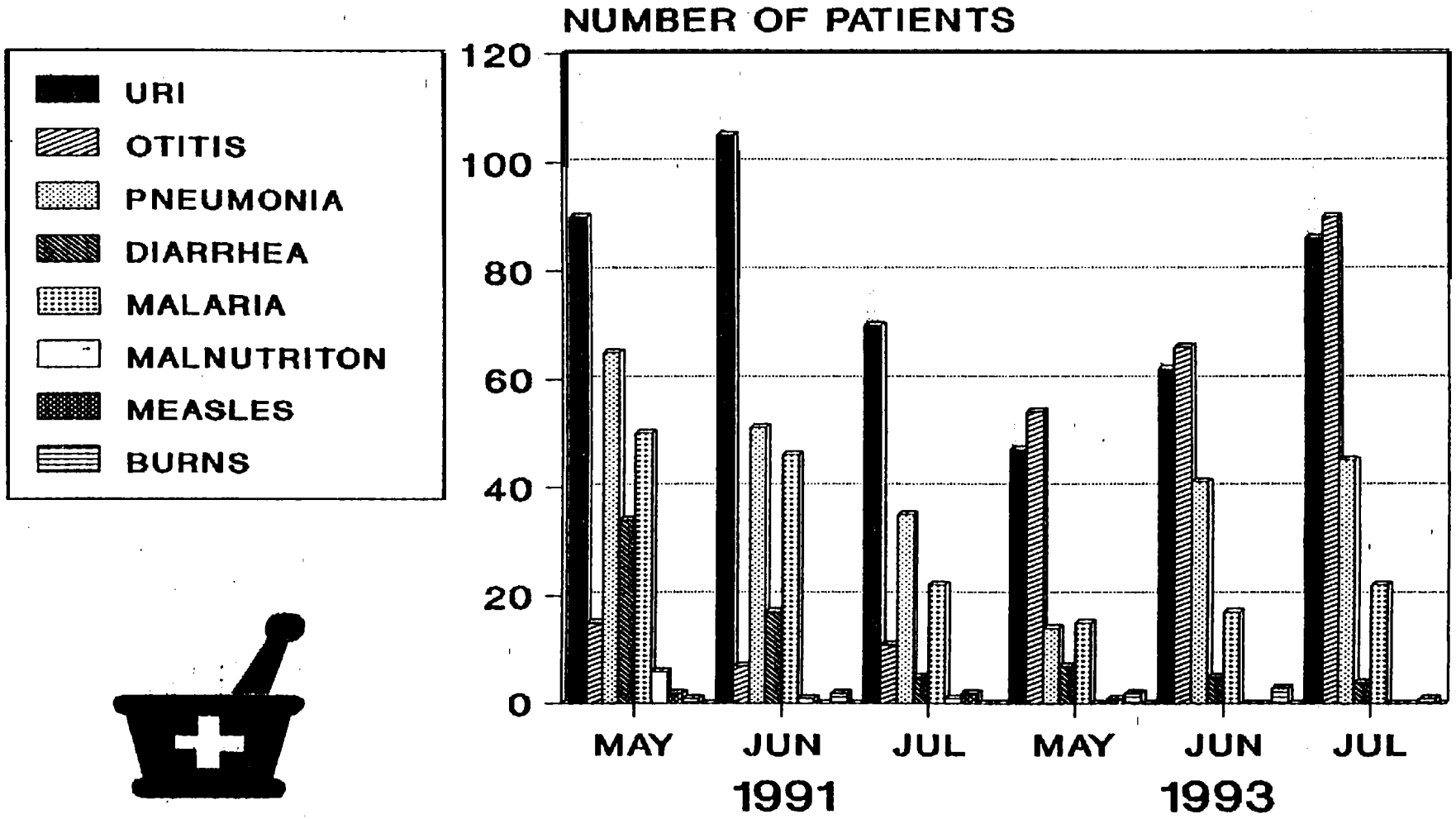

FIGURE ONE

SOURCE: HC STATISTICS

MONTHLY DISTRIBUTION OF SERVICES CHANDARIA-MIHV HEALTH CENTER

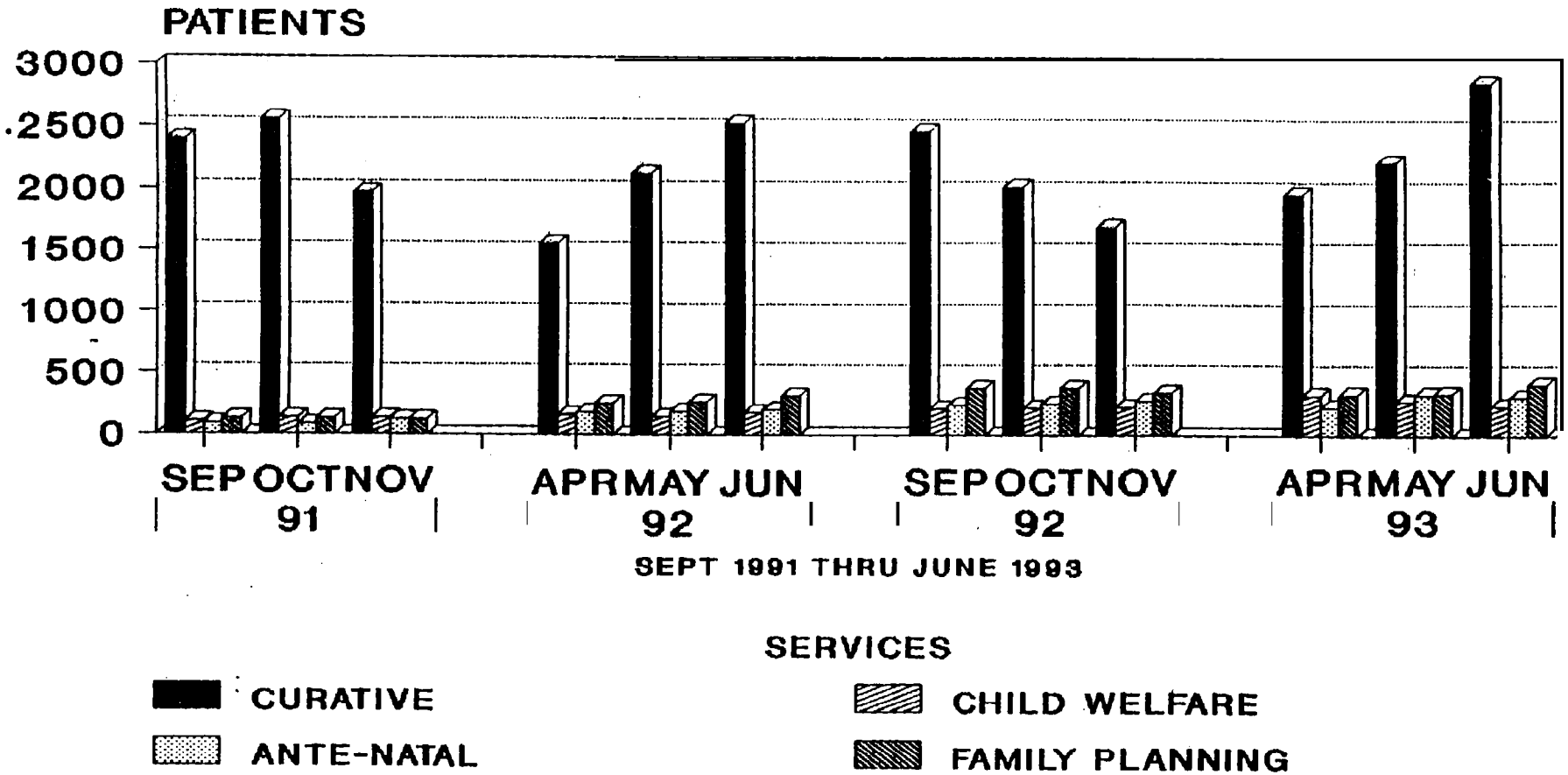

FIGURE TWO

SOURCE: HC RECORDS

DIST. OF MORBIDITY BY INFECTION AT CHANDARIA-MIHV

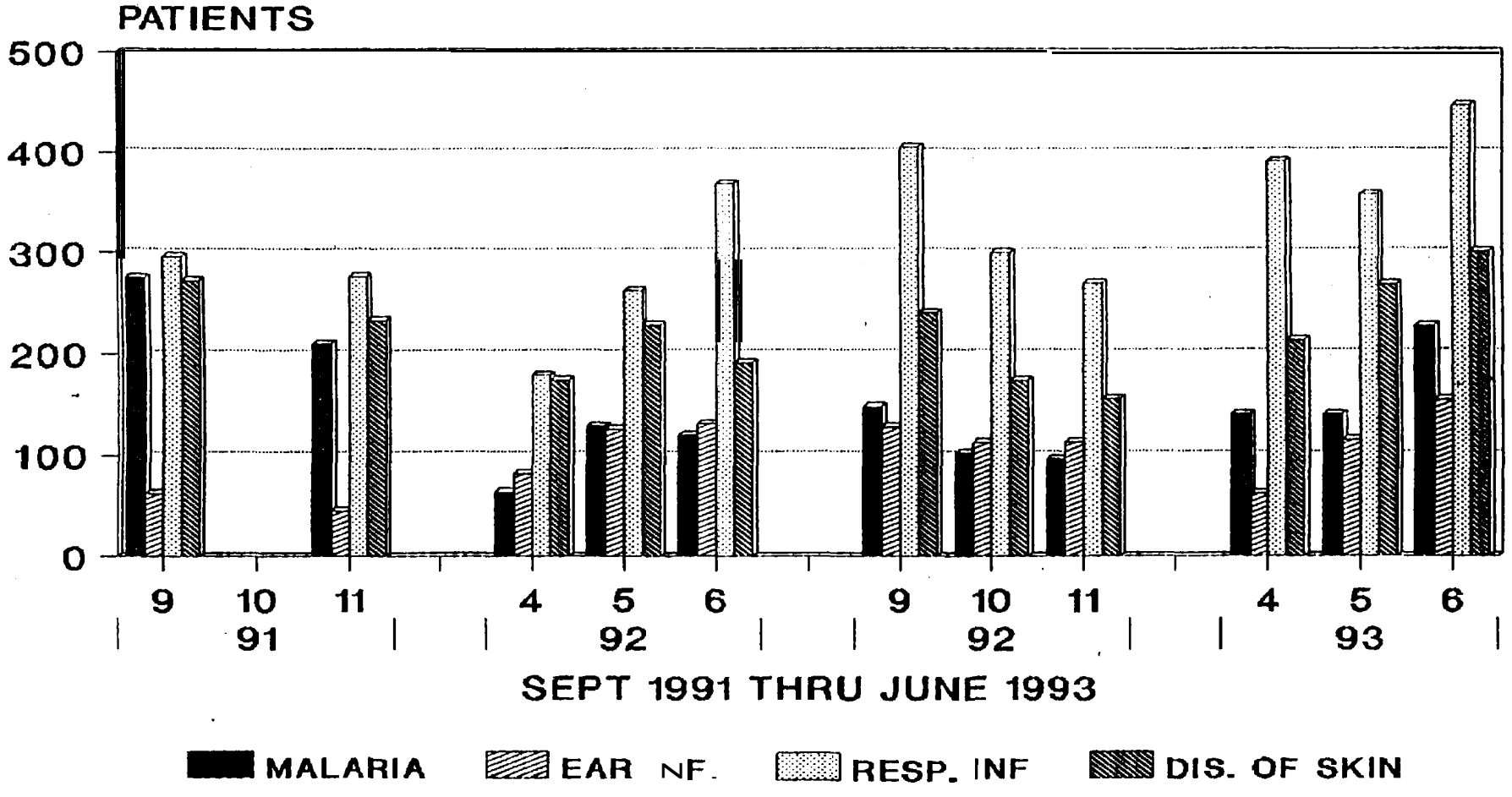

FIGURE THREE (B)

SOURCE: HC STATISTICS

FIGURE 4 - SAMFLES OF REGULAR MONTHLY/QUARTERLY/ANNUAL REPORTING FORMAT

1. INTRODUCTION:

   1.1 Brief statement to the background of month/quarter/mid-year (6 months)

2. MAJOR ACCOMPLISHMENTS

   Needs to be outlined in the outlined format

   E.g.
   - EPI
   - Nutrition/GM/Training/breastfeeding
   - Community participation
     - major activities done by the community with:
       a) project staff initiative
       b) own initiative
   - Training/health education
   - IGAs
   - Sustainability
     Specific event demonstrating indication for sustainability - done mainly done by community, government, NGOs or individuals

3. REGULAR/ROUTINE ACTIVITIES

   Those activities which are part of process - but which are common but not unique.

   E.g. Normal CSD intervention as planned

4. UNIQUE ACCOMPLISHMENT

   E.g.
   - community bought fuel for EPI team
   - CHWs/TBAs distributed FP contraceptive to 250 women in Mamba community etc.

5. CONSTRAINTS

   E.g.
   - Vehicle broke down
   - Politician interfered
   - Funds were delayed
   - Senior management canceled evaluation schedule etc.

6. PLAN OF ACTION FOR NEXT:-

   - month
   - Quarter
   - Year

7. RECOMMENDATION TO MANAGEMENT

8. FINANCIAL REPORT (SEPARATELY)

FIGURE 5 - SAMPLE OF QUANTITATIVE REPORT

Indicators	Pre-project BLS	Mid-term	Targeted/ Projected	Final	Remark
Immunization					
BCG					
DPT3					
OPV3					
Measles					
All					
TT					
Total					
Prevalence of moderate malnutrition					
No. of BOM meetings conducted					
No. of mothers using ORS					
No. of planning staff meetings held jointly per month/ quarter/annual					
Prevalence of contraceptive utilization					
No. of joint clinical/CBHC staff meetings held					
Incidence of diarrhoeal/diseases					
Prevalence of breast feeding					

FIGURE 5 (Contd)

Indi caters	Pre-project1 BLS	Mid-term	Targeted/ Projected	Final	Remark
No. of VHCs trained1 and active					
CBD Agents trained and active					
No. of homes visited by CHWs					
No. of CHW visited by supervi sor at their homes					
No. of CHW training1 sessions conducted					
No. of JHC/TOT training sessions					
No. of baraza's/ communi ty meetings					
Comments:					