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RURAL HEALTH/MATERNAL AND CHILD HEALTH/FAMILY PLANNING

United States Agency for International Development

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STAFF PAPERRURAL HEALTH/MATERNAL AND CHILD HEALTH/FAMILY PLANNINGTable of Contents

	<u>Page</u>
I. <u>BACKGROUND AND PURPOSE</u>	1
A. <u>Background</u>	1
B. <u>Purpose</u>	5
II. <u>EVALUATION: MAJOR FINDINGS</u>	6
A. <u>Family Planning Program</u>	6
1. <u>Specific Problem Areas</u>	7
Program Goals	7
Program Scope	8
Planning	9
Integration with Rural Health	9
Implementation	9
Health Education	10
Staffing	11
Evaluation and Research	11
Facilities	13
Management Systems	13
Accountability, Financial Planning and Reporting	14
Donor Liaison	14
Training	14
2. <u>Recommendations</u>	16
Change the Program's Goals	17
Change the Program's Scope and Time Frame	17
Change the Scope of the USAID Family Planning Project	18
Improve Health Management Systems	19
Improve Donor Coordination	20

	<u>Page</u>
Additional Program Recommendations	20
Health Education Unit	20
Data Collection and Service Statistics	21
<u>B. Rural Health</u>	23
1. Assessment of the GOK Family Planning Program	24
GOK Health Care Policy	24
GOK Family Planning Policy	24
Relationship between Health and Family Planning Policies	25
<u>I. PROPOSED USAID APPROACH</u>	29
<u>A. Introduction</u>	29
<u>B. Continue Family Planning Support</u>	30
1. Change the Demographic Goals of USAID's Project	31
2. Change the Scope of USAID's Project	32
3. Provide a Planning Study to Health Education Unit	32
4. Provide a Planning Study to the Training Division, NFWC	32
5. Provide Statistical Backstopping	33
6. Assist in the Purchase of Service Delivery Points	33
<u>C. Provide Long-Term Technical Assistance</u>	34
<u>D. Expand Rural Health Through MCH</u>	34
1. Health Awareness/Health Motivation	35
2. Nutrition Awareness/Nutrition Screening	35
3. Training	37
4. Health and Disease Data	37
5. Technical Assistance	38
<u>V. CONCLUSIONS AND COURSE OF ACTION</u>	39
 <u>APPENDIXES</u>	
APPENDIX I PLANNED USAID COMMITMENT	A-1
APPENDIX II GOK FAMILY PLANNING PROGRAM ACCOMPLISHMENTS	A-2
APPENDIX III RURAL HEALTH PROBLEMS AND NEEDS: A SUMMARY	A-4
APPENDIX IV AN ILLUSTRATIVE MCH SERVICE DELIVERY POINT	A-9

## STAFF PAPER

### RURAL HEALTH/MATERNAL AND CHILD HEALTH/FAMILY PLANNING

#### I. BACKGROUND AND PURPOSE

##### A. Background

It is generally well known that the Government of Kenya (GOK) was the first African government south of the Sahara to enunciate a population policy, and to inaugurate a program designed to achieve that policy's goals. In 1965, just two years after independence, the GOK requested the Population Council, Inc. to make a study of the impact of population growth on development, and to place before Government recommendations to deal with the situation. In a large part as a result of that study, the Government announced in 1966 its intention "to pursue vigorously policies designed to reduce the rate of growth through voluntary means." Concurrently the GOK announced that family planning was to become a part of the Government's overall development policies.

In 1967 the Government launched its National Family Planning Programme with the stated intention to provide family planning information and services throughout the country to those who wanted them. A major shift in policy and program emphasis came in a new five-year (1974-1979) Maternal and Child Health/Family Planning Program, when specific demographic and program targets were set, and a comprehensive, complex plan was written to achieve these targets.

The United States Agency for International Development is one of six international donors committed to helping the Government of Kenya do something about a very serious population growth problem. In 1974, IBRD/IDA, SIDA, UNFPA, DANIDA, FRG and USAID agreed to help the Government of Kenya with its second five-year family planning program. The total cost of this multi-donor, five-year effort is estimated to be about \$41.0 million.

It is assumed that if all donors and Government maintain interest in and commitment to the project, the necessary national infrastructure will have been created (i.e., enough personnel trained, adequate facilities created, staffed, and offering services, people properly motivated, etc.), so that by the end of the plan 640,000 contraceptive acceptors will have averted 150,000 births, which in turn will have the ultimate demographic

impact of reducing the natural rate of increase from 3.3 percent per annum to 3.0 percent per annum.

The U.S. Agency for International Development has long recognized the serious implications of sustained high rates of population growth on economic development and human health, so it was only natural that A.I.D. would respond favorably to the Government's request for assistance for the national family planning program. The Program began in late 1974, but a GOK/USG Project Agreement was not signed until June 16, 1975.

Briefly, the five-year MCH/FP program was to have created a national infrastructure composed of the following major elements:

1. A National Family Welfare Center consisting of four Divisions: Clinical Services; Training; Information/Education; and Research and Evaluation.
2. Associated facilities including a training center, a demonstration family planning clinic, and a Health Education Unit.
3. Thirty rural health centers.
4. Eight community nurse training schools.
5. Forty-six nurse trainer/supervisor (NT/S) offices.
6. Forty-six Family Planning Education Field offices.

With this national infrastructure in place, the following end of project status would be achieved.

1. 400 full-time Service Delivery Points (SDP's) staffed by 400 trained enrolled or community nurses and 800 Family Planning Field Workers (FPFW's) would be offering total MCH/FP care on a daily basis.
2. 190 part-time SDP's served by 17 mobile units staffed with 17 enrolled or community nurses and 17 Family Planning Field Workers would be offering MCH/FP care on a part-time basis.
3. Employment in the program would reach the following limits:
  - a. 417 Community Nurses employed,
  - b. 217 Family Planning Field Workers employed,
  - c. 92 Supervisory/Professional workers employed,
  - d. 12 NFWC Administrative Personnel employed,
  - e. 99 Health Education Unit (HEU) workers employed.

(The entire program including donor and GOK contributions is spelled out in IBRD/IDA documents 266a-KE and 267a-KE, February 1974.)

A.I.D.'s Non-Capital Project Paper (PROP) signed December 3, 1974 envisages that USAID will provide the following to the MCH/FP program. (USAID costs were estimated at \$3.53 million over the five-year period.)

Personnel:

- Communications Advisor
- Public Health Educator
- Short-term Advisors
- Contract Personnel
- Population Officer

Training:

- Provincial Medical Officers
- District Medical Officers
- Provincial Matrons
- Nurse Supervisor/Trainers
- Family Planning Field Officers
- Health Education/IE&C Officers
- NFWC Staff
- Research/Evaluation Staff
- Nurse Tutors

Commodities:

- Audiovisual equipment for the HEU
- Small scale office equipment for the NFWC
- Clinic equipment for fixed service points
- Clinic equipment for mobile service points
- Condoms
- Other contraceptives as needed

Other Costs (Salaries/Operational costs on a reimbursable basis):

- Administration of NFWC
- HEU personnel
- Supervisory Officers, Provincial and District Personnel
- SDP personnel

As mentioned previously, the USAID cost for these activities was estimated to total \$3.53 million over the life of the Government's program. If planned FY 1975 obligations had been made, \$974,000 would have been obligated rather than the \$52,000 which was obligated for five long-term participants. Had the program started on time and had USAID obligations been made according to the PROP, a total of \$2.432 million would be obligated through FY 1976. Instead, total USAID obligations to date have been \$92,125 with an estimated obligation of \$467,000 for FY 1976. Thus, rather than \$2.432 million obligated by June 30, 1976, as anticipated, approximately \$559,125 will be obligated.

Inputs from all contributors were estimated to be:

<u>Donor</u>	<u>In \$ Millions</u>	<u>Major Purpose</u>
GOK	10.1 - 14.3	Personnel, Operating, Capital, Research
IBRD	12.0 (Loan)	Construction, TA, Vehicles, Prog. Adv.
SIDA	5.4	TA, Rent, Salaries, Constr., Trng., NEU
USAID	3.5	Personnel, Trng., Commodities, Other
UNFPA	3.0	Equipment, Salaries, Advisors, Research
NORAD <sup>1/</sup>	1.8	NFWC, Capital/recurrent costs/salaries
FRG	0.9	Trng. School
DANIDA	0.6	Trng. School
<b>Total</b>	<b>\$37.3 - \$41.5</b>	

A look at planned USAID commitments vs. all actual project obligations (Appendix I) will show that not only were total financial obligations behind, but discrete program activities as well; namely participants trained, salaries paid, consultants used, commodities ordered.

GOK program accomplishments as of late 1975 are shown in Appendix II. Again, in specific areas program targets were behind, especially in hiring of personnel, production of educational materials, personnel trained. In fact, only acceptors and Service Delivery Points (SDP's) appeared to be approaching target levels.

<sup>1/</sup> NORAD withdrew from the program in March 1975 but re-programmed its commitment to construction within the Rural Health Program.

It was against this backdrop in mid-1975 that USAID began to seriously question whether its initial commitments were accurate and whether some adjustments were called for. Further, USAID had reservations that the program as designed could affect the serious demographic problems facing the GOK.

Throughout late 1974 and through most of 1975, there was some growth (and growing pains) in the Program and some small amounts of donor monies began to trickle into the Program. By no means was the Program stagnant, nor progress non-existent during this period. In some respects considerable efforts on the part of MOH personnel brought both respect and results. However: (1) because of the slow start up and slippage in parts of the program in the first year or so; (2) because USAID/Kenya had for some time serious questions about the Program's ability to impact on fertility; and (3) because USAID/Kenya was not satisfied it (USAID) was doing all it should (could) in the health sector, early 1976 seemed like a propitious time to undertake an evaluation of USAID's Family Planning Project and to make any adjustments called for early on. Such an evaluation was undertaken in January 1976 with the assistance of two non-U.S. Government physicians.

B. Purpose

The purpose, therefore, of this Staff Paper is to consider major portions of the evaluation report as well as consider what approaches and needs for USAID assistance might be called for. The following section looks at the major findings of the evaluation.

## II. EVALUATION: MAJOR FINDINGS

The terms of reference for the evaluation included:

This evaluation will primarily assess the capacity of the current program to solve the serious problem of population growth, the program's progress to date, problems encountered in the implementation, and at the same time evaluate AID's contribution in helping Government achieve demographic targets of the national five-year program. Whether AID's assistance, as currently envisaged and planned, can in fact contribute to alleviating these severe demographic pressures is the question at the center of the evaluation. If the conclusion is negative, the question which the evaluation must address is how can AID's financial and technical assistance be brought to bear on, and more effectively be utilized in, the achievement of Kenya's national family planning program goals.

### A. Family Planning Program

With respect to the mandated points in the above paragraph the following were addressed by the report.

... the capacity of the current program to solve the serious problem of population growth

The evaluation concluded that the demographic goals of the family planning program were both unachievable and unverifiable. The evaluation did not in any way diminish the seriousness of the population problem or the necessity of solving it, but simply indicated that other, perhaps more operational goals be substituted while keeping in mind that a demographic impact is ultimately necessary. The evaluation did not address the question of whether the GOK's MCH/FP efforts would or would not eventually impact on population growth.

... the program's progress to date

Taking into account the growing pains of a nascent program, the evaluation found both significant progress --- especially in training and in the establishment of Service Delivery Points (SDP's) --- and significant inaction --- especially in Information, Education and Communication, planning and implementation, donor liaison and communications. Specific key problem areas were identified, and recommendations to address those problems were made.

problems encountered in implementation

Problems impacting on implementation were identified as: (a) difficulty in achieving demographic goals; (b) lack of an up-dated timetable of events (re-planning); (c) complexity and immensity of the Program; (d) ambiguity in differences between rural health and MCH/FP; (e) problems attendant to posting and hiring of personnel (i.e. staffing); (f) the need to strengthen "the planning, operations, evaluation, training and financial management of the Family Planning and Rural Health Programs"; (g) poor donor liaison; and (h) lack of an up-dated manpower and training work plan.

1. With respect to implementation, the evaluation report identified the following SPECIFIC PROBLEM AREAS:

"Program Goals

The goals of the Program as originally proposed in the World Bank Plan are based upon a projected demographic impact, i.e., a reduction in the rate of natural increase of 0.3%. This endpoint would presumably be measurable. As an intermediate to this demographic goal, it was stated that 150,000 births would be averted by the projected 640,000 acceptors of contraception through the life of the 5-year Program. Therefore, the projected number of acceptors was considered an intermediate goal.

During the pre-program period in 1973, many individuals who reviewed the plan questioned the possibility of achieving the demographic goal. Many doubts that were raised then are still present. First, even under optimal implementation, the Program is projected to have direct impact upon less than 10 percent of the fertile women in any year. Thus, the effectiveness of the Program on the fertility of these women who do accept could easily be obliterated by any of several trends that might be experienced by the remaining 90 percent of the reproductive women.

Next, the measurement of the Program's impact is dependent upon the ability to measure the birth rate, a problem that was apparent in the initial years of the Program.

The vital statistics quoted for the initial year are different in various source documents, so that the starting point is not clear. Even today there are significant segments of the population not covered by reliable birth registration.

The use of acceptors as an index of success can be valid from the point of view of services delivered. Without a rigorous method of record linkage through which one can ascertain continuity of care for each patient, however, it is a giant leap of faith to relate the number of acceptors to the number of births averted.

The goals of the Program may have been carefully thought through in a demographic or academic sense. On the other hand, the operational goals that would have to have been identified and then achieved before demographic success could occur are certainly inadequate. Therefore, we emphasize again, as was done in 1973 by several reviewers, operational goals need to be projected for each operational year. A timetable of expected events needs to be updated annually and circulated within the GOK and to all donors.

Further, the goals of the Program are stated almost entirely in family planning terms. It is certainly clear that although the activities in the MOH do include family planning, it is definitely in a secondary role. The MOH program goal, as we perceived it, would be more appropriately defined as an effort to expand a rural health care delivery system of integrated services with emphasis on preventive services, including child welfare, antenatal care, nutrition and family planning.

#### Program Scope

The original proposal was very complex and included:

- construction or renovation of many new service delivery facilities,
- service delivery,
- construction of training
- student selection,
- manpower training.

The major problem in scope is the immensity of the Program. Even the role to be played by AID, or through AID support, is extremely broad.

### Planning

The original plan for this massive multidonor Program was the World Bank proposal, written in 1973. This original document was then revised by the GOK/MOH. Since that time there have been no major updates of the plan. During one of the Evaluation Team's meetings with representatives of the MOH, it was said that once the final Kenyan proposal was completed in December 1973 all the planning had been done. Presumably, what remained was to implement according to that master plan.

This is contrary to the approach used in many successful health programs. Although formal documents need to be updated only periodically, planning and re-planning must be a continuous process. At least once a year, there should be a new plan written with revised timetables for all outstanding events.

### Integration with Rural Health

While the original GOK/World Bank Program stressed family planning, the total MOH action program heavily emphasizes the fact that all clinics are integrated and therefore offer many services. Further, the Rural Health Division of the MOH is the central point of supervision for the whole system of government clinics and out-patient services. The lines of delineation between the Rural Health Program and the MCH/FP Program are very unclear or non-existent. This ambiguity raises questions about the chain of command and lines of control from the staff levels of the MOH to the common service delivery points in the field. This may, of course, only be a problem for donors like USAID/Kenya who seek to identify clear family planning inputs and outputs.

### Implementation

... The entire Program, with the exception of the recognition of established service delivery points, is behind schedule. Many of the delays in implementation

are closely related to gaps in detailed planning and in the non-recognition before the fact of the intricacy or complexity of certain chains of events at the time they were initiated. Further, the GOK may too readily have accepted the World Bank projections on the rapidity with which plans can be converted into action. Once difficulties in implementation became clear, it would have been highly desirable to reschedule many events, even pushing forward whole segments of the plan.

A case in point is the utilization of trained family planning field workers. The proposal, signed by the World Bank and the GOK in December 1973, projected 200 FPFWS in the first year, and 200 in the second. From that one could believe that there should be 400 FPFWS in the field at present (January 1976). In fact, there are only 48, and these had their first formal training in October 1975. Admittedly, there are now more positions in the GOK for FPFWS. These have only recently been established, however, and the tasks of appointing these new individuals and training them will require months.

#### Health Education

A major problem in the Program's Health Education Division is the ambiguity of leadership. Essentially the Director answers to many individuals at the next higher level within the MOH. It is not at all clear how priorities are set or through what mechanism specific products are delivered.

In addition, it is not easy to determine who pays for what. Therefore, if a donor wanted to support one particular educational process which could be used for all health services, it could be done. But if a donor wished to support health education activities for only selected services it would be very difficult to do and to show, after the fact, that the products had been delivered as expected.

The Information and Education Section of the Health Education Division is responsible for generating ideas which are to be translated into educational messages. Then the Graphic Arts Section produces the audio-visual materials needed to get the messages across. Although a few brochures and posters have been created, there was no flood of creative ideas apparent. This despite an already heavy investment in the program from earlier USAID projects, stretching back for over four years.

Another major difficulty in evaluating the status of activities within the Health Education Division is the absence of a pre-defined work plan. Expectations exist as undated desires, and operation changes that result from external constraints are not readily apparent. For example, the most recent plan for health education materials for 1976 included the production of 200,000 calendars. It is not at all clear, however, that calendars will be produced for 1976.

Finally, the Health Education Division has apparently become the section responsible for training of PFWs - rather than the Training Division. The first training course was held in October 1975, and it is not clear why this activity was so late in occurring. There is a definite need to establish a sound training base, but the rationale for separating the responsibility for medical and non-medical training is questionable.

#### Staffing

Problems of personnel management appear to be particularly acute. First, the establishment of new positions is extremely difficult. Preparations must be made years in advance so that the personnel ceilings in specific sections can be raised appropriately. Second, once a position is established, recruiting persons with adequate background is difficult because government salaries are not competitive with the private sector. Third, even though unemployment in Kenya is high, requirements for the majority of the jobs created through the new program require skills that may not be readily available. Fourth, recruiting procedures require that all applications go through the Office of the Permanent Secretary. It can take months for the applications in a specific area to get back to the people who will be doing the hiring.

#### Evaluation and Research

The Evaluation and Research Division occupies a key role in GOK's Family Planning Program. The Evaluation Team feel that the Division's primary responsibility should be the evaluation of the Program's operations and management. At present, the Division is staffed by two experienced expatriate advisors and a GOK supported statistician. The head of the Division has not yet been recruited. In the meantime, however, service statistics are beginning to be compiled and analyzed.

With regard to the Division's interest in academic research, it should be pointed out that there are tremendous difficulties inherent in attempting to do such research within any service delivery program. Research standards must be extremely rigorous if one is to demonstrate causality. Further, the tremendous difficulties that exist in Kenya just to maintain operational statistics preclude the possibility of valid academic research within the current program context. No research has been started within the current program, and we do not think that academic demographic research is indicated.

Even when the issue of causality is not at stake, but one wants to prove effectiveness or efficiency of certain approaches or methods, records must be very carefully kept, and must be easily retrievable.

Earlier, the impracticality of pursuing a demographic endpoint as a goal was discussed. Here it must be stressed that service statistics can never be adequate to show a demographic impact. In family planning, service statistics address only the individuals who have entered in service population, and not the universe at risk. However, vital rates, measures of demographic impact, are determined by the actions of the whole universe of fertile women. Therefore, the service population's fertility or non-fertility, is not indicative of the whole population's fertility or non-fertility.

Service statistics may be adequate to show acceptors, and if these records are kept in such a way that records about sequential events for single patients can be linked, the continuity of care can be determined and estimates can be made of births averted. However, even the estimate of continuation rates for patients in Kenya is made very tenuous for the following reasons:

- Unique identification of patients over time is very difficult. A significant portion of patients are illiterate, and therefore even the spelling of their names depends upon the nurse, or record keeper, and a turnover of personnel is to be expected. Patients are given a card with a pre-assigned number, but when that card is lost (which was reported to occur frequently) the thread of continuous identity through

an assigned number is easily broken, even when a woman returns sequentially to the same clinic.

The patient population is known to be geographically mobile, but the actual frequency of mobility among clinics is unknown. During our field investigation it became clear that one woman could be enrolled as a new acceptor in several clinics in any one year, which would create two kinds of errors. On the one hand, the new acceptor count would be falsely elevated. On the other hand, the continuation rates (assuming this type of patient would stay non-pregnant as she goes from clinic to clinic) would be falsely low, because she would appear as a drop-out in each of the clinics to which she failed to return.

#### Facilities

At the time the original GOK/World Bank proposal was written, assumptions about the adequacy of facilities already in existence were made. These assumptions proved to be inaccurate once the implementation of the plan was begun. In order to approach the number of service delivery points originally projected, additional space will be required in about 200 locations. The Director of Clinical Services has requested 200 prefabricated units and has proposed four different designs, which in turn are dependent upon the location and the projected patient load. The cost for these units was obviously not included in the original plan's projections, and the GOK will probably seek donor assistance to finance these additional units.

#### Management Systems

Part of the difficulty in implementing the Family Planning Program is due to the need for improved management systems in the MOH. In the past, USAID/Kenya has tried to interest the GOK regarding possible support for such an effort... [Little] action has been taken in this area. Nevertheless, it is recognized, not least of all by the MOH, that steps must be taken to strengthen the planning, operations, evaluation, training and financial management of the Family Planning and Rural Health Programs.

### Accountability, Financial Planning, and Reporting

At present, the Director of the Family Planning Program does not have a fiscal advisor who is responsible for knowing the accountability requirements of all the donors plus the budgeting requirements of the MOFP. Thus, there is no one charged with the maintenance of fiscal plans, the records on all expenditures to date (particularly those which are expected to be reimbursed by any of the donors), nor the preparation of the fiscal aspects of all reports to the donors.

### Donor Liaison

The GOK was supposed to be the point of central communication for all the donors. Actions to date suggest that the GOK wished to deal with each donor individually, but as often as the donor wished. This approach has led to varying degrees of dissatisfaction among the several donors, because none of the donors wish to be redundant, and almost all are interested in hearing what the others are doing.

### Training

The training portion of the Program is truly an immense undertaking. Many of the difficulties were unrecognized in the earliest planning stages, and updated plans reflecting the myriad of details that must be taken into account have not yet been produced.

A very significant drop-out rate appears to plague all levels of trainees, the enrolled nurses, the health educators, and even those who will become the nursing trainers. Clearly the GOK must begin to plan for high attrition rates during training, and a loss to the open market right after training. This is a major constraint to be quantified and be taken into consideration in all future training proposals.

The 8 week training program for registered nurses appears to be successful and the request was made that it should be continued beyond the number originally projected for training (42). Further, a most appropriate request was made to run refresher courses on family planning for the 4,000 enrolled

nurses who are currently in the field but who have never received any updated instruction in family planning. To date, neither of these requests is in the original plan, or in any formal request to a donor."

... evaluate AID's contribution in helping Government achieve demographic targets

After thoroughly reviewing inputs, outputs and progress to date, the evaluation concluded that USAID places too high a priority on family planning, demographic targets, and found USAID's response inadequate in several important respects: "If this situation persists, USAID/Kenya may be making a mistake in putting all its Population/Health resources into one family planning basket that has a demographic impact as the only outcome that would be considered a success."

The report also states: "In addition, USAID/Kenya's policy in this sector places its emphasis on rapid population growth and its socio-economic consequences. It ignores the health sector with all its humanitarian and development related aspects. Furthermore, it is almost totally oblivious of the nutrition sector."

"Therefore," the report continues, "the conclusion of the Evaluation Team is that USAID/Kenya's Population/Health policy, and the implementation of that policy primarily through the Family Planning Project, do not measure up to the great potential that this sector offers the U.S. foreign assistance program in Kenya."

However, the evaluation recognized that USAID was not unaware of these deficiencies and was receptive to taking steps to improve its response -- the first step being its willingness to have itself evaluated and to look at alternative futures.

The terms of reference above continue: "Whether AID's assistance, as currently envisaged and planned, can in fact contribute to alleviating these severe demographic pressures is the question at the center of the evaluation."

... if the conclusion is negative, the question which the evaluation must address is how can AID's financial and technical assistance be brought to bear on, and more effectively be utilized in, the achievement of Kenya's national family planning goals.

The evaluation did not address in a specific yes or no way whether

or not AID's (and others) assistance would eventually alleviate Kenya's severe demographic pressures. The evaluation did strongly suggest and urge that a different approach by USAID would be more amenable to the policies and programs of the Government of Kenya and the United States Government; namely that USAID should more closely integrate its MCH/FP assistance with other Rural Health activities. Indeed, a part of the evaluation responded with the rationale for this suggestion. (See: B. Rural Health)

2. With respect to the SPECIFIC PROBLEM AREAS above, the evaluation report made the following RECOMMENDATIONS:

"A project as large as the GOK's Family Planning Program would be difficult to implement in any country, including those with more resources, manpower and a more complete health infrastructure. As the Program enters its third year, it is clear that there have been both notable successes and difficult problems. Almost all of the problems identified in the Evaluation Team's ... review seem either soluble or avoidable. But to do either will require a significant amount of work.

With regard to USAID/Kenya's participation in the Program through its Family Planning Project ..., it appears that a revitalized spirit of cooperation is urgently needed. ... Communication is the basic problem, but the burden of correcting miscommunication {devolves upon} both USAID/Kenya and the GOK.

... Contributing factors ... are:

- ... disparity of goals
- varying appreciation of the magnitude of the Program
- differing perceptions concerning the relationship of the Rural Health Service Program and the Family Planning Program
- divergent opinions regarding the need and usefulness of improved health management systems.
- inadequate donor coordination.

There follows recommendations regarding these five factors .

Change the Program's Goals

The demographic goals that are currently defined for the GOK/MOH Family Planning Program condemn the Program to certain failure. Without adequate baseline data and reasonably accurate vital statistics, it is impossible to measure the Program's impact on population growth rates.

The Evaluation Team strongly recommends that the Program's goals be altered and that emphasis be given to operational objectives. This approach has been discussed with the GOK Ministries of Health, and Finance and Planning, as well as with most of the other donors. All seem to be in agreement that a re-examination of the demographic goals is in order.

Change the Program's Scope and Time Frame

The GOK's Five Year Family Planning Program is probably the largest and most complex project that the MOH has had to implement in the past decade. The Program requires that many pieces be put into place including:

- an organizational structure including the National Family Welfare Center
- manpower
- management systems
- training programs
- educational/motivational program
- new or renovated facilities
- equipment

At the present time, the implementation of some parts of the program (e.g. training) are outpacing others (e.g. communications). It is doubtful if all of the pieces of the program will fall neatly into place during the five-year time period. Furthermore, it is questionable if sufficient funds will be available during the five years to finance the total program as originally conceived. This is due to the fact that such costs as construction/renovation and inflation were not adequately accounted for in the original plan.

In addition, it is not certain that the Rural Health System has the capacity to absorb the Family Planning Program as presently designed.

Another important factor is the magnitude of the recurrent costs of the Family Planning Program. This has previously been estimated to represent an average growth in the MOH's budget of 11.3 percent per year. It appears, however, that the original Five Year Plan underestimated several aspects of the Program including costs for facility construction and renovation.

Thus, consideration must be given to one or both of the following alternative courses of action:

- A downward revision in the operational goals of the Family Planning Program.
- An extension of the program time period beyond 5 years.

A decision regarding these alternative courses of action would require:

- extensive review of the Family Planning Program's accomplishments.
- detailed revision of the Five Year Plan.
- identification of key program components with a recalculation of their costs.
- realistic appraisal of the time required to accomplish such goals as manpower recruitment and training, facilities renovation or construction, and family planning information and education programs based on the first two year's performance.
- consultation with the Ministries of Health, Works, and Finance and Planning.
- consultation with the donors.

#### Change the Scope of the USAID Family Planning Project

The scope of USAID/Kenya's Family Planning Project must become more compatible with the health policies and rural health emphasis

of the GOK/MOH. This will require some modification of the USAID project. It is quite likely that this change will be welcomed by AID ..., particularly with the new emphasis on the development of rural health delivery systems.

At the same time, the MOH should take into account the broader base of service delivery that is available through the missions and voluntary agencies. It is obvious that the rate at which the MOH can absorb the large amounts of aid potentially available to it is limited by many external constraints. Meanwhile, there are many non-governmental service delivery outlets (e.g. missions hospitals) that could expand much more rapidly because they are free from constraints of funding ceilings, personnel ceilings, etc.

#### Improve Health Management Systems

The Government of Kenya's MOH is well aware of the management problems related to its organizational structure, functions and staffing. The GOK's "Development Plan 1974-1978" and the MOH's "Proposal for the Improvement of Rural Health Services" identify these areas quite clearly.

Despite Kenya's health care and health management needs, Kenya's potential is great for achieving a sound health delivery system during the next two decades. USAID/Kenya recognizes this potential and would like to assist the MOH deal with some of its health management problems. ...

In no other sector could USAID assistance be more timely. Such support, however, [to] be offered within the context of the dedication and professionalism that characterizes the personnel in the MOH.

The Evaluation Team believes that a proposal should be made to the MOH to modify the existing Family Planning Project to include long and short term technical assistance in a wide variety of health care disciplines. Consultants, to be chosen and assigned by the MOH with the concurrence of USAID/Kenya, should be made available not only to the GOK Family Planning Program but to the entire MOH as well. This technical assistance might include such areas as:

- planning
- manpower
- accounting and budgeting

- logistics
- data and service statistics
- facilities management
- health education, communication and information.

#### Improve Donor Coordination

In discussions with several donors, all were interested in more frequent donor meetings.

If donor coordination is to be improved, it must be done with an appreciation for the views of the GOK/MOH. It would be important to inform the MOH of any joint meetings or impending joint actions of the donors. It would be appropriate to invite an observer from the MOH to attend all joint donor meetings.

In addition, the initiative for improving donor coordination and for providing the forum for meetings should probably come from one of the international organizations.

#### Additional Program Recommendations

##### Health Education Unit

A difficult decision must be faced by USAID/Kenya with respect to the continuing support of the Health Education Unit. One American technician<sup>worked</sup> in Kenya for four years and was expected to train 20 health educators each year. He left last year and had been able to train only 14, of whom only 6 remain with the program. Another American technician's tour will terminate in June of 1976 and there is no Kenyan to take his place in the highly technical audio-visual arts production area.

The dilemma is clear. If USAID/Kenya decides to end its technical assistance in this field, the Health Education Unit will be reduced to a few idea men and a printing press. However, large amounts of highly complex audio-visual equipment have already been requested, and they would serve no purpose if there were no one in the MOH competent in this technical area. Furthermore, with the repeatedly demonstrated high dropout rate among trainees, it would seem naive to think that a single additional year for an audio-visual advisor would put the program close to a self-supporting level. Therefore, the provision of technical assistance by an audio-visual aids advisor might be based on a projected 3-4 year commitment.

...

On the other hand, there is a group of fourteen health educators now in training. Either long term or short term consultation for that group might be highly desirable. Additional requests have been made for short term consultation.

This type of commitment to health education is clearly dependent upon the resolution of the original goals and a policy shift in the direction of providing support services for integrated health service delivery.

Finally, the Health Education Unit has been the primary trainer of non-medical personnel. A specific request has been submitted to USAID/Kenya to support the trainers. That request should be reviewed when it is time to initiate any future project agreements under the Family Planning Project.

#### Data Collection and Service Statistics

The potential for continuous, accurate assessment of services delivered can be realized if the 80 statistical clerks to be hired are adequately trained, motivated, and guided, and if the central office is staffed as projected. Currently there are great problems associated with the service statistics system as it now exists.

The Evaluation Team would like to make two recommendations:

- Discourage all discussions of esoteric studies, demographic modelling, or universal rapid feedback as the next steps in the research and evaluation system;
- Concentrate on the upgrading of the current system in such a way as to:
  - a) minimize the possibility of field errors by keeping the basic data demands as simple as possible and;
  - b) focus ... on a system of service surveillance that will give good ball park figures for:
    - i) number of working hours per clinic site per month by discipline of the workers

- ii) number of patient visits per month. This could be further broken down to determine number of patients who came primarily for child welfare, for pre-natal care, for nutrition, for communicable disease control, or for family planning.

In hope that continuation rates might be calculated, there must be careful review of the problems of unique identification of family planning patients over time and of mobility among various clinic sites.

Currently there are two UNFPA advisors in the Research and Evaluation Division who could be key resource personnel for:

- Defining the specific information which can be answered practicably by service statistics.
- Defining the levels of accuracy needed in the collection of service statistics in order to answer service questions.
- Training counterpart personnel in the central office and providing the original and in-service training for the field personnel in statistics.
- Designing the new forms that will be needed to provide service statistics for the integrated Rural Health Program.
- Implementing the new field record system and converting central office compilations to accommodate both the current and revised source documents until the family planning records now in the field are replaced or exhausted.

The Evaluation Team recognizes the problems associated with the use of a computer for this Program. However, the Team is divided as to the advisability of an expanded role for computerized records at this time.

Without long term consultants or frequent visits by the same short term consultant, any expansion of the current data collection and service statistics system would be perilous. The two T/A skills needed are (1) an experienced health records manager who has worked with computerized records and (2) a programmer-systems analyst.

There is an excellent resource already present in the advisory personnel on assignment from Dualabs. The contract with Dualabs has been extended

for a year but it should be redirected so that at least 50% of the time will be spent on MCH/FP needs. Thus, the only additional consultation needed would be that of an experienced health records manager.

Assessment of continuity of care can be done through clinic records only if sequential records for single patients can be successfully linked. If one has large numbers of records, the only effective way to do this is by computer, and this record linkage has already been begun by the Dualabs consultants.

The first responsibilities of the new record clerks should be record-keeping supervision at the clinic level. When they are experienced and know the record-keeping practices and problems in the field, they can begin filling in the gaps in the current data base. It would be preferable to work first with those clerks with the highest interest and motivation, and then spread the catch-up operations to all statistical clerks.

Currently there are many follow-up visits for which no first visit is recorded. The record clerks could take sample cases of this problem which originated from their own clinics and retrieve the true admission data. They could concurrently try to identify the various reasons why this problem occurred.

Next, the record clerks could identify a specific sub-set of patients lost to follow-up, and ascertain why this problem occurred.

Continuing in this way, the data collection aspects of the data system could gradually be strengthened. It must be recognized, however, that it will take several years before a smoothly functioning data collection system can be well established."

#### B. Rural Health

As stated above, a part of the evaluation report provided the rational foundation of an integrated rural health MCH/FP approach. The following are extracts from the report relating to "--- A new initiative in the health/population sector that integrates the family planning project into a rural health services project," an approach which appears to satisfy the views of recipient countries, the U.S. Congress, and AID.

The report has the following comments:

1. Assessment of the GOK Family Planning Program

GOK Health Care Policy

According to the GOK's "Development Plan 1974-1978", Kenya's main health objectives are to "control and prevent and ultimately to eliminate communicable diseases, deficiency conditions, environmental health hazards and those hazards associated with child-birth and child rearing."

The GOK recognizes that the major constraints that stand in the way of achieving these goals are:

- shortage of manpower,
- unsatisfactory levels of service in rural areas due to insufficient service delivery points.
- inadequate resources and organizations.

The emphasis in the GOK's health policy is on the development and improvement of health services. The Government will seek to expand paramedical training and implement an integrated and comprehensive plan for rural health services. This will involve the promotion and acceleration of preventive and family planning services. Both are appropriate areas of emphasis for Kenya.

Rural health services will emphasize maternal and child health services and include:

- health education
- nutrition education
- prenatal and postnatal care
- family planning services
- protective services (e.g. vaccinations).

To accomplish this goal, rural health delivery facilities will be improved, manpower will be added, and equipment will be upgraded.

GOK Family Planning Policy

As described in the GOK's "Development Plan 1974-1978", the Family Planning Program is a part of public health services, and will "concentrate on areas with high demand and high population density,

and delivery points will be made available in every district." Family Planning is primarily intended "to enhance the health and welfare of mothers and children." The service objectives of the Five Year Family Planning Program are well integrated into the GOK's "Development Plan 1974-1978." These include:

- the provision of daily services at the service delivery points (SDP's).
- the availability of services through mobile teams.
- the education and training of community/enrolled nurses in modern concepts of family planning.
- the employment of family planning field workers.

#### Relationship Between Health and Family Planning Policies

In reviewing the GOK's health and family planning policies, the Evaluation Team was impressed by two important points. In the GOK's "Development Plan 1974-1978":

- Family Planning policy is a part of the GOK's overall health policy and is not separate and distinct from it.
- No mention is made in the Health Chapter of the demographic goals of the family planning program. Indeed, the primary intent of the program is to "enhance the health and welfare of mothers and children."

In discussions with officials in the MOH and MFP, the Evaluation Team was told that family planning is a top priority of the GOK. Both groups stressed, however, that family planning is an integral part of the rural health delivery system, and is not a free-standing service. It was clear that the significance of the demographic outcome was much more important to the MFP than many officials in the MOH.

The desire of the GOK to integrate family planning with maternal child health services in a rural health system is illustrated by the fact that one man heads both the Rural Health and the MCH/ Family Planning program in the MOH. At the other end of the system, at the service delivery points, the integration of family planning with maternal-child health and other services is even more apparent.

Thus, it appears that the separate identification and emphasis give to family planning by AID and the other donors is not entirely shared

by the GOK. In actual fact the distinction is somewhat artificial. The major beneficiaries of the donors' support will be the rural health services program and maternal-child health services. Thus, there appear to be significant differences between donor and recipient priorities. The absence of demographic objectives in the GOK Health Policy indicates another area where donor and recipient goals may not entirely coincide."

The report identifies Integration with Rural Health as a specific problem area with these words:

While the original GOK/World Bank Program stressed family planning, the total MOH action program heavily emphasizes the fact that all clinics are integrated and therefore offer many services. Further, the Rural Health Division of the MOH is the central point of supervision for the whole system of government clinics and out-patient services. The lines of delineation between the Rural Health Program and the MCH/FP Program are very unclear or non-existent. This ambiguity raises questions about the chain of command and lines of control from the staff levels of the MOH to the common service delivery points in the field. This may, of course, only be a problem for donors like USAID/Kenya who seek to identify clear family planning inputs and outputs.

The report makes several recommendations, one of which is to change the scope of the USAID family planning project. In this respect the report states:

The scope of USAID/Kenya's Family Planning Project must become more compatible with the health policies and rural health emphasis of the GOK/MOH. This will require some modification of the USAID project. It is quite likely that this change will be welcome by AID/Washington, particularly with the new emphasis on the development of rural health delivery systems.

Actually the case of the non-separation of MCH/FP from Rural Health and vice versa, could even be made in stronger terms. Those familiar with the operational aspects of these activities could only be lead to the conclusion that the vast majority of Rural Health is Maternal and Child Health, of which Family Planning is a part. At the field operational level there is virtually no distinction between Rural Health and MCH. Attempted distinctions and terminologies that suggest these are two separate programs are therefore artificial. A single case in point: Family Planning Field

Workers (PPFW) are not what their title suggests but are in fact (and should be called) Family Health Motivators. Their training and their jobs clearly indicate they are to work in the community informing and motivating mothers to avail themselves and their children of the health services available. To inform about and to motivate toward the acceptance of family planning has no greater, nor no lesser, importance than mother, baby and child care. Many other examples throughout the system suggest a similar non-distinction between MCH/FP and Rural Health.

According to the WHO proposal for the Improvement of Rural Health Services, the Rural Health Program is concerned with four problem areas: Family Health; Communicable Diseases; Environmental Sanitation; Problems Related to Nutrition. If MOH officials were asked what the purpose of the Rural Health Program is, the reply would likely be: "to increase the efficiency and coverage of rural health care."

One problem not covered in the report is that the Rural Health (MCH/FP) project with its emphasis on promotive and preventive care is constantly competing for space, attention and resources with the more established and acceptable diagnostic, treatment and curative care. In a word, MCH/FP (Rural Health) is "the new kid on the block" and is trying to be recognized and accepted. The report does not define, or say what is meant by "integrated Rural Health."

For purposes of this Staff Paper, "integrated rural health" simply means planned coordination of various rural health functions into a unified program so that each of the functions has a direct relationship to, and impact on the process of rural health care and delivery.

The evaluation report presented USAID with five options for its consideration:

- (1) TERMINATE THE USAID FAMILY PLANNING PROJECT
- (2) MODIFY THE USAID FAMILY PLANNING PROJECT AND DECREASE USAID INPUTS
- (3) CONTINUE THE USAID FAMILY PLANNING PROJECT UNCHANGED
- (4) MODIFY THE USAID FAMILY PLANNING PROJECT AND INCREASE USAID INPUTS
- (5) DEVELOP A NEW INITIATIVE IN THE HEALTH/POPULATION SECTOR THAT INTEGRATES THE FAMILY PLANNING PROJECT INTO A RURAL HEALTH SERVICES PROJECT

The report recommended that USAID give consideration only to options No.2 and No.5 above. This Staff Paper recommends that Option No. 5 be given consideration. The remainder of this paper will attempt to give the

background needed for serious consideration of Option No.5 and to propose a possible USAID approach and a plan of action for implementing this option.

In summary, one could postulate three reasons for an integrated Rural Health/MCH/FP Project:

1. There is almost no distinction between Rural Health/MCH/FP in policy and practice in the Ministry of Health; i.e., they are viewed as the same thing.
2. There are new U.S. trends (post-Bucharest) which have the support of the Congress and the Secretary of State, which suggest more USAID involvement in rural health care.
3. One can recognize a sense of urgency among some Kenyans to do something about both health problems and demographic problems. Clearly Kenya has earmarked the disadvantaged rural poor for special health attention and has also realized the impact of population growth on achievement of development goals.

### III. PROPOSED USAID APPROACH

#### A. Introduction

Having looked at the problems and recommendations the evaluation report identified with respect to family planning and rural health, it is now appropriate to look at what the Rural Health (RH) program should be doing, and is doing, so that in some fashion one can arrive at suggested ways in which USAID might be of assistance.

WHO documents record that the primary health problems to be attacked by the RH Program are: Family Health (including family planning); Communicable Diseases; Environmental Sanitation; and Problems Related to Nutrition. Another document suggests the health objectives of the RH Program are to "control and prevent and ultimately eliminate communicable diseases, deficiency conditions, environmental health hazards and those hazards associated with childbirth and child rearing." (Development Plan.)

According to a World Bank document, the 10 year rural health plan "... is based on consolidation and expansion of rural health services and the provision of more effective MCH services coordinated with an expanded family planning program. This goal is to be achieved by reducing the shortage of qualified manpower, particularly at the paramedical level, and improving the coverage and distribution of rural health facilities." (Appraisal of a Population Project: Kenya IBRD/IDA Report No.266a-KE, February 20, 1974).

If health officials are asked what the purpose of the Rural Health Program is, the reply will likely be: "To up-grade and extend health care and facilities to the rural people." There seems to be general agreement that RH is both preventive and promotive in nature.

It would not be too severe, too critical, or unfair to make the statement that --- at the moment Kenya's Rural Health Program is basically, and for all intents and purposes, Maternal and Child Health. While there is some communicable disease control, some training of health workers in nutritional matters and nutrition talks are given at the clinic level, some effort at environmental sanitation (such as water surveillance and rat control, disease identification), there clearly is no plan, no emphasis, which will match the MCH component of Rural Health. It is MCH which is getting the most attention, the most commitment, the most money, the most human resources, the most publicity. MCH is often referred to in health circles as "an emphasis program within Rural Health." It has its own emphasis as well: Family Planning. Around family planning is built a potential bureaucratic empire: A National Family Welfare Center (NFWC) with four divisions whose personnel will eventually number in the hundreds.

On several occasions it has been stated by professionals in the MCH program that there can be no MCH program without family planning just as there can be no MCH without prenatal counselling and care, and therefore to speak of MCH as MCH/FP is redundant. This view is expressed in different ways by different health workers but the view is the same: maternal care is not complete maternal care without family planning.

Thus, one conclusion so far is that USAID through its Family Planning Project is already involved in Kenya's Rural Health Program. There is almost no part of the Government's national family planning program which does not affect the broader aspects/goals of the rural health program.

Another conclusion is that at the moment, with the sole exception of the government's efforts to increase the efficiency and availability of services to the rural people, little in addition to MCH is being accomplished in the Rural Health Program.

It is suggested that USAID simultaneously support the following three approaches (action areas), none of which are mutually dependent or mutually exclusive, but rather are mutually reinforcing.

1. Continue distinct and discrete support for family planning, although modifying that support from time to time to meet changing demands and needs. (See: B. Continue Family Planning Support)
2. Provide long-term technical assistance to the Ministry of Health which would identify the requirements for a viable Rural Health Program and to make recommendations as to the specific assistance role of USAID in accomplishing the rural health goals of Government. (See: C. Provide Long-Term Technical Assistance)
3. While numbers one and two above are on-going, begin to implement assistance in several discrete, important low-cost/high-impact areas of rural health care, all of which would inter-face with efforts under number one above, and none of which would need to wait for completion of number two above. (See: D. Expand Rural Health Through MCH)

Each of these action areas are discussed in some detail below.

#### B. Continue Family Planning Support

In continuing to support the GOK's family planning efforts through the existing Project, the following actions are called for:

1. Change the Demographic Goals of USAID's Project

The project should not continue without some demographic goals. The imperative to do something about Kenya's population growth problems is absolute. To be part of a family planning project in a situation demanding demographic impact, which does not in effect have as one of its ultimate goals a reduction in fertility, would be irresponsible. It is suggested here that USAID, without getting involved in the goals and expectations of other donors (they can be part of the program for whatever reason they choose), simply recognize: (a) an eventual slowing of population growth is essential; (b) it may take ten years rather than five years before a truly statistically significant fertility decline is made; and (c) USAID can be of assistance in this area.

In WHO's detailed Proposal for the Improvement of Rural Health Services, it is recognized that by 1984 the changes occurring in the reduction of infant mortality due to better health care will more than offset the births averted by the estimated 320,000 contracepting women in 1984! In fact, the Proposal estimates that by 1984 only 7 to 8 percent of all births will be averted due to program efforts, and suggests additional births averted will be dependent on increasing motivation to control fertility.

The justification of these family planning efforts is described as follows in the Proposal:

However, when and if this change in motivation has been brought about, this project will have been essential in preparing the way for the widespread use of family planning. By providing the facilities, the trained staff and making the methods available to one-third of the people by 1984, and by providing the example of the 320,000 women acceptors among the population group, this project will have laid an absolutely necessary foundation for building up a national population programme. Without this foundation, the provision of the clinical family planning services, there is no point in starting an attempt to change public knowledge, attitudes, motivation and behavior for fertility control. This, plus the considerable improvements in health and services already described, provides the major justification for this project.

This recommendation can be implemented without any substantial negotiation with Government or donors.

2. Change the Scope of the USAID's Project. This recommendation would be implemented by adding USAID assistance to some discrete elements of the Rural Health Project, so that USAID's health inputs would be more than just family planning. The type and magnitude of these inputs will be described below under D. Expanded Rural Health Through MCH.

3. Provide a Planning Study to Health Education Unit

The evaluation pointed out that a key bottleneck in the national family planning program was the Health Education Unit and its Information and Education Division. Lack of a work plan, lack of production, lack of personnel, and, with an AID direct hire technician leaving imminently, lack of technical advisors, are some of the problems. The matter is complicated by the fact that Government had formally requested a large complex and costly list of sophisticated audio-visual and other equipment for the new HEU building some months after USAID notified Government that the U.S. technician assigned to the HEU would finish an extended second tour in mid-1976.

Because this Unit is absolutely critical to the achievement of all of the MOH's health and population goals, it is proposed that USAID provide to the Ministry of Health a special study for the HEU which would look at such matters as staffing needs, training needs, availability of personnel, a mass communications and motivation campaign (phased into other program activities), equipment needs, and consultant and other Technical Assistance needs. This detailed plan of action for the HEU which would cover a project plan period of the next several operational years, would be done in a minimum amount of time, and to the extent possible, would be undertaken by those close to the scene and understanding of the particular communication and motivation problems of Kenya. However, U.S. consultants should be considered to be part of the study team.

4. Provide a Planning Study to the Training Division, NFWC

U.S. training opportunities and technical assistance can play a vital part in solving the enormous problem of lack of trained manpower. For this reason, the current USAID Family Planning Project includes a large component for participant training. It appears however, that the Ministry is not at all certain how it should or can tap into the great reservoir of American training opportunities.

In an effort to bring some order into this very complicated and critical component of the NFWC, it is proposed that USAID provide to the Ministry, a special study team to look at the RH/MCH/FP training needs, capacities and problems and prepare a workable plan of action for training to cover the life of the Rural Health Project. The actual study should be of short duration, and should be composed of members who are familiar with the problem solving process in the Kenyan context. However, some U.S. technical assistance should be considered if higher utilization of U.S. training opportunities is to be achieved.

5. Provide Statistical Backstopping. With the possible loss of the services of the Dualab technicians and the client/clinic service statistics they provided, the Research and Evaluation Division of the NFWC will need backstopping assistance if service statistics are to continue to be generated. While a number of the Division's research needs and backstopping help can come from the proposed Population Studies and Research Center (PSRC), operational program service statistics must flow from the program itself and be directed and guided, on an operational day-to-day basis, by the unit which will use the data.

A Research and Evaluation Division which does not have operational a viable service (client and clinic) statistics system which not only measures progress, but offers management information for key decision making, is worth very little to the program.

With the probable departure of the Dualabs project technicians, the current service statistics system will end, and at some point it will have to be re-created in some form. USAID should assist in solving this problem.

6. Assist in the Purchase of Service Delivery Points (SDP's)

Just as USAID has insisted to donors and Government alike that the initial goals of the Program should be looked at occasionally and readjusted as necessary, so should USAID look at its commitment and the needs of the program especially in light of helping with the facilities which are the end points where people receive health services. Without these physical facilities health care cannot be provided to the rural areas.

Government has admitted that it had an incomplete and inaccurate physical facilities survey upon which was based future SDP sites. A large number of these planned sites were found not to exist and/or are of such a dilapidated shape as to be unuseable. The MOH has decided one way to solve this problem of inadequate space is to purchase various types of pre-fabricated units to be used as SDP's, each of which will be attached to a rural health facility.

It is recommended that USAID take a serious look at Government's needs in this area, and to the extent possible, assist Government in finding a solution to this key problem. Purchase of additional pre-fabricated units is one possible solution. Other alternatives may be called for.

C. Provide Long-Term Technical Assistance

One area where the MOH would likely welcome U.S. assistance is in overall rural health planning and implementation. U.S. assistance could be of enormous value to the GOK by providing an in-depth plan and implementation schedule to achieve the goals of the Rural Health Program, with recommendations on how USAID might assist in the achievement of these goals.

It is proposed that USAID offer to Government the services of two full-time consultants --- perhaps a health economist and a rural health planner --- for up to two years (total: four person years) to work in the MOH with relevant personnel, and together with MOH personnel work on and design a comprehensive system of rural health care implementation. These technicians working in the Ministry and reporting to the Ministry would assist Government in identifying its specific rural health needs, identifying additional assistance requirements (including but not limited to USAID assistance), and in preparing a detailed, realistic implementation plan.

In accepting this recommendation, USAID should be prepared to favorably consider the cost of counterpart salaries and the cost of training as a key component of this technical assistance activity.

D. Expanded Rural Health Through MCH

As a backdrop to the recommendations and suggestions which follow, Appendix III, Rural Health Problems and Needs: A Summary has been prepared. Given the health situation in the countryside among the Rural Health Program's target population (women and children), it is obvious from the Summary there are certain areas where additional effort is needed if an impact on mortality and morbidity is to be made. Other important points which emerge from the Summary: many of the conditions most adversely affecting mothers and children are (1) preventable, and (2) are related directly to ignorance and/or lack of motivation. This is not to over-simplify the complex relationship between health and health care use on the one hand, and the patients' social/economic/traditional environment on the other. The conclusion can be reached, however, that there is more preventive and promotive care which can be done through planned and existing MCH rural health efforts, and which can be low-cost/high impact efforts on mortality and morbidity.

So that the suggestions which follow can be seen in the context of maternal and child health care, a model, or illustrative MCH Service Delivery Point (SDP) has been prepared, and is presented as Appendix IV. It will be noted that the illustrative SDP incorporates many if not most needed health care actions of an SDP, which in total, are not likely to exist in a single SDP unit. The suggested

actions which follow do, however, markedly increase the health care coverage of the average SDP, while at the same time addressing the health needs of rural women and children as indicated in Appendix III.

The following actions should be undertaken as part of expanded rural health/MCH, through the Service Delivery Points. Additional USAID assistance for these activities should be considered.

1. Health Awareness/Health Motivation <sup>1/</sup>

The most important tool for dealing with the massive health problems in the countryside, of which most are preventive, is not costly, and most certainly is not new, better, more available medical technology, but rather the ability to change people's behaviour, attitudes, beliefs, traditions, etc. Preventive care in the countryside is not dealing with immediate, life-compromising medical problems, but rather dealing with long-range, life-extending, behavioral change.

Curative care, as is well known, is many times more expensive than preventive care, and within preventive care some prevention problems are very expensive (e.g., eradicating malaria and typhoid), whereas some are relatively inexpensive and have a very high pay-off in terms of reduced mortality/morbidity. But, technology is not always the answer. The answer almost always has to do with solving the awareness/understanding/motivation equation; for example, the leading causes of infant and childhood deaths in rural Kenya have a great deal to do with a mother's awareness, and her behaviour partly based upon that awareness.

How this area of health awareness and motivation should be approached is discussed further under nutrition below.

2. Nutrition Awareness/Nutrition Screening. It can be shown that no single, rural health, preventive care effort will have a greater, more immediate impact on the health of mothers and children than will the relatively inexpensive efforts of dealing with nutritional problems. It is proposed that a two-pronged action through the Rural Health Program (that is to say, MCH) be undertaken as soon as possible: (a) action directed at creating nutrition awareness and motivation and (b) identifying current and potential nutrition problems through a nutrition screening program.

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<sup>1/</sup> The word "education" will be avoided in discussing health and nutrition, and the word "awareness" will be used instead. It is felt that awareness more closely approximates what end point is being sought. Too often health programs try to "educate", when simple health literacy (awareness) is the goal not health knowledge or facts. Further, too often programs try to make nutritionists out of mothers, when the goal is simply to make mothers aware of, and motivate them toward, correct feeding and eating practices.

There should be no hesitation in considering this suggestion because the GOK has no nutrition policy, nor because there is no viable nutrition unit in the MOH. These efforts should not be held up because there is no coordination with other Ministries concerned with nutrition, nor should they be held up to take another study. For the moment, none of the above are important to the success of a nutrition awareness and nutrition screening program.

The health awareness and health motivation, nutrition awareness and nutrition screening will at the field level involve only those currently involved in MCH/FP. A slight modification of training and curricula will be necessary, but for the moment at the service delivery level, no new persons will be needed.

For example, the HEU unit will have a key role to play in these efforts, but it will need a plan, it will need imagination, it will need vitality, it will need to staff up vacant positions, it will need technical assistance, it will need various kinds of leadership, and it may need additional financial resources. Based upon a viable and workable HEU plan proposed earlier under family planning (III.B.), USAID should be prepared to join with MOH in providing training and technical assistance in order to implement these recommendations.

Another example is at the field level with the Family Planning Field Workers (FPFW), who should be renamed. These field personnel who are actually Family Health Motivators (FHM), would play a key role in bringing health and nutrition awareness into the community. They would be part of a chain of health/nutrition workers from headquarters in Nairobi to Provincial Offices, to District Offices, to the clinic (rural health unit), to the individual mother and child.

Nutrition screening should ideally be done both at the clinic and in the community. At either place it can be done by the lowest level of skilled workers in the system. It is believed that the FPFW's (FHM's) could be trained in just a few hours to do minimal nutritional screening. Their duties might involve:

- a. Height measurement
- b. Weight measurement
- c. Upper arm circumference measurement
- d. 5 simple questions on child feeding/eating practices
- e. 3 simple questions about home/community sanitation
- f. 5 simple questions about family planning attitude/knowledge/availability

Obviously health awareness, health motivation, nutrition awareness, and nutrition screening tacked on to the existing MCH efforts does not create the larger mechanism necessary for a massive attack on ignorance and poor nutritional state. It is however, an important first step which will impact on death and sickness. These efforts are manageable and measurable.

3. Training. In order to support the above efforts and possibly to support new emphases in the years ahead, USAID should be prepared to provide an expanded training effort throughout the RH system. The parameters of this effort could be part of both a health manpower and training needs study proposed under USAID's Family Planning Project, and the proposed study of the Health Education Unit. This approach gives these efforts (the current Family Planning Project and the new health/nutrition awareness efforts) an integrated approach from the very beginning.

A brief survey of existing facilities, curricula, expertise in health awareness, health motivation and nutrition awareness should be made so that these capabilities could be tapped for the training needed in the initial stages of these new efforts.

4. Health and Disease Data. It is not unusual for a developing country to enunciate a wide-ranging policy, and construct complex, costly health programs in the absence of accurate and reliable data. The need for health care is so acute that it really doesn't matter if there is data reliability, for example, in infant mortality rates. The need to reduce infant deaths is so apparent that the estimate's reliability is not necessary to undertake health programs.

However, at some point there must be progressively better information about disease, sickness and cause of death if the country is going to move from the early stages of increasing the efficiency and number of service points for the rural population, to the later stages of attending to specific health problems.

An epidemiological surveillance system might be in the cards at some later date, but a certain minimum health data collection system can be piggy-backed on current efforts in the Research and Evaluation Division and the proposed Population Studies and Research Center. An essential part of the health data needs of the country can be obtained from a viable national vital events registration system (which currently does not exist); especially births, deaths and cause of death. Baseline surveys are likewise essential. The point is, data is often ignored or set aside because of its immense costs and the lead time necessary before reliable data is available to policy makers and program administrators.

USAID should be prepared to assist the MOH in drafting a work plan for minimal health data collection either on a sample basis or in a pilot demonstration area. Discussions on such a plan might likely involve, in addition to the MOH, the Central Bureau of Statistics, the Population Studies and Research Center, the Department of Community Medicine of the University of Nairobi Medical Faculty, among others.

A new mechanism, however, is not contemplated at this time. The scope of work of the Research and Evaluation Division of the NFWC could be expanded slightly to include the collection and analysis of some minimum family planning, health and management data. The Division could be backstopped by the Central Bureau of Statistics (CBS), especially in the areas of data storage and retrieval. USAID would be prepared to support these efforts.

5. Technical Assistance. USAID is prepared to meet with Government on each of the proposed areas of action above and discuss the MOH's needs for technical assistance in each area. In some cases the technical assistance will need to be phased in a well coordinated way; that is to say, some needs will be of very short duration, some will be needed longitudinally but not continually, while other needs may require long-term assistance. USAID could provide a valuable contribution to the MOH by discussing with Ministry officials the kinds of U.S. technicians and consultants available for each of the above separate emphasis areas. In this way a more comprehensive technical assistance package could be contemplated.

#### IV. CONCLUSIONS AND COURSE OF ACTION

This Staff Paper, as explained in Chapter I, Background and Purpose, grew out of a January 1976 evaluation of USAID/Kenya's commitment and contribution to the Government of Kenya's five-year, multi-donor supported Maternal and Child Health/Family Planning Program. The background leading up to that evaluation was reviewed in some detail, not only in Chapter I, but in Appendixes I and II. The level of USAID's contributions to the Program was reviewed as well as the Program's overall progress toward achievement of the Program's five-year targets and goals.

While the evaluation initially centered on whether or not and to what extent the Program could achieve its demographic targets, the evaluation findings were much broader in scope. In a larger sense, the evaluation report reminded USAID that its limited demographic goals were inappropriate. The major findings of the evaluation disclosed thirteen (13) specific problem areas, along with eight (8) broad recommendations to deal with these problem areas. It was obvious from the major findings of the evaluation that certain problems and their solutions could only be dealt with by Government, some could be dealt with by USAID, while most required joint GOK-USAID action. The major recommendation of the evaluation report, however, called for USAID involvement in an integrated rural health project.

Taking into account the various evaluation report recommendations, comments and findings, the remainder of this Paper attempted to present the rationale for serious consideration for the evaluation report's recommendation that USAID should "develop a new initiative in the health/population sector that integrates the family planning project into a rural health services project." In accepting this recommendation as valid, the paper proposes three simultaneous actions for USAID: (1) continue support for family planning; (2) provide long-term expert assistance to the Ministry of Health for rural health planning and implementation, and (3) expand certain rural health activities through MCH Service Delivery Points. A large part of the Paper was given to an explanation of these proposed actions, with specific actions detailed for each proposal.

In brief, therefore, this Staff Paper concludes: (1) the major findings of the evaluation are valid, and to the extent possible

should be acted upon by both Government and USAID; (2) USAID has a wider role to play in expanded rural health; (3) USAID should be prepared to enter into serious discussion with Government concerning those proposed actions which Government feels will be of benefit to its rural health goals.

Based upon the findings in this Staff Paper, and upon a United States foreign policy commitment to assist the Government of Kenya to solve its rather severe demographic problem and to solve its equally severe rural health care delivery problems, USAID will undertake the following actions.

1. Distribute this Staff Paper to relevant Government of Kenya officials, requesting review and comments on the Paper's recommendations and suggestions. The GOK's comments will be seriously considered and discussions will be held with Government on those items Government feels are beneficial or otherwise helpful in achieving its health policy goals.

2. For the moment, USAID will continue its Family Planning Project assistance to the Government's five-year program. This continued assistance should proceed with those modifications mentioned earlier in this paper, after discussions with Government have been held on their feasibility and appropriateness. Further it is assumed that continued support for family planning will be subject to continuous evaluation and adjustment in light of the Program's progress, achievements and needs. If, as seems likely, family planning assistance will eventually become part of a larger integrated rural health assistance package, a major restructuring of the project will over time become necessary.

3. In carrying out its continuing commitment to the Government's family planning assistance needs, USAID for its part, will continue to monitor and evaluate not only the family planning efforts, but will stand ready to modify USAID inputs as changing needs and requirements arise and in accordance with established AID procedures.

4. USAID will continue to carefully evaluate its centrally funded population projects (i.e., those worldwide and regional projects funded by the A.I.D. Washington office) and invite the participation of those projects which are consistent with, and helpful to, Government's needs and priorities. All such projects will be thoroughly evaluated in light of their contribution to Government's various population programs.

5. USAID will work with Government, if Government so chooses, to establish a mechanism whereby, over time, the GOK can take advantage of a broader USAID participation in its rural health program. One important step in this direction is a major recommendation of this Staff Paper; namely, to provide to the Ministry of Health long-term technical expertise to work within the Ministry and prepare a proposal for expanded AID assistance to rural health. Should Government react favorably to the proposal, USAID will enter into immediate negotiation for its effective implementation.

6. If the Government's review of this paper is generally positive, USAID is prepared to begin immediately to discuss with relevant Government officials the implementation of all aspects of the Paper's suggestions and recommendations.

APPENDIX IPLANNED USAID COMMITMENT AND ACTUAL FAMILY PLANNING  
PROJECT OBLIGATIONS

	PLANNED (by year)		ACTUAL (by year)	
	<u>FY 75</u>	<u>FY 76</u>	<u>FY 75</u>	<u>FY 76</u>
<u>1. Personnel</u> (positions)				
A. Direct Hire...	Population Officer (2 yrs)		Population Officer (1/2 yr)	
	Communications Resource Officer (1 yr)		Communications Resource Officer (2 yrs)	
	Health Educator (1/2 yr)		Health Educator (1/2 yr)	
B. Contract/PASA.. short-term trainers, health educator...			nil	nil
<u>II.. Participant Training</u> (number by year of funding)				
A. Long-term	7	9	5	-
B. Short-term	20	23	-	1
<u>III. Commodities (value \$000)</u>				
A. Health Education Equipment	\$93.0	\$23.0	-	-
B. R&E Equipment	3.5	0.8	-	-
C. Clinical Equipment	91.5	66.0	-	-
D. Contraceptives	20.0	20.0	-	-
<u>IV. Recurrent Costs</u> (\$000 by year)				
	331.0	361.0	-	-

GOK FAMILY PLANNING PROGRAM ACCOMPLISHMENTS

(MCH/FP - AID Indicators of Progress)

<u>Personnel</u>	<u>Planned Cumulative to 6/30/76</u>		<u>Accomplished</u>
	<u>FY 75</u>	<u>FY 76</u>	(as of 12/30/75)
NFWC: Admin. Div	17	19	
HEU (24 on board at start)	21	28	31 on board now
EN/CN	105	205	216
Nurse Sup/Trainer	34	42	35
FPFO	17	27	-
FPFW	205	405	71
<u>U.S. Participants (returned)</u>			
PMOs	-	1	- 1/
Prov. Matrons	-	2	-
DMOs	-	5	- 2/
Nurse Sup/Trainer	-	5	-
FPFO	3	6	-
H.E./IE&C	2	6	-
NFWC (excl. Res.& Eval)	2	15	-
Nurse Tutors (training)	3	15	-
Nurse Tutors (RHCs)	-	3	-
Research & Eval.	1	13	-
Administration	-	-	1
<u>Educational Material</u>			
FP Calendars	200,000	400,000	200,000 (CY 1975) 25,000 (CY 76)
Handouts	2,000,000	4,000,000	294,000
Slide sets	20	40	10
30 min. film	1	2	2
Posters	2,500	5,000	121,000
Exhibits	60	120	44
Books, pamphlets	100,000	200,000	10,000

1/ Four PMO's in training2/ One DMO in training

Training (in Country)

Nurse S/T	30	37	7
Nurse " Refresher	-	30	-
FPPOs	30	37	-
FPPOs Refresher	-	30	-

Service Delivery Points

Fixed	100	200	198 to date
Mobile (MOH)	5	5	..*
<u>Acceptors</u> (by FY	55,000	91,500	52,000 (FY 1975)

\* The FPAK is operating seven mobile clinics for the MOH for CY 1976 under a special grant from SIDA

RURAL HEALTH PROBLEMS AND NEEDSA SUMMARY

Health policies and plans are highly dependent on information about the health of a population. Demographic, vital and health statistics tell a great deal about mortality, morbidity, disease specific fatality rates, the prevalence and incidence of communicable and endemic diseases, and so forth. Reliable data on health indicators, as well as vital events data, and demographic data which yields cognate health indicators simply does not exist.

It would be helpful to know with some certainty, for example, the crude death rate, age-specific death rates, infant mortality rates, maternal mortality rates, foetal wastage, cause of death, fertility rates, age-specific fertility, age at marriage, life expectancy at birth, etc. Not only would this data give some idea of mortality and fertility, but more importantly, it would indicate who specifically (by age, sex, location, etc.) in the population is at greatest risk, or has the greatest need for health care. In the long run, and based upon scant data, the RH/MCH/FP Program must affect the status of the health of what is believed to be the greatest at-risk population: mothers and children.

However, some information is available or reliably estimated about the RH/MCH/FP target population.

It is well known that infants and children are highly susceptible to sickness, disease and death. If an infant survives its first year of life its chances of surviving to adulthood increases immeasurably, and if a child reaches five years of age, the Kenyan child's life expectancy increases by 6.9 years from 46.9 to 53.8 years. (Kenya Statistical Digest, June 1971, Vol. IX, No. 2, p. 6).

Of the eight leading causes of death in Kenya, five are generally associated with infant and childhood disorders. The leading cause of death of infants and under fives are: gastroenteritis and colitis; kwashiorkor; measles, tetanus (neonatorum); and pertussis (whooping cough). It is believed that in the under fives group, 20 percent of all deaths are due to measles, 15 percent due to gastroenteritis and 15 percent due to whooping cough.

Because only about one-third of all deaths which occur outside of health facilities are registered, and only about five percent of all deaths are medically certified, very little is known about cause of death in the countryside.

Clinic records indicate that the leading cause of infant and child sicknesses are: measles, whooping cough, anaemia, Protein-Calorie-Malnutrition (PCM), general respiratory track infections (pneumonia, TB, etc.), and gastro intestinal disorders with acute diarrhea being especially severe and debilitating.

Health patterns of children in Kenya (estimated by M.L. Oduori, Rural Health Services, "Paediatrics in Rural Kenya," 1974, pp. 41-42) vary somewhat by geographic area. For example, schistosomiasis, scabies, malaria, hookworm anaemia are not common disorders throughout the country but are common only in certain areas. However, there are some main health problems which are common for children in every District and Province: measles, malnutrition, gastroenteritis, TB, and bronchopneumonia. As one author describes the situation: "The main causes of the high morbidity and mortality with the under fives is an interaction of infectious diseases and malnutrition and the poor system of antenatal care and lack of supervised delivery." (Dr. N.L. Kijpara, Rural Health Services, "Public Health Priorities in Rural Areas," 1974, p. 40)

It is not easy to attribute cause of death to a single sickness, especially in a highly interacting, multi-variate environment in which the following are important factors relating to personal health: poverty, ignorance, cash income, status of mothers, traditional beliefs about eating, waste disposal, care of animals, etc.

Multi-causal mortality/morbidity patterns is illustrated by the following:

Pneumonia which is at the top of the list is frequently the fatal result of measles, malnutrition and malaria. Gastroenteritis, mostly in combination with malnutrition, is often the fatal outcome of measles. In many instances malnourished or undernourished people, especially infants and children, cannot resist pulmonary infections, and complications of measles and whooping cough often result in death despite the available modern drug treatment.

In developed countries the case fatality rate of pneumonia and gastroenteritis has been brought down to a few percent; in Kenya these deaths should -- in most cases -- be attributed to underlying nutritional deficiencies to the top of the list of causes of death. It is known that some times nutritional deficiencies may result from infectious diseases. There is epidemiological evidence that high mortality from communicable diseases will be brought down drastically only by improved socio-economic and hygienic conditions, which will reduce either the morbidity incidence rates or the case fatality rates or both. (J. Bonte, "Patterns of Mortality and Morbidity," in Health and Disease in Kenya, pp. 84-85.)

The status of an infant, a child or a mother's nutritional state is (as stated previously) related to a set of complex variables such as availability of health care, social status, cultural beliefs, family stability, economic position, educational status, food availability, etc. In fact, nutrition or malnutrition is: (1) the most important health problem facing the target population (and those who deliver care to the population); (2) the most preventable of all the preventable disorders and sicknesses; and (3) the most complex and intertwined health condition, since it has a direct bearing on, and is affected by, most other diseases and disorders. This may be most simply demonstrated: wrong child feeding practices + poor hygiene + infection + parasites = poor nutritional state leading to other serious conditions, or at least, leading to a constant state of ill health. This poor nutritional state, which can be arrived at through combinations of other socio-economic-familial-traditional routes, will in turn lead to more serious medical problems. It is widely held that malnutrition is the major reason measles is such a killer of infants and children.

While there are many factors which exert a strong influence on the state of both childhood and maternal nutrition, mother's acceptance (or society's demand) of traditional child feeding coupled with ignorance, strongly influence the health of children in Kenya and, without realizing it, a terrible toll is being paid in Kenya in the irreversible physical and mental retardation of its people in the first five years of their lives.

Nutrition has many stages and phases, from some undernourishment (slight weight loss) to severe and more advanced conditions of PCM: kwashiorkor and marasmus as prime examples. (For a description of these conditions, see D.M. Blankhart, "Human Nutrition," Health and Disease in Kenya, p. 410.) Kwashiorkor and marasmus of course make the dramatic picture of the child just before death. It is important to realize that many deaths and sicknesses and diseases are related to serious but less dramatic and less known nutritional conditions. What is not generally realized is that most nutritional disorders are preventable.

Deputy Director of Medical Services, Dr. S. Kanani estimates that 75 percent of all rural health problems in Kenya are connected with the treatment, prevention and cure of the health problems of mothers and children. If not data, certainly field observation supports this view. One observation:

"From the sex ratios it can be seen that --- with the exception of neoplasms, accidents, diseases of the newborn and infective and parasitic diseases --- male patients attend OPD's less frequently than female patients. On

the other hand, male admissions outnumber by far female admissions if from it, diseases of the newborn and deliveries are excluded. It is not unlikely that women have a lesser chance to be taken to a hospital than men. Once admitted the chances of recovery are roughly the same for both sexes." (J. Bonte, op. cit., p.85.)

There is no reliable data on maternal mortality or maternal morbidity (especially death and sickness related to pregnancy and childbirth), but that they are high is beyond doubt. Aside from the most serious pregnancy-related and birth-related causes of morbidity, women appear to be subject to the following health conditions: respiratory disorders; infectious and parasitic diseases (malaria, respiratory TB, tetanus, etc.); digestive system disorders (gastroenteritis and colitis dominate); nutritional deficiencies; and anaemia (iron deficiency in women is widespread, and iodine deficiency and vitamin A deficiency in women is common in certain areas and in certain seasons). While again data is lacking, it is believed that constant anaemia is a serious health problem with women, and 95 percent of all female anaemia is due to an iron imbalance (caused by diet or hookworm), and/or anaemia from malaria, and/or folic acid imbalance (due to diet). The result is not only an unhealthy mother but often an underweight, underdeveloped, premature infant.

Because of lack of data, a strong causal relationship between infant death and state of maternal health cannot be made. Logically, however, maternal morbidity plays an important part in the survival chances of the 25 to 30 percent of Kenyan babies who die in the first year of life. There is no accurate data which measures foetal wastage, and no data to reliably relate miscarriages and still births to the health of the mother.

One common health problem which is often overlooked in the rural areas is eye diseases, eye problems and blindness. (Blindness is not registered or recorded in Kenya, but it is estimated that one percent of the population is legally blind.) One could postulate the reason why eye conditions are overlooked: serious eye infections have all but disappeared among the educated groups in Kenya, whereas, the highest prevalence is among the most disadvantaged rural poor, and especially among poor children. Factors related to this condition are a combination of, or all of, the following: ignorance, poor hygiene, malnutrition, infectious diseases, and lack of clean water. In a word, then, eye conditions spring from the same set of social/economic/traditional conditions that promote ill-health generally. Additionally, and more importantly, the largest portion of eye conditions seen in children at rural health clinics in Kenya for treatment and cure, could in the first instance have been prevented.

The highest incidence of eye conditions (especially conjunctivities) is by far during childhood, and females are more seriously affected than males. (Bisley and Burkitt, "Eye Diseases," Health and Diseases in Kenya, pp. 461-468.)

At the risk of overstating the obvious, there are serious health problems for women and children in rural Kenya. The majority of these conditions are preventable, and if prevented two important circumstances occur: (1) the health of the family (and thus the total rural population) is immeasurably improved and (2) the current drain and load on curative care is reduced. A World Bank document summarizes the situation quite well:

"It is estimated that the present conditions in the rural sector are responsible for some 10 million cases of diseases annually. With a fast growing population, and without major improvements, the figure may grow as high as 16 million cases of diseases in 1984, which would mainly be concentrated around maternal and child health problems; communicable diseases such as measles and whooping cough; water-borne and vector-borne diseases originating in the physical environment; nutritional problems such as protein and caloric deficiencies; and digestive and respiratory diseases." (Appraisal of a Population Project: Kenya. IBRD/IDA Report No. 266a-KE, February 20, 1974)

AN ILLUSTRATIVE MCH SERVICE DELIVERY POINT

Maternal Care:

- Health awareness of mothers about themselves
- Health awareness of mothers about their children
- Prenatal care
- Delivery care
- Postnatal care
- Immunization
- Cervical cytology
- Nutrition awareness of mothers about themselves
- Nutrition awareness of mothers about their children
- Environmental awareness of mothers
- Awareness of vaccination for children
- VD screening
- Communicable disease screening
- Tuberculin screening
- Nutrition screening
- Nutrition Rehabilitation
- Family Planning (complete counselling and services)
- Motivation: all the above
- Referral

Child Care:

- Vaccination and immunization
- Tuberculin testing
- Treatment of disorders and diseases
- Nutrition screening
- Nutrition Rehabilitation
- Communicable disease screening
- Deworming
- Treatment of communicable diseases
- Treatment of nutritional problems
- Eye examination and treatment
- Referral

Note: It should be remembered that the above MCH outline is only illustrative of a more or less complete integrated clinic. This model situation does not exist in Kenya, and may not exist for some time. It is presented simply as one model.