

PM 766-437

59170

CONTROL OF DIARRHOEAL DISEASES PROJECT
KENYA

A Report Prepared By PRITECH Consultant:
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During The Period:
MARCH, 1983

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT

Supported By The:

U.S. Agency For International Development
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:
AID/S&I/HEA: 9/16/88
ASSGN. NO: DC 415

1. SCOPE OF WORK

The consultancy was awarded to facilitate development of strategies and plans for a multi-media public health education campaign to promote more effective treatment and prevention of diarrhoeal diseases and lay the ground for preparation of teaching materials for use in health workers' training programmes within the CDD Unit of the Ministry of Health, Kenya. Specific duties included:

- (i) To provide long-term technical assistance in health communications to the Ministry of Health's CDD Programme.
- (ii) To co-ordinate CDD health communications activities in government, NGO's research projects and other institutions.
- (iii) To develop and execute plans for design, testing, production and dissemination of training materials and public education materials, both print and broadcast.
- (iv) Serve as a point of co-ordination between government, USAID and UNICEF, especially in relation to project disbursements and reports.
- (v) To assist the CDD Management Unit in planning, co-ordinating, implementing and supervising of CDD activities.

This was a short term consultancy to be followed by a two-year long term communication consultancy. The work was carried out in a team with three other Pritech-provided consultants (Chief-of-party, a child survival and Development Fellow and a short-term Communications Consultant) and the MOH CDD team.

2. PURPOSE OF THE PROJECT

The Government of the Republic of Kenya is committed to realisation of the goal of health for all by the year 2000. It is additionally committed to the ideals of Child Survival and Development (CSD) and is implementing a number of strategies both to bring health services within easy reach of the population and promote CSD technologies. The Kenya CDD project is one of the strategies the government is implementing.

The figures in the table below illustrate the significance of the Kenya CDD project.

THE TEN MOST COMMON INFANT AND CHILD DISEASES
1978, PER CENT

	INFANT 1 YEAR	CHILDREN 1-4 YEARS
Pneumonia	26%	21%
Enteritis and other Diarrhoeal Diseases	21	10
Measles	10	23
Malaria	6	8
Acute Respiratory Infections	5	4
Bronchitis Emphysema & Asthma	4	5
Tetanus	3	-
Symptoms and Ill Def. Conditions	2	2
Anaemia	2	3
Meningitis	1	-
Burns	-	3
Avitaminoses	-	3
Other	20	18
T O T A L	100%	100%

- Not among the ten most common

Source: ROK, Health Information Bulletin Vol. 4 No. -
4, 1992.

Information based on 1978 Health Information systems data shows the following mortality rates among the under-ones: pneumonia 31% of infant deaths, tetanus 17%, enteritis and other diarrhoeal diseases 12%, measles 8% and others 32%. Among the 1-4 year age group pneumonia accounts for 25% of the death, measles 24%, enteritis and other diarrhoeal diseases 9%, avitaminoses and other nutritional deficiencies 8% and others 34%.

The country's infant mortality rate of 86 per 1000 and early childhood mortality rate of 174 per 1000, although lower than those obtaining in many developing countries, is discomfotingly high. It is estimated that about one of every three Kenyans who dies is below the age of five compared to about one in twelve in many of the economically developed countries. Out of these deaths, 40% are estimated to occur during the first month of life.

The purpose of this project, therefore, is to promote child survival and development by reducing mortality and morbidity associated with diarrhoea, a major disease among children.

METHODOLOGY

The consultancy started off with a two-week trip to Nyanza Province, one of the two provinces in which a CDD promotion pilot is being planned. The purpose of the trip was:

- to provide back-up to the short term communications consultant who was conducting focus group discussions
- to get a feel of project field activities
- meet MCH field staff, administration officials and project beneficiaries to share ideas and gather information and insights relevant to project activities.

The field trip was followed by review of relevant literature and discussions with MOH officials and Pritech Consultants. During this period I participated in a preview of some of the episodes of the Kenya Medical Association/Voice of Kenya "A HEALTHY NATION" TV series and assisted in Communication Planning for the MOH/UNICEF Immunisation Campaign. Participation in the latter two activities was very useful in providing insight into the MCH's operations, especially in relation to communications.

4. SUMMARY OF OBSERVATIONS AND FINDINGS

4.1 Project Document

The major observation that came out of this consultancy is the obvious lack of a focused, co-ordinated project document with a time frame to go by. The only document in existence - the MOH generated CDD plan - is a good declaration of intent. It contains a great deal of useful detail, but it is neither focused nor actionable.

4.2 Co-ordination and team work

Another inadequacy was the glaring lack of co-ordination and team spirit. This was due, in part, to the absence of a single integrated project or concept document which ties together the various aspects of the project. It is also clear that the various actors on the project are yet to 'find' each other and begin working as a team. While the various sections of the project were quite active in discharge of their duties, they appeared to be hardly aware of the significance of the contribution of other team members and sections and consultation was therefore limited.

4.3 Policy and decision taking

Again partly as a result of the absence of a project document/concept paper, many policy decisions remain unmade. Once in a while they are brought up for discussion. But as the structure for resolving such issues was not yet established and institutionalised, many of the issues remain unsolved. Outstanding policy issues to be decided include:

- preferred sachet sizes
- whether local manufacture/packaging or continued importation
- labels on the sachets to facilitate promotion
- ORS mixing containers and container sizes

- whether SSS will be promoted and how
- whether community based distribution or only clinic distribution.

A survey addressing sachet sizes and ORS mixing containers and container sizes has been concluded and data analysis is in progress. Recommendations which will guide decision making are expected soon.

4.4. Programme Management

The field visit made to Nyanza Province and discussions held with staff indicated inadequacies in the structure and process of programme delivery. MOH district staff complained of 'too many' Nairobi-based MOH departments and staff sending them circulars and paying them visits to ask them to do this and the other. These 'demands' were often made without adequate notice; without taking into account the views and programmes of the officers on site and without meaningful involvement of these officers. They also said CDD had also been an offender in this regard. Over the last few years various CDD teams had visited the province and each team gone about its work without reference to the work of previous teams. 'Next time you come we would like you to come as a team. Bring all the departments of CDD, including the Director of the Family Health Division if possible so that we can know that you are one team and not individuals working in isolation' one health officer eloquently summed up these sentiments.

4.5 Disbursement of Funds

On this trip the Communication Consultant carried with her a large amount of money to pay for petrol, per diems, meals and transport claims for the MCH and the Aga Khan Foundation officers who participated. This system has obvious advantages in that it ensures that.

- claims are promptly settled
- financial control is effective
- neat accounts can be produced

It has, however, enormous disadvantages which could wreck the project and diminish prospects for sustainability.

- it drags the project staff into financial squables which erode their effectiveness. Part of the time during the trip was spent sorting out differences over money.
- it tends to associate project staff and, therefore, the project, with money rather than the service.
- it tends to isolate the project from other MOH programmes as its funds are seen as distinctly different from the rest of MOH funds. Integration of the project into the MOH activities becomes more difficult. Most staff expressed reluctance to use Ministry vehicles or fuel on the project unless money was expressly made available per trip as CDD funds are seen as quite separate from MOH funds which support vehicle running.
- it bogs down project staff with cashier and accounting rather than project work.

5. RECOMMENDATIONS AND ACTIONS TAKEN

These issues were discussed with the MOH staff and short term Pritech Communications consultant. On return to Nairobi I raised the issue at the Pritech staff meeting. Following upon this meet/ a series of brainstorming and planning meetings took place. At the end of these discussions I prepared the attached paper, "KENYA CONTROL OF DIARRHOEAL DISEASES PROJECT CONCEPT PAPER" which contains some ideas and recommendations which can provide a basis for thinking through a focused, actionable project document, help streamline project implementation, enhance management and co-ordination and involve district health staff and the community more intimately. ing,

The March-September budget presented to Pritech is based on the ideas and recommendations contained in this concept paper.

DRAFT FOR DISCUSSION AT PRITECH

*MINISTRY OF HEALTH
AND
TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH)*

*KENYA CONTROL OF DIARRHOEAL DISEASES PROJECT
CONCEPT PAPER*

NAIROBI, MARCH 1988

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1. COUNTRY SITUATION

1.1 The Land and The People

The Republic of Kenya lies across the equator on the eastern coast of Africa. It has an area of 569,249 sq. km. and a population of 22,656,000 people, giving an average population density of 27 persons per sq. km. The population is, however, unevenly distributed. The northern half of the country, has desert and semi-desert conditions and is sparsely populated with as few as two persons per sq. km. in some parts (e.g. Isiolo and Marsabit Districts). Areas with adequate rainfall and fertile soils (mainly in Central and Western Kenya) sustain population densities as high as 570 persons per km. (Kisii District of Nyanza Province). Within the high density districts some areas sustain as high as 1000 persons per sq. km, a great population pressure considering that the main source of livelihood is agriculture.

85% of the population live in the rural areas and derive their livelihood directly from agricultural activities. High potential agricultural land is, however, scarce. Only 18% of the country is of medium to high agricultural potential. This small proportion of the country supports up to 80% of the population. 70% of the country has inadequate rainfall which can only support stock rearing activities with stock carrying capacity decreasing with the reducing rainfall. The map at annex one summarizes population distribution by district.

Administratively, the country is divided into seven provinces and 41 districts (see map at Annex Two). The districts are in turn divided into progressively smaller units, namely: sub-districts, divisions, locations, sub-locations and villages. The country has 80 ethnic groups with about a dozen major tribes and tribal clusters with significant linguistic diversities within tribal and linguistic groups. The schedule below summarizes the country's linguistic composition by province:

ETHNIC GROUPINGS BY LINGUISTIC GROUP AND PROVINCE

PROVINCE	LINGUISTIC GROUP
Coast	Mijikenda Taita Taveta
North Eastern	Somali
Eastern	Orma, Rendile, Bornu (North) Meru, Embu (Central), Akamba (South)
Central	Kikuyu
Rift Valley	Turkana, Pokot, Samburu (North), Kalenjin (Central), Maasai (South)
Nyanza	Luo, Kisii, Kuria
Western	Luhya, Teso

Source: 1984 UNICEF Country Profile

1.2 Population Structure

Kenya has a youthful population; 51.7% are children below the age of 15 years. Central Bureau of Statistics projections for 1988 indicate that there are 11,450,000 children aged 0-14 years old; of these 4,553,000 or 18.5% of the whole population are aged 0-4 years. Assuming the country's high fertility (8 children per woman at the end of her reproductive years) and a population growth rate of about 4% per year - one of the highest in the world - the under-five population is expected to rise to 5.3 million by the end of 1990 and to 8.1 million by the year 2000. The map at Annex Three shows the under-five population distribution for 1990. The under-five population

projections in the CLD pilot area - Nyanza and Western Provinces - is as below. The figures are based on 1979 census. Total population figures are also provided for comparison.

PROVINCE DISTRICT	1980		1990	
	Total	under-five	Total	Under-five
Nyanza Kisumu	560,000	110,000	770,000	160,000
Siaya	550,000	110,000	770,000	150,000
Kisli	1,000,000	240,000	1,440,000	340,000
S. Nyanza	950,000	190,000	1,300,000	270,000
T O T A L	3,060,000	650,000	4,240,000	920,000
Western Kakamega	1,100,000	250,000	1,600,000	350,000
Bungoma	540,000	130,000	800,000	190,000
Busia	320,000	70,000	480,000	100,000
T O T A L	1,960,000	450,000	2,880,000	640,000
GRAND TOTAL	5,020,000	1,100,000	7,320,000	1,560,000

1.3 Economy and Livelihood

As indicated above, Kenya is a predominantly agricultural country with virtually all of the 85% of the population who live in the rural areas depending directly on this economic sector for their food, employment and income. Already, a very high population pressure is being experienced in the 18% of the country with medium to high agricultural land. The pressure continues to increase in view of the high population growth rate and in spite of the considerable rural to urban migration, especially by young people in search of employment and an improved standard of living. The high population pressure, both in towns and in the rural areas limits peoples access to food and income. In urban areas unemployment is acute while inadequate incomes and lack of access to the right kinds of food remain problems in the rural areas. There are, however, considerable differences between the rural sub-sectors. These include large scale farmers, usually with very high incomes, small farmers, pastoralists, and the landless rural workers with much less income.

The country's first Integrated Rural Survey conducted in 1974 found that 36% of the small holding households had annual incomes of less than KShs.2,000. 52% received annual incomes of between KShs.2,000 and KShs.7,999 and only 12% earned KShs.800 per year and above, with a mean of just under KShs.13,000/- per year.

In comparison, the small urban population has been estimated to earn 43% of the total national income, giving an estimated 5:1 consumption gap between urban and rural incomes. The gap between the income of the unemployed, the lowly paid and the highly paid is, however, substantial.

1.4 Literacy

61% of the rural male aged 12 years and above are able to read in at least one language compared to 38% of the female population. Differentials in reading ability between male and female at the district level range between 13-14% in districts such as Nyeri, Kajiado, Narok, Nandi, West Pokot, Elgeyo Marakwet and Kwale and 30-33% in districts such as Siaya, Kericho and Busia. While there is no clear pattern in the differentials, differentials on the lines of gender are significant.

The National Adult Literacy Programme launched in 1979 may narrow this gap with time. While a considerable gap has remained among the older age groups, it has considerably narrowed among the younger age groups as educational

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opportunities among women have improved since independence. Central Bureau of Statistics maps at Annex 4 (a) and (b) show the literacy distribution among men and women per district, excluding the northern districts which were not surveyed.

1.5 Health Services

Kenya's Ministry of Health is organized into five divisions: Curative and Institutional Management; Division of Communicable Diseases; Family Health Division; Health Technical Support Services and Laboratory Services, each headed by a senior Deputy Director of Medical Services (see Ministry Chain of Command Chart at Annex 5). The Control of Diarrhoeal Diseases section is located within the Department of MCH/FP in the Family Health Division. Other sections of the MCH/FP department are the Kenya Expanded Programme on Immunization (KEPI) and Nutrition. Each of the sections is headed by an Assistant Director of Medical Services or a Senior Medical Officer.

While at the headquarter level the various services fall under different divisions, departments and sections, delivery of all health services in the provinces and in the districts is integrated within the health delivery facilities, namely: hospitals, health centres, sub-health centres and dispensaries under the coordination of Provincial and District Medical Officers of Health. The table below summarizes the distribution of the health delivery facilities by province as of 1984.

HEALTH INSTITUTIONS AND HOSPITAL BEDS
AND COTS BY PROVINCE, 1984

PROVINCE	HEALTH INSTITUTIONS				HOSPITAL BED AND COTS	
	Hospitals	Health Centres	Health centres and Dispensaries	Sub- Total	No. of Beds & Cots	No per 100000 Population
Nairobi	17	8	86	111	5,610	508
Coast	25	26	142	193	3,005	178
Eastern	31	39	227	297	4,287	125
N. Eastern	3	8	21	32	414	85
Central	48	41	193	277	4,848	166
Rift Valley	50	82	406	538	5,844	141
Nyanza	28	55	150	233	4,114	117
Western	16	34	48	98	2,764	122
TOTAL 1984	218	293	1,273	1,779	30,886	158

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The table below analyses health facilities available in 1982 by ownership.

HEALTH FACILITIES 1982

<i>OPERATING AGENCY</i>	<i>HOSPITALS</i>	<i>H/C</i>	<i>DISPENSARIES (SUB-H/C)</i>	<i>TOTAL</i>	<i>% OWNERSHIP</i>
<i>Central Govt.</i>	84	233	802	1,109	66.6
<i>Municipalities</i>	2	2	19	23	1.4
<i>Missionary Organizations</i>	84	38	232	354	21.3
<i>Private</i>	48	1	130	179	10.7
<i>TOTAL</i>	218	264	1,183	1,665	100.0

Source: National Development Plan 1984-198

The Ministry of Health headquarters in Nairobi provides policy guidelines and supervision necessary for effective management of health services throughout the country. Under the guidance of the Director of Medical Services, each head of division, department and section is responsible for the efficient provision of services under his/her jurisdiction. This is achieved through various channels which include issuing policy guidelines, training, seminars and consultations, supervision, monitoring and evaluation. While some departments/divisions/sections are represented at the district down to the local level, others have no specific representation and work through the health staff already in place.

To facilitate resource sharing and enhance management of health services, representatives of the various units of health services at the various levels form health management teams (HMTs) which plan, co-ordinate and manage the health activities in their areas under the leadership of Provincial and District Medical Officers of Health. In discharge of their duties, these teams are assisted by the District Health Committees which are sub-committees of District Development Committees (DDCs), inter-sectoral committees, chaired by District Commissioners and responsible for development co-ordination throughout the district. While DDCs are generally active committees, the activeness of the health committees and HMTs varies.

The Government of the Republic of Kenya is committed to the goal of Health for All by the Year 2000. To this end, the Government, boosted by the Kenya's renowned harambee (self help) efforts of the people, has pursued a sustained policy of expansion of health facilities throughout the country as shown in the table below.

EXPANSION OF HEALTH FACILITIES AND STAFF, 1963-1982

FACILITY/CADRE	1963	1972	1982
Hospitals	148	N/A	218
Health Centres	160	N/A	274
Dispensaries	"A few"	400	1,184
Doctors	339	N/A	787
Health Workers (including paramedicals)	6,303	N/A	30,752
Medical training institutions	N/A	40	72

Source: National Development Plan 1984-1988

In spite of these expansions, which have ensured almost a complete Kenyanisation of the health sector, more than 57% of households still travel four or more kilometers to obtain health services and only about 30% of the population live within easy reach (two kilometers or less) of a health facility. According to the National Guidelines for Implementation of Primary Health Care in Kenya published by MOH, NGO Health Organizations in Kenya, WHO and UNICEF in 1986, another problem facing delivery of rural health services in Kenya "continues to be the standard of services provided at the facilities in view of the budget constraints". The publication notes that "funds allocated for drugs, supplies, fuel and maintenance of equipment, buildings and vehicles are inadequate. While numbers and patterns of staffing have improved considerably since 1970, the Ministry is now confronted with a situation where buildings and staff may lie idle because of lack of funds to run the facilities. This problem is aggravated by low morale of the staff, resulting in a further deterioration of the quality of services provided".

The publication further notes that although NGO's are active in the provision of health services, these activities are not closely synchronized with government efforts.

It is the view of the Government that Primary Health Care approach which employs the concept of Community Based Health Care is a critical strategy in efforts to bring health services to the 85% of the people who live in the rural areas. This approach, which defines PHC as essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation at a cost the community and the country can afford, is seen as a cost-effective way of addressing the problems of inadequate funding and the high cost of maintaining services at static facilities. This strategy recognizes that the efforts of the government and NGOs alone cannot bring about Health for All without the active participation and contribution of service consumers as partners in health care. The aim, therefore, is to make more and more health information available to the people in order to empower them to understand the factors which influence their health so that they can take action which will positively impact on their own health, the health of their families and ultimately the health of the community and that of the nation. This is in line with the country's motto of Harambee.

Development of PHC strategies in Kenya started with the implementation of a community-based health care project in Kakamega District in 1977. The purpose of the project was to assess the feasibility and benefits of community participation in health decision taking and delivery of their own health care. Following the success of this project, the Government adopted the policy of Primary Health Care in 1982. To-date, PHC activities

have been introduced in all the country's 41 districts and PHC training workshops have been conducted for 614 provincial and district heads designated as PHC/CBHC coordinators. Inter-sectoral teams have been set up to assist with implementation of the PHC strategy in many districts. Members of these teams have received one week courses to upgrade their ability to discharge their duties.

1.6 National Health Status

As a result of the expansion of health services and improved standards of living, especially since independence, the overall health status of Kenyans has continued to improve. According to the 1984-1988 National Development Plan, the death rate among the population has dropped from 20 per 1000 in 1963 to 14 per 1000 in 1982. Over the same period, the infant mortality rate dropped from 120 per 1000 to 86 per 1000, early childhood mortality (below 2 years) dropped from 174 to 125 per 1000 while life expectancy increased from 40 to 54 years.

Improved health care, nutrition and sanitation are considered to be the main causes of the dramatic declines in infant/early childhood mortality and improved life expectancy. Overall, the environment in which a child begins its life is less hazardous now than it was formerly.

In spite of this progress, both the infant mortality (86 per 1000) and the early childhood mortality (125 per 1000) are high. It is estimated that about one of every three Kenyans who dies is below the age of five compared to about one in twelve in many of the economically developed countries. Out of these deaths, 40% are estimated to occur during the first month of life. According to the 1982 Rural Child Nutrition survey, early childhood mortality is strongly associated with the prevalence of malaria and malnutrition as the table below shows.

DISTRICTS WITH THE HIGHEST EARLY CHILDHOOD MORTALITY
RATES AND PREVALENCE OF MALARIA AND MALNUTRITION
(STUNTING)

DISTRICT	EARLY CHILD- HOOD MORTALITY	MALARIA RANKING /a	NUTRITIONAL RANKING /b	PROVINCE
S. Nyanza	216	1	2	Nyanza
Kilifi	212	2	1	Coast
Siaya	211	1	1	Nyanza
Lamu	200	4	1	Coast
Kisumu	199	1	3	Nyanza
Busia	198	2	3	Kakamega
Kwale	190	3	1	Coast
West Pokot	188	3	3	Rift Valley
Tana River	181	2	1	Coast
Baringo	171	4	3	Rift Valley

a / Ranking from high to low prevalence on a scale of 1-6
b / Ranking from high to low prevalence on a scale of 1-4

Source: Based on ROK, Third Rural Child Nutrition Survey, 1982

According to the UNICEF 1984 Kenya country Profile, the chances of an infant dying before the age of one year are lower than the national average in Central, Rift Valley, Eastern and Nairobi provinces and considerably higher in Western, Nyanza and Coast Provinces, ranging from a low of 56 infant deaths per 1000 live births in Central Province to 128 and 129 in Nyanza and Coast respectively (see the table below).

INFANT MORTALITY BY PROVINCE

PROVINCE	CHILDREN BORN	
	PRE - 1967	1967 - 1976*
Central	88	56
Rift Valley	103	64
Nairobi	100	75
Eastern	100	77
Western	110	109
Nyanza	162	128
Coast	156	129

* Excludes births within 12 months of survey date. Based on mother's residence at the time of survey

Source: Based on Kenya Fertility Survey 1971-1978; Social Perspectives, 681,2

The map at Annex six details early childhood mortality by district. Data on morbidity and mortality in Kenya are sparse and not very reliable because of widespread under-reporting. However, available information indicates that 70% of the reported out-patient morbidity of the population, 1978-79 was infectious and parasitic diseases, (see table below).

*DISEASES REPORTED BY HEALTH CENTRES, HEALTH SUB-CENTRES
AND DISPENSARIES, 1980*

<i>TYPE OF DISEASES</i>	<i>NO. OF CASES (1000's)</i>	<i>% OF TOTAL</i>	<i>% CHANGE FROM 1978</i>
<i>Acute Respiratory infections</i>	<i>5,200</i>	<i>25</i>	<i>- 11</i>
<i>Malaria</i>	<i>5,400</i>	<i>26</i>	<i>+ 12</i>
<i>Diseases of the Skin</i>	<i>3,900</i>	<i>18</i>	<i>+ 12</i>
<i>Diarrhoeal Diseases</i>	<i>1,900</i>	<i>9</i>	<i>+ 12</i>
<i>Intestinal Worms</i>	<i>1,700</i>	<i>8</i>	<i>+ 15</i>
<i>Accidents</i>	<i>1,600</i>	<i>7</i>	<i>+ 15</i>
<i>Measles</i>	<i>200</i>	<i>1</i>	<i>- 32</i>
<i>Pneumonia</i>	<i>220</i>	<i>1</i>	<i>- 24</i>
<i>Other</i>	<i>1,100</i>	<i>5</i>	<i>+ 13</i>
T O T A L	21,000	100	+ 11

Source: ILO, 1983, 203

Among the infectious diseases, the three major causes are malaria, respiratory infections and diarrhoeal diseases mainly related to the environmental living conditions of the people (ILO, 1983, 169). Among the under-fives, the major diseases are pneumonia, diarrhoeal diseases and measles which account for more than 50% of all reported cases (see table below). Most of the reported diseases are preventable through CSD strategies, namely: immunization, breastfeeding, nutrition, and growth monitoring, increased use of ORT, community education and improved environmental hygiene.

THE TEN MOST COMMON INFANT AND CHILD DISEASES
1978, PER CENT

	INFANT < 1 YEAR	CHILDREN 1-4 YEARS
Pneumonia	26%	21%
Enteritis and other Diarrhoeal Disease	21	10
Measles	10	23
Malaria	6	8
Acute Respiratory Infections	5	4
Bronchitis Emphysema & Asthma	4	5
Tetanus	3	-
Symptoms and Ill Def. Conditions	2	2
Anaemia	2	3
Meningitis	1	-
Burns	-	3
Avitaminoses	-	3
Other	20	18
T O T A L	100%	100%

- Not among the ten most common

Source: ROK, Health Information Bulletin Vol. 4 No. 4, 1982

Information based on 1978 Health Information system data shows the following mortality rates among the under-ones: pneumonia 31% of infant deaths, tetanus 17%, enteritis and other diarrhoeal diseases 12% and measles 8% and others 32%. Among the 1-4 year age group pneumonia accounts for 25% of the death, measles 24%, enteritis and other diarrhoeal diseases 9%, avitaminoses and other nutritional deficiencies 8% and others 34%.

2. THE PROJECT

The Government of the Republic of Kenya is committed to the goal of Health for All by the Year 2000 and is currently implementing multiple strategies to achieve this goal. The strategies include all-round expansion of the health sector, implementation of PHC and promotion of Child survival and development technologies as a means of reducing infant and early childhood morbidity and mortality and creating a firm health foundation all round. The control of diarrhoeal diseases (CDD) is one of the Child Survival and Development programmes being implemented.

The Kenya CDD Programme was launched in November 1986 with the following objectives for the 1986-1992 period:

1. To reduce the prevailing under-five morbidity due to diarrhoea by 50%.
2. To reduce the prevailing under-five diarrhoeal mortality by 30%.

Since it was launched, the programme has sought to achieve these objectives through promotion of the WHO recommended strategies of:

- .. improved care and management of diarrhoea;
- .. promotion of breastfeeding and proper weaning practices;
- .. use of safe water;
- .. good personal and domestic hygiene; and
- .. measles immunization.

The achievements of the programme to date have been as follows:

- i. The appointment of the CDD manager;
- ii. Designation of CDD clinical training personnel. Recently, a Health Educator was assigned to the CDD programme on a part time basis;
- iii. Implementation of clinical training activities as a way of improving care and management of diarrhoea. To-date the following training activities have been accomplished:

<i>COURSES</i>	<i>NO. OF COURSES</i>	<i>PARTICIPANTS</i>
<i>Supervisory skills</i>	<i>6</i>	<i>134</i>
<i>Clinical Management</i>	<i>5</i>	<i>167</i>
<i>Operational level</i>	<i>15</i>	<i>415</i>
<i>Curriculum Development</i>	<i>1</i>	<i>15</i>
<i>T O T A L</i>	<i>27</i>	<i>731</i>

Training activities are expected to continue throughout the life of the project. Efforts will be made to develop training manuals with a local orientation to cover all levels of training.

- iv. Establishment of Oral Rehydration Therapy (ORT) centres for district level training and as effective service delivery points. In all, 11 centres have been established. Owing to various problems, among them staff transfers, three of these centres are non-operational. Eight, including the Kenyatta National Hospital Centre and seven district centres are fully operational. Ten more ORT centres are expected to be opened in 1988 and more will be opened over the next few years.*
- v. A survey on home fluids aimed at collecting data which will guide the policy on sachet sizes and containers for mixing ORS has been completed and data analysis is in advanced stages.*
- vi. In September, a nationwide baseline survey on morbidity and treatment of diarrhoea was conducted in 15 districts. A final report with useful data for future planning has been prepared.*
- vii. Communications and operation research consultants have been provided by PRITECH to assist with the planning and implementation of a comprehensive CDD promotion pilot in Nyanza and Western Provinces to be implemented in 1988 at the end of which a national CDD promotion plan will be drawn up early in 1989.*

- viii Focus group discussions to collect data to guide development of communication strategies and materials have been conducted in the pilot areas and analysis is in progress.
- ix Work is currently in progress to plan and implement the CDD promotion pilot project in Nyanza and Western Provinces. The purpose of the pilot is to test strategies which can significantly accelerate the process of diarrhoea control in Kenya. The objectives of the pilot are to:
- i. Reduce the current morbidity due to diarrhoea in the pilot areas by 5%;
 - ii. Reduce the current under-five diarrhoea morbidity by 10%;
 - iii. Increase knowledge about the dangers of diarrhoea and promote among staff and in the community behavior which will contribute towards reduction in morbidity due to diarrhoea in the community and among health staff;
 - iv. Put in place a CDD management and co-ordination mechanism capable of enhanced mobilization of individuals, the community, institutions and community resources for promotion of CDD activities;
 - v. Promote activities which will lead to improved project logistics: production, packaging, and supply of ORS sachets.
 - vi. Promote appropriate reporting, monitoring, evaluation and operational research which will improve project activities;
 - vii. Document the pilot implementation experience and make recommendations for replication nationwide.

2.1 Project Elements

In order to achieve these objectives implementation of the pilot will need to be inter-sectoral in nature. It will take stock of related activities of other government departments and NGOs and existing resources which can be tapped in order to enhance project activities, promote co-ordination and maximize impact. The PHC/CBHC structure being laid throughout the country offers a good infrastructure and will be utilized as far as possible. Provincial and district health staff will be involved in decision making, planning and implementation of every step in order to enhance sustainability, provide on-the-job-training and build implementation capacity (see 3.2). The

project will place emphasis on:

- .. preventive measures;
- .. case management;
- .. training;
- .. health communication and social mobilization;
- .. improved supply and logistics;
- .. programme management and co-ordination; and
- .. operational research and information systems.

2.1.1 Diarrhoea Preventive Measures

Diarrhoea is a parasitic disease transmitted mainly through contaminated food, water and fingers. It can quickly lead to dehydration and death when dietary management of a patient is poor and fluids are withheld. The disease has, however, a relatively low case fatality and its commonest consequence, especially among infants, is rather a faltering in growth of the infant. Its most widespread damage is more in its frequency than in its severity. While case management is an effective strategy in the short term, preventive strategies are the most effective in bringing down diarrhoea-related mortality in the long run. Effective preventive measures are those that promote use of heat, water and soap to kill the infectious disease agents. In recognition of this, the project will promote:

- .. the use of safe water;
- .. protection of water sources;
- .. improved water storage;
- .. frequent hand-washing;
- .. personal and domestic hygiene;
- .. food hygiene; and
- .. human waste disposal.

Implementation of these measures will need the collaboration of other agencies.

2.1.2 Case Management

Effective case management in the home and at the clinic to restore and maintain the level of body fluids and salts in children with diarrhoea will be promoted. Diarrhoea can strike anywhere any time, sometimes when conditions do not permit timely presentation of the child to the clinic. This is particularly so in the rural areas where more than 57% of the population still have to travel four or more kilometers to the nearest health facility and where transport difficulties abound. The situation is often worsened by lack of knowledge on the dangers of diarrhoea and management measures that can be taken to manage the situation as soon as diarrhoea starts.

In view of these difficulties, an information, education and communication campaign will be waged to educate the community on the symptoms, dangers, prevention, home management and when to seek help. Among other things, the education efforts will promote appropriate dietary habits during diarrhoea, and use of home fluids and ORS at home. Shops and kiosks down to the village level will be encouraged to stock ORS sachets. Availability of ORS sachets may, however, not necessarily lead to increased use as many rural families may not have the money to buy them. Through discussions with the relevant officials and agencies and district level, mechanisms for community based a distribution and pricing system favoring the rural and urban poor will be worked out. In addition, a mechanism of distribution of government provided ORS will be worked out. Agents for such distribution may include Family Health Educators, Community Health Workers who have been trained in the PHC/CBHC programmes and the various community groups operating at the village level. The agents who are selected will receive appropriate training to enhance their work.

Promotion of ORS and fluid use in the community will be greatly facilitated by:

- .. making a policy decision on standardized sachet sizes for the country;
- .. appointing/stimulating local ORS production or packaging with MOH approved sachet design incorporating locally relevant brand name(s) and message(s) which synchronizes with the rest of the promotional activities;
- .. making a decision on sizes and types of containers to be promoted in mixing ORS; and

.. deciding on foods and home fluids to be promoted.

The second line ORT management will continue to be the health facility. Additional ORS treatment centres will be opened at appropriate intervals to:

- .. serve as model treatment centres;
- .. provide leadership and support to other health facilities;
- .. serve as training centres for diarrhoea treatment staff of neighboring health facilities;
- .. serve as local referral centres in matters of diarrhoea treatment.

These centres will be appropriately equipped and staffed with trained personnel. The ORT centre at Kenyatta National Hospital in Nairobi will serve as the National ORT referral centre and will provide leadership to other ORT centres.

All health facilities in the country will be expected to stock and prescribe ORS in treatment of diarrhoea as appropriate. They will treat all forms of diarrhoea, including those which require treatment additional to ORS.

2.1.3 Training

Training activities will be intensified to cover the various health levels which will be expected to take an active part in the implementation of the project. Appropriate training will also be given to community members, as they will be the first line diarrhoea managers. Training will include:

- .. management training at the national, provincial and district level;
- .. mid-level management courses;
- .. operational-level training at the district and clinic level;
- .. courses for trainers and extension agents of other organizations;
- .. the Administration and opinion leaders;
- .. community courses at the district, divisional, locational, sub-locational and village level;
- .. special groups such as TBAs, community/traditional "medical consultants", etc.

Current CDD management and mid-level management courses utilize the standard WHO modules. While these are adequate in general terms, they are deficient in aspects such as local orientation, health communication and social mobilization which are critical for maximum project impact (see below). Work is in progress to develop an operational level training manual. However, no training guides exist for use in the other categories of training.

Existing training programmes will be enhanced and appropriate training manuals with a local orientation prepared for all categories of training. Management and operational level courses will be conducted by the Nairobi based CDD unit with consultant assistance as appropriate. After their training, provincial and district teams will in turn identify appropriate trainers, extension agents, administration officials, and special groups in their areas, plan and implement training activities for them with the support of the Nairobi based CDD unit (see 3.2). These latter categories will be sensitized and trained so that they can work side by side with health workers in:

- .. disseminating facts about diarrhoea, signs, dangers, prevention and management;
- .. motivating the community to take action on diarrhoeal preventive measures at the community, family and individual level;
- .. conducting village level courses for appropriate targets;
- .. instructing mothers, community groups and other targets on when and how to mix and administer ORS and when to seek help.

Appropriate authorities will be approached to introduce CDD management training in pre-service training of clinical officers, nurses and doctors. In addition, CDD weekend seminars for paediatricians will be conducted and schools colleges and other institution approached to incorporate diarrhoea control measures in their activities.

2.1.4 Health Communication and Social Mobilization

The Kenya Control of Diarrhoeal Diseases project will be implemented according to PHC principles and as far as possible within the PHC/CBHC infrastructure already in place in some parts of the country and in recognition of existing community channels. Every effort will be made to accelerate the programme through sustainable activities which will both

create demand for diarrhoea control measures in the community and ensure that the demand so created is met by not only making the necessary services available but also accessible to individuals and families who demand them. The idea will be to make ORS a household name to be demanded and obtained when there is need. Demand creation will be achieved through a health communication and social mobilization programme which will:

- .. disseminate facts about diarrhoea - signs, dangers, prevention measures and management;
- .. maximize community involvement in decision taking, planning and implementation of project activities;
- .. mobilize the health delivery system, the administration, the community and local resources for accelerated programme implementation.

i. Health Communication

Communication is one of the most frequently mentioned and least understood or appreciated of programme components. To many, laymen and practitioners alike, it may mean as little as burning the midnight oil to draft a pamphlet, an odd radio programme for the rural folk or a prestigious pamphlet to promote a health behavior among the urban population. Effective communication is, however, a more serious activity; it is consumer-oriented, it has a beginning and an end; it is scientific and systematic; it is a process; it promotes definite, coherent and actionable messages; it produces better results when mutually reinforcing multiple media are used and it starts with clear cut, manageable, specific, and measurable objectives which are evaluated at appropriate intervals to determine impact.

In this project, a scientifically sound communication strategy will be developed and implemented with the full and active participation of the national and district CDD programme implementation teams and with the involvement of all those participating in the project as well as the communities for which the communication efforts are planned. Communication planning and implementation will follow the following outline:

1. *Determination of primary, secondary and tertiary audiences;*
2. *Focus group discussions to obtain qualitative KAP data and determine operational research questions;*
3. *Baseline KAP, (among health workers and in the community);*
4. *Supply and logistics survey and recommendations;*
5. *Establishment of a structure of programme planning and institutional delivery.*
6. *Determination of media channels and formats;*
7. *Development of operational, measurable objectives specifying KAP, material production and service utilisation targets;*
8. *Strategy development;*
9. *Message and materials development, pre-testing and production;*
10. *Implementation (strategy testing);*
11. *Monitoring and evaluation;*
12. *Review of experiences, programme adjustment and forward planning;*
13. *Replication.*

The steps discussed in this section will be partly expounded upon in section 3 and again in more detail in a separate paper. Involvement of the health teams at all levels should provide an invaluable on-the-job training opportunity to those participating and build capacity for planning and implementing similar activities, not only in relation to CDD but in respect of other PHC programmes.

ii. Community involvement and Social Mobilization

Properly planned and implemented, health communication can lead to a significant shift in knowledge, attitude and behavior in the desired direction. In a stable society such as ours, however, word from the conventional, sophisticated communication sources such as the radio, TV and print media alone rarely leads to action. For action to result, the message undergoes a process of checking, counter-checking and reinforcement through the established community network of friends, relatives, opinion leaders, reference groups, etc. Change of attitude and behavior is, therefore, more than a matter for the individual but the end result of a great deal of interaction within the community and, perhaps, the society as a whole. Programmes which seek to change attitudes and behavior, therefore, enhance their chances of success when they take a community approach and adopt strategies which mobilize the whole community, its resources and institutions. This is achieved through the process of social mobilization.

Social mobilization can be defined as the process of social organization, communication and interaction which aims at significantly increasing awareness about a specific community concern and evolving mechanisms for identifying, pooling and channelling the resources and efforts of that community and its institutions into accelerated, sustained corrective action to which the community eventually becomes committed. Like conventional communications, social mobilization is, in the first place, concerned with effective communication in order to create demand for a service. But concerned about maximizing positive action and sustainability, it seeks to mobilize the goodwill and support of the community as a whole. This includes community members who may not be required to directly take the recommended action themselves. In addition, social mobilization facilitates the process of pooling and channelling individual, institutional and community resources into effective action.

This process involves a good measure of community organization which, in turn, facilitates transfer of programme ownership and responsibility to the community. Involvement of large numbers of people and institutions heightens enthusiasm and motivation as each participants' contribution goes towards achievement of tangible gains, thereby setting a faster tempo of programme implementation. Managed and channelled properly, the broad-based enthusiasm can significantly contribute towards programme sustainability.

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Under the guidance of the provincial and district health teams, this project will seek to achieve optimum, sustainable levels of social mobilization. Each district will develop and implement mobilization strategies of their choice consistent with the national strategy of District Focus for Rural Development.

2.1.5 Supply and Logistics

A programme will achieve limited results if the demand outstrips supply. This situation will only breed frustration, disillusionment and animosity towards the project. Project supply and logistical strategies will, therefore, need to be developed and implemented ahead of launching the health communication and social mobilization component to avoid the possible frustration.

The envisaged communication and social mobilization programme is intensive and aims at creating demand at the household and village level. To satisfy the anticipated demand, it is imperative that ORS supply lines are open from the national stores in Nairobi to the village level where diarrhoea is most prevalent. The programme, therefore, calls for the design of a supply and logistics system which will ensure:

- .. timely receipt of ORS from the donors/manufacturers to the Central Medical Stores;
- .. an efficient ordering/supply system from the Central Medical Stores to the - provincial stores - districts stores down to the individual dispensaries;
- .. an adequate record/keeping and stock replenishment system at all health stores and health facilities;
- .. a suitable system through which pharmacies, shops and kiosks down to the village levels will obtain from the manufacturers/suppliers stock and sell at a reasonable (perhaps subsidized) price. These arrangements will be made and implemented in collaboration with manufacturers;
- .. an arrangement by which NGOs will obtain their supplies;
- .. adequate arrangement for FHEs, CHWs and organized groups to obtain ORS supplies from health facilities to supply families who need them in the village.

2.1.6 Programme Management and Co-ordination

An adequate programme management and co-ordination machinery is essential for the smooth running and sustainability of the project. The management and co-ordination system will recognize:

- .. staff shortages
- .. the benefits of community involvement
- .. need to upgrade the project implementation capacity of both MOH staff and service delivery system .
- .. need for inter-sectoral collaboration and participation
- .. need for social mobilization
- .. need for programme sustainability
- .. the district focus for rural development strategy.

The project will, therefore, seek to involve as many people sectors as possible. At the same time, it will seek to expose participating individuals and institutions to all stages of project planning and implementation and provide opportunities for contributing, thereby building a reservoir of people who have gone through the total experience and can and implement similar projects.

In order to achieve these aims, the following management and coordination structure is proposed:

- .. A CDD retreat to generate a CDD project document, work plan and on policy and guidelines;
- .. A national inter-sectoral coordinating and advisory committee comprising of departments and collaborating NGOs with the CDD unit as the secretariat;
- .. Provincial inter-sectoral committees/task forces possibly chaired by the PC with the PMO's office as secretary;
- .. District inter-sectoral committees/task forces (perhaps existing PHC Committees) possibly chaired by the DC;
- .. Similar committees/task forces at the Divisional, locational, sub locational levels with the involvement of the respective heads of these administrative units;

- .. Formation of health committees within existing groups at all levels.

Some of these committees already exist. This project may help strengthen these committees and revitalize inactive ones. In addition ways and means of sustaining a high level of activeness in these committees will be explored. The committees will be responsible for identifying and tapping local resources and talent for successful implementation of a sustainable, broad-based programme.

An appropriate system of disbursement of funds to support district level activities will be worked out in consultation with the appropriate authorities.

2.1.7 Operational Research and Information Systems

In implementing this project, every effort will be made to apply cost-effective strategies that are both replicable if found suitable, and sustainable in the long run. To be able to achieve these aims, it is imperative that as far as possible decision taking be informed and based on hard facts obtained through scientifically sound investigations such as, surveys, continuous surveillance, monitoring, sentinel reporting and periodic evaluation. Every effort will be made to involve district health teams and committees in these activities in order to transfer skill and provide participants with an opportunity to gain a greater appreciation of the importance of data collection and utilization. Operational research and documentation activities will include:

- .. A survey covering home fluids and containers for mixing ORS (already conducted in the pilot areas. Data is currently being analyzed).
- .. Baseline surveys will be planned and implemented by district health teams and committees under the guidance of the CDD unit in Nairobi to establish diarrhoea morbidity and mortality; diarrhoea-related KAP for health staff and the community and availability and utilization of ORS in the pilot districts. These activities will be repeated at the end of the pilot to assess impact. Similar formative and summative evaluations will be undertaken by district health teams and committees in all the districts as the project is replicated to the rest of the community.
- .. District health teams and committees will undertake data collection activities in their areas to gather information on resources, facilities, groups,

structures, etc. available in their areas which can be mobilized for promotion of CDD activities.

- .. Improving routine information gathering, utilization, reporting and information sharing activities from the periphery to the districts, province up to the Family Health Division in Nairobi.
- .. Establishing sentinel reporting centres.
- .. Focus group discussions
- .. "Listeners questions"-type radio programmes
- .. Maintaining print media cuttings, books.
- .. Documenting all project activities through written reports, videos, etc.
- .. Listener surveys
- .. Newsletter to promote experience sharing between the districts.

3. THE PILOT

Project concepts and ideas discussed above will be tested in a pilot project to be implemented in Nyanza and Western Provinces over a one year period between March 1988 and February 1989 as follows:

3.1 Time Frame

3.1.1 Planning - March - August

- .. national planning retreat
- .. generation of a project document and work programme
- .. planning at the national and district levels
- .. establishment of the management and co-ordination mechanism
- .. community organization and social mobilization activities
- .. generation of policy guidelines and decision taking on unanswered questions.
- .. preparation of appropriate guidelines for the districts
- .. initial operational research (baseline surveys and

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- data collection activities in the districts, establishment of sentinel reporting centres, literature review, etc.)
- .. review and strengthening of information gathering, utilisation and reporting systems
- .. communication planning (focus group discussions, audience segmentation, message development and testing, etc.)
- .. Development, pre-testing and production of educational material
- .. development of training materials
- .. training activities at all levels
- .. preparation for launching of communication activities
- .. establishment of appropriate supply and logistics mechanisms.

3.1.2 Intensive Communication & Social Mobilization Activities (September - November)

- .. national and district launch of intensive communication and social mobilization activities in the media and in the community
- .. intensive social mobilization, community training and mobilization activities
- .. intensive media activities
- .. distribution of posters, pamphlets, etc

3.1.3 Communication & Social Mobilization Activities on a Reducing Scale (December to mid-January)

Communication and social mobilization activities continue as at 3.1.2, perhaps on a lower level, December being a slow month.

3.1.4 Evaluation and Recommendations for Replication (Mid January - February)

3.1.5 Review & Generation of Replication Document (March)

Retreat to review evaluation report and generate a strategy for the national programme

3.2 Implementation Process

In line with the aims, concepts and strategies discussed above the implementation of the pilot will proceed by the following steps:

- i. A CDD unit retreat to discuss the project strategies, processes, standards and policies.
- ii. Visit of the CDD team to the two pilot provinces to meet provincial health management teams to discuss with them the strategies, processes and policies agreed upon at the retreat. All the sections of CDD will be represented. The team will take the opportunity to call on the PCs to brief them and solicit their support and participation.

After these initial discussions the PHMTs call a meeting of the key implementing officers from the districts (the DMOs plus 2-3 others). These meetings will be jointly led by the CDD team and PHMTs. The CDD team remains behind to call on DCs for discussions.

- iii. District representatives return to station, brief full DHMTs and form/revitalize inter-sectoral health committees/task forces to plan and implement CDD activities.
- iv. Sensitization and information gathering on resources, institutions, etc. Establishment of sentinel reporting centres.
- v. Districts organize planning workshops to generate district plans, study and give input into a draft baseline survey instrument.

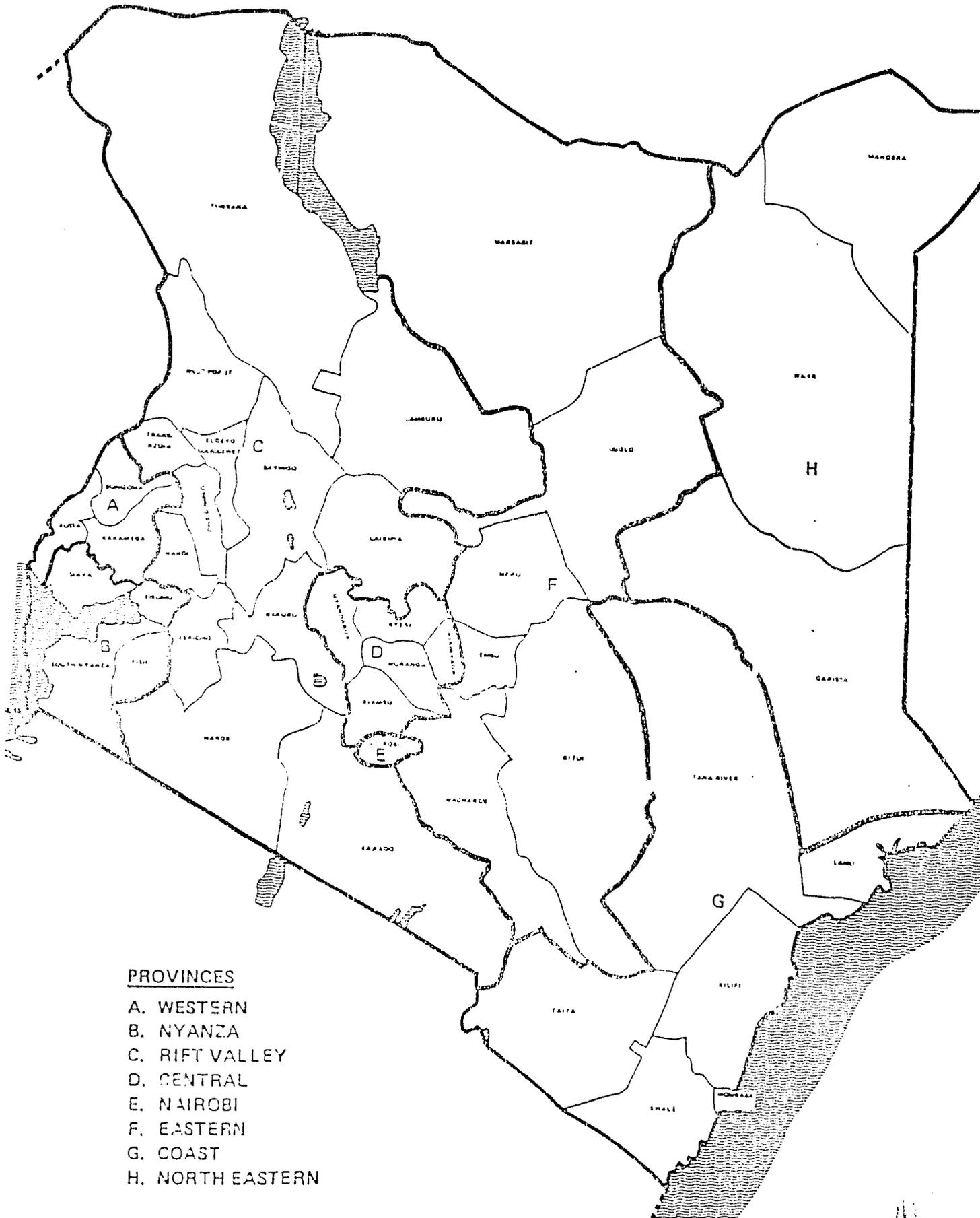
NB: Steps vi - x overlap and will, perhaps, proceed concurrently)

- vi. Baseline survey administration. Each district will plan and administer its own baseline survey using the common instrument which will be drafted at the CDD unit with room for questions of interest to specific districts. The officer in charge of operations research will provide technical assistance and oversee survey activities in all the districts.

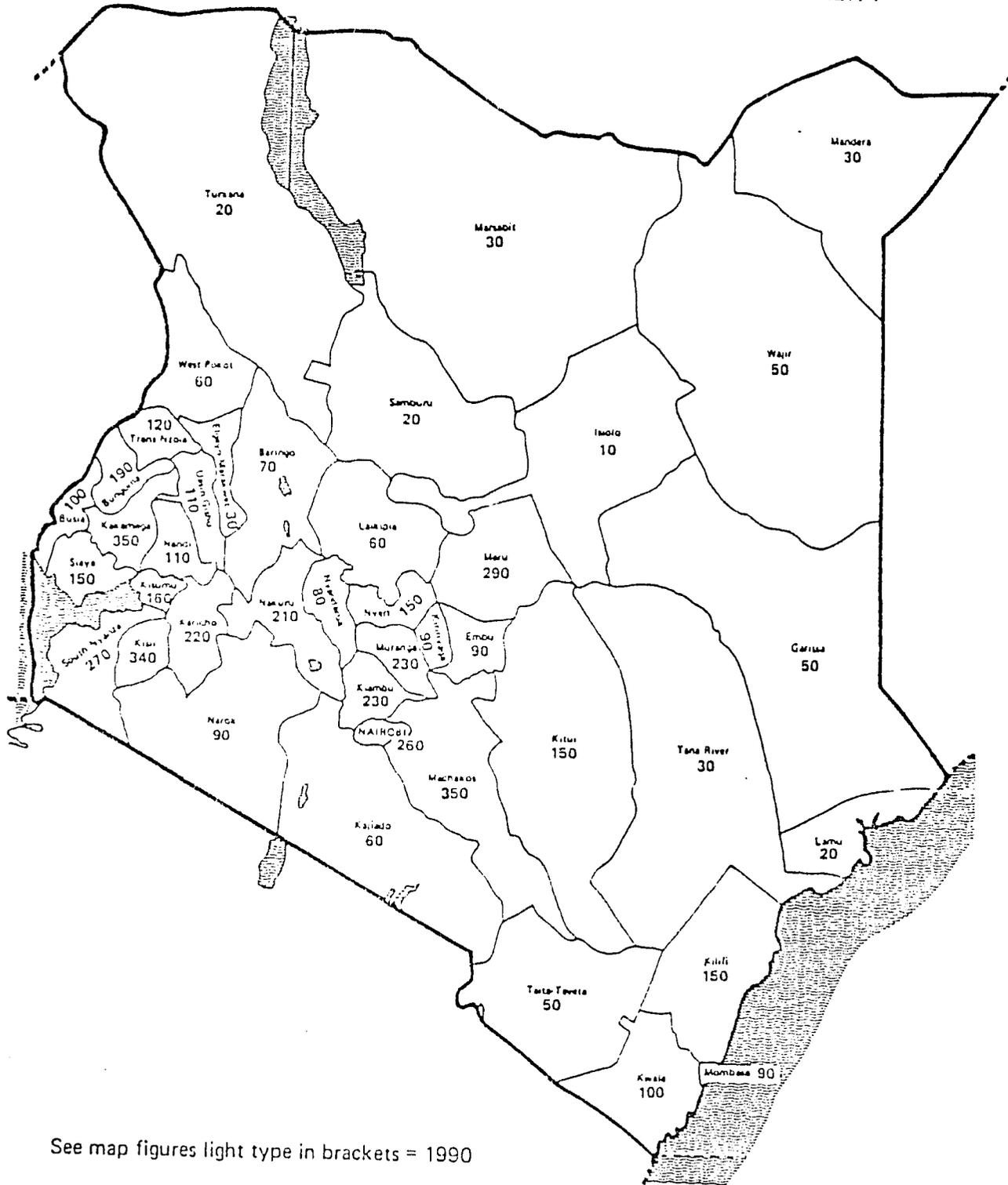
of

- vii. *Training of trainers, extension workers, and the administration at the district, divisional, locational and sub-location levels by the DIIMTs*
- viii. *Review and pre-testing of materials, review of translations, etc.*
- ix. *Review and establishment of an adequate supply, distribution and logistics system*
- x. *Make preparations for the launching and implementation of the communication and social mobilization activities*
- xi. *Intensive communication and social mobilization activities*
- xii. *Summative evaluation by district*
- xiii. *Review and recommendation by district*
- xiv. *National retreat to review the pilot and plan for replication.*

FIGURE 1.1 ADMINISTRATION – KENYA



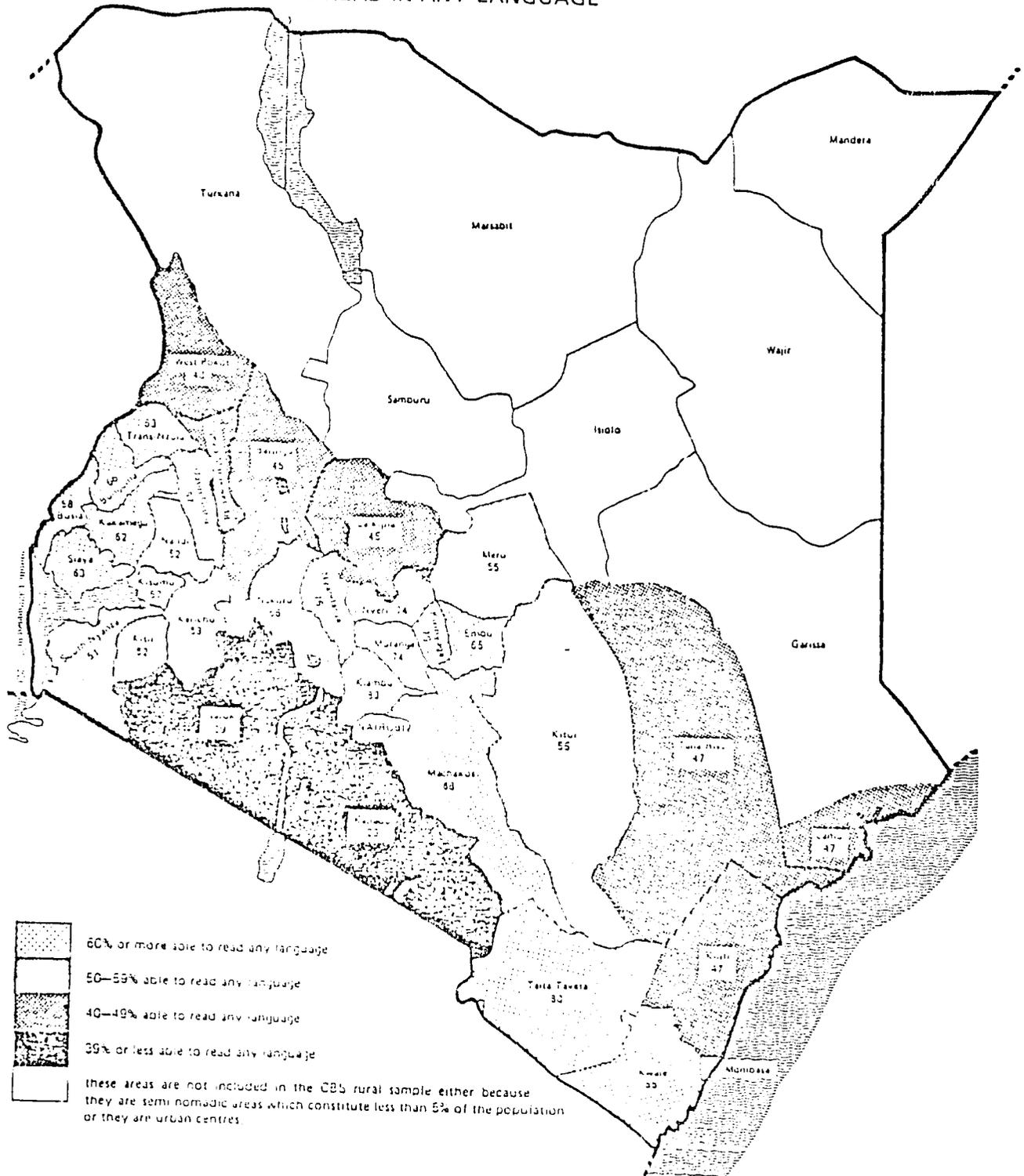
MAP 4. CHILD POPULATION UNDER 5 YEARS PROJECTIONS IN 1000's BY DISTRICT FOR 1990*. ASSUMING CONSTANT LEVELS OF FERTILITY AND MORTALITY



See map figures light type in brackets = 1990

*BASED ON 1979 CENSUS PROJECTIONS BY THE CENTRAL BUREAU OF STATISTICS

MAP 14. MALE LITERACY IN RURAL KENYA BY DISTRICT 1980/81*
 PERCENTAGE ABLE TO READ IN ANY LANGUAGE



*BASED ON THE 1980/81 RURAL SURVEY BY THE CENTRAL BUREAU OF STATISTICS.

CHAIN OF COMMAND CHART

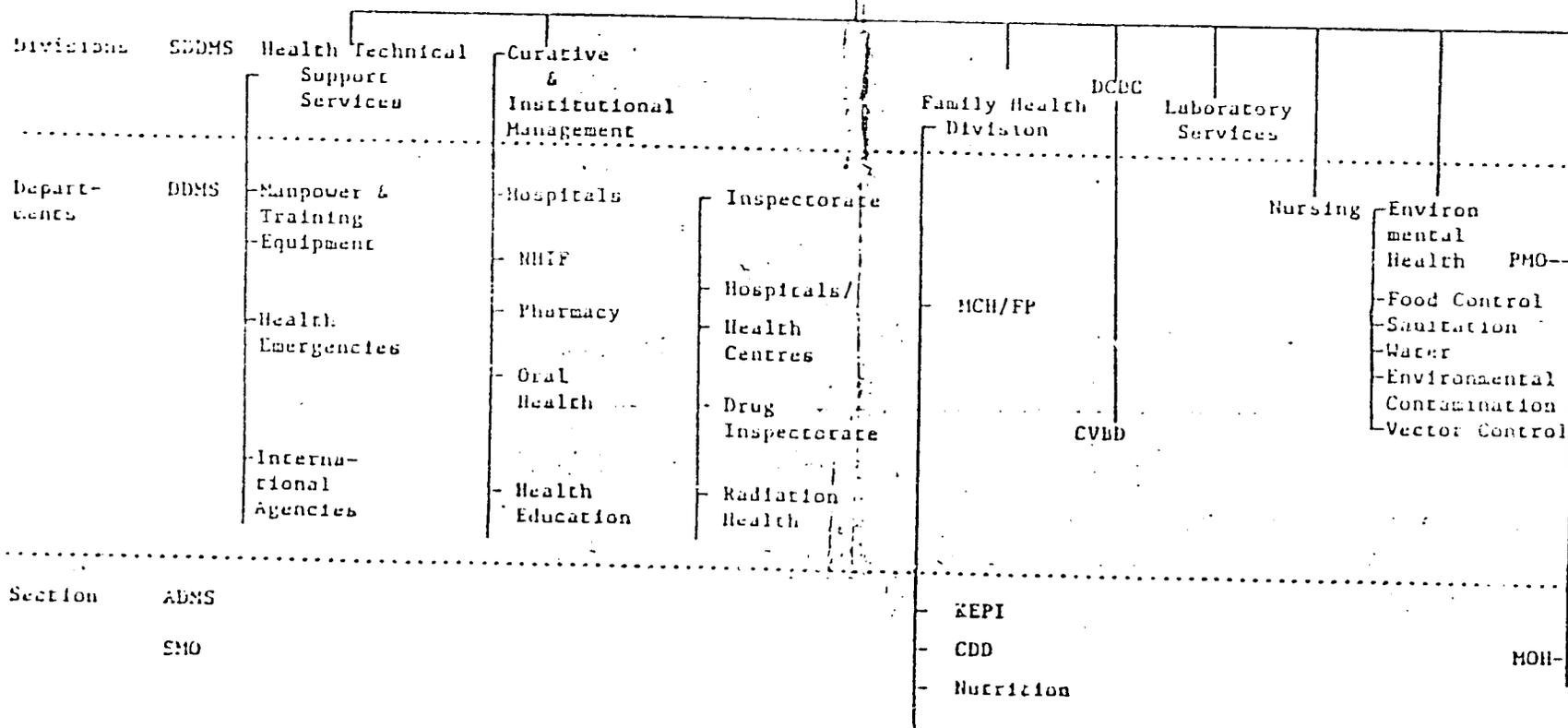
TECHNICAL SERVICES (MOH)

MINISTER

ASSISTANT MINISTER — ASSISTANT MINISTER

PERMANENT SECRETARY

DIRECTOR OF MEDICAL SERVICES



PROGRESS REPORT: NOVEMBER 1987 - FEBRUARY 1988

HEALTH COMMUNICATIONS COMPONENT

KENYAN NATIONAL CDD PROGRAM

Submitted to:

Director of Family Health
Ministry of Health

By:

Jean Mayer
PRITECH Health Communications Consultant

EXECUTIVE SUMMARY

My activities for this period were geared toward planning for and conducting developmental research in preparation for message development, and responding to timely events, such as local workshops, to broaden my framework for communication planning. I continued to focus on laying the groundwork for collaboration and coordination at the central and regional levels-- networking; sensitizing relevant individuals and institutions to CDD Program objectives; identifying research, educational and training resources that might prove helpful to the program; and, gathering and summarizing existing data. I am particularly satisfied with the collaborative relationships forged during this period; in the months to come, these efforts should bear considerable fruit.

ACCOMPLISHMENTS during this period included:

Developmental Research

- Twelve focus group discussions (FGD's) were conducted in January in collaboration with DHMT's in Western Province (Phase I), and ten FGD's were conducted in February in collaboration with DHMT's in Nyanza Province (Phase II). Findings from both activities are now being analyzed in Nairobi. A final report will be drafted and shared with the districts as a next step in the message development process.

Institutionalization

- Selected health education officers at the central, provincial and district levels (in the project area) were oriented to CDD communication planning objectives and notions of consumer-oriented developmental research.
- The new PRITECH Communications Resource Officer has been oriented to CDD objectives, the current status of the CDD health communications planning process, FGD methodology and findings on diarrhoeas, and to key provincial and district actors in Nyanza.

Collaboration for Sustainability and Coordination

- Collaboration from other government sectors and NGO's was solicited and obtained at the central, provincial and district levels for developmental research and later program activities.
- Very preliminary steps have been taken to ensure technical collaboration and coordination with UNICEF on social mobilization.

Administration

- Some administrative details re: funding mechanisms for health communications and other activities, and transport were worked out during a series of meetings with UNICEF.

Program Planning

- Preliminary discussions have been held between myself, the WHO advisor, and the KEPI advisor regarding plans for a mid-year measles awareness activity in Western Kenya in the context of diarrhoeal disease prevention.
- The latest information on "P" (practice) studies and health education evaluation methods was requested of CDC's International Health Program Office (IHPO) during the November WHO CDD Program Managers' Course. These will assist CDD in developing instruments and strategies with DHMT's for monitoring and evaluation of upcoming health communications efforts in their areas.

Materials and Production Facilities

- + A rough pricing of local poster and brochure production was worked out with assistance from FPPS. This information will be used to revise the educational materials budget to be presented to UNICEF for funding.
- An exhaustive list of materials production resources (artists and institutions) was drawn up in the process of reviewing applications for the PRITECH Communications Resource position. This will serve CDD well when it is ready to select production facilities and personnel.
- A resource packet was drafted with the aim of providing background information, policy statements, and current control strategies recommended by the CDD and KEPI programs to other government departments, NGO's and the press. More precise messages, prototype graphics, and specifics of Western Kenya campaign strategies will be added as they are developed.
- A series of photos on aspects of child survival, including ORT, has been made available to the CDD program by Salvation Army, and an additional image bank has been identified at UNICEF. The concept of a photo flipchart w/ health worker notes is being explored.

Teaching Aids/Curriculum Development

- A draft curriculum outline for communications skills (tasks and learning objectives) was provided to the CDD curriculum revision team during a November workshop for incorporation into the pre-service training of nurses and clinical officers. This is the first step toward development of a communications skills curriculum, materials and trainers guide to serve both pre-service and in-service CDD training needs.

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- The learning level of trainers of CHW's was assessed at an Aga Khan/AMREF-sponsored TOF workshop in Nairobi in November. This assessment, supplemented by information from a systematic investigation of training needs at that level, will be incorporated into development of ODD training materials for that category of worker.

Technical Assistance/Resource-Sharing

- Current resource materials on state-of-the-art communications planning and qualitative research were shared with University of Nairobi Departments of Sociology, Journalism, Literature, and Population Studies, as well as with the Lake Basin Authority and Aga Khan PHC Project to bolster local know-how in this important area.
- Comments and suggestions were provided to KEMRI for a research protocol on the impact of health education on the incidence of childhood diarrhea in Kakamega District.
- A critique of the diarrhoeal disease and immunization portions of the Westinghouse Health and Demographic Survey was developed in collaboration with a MRC epidemiologist, the WHO Advisor, and the KEPI Advisor.

 The following ISSUES were raised in the course of health communications activities during this period:

Institutionalization/Sustainability

The goals of institutionalization and sustainability are jeopardized by the uncertainty of full participation by central level health education officers in the systematic planning and implementation of the ODD health communications component.

Likewise, sustainability of the project at the district level will depend on ODD's ability to creatively engender ownership of the project at that level, and a perception of its role as a team of technical advisors, not owners and funders. Problems with cooperation in the field during the Western Province activity point to a possible perception of ODD as 'just another centrally funded project from Nairobi'.

Collaboration with Other Sectors: Governmental and Non-Governmental.

Problems with soliciting full collaboration from the University suggest that there are certain conditions of participation which ODD must explore to determine if these are consistent with its goals and project approach.

Likewise, ODD should further consider circumstances under which the participation of selected NGO's is desirable, and the spirit and conditions under which that collaboration is offered.

Visits to certain departments at the central and peripheral levels suggest that ODD should consider soliciting collaboration and coordination from other government sector headquarters in Nairobi in some concerted manner, to the degree deemed necessary and sufficient to permit successful execution of the project on the ground.

Coordination

The expected onslaught of communications, research and training efforts by many MOH departments in communities and health structures in Western Kenya this year begs coordination at the central level, perhaps in the form of a PHC Coordinating Committee. Otherwise, we can expect to see duplication of effort and dilution of impact, rather than the synergistic effect we are all looking for. We face a similar risk in ODD-KEPI this year.

As UNICEF is gearing up for social mobilization, and assisting with revival of the Health Education Network and the development of the KMA radio and TV series, it is of concern that ODD health communications staff have not yet been included in the planning, despite overtures we have made toward collaboration and coordination. Efforts should be made to coordinate ODD baseline data collection efforts with UNICEF's efforts through CBS to update its Situational Analysis.

Program Policy Direction

Policy direction is still required on home fluids, container size, sachet size and design, and ORS flavoring in order that message development might proceed in an expeditious manner. Field experiences by the FGD teams suggest some specific improvements in ORS sachets and salts.

The recent ODD participation in a pretest of Salvation Army materials on ORT raised the question of the nature of policy guidance ODD should give to NGO's to ensure standardization of messages, and coordination of control and prevention approaches.

The issue of guidance or even regulation also comes to light as (i) ODD learns that KMA/VCK has gone ahead with production and airing of a segment on diarrhoea management, despite requests by ODD that the media wait on the message; and (ii) UNICEF has produced 1000+ copies of a series of 8 posters on diarrhoea and malnutrition that ODD will have trouble using.

Administration

Field realities and competing needs for funding and transport within ODD indicate that (i) funding ceilings are too low to accommodate expected ODD activities; (ii) guidelines for field expenditures are not explicit enough or agreed on yet by all ODD staff; (iii) available transport is insufficient to meet the demand; and, (iv) the current mechanism for furnishing vehicle expenses for trips and clocking driver hours does not allow for adequate monitoring.

Office space and secretarial and equipment support are still inadequate to render the offices functional, especially with the addition of health communications and HIS staff.

The proposed NEXT STEPS to be taken include:

- CDD (KEPI) meetings to review yearly workplans and coordination within the unit(s).
- Information-sharing meetings among those responsible for PHC/CEHC on program activities planned for this year, incl. DFH and AMREF, among others.
- Fleshing out of sustainable mechanisms for district involvement and eventual ownership of the project, and for strengthening the technical assistance role of central level staff to the districts, including a visit by key elements of the CDD team to present a united, coordinated "front" to the provincial, and later the district authorities.
- Formation of a two-tiered Health Message and Materials Development Committee, the first tier at the central level and the second tier in the provinces.
- Message development at the central level based on a thorough review of all existing data - from KAP studies, district socio-cultural profiles, focus group discussions, and home fluids/container surveys.
- Development of prototype materials which incorporate newly drafted messages for testing.
- Message and materials testing and revision by the second tier of the Health Message and Materials Development Committee in the provinces.
- Communications strategy development (phase I) by the same central level body which drafted messages, followed by more detailed planning at the district level, and finally planning for coordination with the provincial teams and/or the second tier of the above-mentioned committee.

A breakdown of these steps is reflected in the revised workplan.

PROGRESS REPORT

To: Dr. Dominic Mutie, Director
Division of Family Health

From: Ms. Joan Mayer, PRITECH Health Communications
Consultant *JEM*

Subject: Report on Health Communications Activities
in support of the Kenyan National CDD Program
November 1 - January 31, 1987

SCOPE OF WORK

My work scope for this period was geared toward planning for and conducting developmental research, and beginning with development of messages and prototype materials, as well as responding to timely events, such as local workshops, to broaden my framework for communication planning. I continued to focus on laying the groundwork for collaboration and coordination at the central and regional levels - networking; sensitizing relevant individuals and institutions to CDD Program objectives; identifying research, educational and training resources that might prove helpful to the program; and, gathering and summarizing existing data. I am particularly satisfied with the collaborative relationships forged during this period; in the months to come, these efforts should bear considerable fruit.

OBJECTIVES

Specific objectives for the period November 1 - January 31, 1987 are reflected in the proposed workplan for November - January (Appendix 1). These included:

November:

- To observe FGD research activity to be conducted in Mombasa by the Population Studies and Research Institute, U. Nairobi.
 - To design FGD study and develop interview guides.
 - To visit W. Kenya to arrange research locations and refine FGD interview guides with Age Khan and U. Meinob/Milomui; as well as follow up and establish new contacts with key individuals and institutions.
 - To identify key District Health Education Officer counterparts and form (i) a Message Development and Health Learning Materials Committee, and (ii) a Folk Media Troupe (assisted by FPPS).
 - To identify key messages and concepts for teaching aids.
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December:

- To prepare prototype graphics for teaching aids to be tested during December-January research and for Pied_Grow.
- To conduct FGD research in W. Kenya Dec. 7th - 23rd.
- To test prototype teaching aids during the same period.
- To analyse preliminary results of the above and prepare a report.
- To observe TOT training for trainers of CHW's (one target audience for materials) by Aga Khan/AMREF - Nairobi.
- To participate in the CDD-sponsored curriculum development workshop for tutors in schools of nursing; focus: integration of CDD into pre-service curricula.

January:

The health communications component is approximately one month behind schedule. Hence, none of the January objectives have been met. This delay is due to (i) several unfulfilled conditions outlined on page 3 of the proposed scope of work for the CDD Health Communications Component for its timely completion (ref. Appendix 2); (ii) the difficulties of scheduling and obtaining collaboration during the six-week period from 1 December - 15 January; and, (iii) the need to continue pursuing some of the objectives begun in the first six weeks (outlined below), as well as to respond to timely requests and opportunities (ref. Additional Activities).

The following additional objectives for this reporting period included:

- To continue to make introductory visits to relevant individuals and institutions, and to explore potential areas of collaboration.
- To identify and review potential candidates for the position of PRITECH Communications Resource Officer (with Dr. Mutie and Ms. Baker).
- To continue to gather and review existing IAH research from W. Kenya and elsewhere.
- To continue to set up the Nairobi office.
- To continue to gather relevant existing educational materials.
- To continue to inventory available graphics/materials production facilities.

- To draft a CDD/KEPI resource packet for journalists, artists and dramatists for the January 23rd Conference for Artists and Intellectuals sponsored by UNICEF.
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ACCOMPLISHMENTS

1) PSRI (U. Nairobi) FGD Activity, Mombasa.

Due to competing priorities at PSRI, this activity was postponed until March. Nevertheless, I shared AED's and my own documents on qualitative research methodology and discussed with Dr. Oucho (PSRI Fellow most experienced in the method) his experiences and the extent of experience with FGD's among Kenyan researchers. It appears that few, if any, Kenyan researchers have used FGD's, but many have conducted community research of one sort or another.

With Dr. Oucho, I attempted to identify Kenyans with the requisite language skills for Western Kenya (Kiluo, Kiluhya [any of 18 dialects], Kigusii, Kuria, Teso) and experience conducting community research. The Department of Sociology seemed a likely reservoir of expertise. However, after numerous discussions and materials shared, no one from the Department was actually available to go to the field. Dr. Philista Onyango, sociology lecturer/researcher in child welfare, has expressed strong interest in the health problems of children in South Nyanza and Siaya, her home districts. She withdrew from her original commitment to accompany us to the field, but may be convinced to assist in interpretation of FGD findings from those districts. Likewise, a women's studies lecturer withdrew. (See Issues/Observations # 8.)

Others identified as FGD moderators or recorders include CDD Management Unit staff, DHMT core staff, the Lake Basin Authority MCH/FP Coordinator, and ORT Center staff, Aga Khan PHC staff, and officers from Adult Education and Social Services. (See Appendix 3: FGD Study Plan.)

2) FGD Study, Interview Guides and Logistics.

Phase I (Western Province) of the Focus Group Discussion Research has been completed with analysis of the findings in progress.

Just before Christmas, Mrs. Opumi (CDD Training Officer) and I paid a 6-day visit to Western Kenya to arrange logistics for FGD's in both provinces. From January 12th-20th, we conducted a 1-1/2 day orientation for field teams (primarily DHMT core staff and one adult educator) and 12+ focus group discussions with 10 cultural/linguistic groups in Kakamega and Bungoma Districts. (Normally, fewer groups would have sufficed. See Discussion Section of FGD Study Plan: App. 3)

Preparations-Western Province

On the December trip to Kakamega, I worked together with Mrs. Opumbi (ODD Training Officer), Mr. Sagalla (ODD/KEPI Health Education Officer), Mr. Singa (PHEO/Western), and Mrs. Abura (Western Provincial Supervisor) to devise a schedule and criteria for selection of focus group participants for the Western Province FGD activity (Appendix 3). Note that Busia District was excluded in accordance with the DC's wishes to keep official activities to a minimum because of recent events along the border. We will probably not return there until we are ready to test the messages we have developed and gather specific terminology in Teso language. At present, I feel comfortable relying on the Busia District Socio-Cultural Profile from the Ministry of Planning for an indication of KAP and related parameters.

Maendeleo ya Wanswake representatives organized the focus groups in collaboration with CDAs from Social Services, and met with chiefs; the PMO, Senior Nursing Officer, and PHEO were informed and welcomed us; and, the PHEO, with Sagalla, was to take care of informing the DC, the DHMT's, Adult Education and Social Services staff, as we could not find any of them in on our brief preparatory visit. They would also confirm the venue for the 1-1/2 day orientation. I was to follow up on all of these arrangements with Mr. Sagalla January 8th-11th in Kakamega, but was unable to do so because of vehicle availability and the scheduling of the PRITECH Communications Position interviews. Neither Dr. Mutie nor I was able to get through by phone to check on preparations with Sagalla or the PHEO. This proved to have a considerable impact on preparations for the activity. (See Issues/Observations # 5 and 6A)

All but one of the 2 PHEO's and 6 DHEO's concerned were on leave during the December visit (and had been and would be for a while!), but both PHEO's willingly collaborated on their own time. Mr. Singa, PHEO/Western, made a 180 degree turnabout from his previous uncooperative posture, and it was largely due to his cooperation that we accomplished so much during our visit to Kakamega. A number of factors may be responsible for this change, but surely it was helpful to come with a letter from Health Education Division HQs, and accompanied by staff he knew, and who was from the same region: Mr. Sagalla and Mrs. Opumbi.

A preliminary briefing document on the activity and guidelines for FGD moderators were shared with PMO's and PHEO's in Western and Nyanza Provinces, along with an abbreviated version of the proposed scope of work developed by Mark Rasmussen and myself for the health communications component of the ODD program (Appendix 4). These were expedited to all DHEO's in both provinces, along with materials on focus group discussions

and communications planning for child survival*, and personal letters soliciting DHEO support for the activity in Nyanza, as well as copies of the "green light" letter from the Acting Director of the Health Education Division.**

Field Work-Western Province

The orientation was opened by the PMO an hour and a half past schedule with 8 MOH employees and 1 Adult Education Officer in attendance. (See Appendix 5.) Field work was completed on schedule and the findings will be useful to the upcoming message development activity. Mrs. Opumbi and I were particularly pleased with the serious participation of Mr. Were, DHEO/Kakamega, Miss Wefila, MCH/FP Coordinator/Lake Basin Authority, Miss Okoti, DPHN/Bungoma and Mr. Danda, DHEO/Bungoma. Likewise, Maendeleo expended much appreciated effort on this activity. Others were not so serious. See Issues/Observations #5, 6 and 6A) for problems encountered and recommendations for the Nyanza FGD activity.

Preliminary FGD findings are now being analysed, and fed into planning for the Nyanza Province activity. Following the Nyanza activity, a final report will be drafted in Nairobi. The CDD team will then return to each of the 7 districts in Western Kenya to present the results to field teams, as well as the existing District PHC Committees.

Preparations-Nyanza Province

Given the relatively greater number of actors, their unavailability during much of December and January, and the difficulties of communication within the province, Nyanza has required more time to organize, with an expected start up date of February 8.

On January 21st, Mrs. Opumbi and I held a very successful meeting with the PHEO and representatives from Adult Education, Social Services, Education, Cooperatives, and Maendeleo Ya Wanawake to ensure that appropriate preparations are made and relevant individuals/institutions involved. Participants were oriented to CDD program policy and FGD study objectives and methodology, and logistics for the study were worked out. Sites for focus groups were selected by consensus, proposed criteria for FGD participants revised, and a schedule finalized. (See Appendix 6 for Nyanza Meeting Agenda)

* 1) Conducting Group Interviews in Developing Countries, A.I.D. Program Design and Evaluation Methodology Report No. 6, April 1987; and, 2) Communication Planning for Child Survival Programs: Draft - July 1987, HealthCom Project, A.E.D.

** N.B. The Acting Director of the Health Education Division was delighted that the Division was being requested to provide support for the CDD Program in the field. "This is the way it should be!" The Division has so long been regarded as non-functional that it receives few, if any, requests.

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Representatives from the various sectors offered to play roles in preparation (organizing groups and identifying FGD recorders for Kisii and Kuria areas) and field research (interpreting for me and other non-speakers of the local language and evaluating the FGD sessions). The efforts of the acting PMO, the PHEO, and the Provincial secretary in organizing the meeting were most helpful.

I have been counting on a February 3rd-6th visit to Kisii, Homa Bay, Siaya and Kisumu to (i) check on efforts to organize focus groups, (ii) brief the new PMO and DMOH/Kisumu, and (iii) spend a little extra time with the moderators and evaluators before the orientation. I hope that a mix-up in the contractual arrangements for the UNICEF driver will not once again mean that vehicle problems will cut short much needed preparation time in the field.

Finally, it should be noted that these FGD activities will serve several purposes. They will

- i) give dimension to existing data on KAP/diarrhea from earlier studies, and help to generate ideas for message and strategy development;
- ii) forge a critical link between the program designers/ implementers - especially HEO's - and the intended program beneficiaries; and,
- iii) provide program designers and implementers with a "quick and dirty" methodology which they will be able to use repeatedly throughout the program to target it, keep it on course, and ensure intended impact.

It was gratifying to hear from the two DHEO's and one DPHN concerned that (i) they had never had such an opportunity to hear such beliefs and practices from women in their area of operation, (ii) they learned something new and useful, (iii) FGD was a good way to hear from the community, and (iv) interviews with health workers servicing the community would not have been an adequate substitute for going directly to the consumers of health products and services.

3) Follow-up and Initiation of Contacts in W. Kenya.

Within the limited time we were able to spend in Kakamega and Kisumu towns during our December trip, Mrs. Ojumbi and I renewed contact with the PMO's and the PHEO's of both provinces, and with the Child Survival Coordinator for Kisumu Municipality Social Services.

In Kakamega, we met with the Chief Health Education Officer and the Community-Based Health Trainer of the Kenya-Finland PHC Project, both of whom were willing to assist with FGD's and other program activities, given the approval of their

Director. It was later determined that the CD4 Trainer was not required for the activity and would be on leave. It is not clear why the Chief HEO did not turn up. Nonetheless, the Project Director granted us use of their facility for the January 12th FGD meeting.

In Kakamega, we also had very fruitful meetings with the Provincial Supervisor of KANU-Maendeleo ya Wanawake Organization (MYWO), whom I had met at Maendeleo HQs with Mrs. Makindi, MYWO MCH/FP Coordinator. She took complete responsibility for organizing the focus groups for Western Province, and did an admirable job despite some problems she had in ensuring that selection criteria and recommended numbers of participants and venue were adhered to by local individuals to whom she entrusted the ultimate task of bringing the women together. She appeared satisfied with the exercise, and I feel sure that we will continue to work together amicably in the Province. The three MYWO District Chairladies also participated to varying degrees in the preparations.

Our meetings with the Kisumu District Mandeleo Chair were also fruitful, although these required considerably more social and waiting time to get down to business. The tangible outcomes of these meetings, including a party for the Minister of Industries, were contacts with the Kisumu District Women's Programme Coordinator, the Kisumu town MYWO leader, and two new Social Development Officers.

The sociologist and eg extensionist from Aga Khan PHC Project/ Kisumu have expressed eagerness to assist us as discussion moderators and recorders, but their schedules did not permit them to join us until February 8; hence, a February 8 start-up date for Nyanza FGD's. Both individuals attended a training session on FGD's by Pop Council, and look forward to practicing what they learned.

Also in Nyanza, the PHEO and I solicited and received promise of support for our activities from the Provincial Director of Social Services (PDSS). His office is the umbrella for Mandeleo ya Wanawake and other women's groups through which we will work from now on. The success of the January 21st inter-sectoral meeting we held in Kisumu for FGD planning was evidence of the support we might expect to get from other sectors for CED activities in Nyanza.

Finally, although transfers have not taken the toll I feared, it is of note that on three separate trips over a three-month period (including January), we will have briefed three different MCH's for Kisumu District, and three PMO's for Nyanza.

4) Health Education Counterparts.

For two months now I have been under the impression that the Director of Medical Services had assigned two Health Education

Officer counterparts to work with me at the CDD Management Unit in addition to assuming KEPI duties. Mr. Sagalla arrived along with his strong application for the PRITECH position: Health Education Officer at the National Division of Health Education since July, after spending a few years at the district level in Bungoma; trained as a clinical officer; a Luhya, he could assist us greatly in Western Province. Mrs. Macharia is a registered nurse who just recently completed her health education training. Both officers took their leave within a week of their assignment, and were to join us in Western Province as soon as they resumed (which conveniently coincided with start-up of activities). However, for personal reasons, neither Mr. Sagalla nor Mrs. Macharia joined us in Western.

It appears now that neither Health Education Officer has in fact been assigned to ODD/KEPI; rather they are "on loan" and will juggle ODD and KEPI with their other ongoing assignments within the Division of Health Education. As there is a shortage of HEO's in the Division, there may be considerable competition for their time. Some solution must be found: perhaps we can reasonably request one of them to be assigned to the entire Division of Family Health. And at least one of them should sit on the Message Development and Health Learning Materials Committee to be formed.

In the interim, Mr. Sagalla is in Ethiopia on a PHC course; Although it was not possible to plan the Nyanza activity as a team, I still hope that he will join us in Nyanza on the 7th of February, immediately after his return, so that his training in PHC would benefit the ODD-KEPI programs.

Mrs. Macharia has so far responded to two of my requests for her participation in specific CDD activities - the UNICEF Conference Jan. 23rd, and the Salvation Army pretest of the ORT flipchart for Machakos. I am glad for her participation and hope it continues. She has agreed to travel with me to Nyanza to check on logistics before the February 8th orientation.

In addition, Mrs. Jane Adar, another strong PRITECH applicant, joined the Division of Family Health under family planning just before New Year's. She has a MPH in Health Education from U. South Carolina and is expected to focus on training systems. By the time Mrs. Adar has made several field visits to follow up trainees, her input will be most helpful to CDD Health Communications in its strategy development phase.

All three health education officers have been provided with materials on qualitative research, communications planning, and visuals for nonliterate. In addition, Mr. Sagalla and Mrs. Macharia have received copies of the proposed policy statement, the map showing established and planned ORT Centers, and the WHO CDD Mid-Level Managers Course modules.

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5) Key Messages and Concepts for Teaching Aids.

The Adult Literacy curriculum revision workshop held by National Adult Education staff in Kisumu in October provided Dr. Alvar and myself an opportunity to draft "quick and dirty" messages on home treatment and prevention. These were included in Appendix E of the first progress report. Some policy decisions re: sachet size, flavoring of ORS, container, and home fluids, as well as suitable local agents for ORS dispensing, will have to be reached and focus group data analyzed before more exact messages are formulated.

I feel strongly that the decisions regarding container and sachet size should result from thoughtful consideration of (1) the availability of containers; and 2) the containers already promoted in PHC programs teaching SSS or ORS preparation. I believe that a "think tank" meeting in mid-to-late February entailing review and debate of all relevant information would lead us to a well-reasoned and appropriate choice.

In the meantime, Jane Adar assisted me with laying out two simple posters illustrating the messages drafted for Adult Literacy for use in the mini-educational sessions the FGD field teams have been conducting after each discussion. We used already existing illustrations from the Health Education Division and the WHO Treatment Module. I am not testing these when I go out because they are far from what we would like to develop.

6) Prototype Graphics/Production Facilities.

Given competing priorities and an agreement with Mrs. Namai, UNICEF Project Communications Officer, to coordinate materials production to the extent possible, I have not yet produced any prototype graphics to test. I requested a trial illustration of a mother and child from a young artist identified in November as a potential candidate for the CDD series, but I could give him no commitment that his work would be used and he has not responded with any illustrations. More important, we do not yet know which home fluids and foods we will recommend, nor do we know which ORS sachet or container to promote.

Nonetheless, with considerable assistance from Jane Adar, FT Health Educator "on loan" to CDD/KEPI for two weeks, we secured illustrations from UNICEF and the Health Education Unit to depict the 3 Rules of Home Treatment and 3 Recommendations for Prevention to accompany the resource packet for the UNICEF Conference. At present, we do not intend for these illustrations to figure in our final CDD materials. However, we welcome them until such time as better materials are produced.

I also priced production of posters and brochures with assistance

from FPPS project:

A3 - 2-color (7/50 each with 2,000 copies);

A3 - multi-color (10/= each on 140 gram glossy and 15/= each on 200 gram glossy);

A4 - foldups (1/50 each for printing and 3/= total [incl. origination] at 10,000 copies);

A4 - 2-color folded in 1/2 (5/= each);

Contrary to earlier indications that Judith D'Inca, the UNICEF graphic artist, was too busy to take on any CDD work, CDD has been informally invited by Mrs. Namai and Mrs. D'Inca to discuss upcoming CDD materials needs. Mrs. D'Inca has a bank of photo images and illustrations that I am looking forward to exploring.

Finally, a draft flipchart and an image bank of child survival-related photographs have been made available to the CDD Unit by Mona Moore, Salvation Army Child Survival Coordinator from Washington, and the Machakos District Child Survival Project. All of the materials were financed exclusively by PRITECH Project over a year ago. (How did this escape our attention??) Additional PRITECH input will be required to put existing photographs into final form and to shoot missing images. As I responded to Mrs. Moore's request to moderate a focus group discussion to test the ORT flipchart messages and images in late January, I am aware of many of the aspects which require revision. Mrs. Macharia also participated in the critique.

The concept of a photo flipchart with health worker messages on back (a la Marcia Griffiths, I am told) received a favorable response from Mr. Baltazar and Mrs. Opumbi, although we all expressed reservations about the Salvation Army messages, and their relative emphasis within the framework of diarrhea treatment and prevention. A draft CDD-KEPI Resource Packet has been passed on to Mona Moore and Mrs. Mutua, Machakos Child Survival Coordinator, to guide their message revisions. Likewise, I jumped out of my moderator role on a few occasions during the pretest exercise to present CDD policy recommendations. However, further efforts might be necessary to ensure that Salvation Army messages are consistent with national CDD policy. This will be particularly important as Salvation Army has an extensive network of women's groups throughout the country who might serve as conduits for the CDD message. (See Recommendations #14.)

After a tedious review of PRITECH Communications Resource applications, I now have a lengthy section in my Kenya address book on Materials Production Resources - individuals and facilities. Jean Baker has an additional lot of applications

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for me to go through soon. I will produce a typed list of these in the near future, including assessments of individuals met and facilities visited.

Mrs. Nema and I made plans to visit a number of production facilities together. We visited Kenya Institute of Education in December, however, since she has been back from leave, she has been tied up with the Conference and I have been in the field. We hope to schedule some visits end of February.

7) Further Introductory Visits/Resources To Be Tapped.

Artists

At the UNICEF-sponsored luncheon to launch the Kenya Association of Journalists for the Child (KAJOC) in December, and the UNICEF Conference for Artists and Intellectuals, I made contact with journalists, artists, dramatists, lecturers from the School of Journalism and Dept. of Pediatrics, and Information officers. These contacts should be helpful as campaign strategies are mapped out. (CDD is now on the list to receive the KAJOC newsletter.)

The UNICEF-sponsored meeting of Artists for Child Welfare and Development should also provide a useful forum for exchange of ideas, although the first meeting I attended was a "no-show" just before Christmas. Likewise, the Annual General Meeting of the Kenya Audio-Visual Aids Association (KAVAA) I attended in December failed to attract many of its regular members. Although the coordinator frequently asks me to consider KAVAA for educational materials production, I suspect that they are barely surviving on a prayer and a shoestring, and would not have the capacity we require.

I spent one "riotous" day at the Dept. of Design in the School of Art and Architecture with Mr. Murithi Kinyua, quite a talented fellow who has done a variety of design, writing and educational materials development work with FPPS and the Dept. of Adult Education. He used to be the editor of Kenya Adult Education Journal. CDD should consider using his services on the operations manual layout and graphics, among other things.

Other Sectors

Dr. Makhulo and I visited the Commissioner for Social Services and the Director of the Women's Bureau to solicit the collaboration of their officers in the field for FGD's and future CDD activities. They were quite receptive, although they require a formal solicitation of collaboration from the DMS through the PS.

Efforts to liaise with Adult Education in Nairobi were unsuccessful because of leave schedules. I understand that

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They are reviewing the Board of Adult Education this year. Mr. Francis Gateru or Dr. Kirui are the ones to see. We shall try again once my counterparts and the longterm PRITECH Communications consultant are all present. (See ISSUES/OBSERVATIONS # 2.)

Other relevant contacts are reflected in the section INDIVIDUALS/INSTITUTIONS CONTACTED.

8) Existing Educational Materials.

Very recently, UNICEF (Mrs. Woldehorgis and Mrs. D'Inca) developed a set of 8 very beautiful posters on PHC, Diarrhea and Malnutrition. At least 1000 of them for distribution through health centers. CDD staff (Alwar and Burstrom) recall commenting on the posters in their very late stages, and requesting certain revisions which do not appear to have been respected. It is difficult to ascertain the intended target audience, although it is clear that only a health worker trained in CDD would be able to understand most of the CDD messages. Also, the use of graphs and sophisticated measurements for ORS appear to confuse, rather than to clarify. As they are, the CDD Program will have difficulty using them.

Since we do not know if these materials were pretested, we have dropped a set in Western Province for informal testing with health workers by the PHEO. Comments from the field will be more valuable and acceptable to UNICEF than comments from the CDD Unit. A set of these was also sent to PRITECH/Washington with John Alwar.

9) Radio Program Development.

Two CDD episodes of "A Healthy Nation" series have been produced and aired on VOK in the past month: 1) Causes (Dr. John Alwar); and 2) Management (Dr. Stephen Kinoti). As I understand it, CDD (John Alwar) did not want to produce the Management program until exact recommendations on home fluids, container size, etc. had been established. It appears that VOK/KMA were not satisfied to wait. I have partial scripts and full audiotapes for those two episodes, however it is against copyright laws for us to make copies. Copies of the whole KMA series or excerpts may be requested in writing from Dr. Orinda, Dept. of Pediatrics, who is coordinating "A Healthy Nation" series. (Appendix 7)

Last week, I responded to a VOK request to discuss CDD messages for radio spots to complement the KMA series. The first meeting will be held with Dr. Orinda in the first week of February. As I will not be in Nairobi, CDD should send a representative to that meeting. Also, Dr. Orinda should receive a draft of CDD policy beforehand.

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Finally, I have learned of a radio listener survey held by the VOK Commercial Department. I am attempting to obtain a copy through Rachel Ogutu.

10) CDD Curriculum Revision for Nursing Schools.

I attended an afternoon session on objective writing and provided a draft of Communication Tasks and Learning Objectives, based on work shared by the Malawi HealthCom Program. (Appendix 8.) Several other activities scheduled for those two weeks precluded my participation in the entire workshop.

11) AMREF/Acs Khan-Sponsored Training of Facilitators for CBHC in East and Southern Africa.

My attendance at a few sessions of this international workshop in November enabled me to get a sense of the level of the trainer of CHW's for whom we will be designing materials, although I suspect that what I saw in this workshop was a bit higher powered than the typical TOF's carried out on the local level in Kenya. I also made a few valuable contacts including AMREF staff; Undugu Society which will arrange for pretests of any CDD materials in a slum area in Nairobi; a skillful management consultant from Kisumu whom we might call on at some point; and representatives of various NGO's involved in CBHC.

12) CDD-KEPI Resource Packet.

In response to an invitation by UNICEF to attend a January Conference of Artists and Intellectuals, I drafted an outline and gathered source materials for the development of a CDD-KEPI Resource Packet, and recruited Jane Adar* to carry out the task during my absence in Western Kenya. Under Jane's able coordination, the CDD and KEPI Unit staff drafted background documents on the CDD and KEPI programs, including general CDD messages on the causes and dangers of diarrhoea, home treatment and prevention, and health center treatment and maintenance therapy with ORS; and, for KEPI, a fact sheet on measles. Both documents were accompanied by illustrations donated by UNICEF. (Appendix 9.)

Fifteen such resource packets were distributed at the UNICEF conference to journalists, theatre troupes, the Director of the Kenya Cultural Center, coordinators and producers of VOK radio and TV programs, including "A Healthy Nation" series,

* Jane Adar is a Health Education Officer newly assigned to Family Planning in the Division of Family Health who was free to assist CDD/KEPI while awaiting specific FP duties. Also, a PRITECH candidate.

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and to UNICEF staff. Although the documents were in draft form, the opportunity to present CDD and KEPI to these people was not one to pass up for the sake of perfectionism. Nevertheless, the packet has been circulated to all CDD and KEPI staff for corrections and comments, and will not be distributed to other individuals or institutions until it has been reworked to our satisfaction. Note that one of my terms of reference was to develop a resource packet/press kit for distribution to NGO's, other ministries, journalists, and others. For this purpose, the revised resource packet will be supplemented with the exact messages and prototype graphics we intend to use in our communications campaign.

Additional Activities

1) KEMRI Research on Pit Latrines and Health Education.

I responded to a request passed on by Bo Burstrom from Mr. Surow Adaw, KEMRI researcher and public health officer, to review and comment on a protocol for a two-year study of the impact of health education interventions on childhood diarrheal incidence in one area of Kakamega District. The study has four cells: 1) Messages on general excreta disposal + technical and minimal financial assistance building pit latrines; 2) same as above + special message emphasis on infant excreta disposal; 3) health education alone (the contents of this cell are still under discussion); 4) no intervention (control).

I am awaiting a revised version of the protocol, and will share it at that time. In the meantime, the sociologist involved in devising a baseline KAP questionnaire for the study was to bring it to me for comment. I imagine that it is still not completed as she was on part-time maternity leave, and December-January is a very difficult time.

2) Westinghouse Health and Demographic Survey.

In November, I responded to a request by the USAID Chief of Health, Population & Nutrition to review and comment on a Westinghouse-sponsored and devised demographic and health questionnaire to be implemented by the National Council on Population and Development. I shared with Bo Burstrom (WHO) and Barry Levy (MRC epidemiologist) my written comments on the section on KAP/diarrhea, and with Peter Rjeergaard (KEPI Advisor, the section on FPI. (Dr. Alwar was tied up with other priorities at the time.) They each added their comments and I think we had a good critique to present. (Appendix 10.)

However, I was misinformed that the time for revision of the questionnaire had not yet come, when in fact Westinghouse was soliciting comments from Dr. Mutie, and proceeding with revisions they considered final. (Normally, one would iron out logistics and questions of feasibility before proceeding

to revise the instrument!) It is unfortunate that signals got crossed, and some time-consuming critique was apparently for naught. However, I was able to catch the consultants before their departure. They appeared open to revisions that CDD deems absolutely necessary, with the reservation that the instrument was reviewed in group, and not easily changed without stepping on toes. During their visit this week, I would like to assess where they stand on the sections CDD staff reviewed.

3) Institute of Applied Nutrition.

Jean Baker and I met with Arney (and Mrs.) Kielmann to discuss areas of collaboration. They are anxious for us to provide topics (and requisite funding support) for operational research to be carried out by their post-graduate students. The outcome of the January 11th meeting of ADDR with John Alwar and KEMRI would be of interest to them, I am sure. I have not as yet come up with any health communications research topics, aside from working on the one which KEMRI has proposed on health education on pit latrine use and infant excreta disposal. Perhaps the FGD's will point up some interesting topics to be explored.

There are periodic seminars held by post-graduate students on research they are conducting in applied nutrition. The next one coming up deals with "Longterm Nutritional Consequences of Immunization Programs". I have requested that the Institute call the Division of Family Health (particularly CDD, KEPI and Nutrition) to announce upcoming seminars.

4) Kenya Institute of Education (KIE) - Early Childhood Education Program.

There is a National Center for Early Childhood Education at KIE as well as district centers in Kakamega, Kisumu, Siaya, and elsewhere throughout the country. In that these centers teach community members (parents and pre-school teachers), they are a vehicle for CDD. Our target would probably be the trainers of parents and pre-school teachers. Although there is a panel for every subject taught in the formal curriculum, "information packages" (e.g., population education) do not have to go through the formal process; rather, these packages can be introduced as pilots. We could begin the process of integrating CDD into the formal curriculum with a letter to the KIE Director indicating our interest in child survival themes (CDD, Nutrition, Measles) and requesting that one of the CDD staff sit on relevant panels. This request might be accompanied by a proposal as it could involve funding as a project. (This aspect requires clarification.) An invitation would then be issued to the MOH. Mrs. Nturibi, the Coordinator, invites us for a second visit soon.

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5) Distribution of Resource Materials.

AED documents on Communication Planning (July 1987) and Qualitative Research (July 1986), and AID's Conducting Group Interviews in Developing Countries (April 1987) have been distributed to all Health Education Officers (HEO's) in Western and Nyanza Provinces, to the MCH/FP Coordinator for Lake Basin, and to University of Nairobi Departments of Sociology, Journalism, Literature, and Population Studies. These and other resource materials have been provided to the three HEO's "attached to" the Division of Family Health, as well as to Mr. Dondi (PRITECH).

6) Contact with USAID.

John Alwer, Jean Baker and I briefed Linda Lankensu in mid-November, and have since met with her quite frequently on a number of issues. I have found her suggestions quite useful: she is a person of action!

7) WHO CDD Managers' Course.

I took this opportunity to request from IHPO/CDC the latest on "P" studies, health education evaluation methods, and related topics. I also met with CDD managers from various countries. (CDD/Kenya is now on the distribution list for Sudan's CDD newsletter; see Dr. Makhulo for Vol. I.)

8) Measles Awareness Activity in Western Kenya.

In December, Dr. Burstrom, Dr. Bjeerregaard and I discussed preliminaries of a measles awareness activity, possibly phased by district, in the pilot area at mid-year. Further details will be discussed in the coming months.

ISSUES/OBSERVATIONS

1) Revised Schedule of Health Communication Activities.

According to the schedule updated in October, FGD activities were to take place during December-January. However, the scheduled preparatory visit to Western Kenya could not take place. First, there was no vehicle or driver available from UNICEF until the first week of December. Given competing priorities, I was not inclined to spend the extra day or so it would have taken to identify and rent a vehicle to go West. (The vehicle/driver issue once again caused delay in the field schedule this week.)

Second, the month was incredibly overbooked with visits, workshops, and continuing to check out technical and institutional resources, and to establish relationships that would benefit the program.

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Third, many administrative details required ironing out, particularly with UNICEF, and I had to be in Nairobi for meetings during Jane Brown's visit to establish and clarify systems and procedures.

Finally, and most important, the individuals who should have been most intimately involved in planning and conducting these activities, that is, the HED's at the central, provincial and district levels, (as well as the longterm PRITECH Health Communications Consultant), were nearly all on leave since the first week of December, some only returning the last week of January!

continued →

Despite these apparent deviations and delays, I feel quite satisfied that my time during the past two months has been well spent, as evidenced by progress reported here in other areas, and by the number, variety and quality of professional contacts made. A revised workplan for January - May is attached (Appendix 12.)

2) Institutional Visits and Work Without Counterparts.

Since November 1, I have made many valuable contacts in and out of the health sector, with governmental and nongovernmental offices. (See Individuals/Institutions Contacted.) Although I have at times been able to make such visits with ODD staff, frequently there has been no one available with whom to do so. Moreover, it is one thing to visit offices with any available ODD staff member, and another thing to visit with a ODD staff member whose scope of work is health communications. As I continue to make introductory and repeat visits to various individuals and institutions, the thought that such visits will have to be repeated with my not-yet-very-present counterparts pains me: valuable program time is being lost.

This is true also for the process objective of skills transfer. Although it frequently takes longer and can be more frustrating to work as a team, the benefit of learning by doing is great. I hope that the health education officers and the longterm PRITECH consultant will be able to participate in the second field phase of developmental research, even if they were not able to assist with planning for it.

Furthermore, decisions must be made in the very near future on messages and media. Whichever avenues are selected now will have to be carried through by those three officers, not by me. It would be a shame if choices were made now which they would have difficulty living with later. Their earlier participation will ensure their investment in the activity later.

3) Office Space/Secretarial Support.

Mrs. Marcheris, Mr. Sagalla, and the expected PRITECH Health Communications Officer have no office space as yet, but it is logical that we should sit together at the CRC. All the more reason that steps should be taken to ensure that the office there is functional, with telephone line, photocopier, typewriter, and secretarial support. (Some of the furniture, including some loaned by USAID, arrived around Christmastime.) I spend considerable time photocopying, collating, stapling and doing errands that could be done at a lower hourly rate by someone hired for that purpose.

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4) My Role as a Resource Person.

Since my arrival, I have not been able to play this role to the maximum because most of my materials have been sitting in Washington. I have wanted to provide examples of national CDD plans, policy statements, operational level materials, educational materials, KAP studies, behavioral profiles for CDD, materials on pretesting and social marketing, etc. The cost to AED of sending the materials on seems little compared with the cost to the program of my working without my materials. This is not the area in which to cut costs.

5) Cooperation for Field Activities.

Although the CDD team (Opumbi and Mayer) received a good measure of cooperation from certain members of the DHMTs in Western Province, we were disappointed in the level of cooperation from certain other members, particularly the PHEO and the DPHN/Kakamega, and to some extent a Health Education practicum student the PHEO seconded to the exercise. Although the PHEO was helpful in arranging some of the logistics for our exercise (venue and some of the invitations), he stopped short of necessary formalities such as following up on the CDD team efforts in December to inform the DMOH's and the DC's, as well as heads of Social Services and Adult Education. Because of vehicle and telephone problems mentioned under Accomplishment # 2, the CDD team itself was unable to complete this necessary followup in early January. Hence, preparations were incomplete.

To facilitate the participation of these officers in early evening sessions to review the day's findings, CDD gave them per diem to stay in town rather than travelling the 70km roundtrip to their homes outside Kakamega. They pocketed the money and then did not show up for the exercise neither for the evenings, nor on Saturday morning, as promised.

When the PHEO participates in earnest, his contributions are most insightful and valuable. But it seems he cannot be counted on. This does not bode well for CDD activities in his area of operation as he and the DPHN would be prime implementers of the strategy. Appropriate action should probably be discussed with the PMO.

6) Finances for Field Activities.

A number of financial issues arose in the field for which there appeared to be no clear guideline in the PRITECH list of allowable per diems and meal rates.* Issues include:

- overtime for work beyond 8 hours/day;
- lunches out for various categories of workers who are participating in a CDD activity within their routine area of operation;

* Devised by Baker and Mayer in December and approved

- compensation for central staff who work on Saturday or Sunday;
- compensation for local staff if they work on Saturday or Sunday, and, because they are at their post, are not entitled to per diem;
- fueling of vehicles (governmental or non-governmental) to accomplish CDD-related work requested of local agents by central CDD staff;
- advances for fuel and transport;
- picking up the tab for lunches of those entitled vs. payment of a flat rate for lunch out (which inevitably costs the project more).

Most of these issues were raised in the context of precedents set by other projects operating in the area, notably UNICEF. CDD needs some hard and fast rules which CDD staff will consistently apply during the many field activities they will conduct in the next few years.

6. Logistical Problems Encountered in FGD's/Lessons Learned.

We encountered several problems that underline the importance of double-checking firsthand the preparations that have reportedly been completed for field activities. These included:

a) The number and composition of the focus groups were rarely respected, although communicated in writing to those ultimately charged with selecting the women. Sometimes as many as 20 eager women appeared (instead of 6 - 10), some without children under five, some community health workers, some women's leaders, some under age, some over age, etc. This required considerable screening before the discussion could begin. The field team then split, one taking the "real" focus group, one taking a "bogus" group. It added to the fatigue of the field work and may have created a bit of confusion.

b) Organizers frequently did not respect our directive to select women and a discussion venue that would minimize the travel time and inconvenience to participants. Some women travelled GREAT distances to come to the discussion, and we could only reimburse them their travel costs, not their time! Furthermore, some "threatening" venues were chosen - DO's offices, Municipal Council conference rooms, chiefs' offices. Although in all cases, it was clear that the chiefs had been informed by MYWD that there would be health-related discussions, the briefings may not have been adequately done. We suspect that some of the inappropriate venues were orchestrated by chiefs who wanted to keep an eye on things because they were not entirely sure of our purposes. To the extent possible, we shifted these venues; but this, at times, added confusion.

c) Another misconception that may have resulted from improper briefing of the chiefs is that ours was an aid program rather than an educational program.

d) Because the PMO had not written to the PC or the DC's, we experienced delays in a few of the first places we worked. Once we managed to get those letters, things went more smoothly.

e) An additional issue related to the inadequacy of 1-1/2 days for orientation of the field teams since with delays and interruptions of one sort or another, the actual time available for training was drastically reduced. 2 or 2-1/2 days is much more realistic.

7) Educational Sessions Coupled with FGD Research.

Lengthy explanations and repetition were required to justify our intentions to meet with only SELECTED members of SOME of the women's groups, and to clarify the benefits of our activity for the discussion participants. It was clear to us that the FGD team would not be able to leave any of the discussion group without first conducting a mini-educational session; though it proved to take more time during the Western Province exercise, it seemed only fair and we will do it in Nyanza as well. The education given does not in any way hinder our results since each focus group is located at quite some distance from the others. (See Appendix 3: FGD Study Plan, FGD Orientation Handout # 6.)

8) Withdrawal from FGD Activity by Two University Lecturers.

It has been suggested by a professor who knows both individuals that their withdrawal from the exercise might be due to a combination of factors: (i) competing priorities for the proposed time period (beginning of classes, upcoming consultancies); (ii) reconsideration of the rate of 400/ per day offered by ODD (too low); (iii) concern about questions that might be raised by authorities about their role in the research given sensitivities about research at this point in time; and, (iv) their desire to be involved from the outset in devising the methodology and the FGD Topic Guide, moving beyond the role of moderator and collaborator in Topic Guide revision during the orientation and the first few focus groups, as planned, to the role of full co-researcher.

These issues will have to be given consideration in future efforts to collaborate with university faculty.

9) Tape Recording FGD's.

FGD's could not be tape recorded because of sensitivity about the research issue.

10) Phasing of Health Communication Activities By District.

I am glad for the decision to focus on Western and Nyanza Provinces, leaving other areas of the Lake Basin to a later time. Still, it seems an unwieldy area for a pilot project. There are many actors involved, and infrastructure will require considerable reinforcement. To make a reasonable impact on health practices, there must be a considerable training input, not just a one-shot effort, but a short series of workshops for any given cadre we hope to use as a conduit for CDD. The training followup and campaign monitoring tasks will be monumental for even one province, given limited personnel. CDD will want to address these issues in a series of strategy meetings in the near future so as to embrace a realistic, but still quite challenging, task.

> Given that authorities in both provinces have been sensitized to an upcoming CDD/Measles thrust in their areas of operation, CDD might consider a phasing of communications efforts by district, rather than deciding to cut certain districts out of the pilot altogether.

11) A PHC Coordinating Committee under the DMS.

As many communications, research, and training efforts come down the pike from various divisions within the MOH - KEPI, AIDS, CDD, ARI, Growth Monitoring - the need for an overall coordinating committee becomes more apparent. Such a group could avoid unnecessary duplication of effort, and dilution of the impact of individual programs that might occur with over-saturation of the community and the health infrastructure with messages, research, and training on everything under the sun at the same time.

In the districts, we shall try to avoid these problems by working through the intersectoral District PHC Committees where they exist. Still, central level coordination of resources is critical.

12) Regular CDD Meetings.

The unit is getting so big and is facing so many challenges in the year to come that we cannot afford not to become a team. Regular meetings will help. A lot was accomplished in our first meeting in November. I look forward to our next one.

13) Regular Meetings Within the Division of Family Health.

Given the integrated nature of much of CDD's work with other aspects of family health, regular meetings (less frequent than CDD meetings) would help us all to coordinate and maximize resources, and standardize messages and approaches.

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14) Folk Media Festival/FPPS.

As this event should be coming up in the next month, it is time to check back with FPPS.

15) RIED_CROW/CARE.

Likewise, it is about time for the drafting of the Communicable Diseases issue of Ried Crow.

16) New Director of Health Education.

Dr. Koinange's posting to the Division of Health Education bodes well for collaboration. A courtesy call is in order.

17) Revival of the Health Education Division.

The World Bank is conducting a feasibility study for the revival of the Health Education Division as a production unit. Rachel Ogutu (KMA/UNICEF) and Paul Ombia (VCK) are among those assisting with the assessment. It should be completed by the beginning of March. An independent board would govern the production facilities, which would be commercial.

18) Health Education Network.

As yet, no one from the Division of Family Health (as far as I know) has been invited to be part of the Health Education Network coordinated by Mr. Nyamoya (AMREF) and Mrs. Namai (UNICEF), despite my few hints to Mrs. Namai.

19) Health Messages and Learning Materials Committee.

This should be constituted soon and might be two-tiered: the first tier would consist of core ODD staff (including a health education officer, of course), an Adult Education representative, a representative from the social sciences such as IAS or Sociology staff, Mrs. Namai (UNICEF), and perhaps Mr. Nyamoya (Health Ed/Health Behavior - AMREF). This group might draft the messages and materials. The second tier would be at the provincial levels consisting of some or all of the 7 HED's and others identified from Adult Education and Information and Broadcasting. This group would review the messages and materials, work together on the vernacular, and on proofing. The feasibility of this idea should be discussed in the next ODD meeting.

20) Availability of Nursing and Health Education Students.

Nursing and health education students do 10-week practices in the field in March-April. Initial discussions with

nurse tutors indicate that they feel that their students would gain from an exercise in pretesting messages and materials. We shall try it. We need to check with Mr. Nzioka (Health Education) on the availability of his students.

21) Maendeleo Ya Wanasake As Conduits for ORT.

Mrs. Makindu, MYWO MCH/FP Coordinator, would very much like her field workers to be distributors of ORS sachets. This notion was echoed by all MYWO leaders encountered during our field activities. CDD staff will have to give this careful consideration when designing a strategy for getting ORT to the grassroots, taking into account the reservations of some regarding the prudence of mixing ORT with FP.

22) CDD Baseline Survey (Alvar with AMREF).

As the Central Bureau of Statistics (CBS) is to conduct data collection activities for the update of UNICEF's Situational Analysis in Kenya, Dr. Alvar may like to explore possibilities for coordination and resource-sharing.

24) ORS Sachets.

Our mini-educational sessions after each FGD confirmed two needed changes in the salts and the sachets:

a) Mothers' puckered mouths and grimaces as they tasted the mixed solution told us that we need to test for and select a flavor. (Let's ask CIBA-GEIGY how they arrived at banana flavoring.)

b) Our demonstrations of sachet preparation were none too smooth or graceful as the perforation on the sachets is very poor. It is inappropriate to tell a group of mothers that the sachet is easy to prepare and that they should open without spilling when we who are demonstrating are busy struggling with a sachet whose contents end up on the ground when the perforation finally gives way!

25) Trip Finances Through UNICEF.

a) The ceiling for funds in the PRITECH/UNICEF account is too low, particularly if Dr. Alvar and I are engaged in field work at the same time (and then there is Mr. Dondi). Funds for both of my FGD activities have not been available in time, and the PRITECH account was too low to compensate for all of my need. This would almost always be the case with the PRITECH account because its maximum balance is only \$1,000, and it is meant for emergencies and incidentals, as I understand it.

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b) The current system of giving funds directly to the driver with the amount unbeknownst to the team leader, and with no copy of accounts to PRITECH is not conducive to accountability and monitoring. Nor had policies of normal work hours, overtime and other such issues been clearly spelled out by UNICEF Transport Office until this week when I requested clarification re: exceptions to the rule during my last field trip. I have requested that Mr. Mbera copy all documents relating to travel expenses met with PRITECH/UNICEF funds to Jean Baker. These could be passed through any of the PRITECH travellers to Jean at the end of each trip or each month. As the UNICEF time sheet is inadequate for tracking overtime, I devised a new one which the driver and I understand (Appendix 15). The four PRITECH staff who would use the vehicle should meet to be sure that we agree on procedures of accountability.

RECOMMENDATIONS

- 1) PRITECH (AED) should act immediately to bring Mr. Dondi on board so that he can play an active role in remaining FGD field activities and message and strategy development.
- 2) The necessary should be done to secure a separate phone line at CRC as soon as possible to make the office functional. To this end, assignment of a secretary from the Ministry and procurement of additional office space from KEMRI (Dr. Were) should be treated as urgent. A lock must also be placed on the door to the seminar room where we hope to set up office.
- 3) By the last week in February, a Health Message and Learning Materials Committee should be constituted as discussed under ISSUES/OBSERVATIONS. A letter of invitation should be issued to Mrs. Namai (UNICEF).
- 4) As an introduction to that first message development meeting, Dr. Alver and I should present our findings from FGD's and the Container and Home Fluids Survey.
- 5) In the first few strategy meetings, CDD Unit should reconsider as a team the issue of phasing health worker training and media campaign efforts by district. The reach of radio broadcasts in the many vernaculars of the Lake Basin Region should figure into any decisions made.
- 6) A failsafe method for monitoring travel expenses from PRITECH/UNICEF funds should be devised and implemented by PRITECH staff.
- 7) A second CDD staff meeting should be called the week of February 22nd when Dondi and Mayer will be back from Nyanza, and Baltazer, Maina and Opumbi will be back from Eldoret.

- 8) Although it appears at present that the doors have been closed on the issue of at least one full-time counterpart from the Division of Health Education, a search for viable alternatives should continue. The importance of transfer of skills from the two PRITECH Health Communications consultants cannot be overemphasized.
- 9) CDD staff should all meet to discuss uniform implementation of financial guidelines during all future field activities.
- 10) Remedies identified for logistical problems encountered in Western Province FGD's should be implemented in Nyanza.
- 11) FPPS and CARE should be contacted ASAP.
- 12) A CDD staff member should follow up with Dr. Orinda on message development for radio spots.
- 13) A letter should be sent to Dr. Orinda to obtain tapes of "A Healthy Nation" series as soon as possible. An audition of those tapes should be staged once they are procured.
- 14) A letter of thanks and of an offer of future assistance in message development should be sent to Salvation Army within the next few weeks.

INDIVIDUALS/INSTITUTIONS CONTACTED

NAIROBI

MINISTRY OF HEALTH

Division of Family Health

Dr. Mutie, Director
Dr. Makhulo, CDD Program Manager
Dr. M. Joan Mujumba, KEPI Program Manager
Mr. Baltazar, CDD Clinical Officer
Mrs. Joy Opumbi, CDD Nurse Training Officer
Mr. G. Maina, CDD Public Health Officer/Logistics
Dr. John Alvar, PRITECH Consultant, Training/OR
Dr. Bo Burstrom, WHO Advisor
Ms. Jean Baker, PRITECH Administrator
Mr. David Kazuo, KEPI Cold Chain Technician
Mrs. Mwangi, KEPI Training Officer
Mrs. Jane Adar, FP Training Officer

Division of Health Education

Mr. Mark Achen, Acting Director
Mr. Ernest Sagalla, Health Education Officer (HEO)
Mrs. Jacinta Mcharia, HEO
Ms. Penina Muli, Nutritionist
Ms. Anne Mbugua, Nutritionist
Mr. Francis Nyenze, Graphic Artist

Division of Health Information Systems (HIS)

Mr. Gaxton Makhete, Statistician/Field Research
Coordinator

Kenyatta National Hospital

GRT Center:

Mrs. Wachira, Clinical Officer
Mrs. Koigu, EN/Sister-in-Charge
Mrs. Kasili, Matron, KEMRI-CRC
Mrs. Wanjohi, EN, IDH?
Mrs. Mwangi, Nutritionist
Mrs. Onqoni, Enrolled Community Nurse (ECN)
Mrs. Murithi, ECN?
Mrs. Joan Apwoks, ECN
Mrs. Gladys Achieng, Family Health Field Educator (FHFE)
Mr. Mario, Records
Mr. Olo, Maintenance

Dept. of Pediatrics

Dr. Grinda, Coordinator of "A Healthy Nation" radio/TV series and of new Epidemiology Unit

KEMRI-MEC

Dr. Were, Director
Dr. Stephen Kinoti, Director, MEC
Dr. Barry Levy, Epidemiologist, Center for Environmental & Occupational Research (BU/Boston)
Mr. Surov Adaw, PHO/Researcher

MINISTRY OF EDUCATION

Kenya Institute of Education (KIE)

Dr. Muita, Resource Section (Radio)
Mrs. Freda Nturubi, Early Childhood Education Coordinator
Mrs. Dhan Banderi, Graphics Section
Mr. David Karanja, Educational Media Service
Mr. David Kameu, TV Production
Mr. Evans Kihio, Publications Office

MINISTRY OF CULTURE AND SOCIAL SERVICES

Mr. Chemoyve, Commissioner for Social Services
Mrs. Oeri, Chief, Women's Bureau

MINISTRY OF INFORMATION AND BROADCASTING

Ms. Adagala, Information Officer?

MINISTRY OF INDUSTRIES

Hon. Mr. Ouko, Minister

UNIVERSITY OF NAIROBI

Institute of Applied Nutrition
Dr. Arney Kielmann, Director
Dr. (Mrs.) Kielmann, Professor

Population Studies and Research Institute (PSRI)
Dr. John Ouko, Demographer

Institute of African Studies (IAS)
Dr. Anne Fleuret, Anthropologist

Institute of Development Studies
Dr. Rachel Musyoki, Research Professor (Women)

School of Architecture and Design

Mr. Murithi Kinyua, Design Lecturer and Freelancer

School of Journalism

Prof. Polycarp Ombio Ochilo, Lecturer, PHC-trained

Mr. Absalom Mutere, Lecturer (Development
Communications)

Dept. of Sociology

Dr. Mburugu, Chair

Ms. Priscilla Kariuki, Lecturer (specialist research
methods & family life education centers, Western
Province)

Mrs. Philista Onyango, Lecturer (Child Welfare)

Dr. Njeru, Anthropologist

Dr. Preston Chitere, Lecturer (Rural Sociology)

Dept. of Literature

Miss Kavetsa Adagala, Lecturer (Oral Tradition and
Gender Issues)

Mr. Waigua Wachira, Lecturer (Interest: Mobilizing
Artists for Child Welfare)

Library

Mrs. Kiasni, Deputy Head Librarian

Mrs. Inoti, Head, East African Collection

KENYATTA UNIVERSITY COLLEGE

Dept. of Home Sciences

Dr. Ruth Oniango, Nutritionist

AFRICAN MEDICAL RESEARCH AND EDUCATION FOUNDATION (AMREF)

Dr. Penina Ocholla, Community Health

Mrs. Margaret Okello, CEMC Support Unit

Miss Editha Nsubugu, Training

Mr. Sam Okore Chieno, Print Manager

Dr. Amri, Curriculum Development

Mr. James Odaga, Management Consultant (Kikomi in Kisumu)

KANU-MAENDELEO YA WANAWAKE ORGANIZATION (KANU-MYWO) HEADQUARTERS

Mrs. Otete, Chairlady

Mrs. Esther Makindu, MCH-FP Coordinator

Mrs. Mwanaidi Shiundu, Sec'y.

Miss Kevin Mpaka, law student volunteer for Western

Miss Dorcas Odhong, law student volunteer for Nyanza

Miss Rose Janet Ayugi, law student volunteer for Nyanza

VOICE OF KENYA (VOK)

Mr. Paul Omalla, Radio Producer "A Healthy Nation"
Mr. Tom Kazungu, Radio Producer (spots)
Mr. Victor Omala, Radio Producer (spots)
Mr. Joseph Murema, TV Producer (?) "A Healthy Nation"
Ms. Nyakanini Kigundu, TV Designer

ASSOCIATION OF MEDIA WOMEN OF KENYA

Ms. Grace Machayo, member

KENYA ASSOCIATION OF JOURNALISTS FOR THE CHILD (KAJOC)
(UNICEF sponsorship)

The Daily Nation: Ms. Dorothy Munyakho, journalist
Mr. Ben Omoro, journalist
Ms. Victoria Okumu, journalist

The Standard: Mr. Amboka Andere, columnist
VIVA Magazine: Mr. Horace Oware, publisher

Ms. Adagala, MOI&B

Mr. Absalom Mutere, U.Nairobi School of Journalism

KENYA ASSOCIATION OF ARTISTS AND INTELLECTUALS FOR CHILD WELFARE
AND DEVELOPMENT (meets at Kenya Cultural Ctr. under UNICEF)

Mr. Alexander Gichuke, Manager of Kenya Cultural Center
Mr. Waigwa Wachira, Lecturer, U. Nairobi Dept. of Literature
Ms. Suzanne Gachukia, Musician/Composer, Musikly Speaking
Mr. Raphael Tuju, TV/Radio Producer, Media Productions
Mr. Elimu Njau, Director, Paa Ya Paa Gallery (artists
& actors)
Mr. Martin Gumba, playwright/radio scriptwriter/actor,
Articulate Communications, Inc., Nairobi

SALVATION ARMY HQs

Mrs. Lt. Col. Margaret Taylor, Territorial Leader of
Women's Organizations, East Africa
Ms. K. Mona Reinhardt-Moore, Health Education Advisor
↑
for Child Survival, SA World Service Office

CDRAT

Mr. Gordon Brown, CBHC Coordinator

UNDUGU SOCIETY, CBHC Program

Ms. Frederika Schroeder, Community Health Trainer

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USAID

Mr. Steve Sinding, Mission Director
Mr. David Oct, Chief, HPN
Ms. Linda Lankenau, Health Officer/PRITECH Monitor
Ms. Molly Gingerich, Health Officer
Ms. Laura Slobey, Population Officer
Mr. Peter Shipp, MSH Consultant to FPAK
Ms. Annie Cross, Westinghouse Consultant to NCFD
Dr. Carolyn Mckinson, " " " "
Dr. Marty Mekenin, Health Care Financing Consultant,KNH
Ms. Cathy Gverholt, " " " "
Mr. Patrick Friel, ISTI Consultant for CSM

PRITECH

Mr. Ron O'Connor, President, MSH
Ms. Jane Brown, Kenya Project Monitor
Ms. Suzanne Pryor-Jones, W. Africa Representative

PRITECH Communications Resource Candidates

Mr. Nicholas Bondi
Mrs. Rachel Ogutu
Mr. George Apudo

WHO

Dr. Robert Hogan, CDD Program Mgt. Officer, Geneva
Dr. Michael Merson, Geneva
Dr. Diego Buriot, Regional Representative, Brazzaville
Mr. Gerald Moore, Essential Drugs, Geneva

CENTERS FOR DISEASE CONTROL

Dr. Ronnie Waldman, IHFO Program Officer
Mr. Scott McKuen, IHFO Program Assistant
Mr. Brad Otto, IHFO Program Assistant

A.C.T. INTERNATIONAL

Ms. Patsy Whitesell, WHO CDD Managers Course Evaluator

UNICEF

Mrs. Mary Rascalis, Regional Representative
Mr. Koffi Ossaye, Regional Information Officer
Mr. Dan Toole, Regional Food Strategy
Mr. John Spring, Sr. Program Officer, Social Mobilization
Mrs. Sheila Barry, Sr. Program Officer, NGO's
Mrs. Eulalia Namai, Project Communications Officer
Mr. Francis Kamondo, CDD Program Officer
Mrs. Mildred Ochila, Finance Officer
Ms. Connie Nyatta, Public Relations Officer
Ms. Agatha Pratt, Nutrition Program Officer
Ms. Judith D'Inca, Graphic Artist
Mrs. Rachel Ogutu, Consultant to KMA "A Healthy Nation"
Mr. Martin Olale, Program Assistant, South Nyanza District
Mrs. Esther Kele, Program Assistant, Kitui District
Mr. Mbers, Transport Officer
Mr. John Ole Ngabaiya, PRITECH Driver

OTHERS

Dr. Magda Ali, CDD Program Manager, MOH, Republic of Sudan
Mr. Bharat Thakrar, Managing Director, ScanAd+Marketing Ltd.
Mr. Phillip Lasse, Private Graphic Arts Teacher/Illustrator
Mr. Ken Kuduki, Student Illustrator
Mrs. Pam Toh, former graphic artist consultant for PRITECH/Niger
Miss Meg Bailey, Community Worker, Methodist Church, Maua
Hospital, Meru
Miss Margaret Price, Community Health Trainer, Swaziland

MACHAKOS DISTRICT

MINISTRY OF HEALTH

Mr. Siyuki, DHEO
Mrs. Mativo, District Nutrition Officer

SALVATION ARMY

Mrs. Beatrice Mutua, Child Survival Coordinator, Machakos
Pilot Project
Mrs. Simiyu, Women's Leader, Machakos Project

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WESTERN PROVINCE

DISTRICT GOVERNMENT

DO1/Kakamega
Mr. Momanyi, DO2/Bungoma
Chief, Kakamega township
Ass't. Chief, Isukha
Chief, South Kabras

MINISTRY OF HEALTH

Dr. Martin Kayo, PMO
Mr. P. Ocholi, Provincial Health Administrator
Mr. Ham Singa, PHEO
Sr. Nursing Officer
Mrs. Masengila, Deputy Sr. Nursing Officer

Kakamega District

Dr. Onyango, DMOH/Kakamega
Mr. Clement Were, DHEO/Kakamega
Mrs. Enid Washika, DPHN/Kakamega
Mrs. Elizabeth Amagoye, Health Education Practicum Student
Mrs. Gertrude Juma, Nurse Tutor, SON

Busia District

Mr. Francis Mudimba, Nurse, Busia Hospital (rep. DPHN)

Bungoma District

Dr. Odongo, DMOH
Dr. Adia, Deputy MOH
Mr. Simon Danda, DHEO
Miss Veronica Okoti, DPHN
Mr. Joel Areko, PHT
Mr. Josepeth Barasa, PHT

MINISTRY OF CULTURE AND SOCIAL SERVICES

Kakamega District

Mr. Odera, Cultural Officer

Bungoma District

Mrs. Dorothy Owino, Acting SDO
Mrs. Susan Mutiso, Assistant SDO
Mr. Abel Juma, Social Services Student Intern
Mrs. Esinas Buchecho, CDA, Cheptais
Mr. Wanyonyi, Municipal Council, Welfare Assistant

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WESTERN PROVINCE cont'd.

MINISTRY OF ADULT EDUCATION

Kakamega District

Mr. Gerishom Alukwiki, Ass't. AEO

KANU-MAENDELEO YA WANAWAKE

Mrs. Abura, Provincial Supervisor
Mrs. Oripa Kiritza, District Chairlady, Kakamega
Mrs. Rachel Luswets, District Chairlady, Bungoma
Mrs. Leah Amuke, District Chairlady, Busia
Mrs. Antonina Achieno, MCH/FP Coordinator, Bungoma District
Mrs. Beatrice Saisi, Leadership Trainer, Bungoma District

PEACE CORPS

Jennifer ?, PCV, Construction/Cooperatives

NYANZA PROVINCE

MUNICIPAL GOVERNMENT

Mr. Okalo, Mayor of Kisumu
Mrs. Gertrude Owiny, Councilwoman, Kisumu

Mrs. Cecelia Obuya, CDO, Kisumu Municipality
Mrs. Ogutu, CDA, Kisumu East
Mrs. Mary Osiro, CDA, Kaolani
Mrs. Mary Orende, CDA, Kolwa West

MINISTRY OF HEALTH

Dr. Okombo, PMO
Dr. Amalo, Acting PMO
Mrs. Adote, Sr. Nursing Officer
Mr. Mark Ondiege, PHEO/DHEO-Kisumu

Kisumu District

Dr. Olewa, Acting DMOH

MINISTRY OF ADULT EDUCATION

Mr. Edwin Onyango, AEO, Kisumu

MINISTRY OF EDUCATION

Mr. M.J. Imbo, Ass't. PEO

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MINISTRY OF CULTURE AND SOCIAL SERVICES

Mr. Chris Ngeri, PDSS
Mr. James Oyugi, PSWO

Kisumu District

Mrs. Phoebe Nyagudi, SDO
Mrs. Munene, SDO

MINISTRY OF COOPERATIVES AND DEVELOPMENT

Mrs. Mildred O. Amsdi, Ass't. PCO

LAKE BASIN AUTHORITY

Miss Mary Wefils, MCH/FP Coordinator

AGA KHAN PHC PROJECT

Dr. Dan Kaseje, Manager
Mrs. Esther Sempebwa, Sociologist/Demographer
Ms. Tabitha Otieno, Sociologist
Ms. Perez Odera, Home Economist/Ag. Extensionist
Mrs. Gunnhild ?, Nutrition Field Worker (NORAD)

KANU-MAENDELEO YA WANAWAKE

Mrs. Lois Mbeo-Onyango, Provincial Supervisor
Mrs. Gertrude Oviyo, District Chairlady, Kisumu
Mrs. Agnee Gor, District Women Dev't. Chairlady, Kisumu
Mrs. Katherine Akumu, Coordinator, Kisumu Town
Mrs. Elseba Miyare, Women Dev't. Program Coordinator,
Kisii Municipality
Mrs. Mbeo (junior), Women Leader, Homa Bay

NOCK

Miss Elizabeth Feilden, Community Dev't. Worker,
Diocese of Maseno South, Oyugis, South Nyanza District

PEACE CORPS

Dr. Ed Wright, Regional Director, Western Kenya

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