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PD-AAJ-165-A

UNITED STATES GOVERNMENT

# memorandum

DATE: October 21, 1981

REPLY TO  
ATTN OF: Jack Slattery, HNP

650175000000

SUBJECT: Mid-Term Evaluation of the CODEL Primary Health  
Care Project, August 1981

TO: THE FILES

1. Report notes that 19.6 percent of Kitui District's population of children under 5 years of age is covered by project. It also notes that for 1980 there were 84,203 recipients in the program. However 48,748 were revisits so it is probably more accurate to call these patient visits rather than recipients which the report does.
2. Based on 3-year depreciation of vehicles, clinical equipment, etc. and recurring expenditures for salaries, drugs, petrol, vehicle maintenance etc., the estimated cost per patient visit is KShs.9.13. When this is added to non-CODEL for vaccines (MOH), housing, office space (Diocese of Kitui) the per patient visit cost increases by Shs.21.58 to a total of KShs.21.58. The bulk of this cost is for vaccines, provided by the MOH, at a cost of KShs.11.54 per patient visit.  
  
Per patient visit cost in U.S. Dollars (US\$1.00 = KShs.8.00) is \$2.70. The report does not provide a patient per year cost, which may not be possible given the manner in which the data was collected. Perhaps the data collection methodology could be modified to do this.
3. Report provides 1969 and 1979 population data for sublocations served by Mobile Clinics (370,000 as per 1979 census) but does not indicate catchment area of clinics nor percent of this population served. This information would be useful in final evaluation, especially to pin down the costs for operating mobile clinics and actual catchment areas.
4. Report notes that Family Planning (FP) services offered are totally inadequate. Natural FP advocated by Catholic Missions is inappropriate for the life styles of the Akamba. Report states that other means of providing FP services through the project activities should be found but does not give any specific recommendations. Was this area explored by the evaluator?
5. Of the various PHC activities, (i.e., MCH, antenatal, immunizations, nutrition, health education, training community leaders and TBAs), the most

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successful activity appears to be the immunization program where Muthale and Mutomo Catholic Mission Hospitals records indicate reduced morbidity and mortality from measles, whooping cough, tetanus and scabies. Malaria, diarrhea, and malnutrition remain severe problems. Tuberculosis is on the increase, apparently in part due to malnutrition in the case of children. Particularly disturbing is that the form of malaria attacking particularly young children is becoming more virulent "causing many deaths" (p. 38) It would be useful to know how many more deaths, i.e. percent increase. This finding also suggests that it might be useful to conduct some special malaria studies (e.g. through CDC) on resistance of malaria strains on anti-malarial drugs to determine most appropriate malarial drugs in Kitui Rural Health Project (615-0206).

6. Findings in item 5 above and findings in the report indicate that the health and nutrition education component and generally the preventive and promotive aspects of the project are ineffective. The project concentrates on curative services and preventive services in the area of antenatal care and immunizations. Community participation is minimal although the project has conducted health education activities and trained some TBAs. Problems associated with the lack of preventive and promotive health care include:

- a) lack of training of team staff
- b) the least qualified of the team staff, i.e., ungraded staff, are given the task of health education
- c) Clinics are not organized to provide sufficient time for health education
- d) Project administration does not place sufficient importance on long-term continuity of community health care by the community for the community
- e) Insufficient number of community leaders, members, women, TBAs trained.

It is interesting to note that the communities desire continuous health services, such as through a dispensary. A trained community worker would help meet this need by providing at least a basic level of health care on a continuous basis.

Though the evaluator makes a few recommendations in strengthening health education, the report does not indicate whether or not project staff would be receptive. Also these recommendations are probably not sufficient to turn the project around in this area.

7. Additional staff, "helpers" or ungraded staff are needed to implement data collection system proposed and to strengthen preventive and promotive health activities. Is ungraded staff qualified for preventive and promotive work? Or should these people be Public Health Technicians (PHTs)? What is the possibility of PHTs from nearby MOH Health Centers going along on Mobile Clinics e.g. visiting each community once every 2 months?

8. A range of health environments are represented in the project area. The Muthale area where rainfall is most plentiful has a better health status, uses more latrines than Mutomo and Kimangao. The Mutito/Nuu area appears to have the most difficult health environment, with the driest climate.

9. The report suggested forms for collecting data implies that food is being distributed in the project area either through static clinics or the mobile clinics. CODEL had requested over a year ago that Corn-Soya-Milk blend (CSM) or milk powder be used on an experimental basis as "duwa" (medicine) for treatment of severely malnourished children during mobile clinic activities. What has been the result?

Also, if data is to be collected on eating patterns and outside food interventions (e.g. CRS/Kenya PL 480 Title II food) this data might be useful in some of the special Title II evaluation activities to be undertaken during FY 1982.

10. The report gives no information on the following:

- a) What steps CODEL has taken to integrate its project in to GOK/MOH activities and how it (CODEL) plans to continue supporting this activity after October 1982.
- b) What, if any, budget additions are required to complete project activities to reach fully the goals and objectives of the project. We know, for example, transportation costs in the project have exceeded estimates. Also funding will be needed for the proposed additional project staff and final evaluation.
- c) Whether or not CODEL agrees with recommended evaluation plan.

11. The August 1981 evaluation Report is a vastly superior product than the November 1980 report. While there remain numerous questions unanswered, a thorough review of this document within the Mission followed by a joint USAID working meetings with CODEL, Diocese of Kitui and MOH Headquarters and Kitui District officers should lead to a better definition of remaining project activities and a follow-on phase to be integrated with the proposed Kitui Rural Health Services Project. In other words CODEL, MOH and USAID have sufficient feedback on the project to make necessary plans for the future.

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