In Search Of A Working Philosophy For The Faith-Based Nongovernmental Development Organisation

By Seth Le Leu

In Search Of A Working Philosophy For The Faith-Based Nongovernmental Development Organisation

Within a post-modern development era how does a multinational faith-based nongovernmental development organisation find a coherent philosophical basis for its development activities in the global setting? A case study of The Salvation Army: a faith based N.G.O. and its involvement in Primary Health Education in East Africa.

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I declare that this thesis is my work, except for those sections explicitly acknowledged, and that the main content of this thesis has not been previously submitted for a degree at any other university.

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Abstract

The role of the Nongovernmental Organisations in development has rapidly expanded over the past thirty years. This growth in scope has resulted in a number of significant problems and benefits. For most NGOs there has been a move from being solely a charity welfare organisation to being required to take over many services previously undertaken by governments in the area of development. A recent further development has been the major change in emphasis by many international development organisations from long-term development to humanitarian assistance as a result of a series of major humanitarian disasters globally. The challenge faced by the international NGO is how to synthesise a comprehensive development philosophy that embraces all its activities. The dominant approach over the last thirty years has been funding projects, with the presumption that these activities would result in sustained community change in the recipient communities. Despite the fact that project-related funding is the main source of development funds, it is very confusing for NGOs in search of a workable philosophy to read the theory on the subject and to find that the development project is almost universally derided as being inappropriate. A synthesis is needed to evaluate the correct place of the project in community development if NGOS are to be consistent in their theory and practice.

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Glossary of terms

AUSAID	Australian Aid
CCW	Chama cha Wanawake (Women's group)
CIDA	Canadian International Development Agency
FBNGO	Faith-Based Non-Governmental Organisation
GRO	Grass-Roots Organisation
KANU	Kenya Association of National Unity
NGO	Non-Governmental Organisation
ODA	Overseas Development Aid
OECD	Organisation Of Economic And Cultural Development
PVO	Private Voluntary Organisation
UNAIDS	United Nations AIDS
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
USAID	United States of America International Development

Chapter 1. Introduction

For the nongovernmental organisation to find a workable philosophy is a complex exercise. Despite all the valiant efforts of the past fifty years to alleviate poverty in the poorest parts of the world, the communities with whom the NGOs are connected are losing hard-won gains and becoming poorer. Systems of governance seem weaker now than in the past. Since the early nineties the huge organisational growth in the NGO sector has been of those organisations that are geared to humanitarian assistance rather than long-term development aid. The funds that are provided for humanitarian assistance mean that no long-term clearly thought-through participatory development occurs, but rather, hasty plans are made to garner large funds from disasters, and then some legitimacy is sought to involve the local communities in planning the recovery process. According to much of the development literature a lot of the effort made in development activity has been of little long-term value. In fact, according to some writers, the process of development has impoverished the poorest sectors of society.

The development process since the Second World War has used the project process to bring development aid. Again development theorists strongly criticise the project process, yet it is still the most dominant means of accessing donor funding. So, if the development NGO is to be consistent then it must look at how successful this process has been. What are the lessons that can be learned from this to seek to reverse the present slide into poverty for more of the world's poorest populations?

An additional cause of confusion is the development theorists who seemingly propose a one-fit philosophy that is meant to fit all situations. Such philosophical neatness may be fine for the small, one-issue focused NGO, but for the multinational NGO such as The Salvation Army, facing 107 different national realities, and countless cultural and developmental environments, it is simply not possible to have or to be committed to such theoretical global uniformity.

The Salvation Army, which is the major case study for this paper, is a faith-based NGO with a plurality of personalities across the world. For its one million members, the Salvation Army is

a church, which seeks to promote the Christian faith and to meet human needs without discrimination (SA Year Book 2000:1). For the public in the many countries in which it operates, it has a multitude of different images, from the largest and best-liked charity in the United States to a Christian sect in Georgia. The dominant activities, in the past, have been institutional care in a welfare approach. This combined with action in humanitarian disasters has contributed strongly to its image as a charity. For the past thirty years there has been a move towards being involved in community development, but as a movement The Salvation Army is not known globally as a major development organisation.

A suggested strategy for the many demands on the NGO is not to hold to any one philosophical approach, but to utilise the best approach to meet human needs in the most appropriate way possible. This means, for The Salvation Army, that a charity activity such as feeding the destitute in Calcutta, India, will operate out of the same premises as a programme that seeks to establish a people's movement to foster mutual support for people living with HIV/AIDS. Both of these will work alongside a community development programme to assist commercial sex workers to find alternative sources of income. Workers from those same programmes could then be mobilised to become involved in cyclone relief work. In that one centre, the first, second and fourth generations of Korten's analysis of NGOS have a place

Figure 1.

GENERATION				
	FIRST Relief and Welfare	SECOND Community Development	THIRD Sustainable Systems Development	FOURTH People's Movements
Problem Definition	Shortage	Local inertia	Institutional and policy constraints	Inadequate mobilising vision
Time Frame	Immediate	Project life	Ten to twenty years	Indefinite future
Scope	Individual or family	Neighbourhood or village	Region or nation	National or global
Chief Actors	NGO	NGO plus community	All relevant public and private institutions	Loosely-defined networks of people and organisations
NGO Role	Doer	Mobiliser	Catalyst	Activist/Educator
Management Orientation	Logistics Management	Project Management	Strategic Management	Coalescing and energising self – managing networks
Development Education	Starving Children	Community Self Help	Constraining policies and institutions	Spaceship earth

(Korten 1990:114). In this sense these philosophies could be seen as tools to be used rather than defining principles. The idea of generations of NGO activity could denote a lineal progression from welfare, charity activities to the promotion of people's movements, in addition it could be inferred that those NGOs working at the fourth stage are more philosophically advanced than those operating at earlier stages. Kaplan speaks against such lineal thinking: 'Following on from the recursive nature of the development process, alluded to above, a further defining characteristic, one which sets development apart from quantitative growth, is its non-linear nature.' (Kaplan2000:ch2)

Kaplan goes on to say that much that happens in the development process is unpredictable and the need for flexibility is vital. Elliot supports this flexibility of approach: 'Despite myself, I would have to endorse that judgement on the basis of field work in a number of slums in three major cities of Bangladesh. There, the clear evidence was that welfare delivery, development conscientisation and empowerment are much more subtly interrelated than assumed by a simple spectrum.'(Elliot 1987:58)

Norman also pleads for a more complex analysis for the assisting of the poor, he says that neither the 'paternalistic fallacy' of the top-down development approach nor the bottom-up process, which he describes as a 'populist fallacy' in that it is stated that the poor have all the knowledge, wisdom and virtue needed for their own development, will work; a more complex mixture of both elements is required(Norman1988:47). These statements come from the development experience of NGOs as they struggle to work in the field. It is little wonder to see the lack of philosophical uniformity in the NGO community. The flexibility of the tool-box approach has much to commend it.

Chapter 2. Development Background

Development has been described by a number of writers as a mess. Kaplan, writing of development activity, says: 'Development is non-linear, therefore unpredictable and even anarchic; at the same time, there appear to be natural phases, sequences and modalities which can be said to characterise the process as a particular pattern or arrangement. The contradiction is a real one, but rather than being the kind of contradiction which demands

resolution, it can be seen as the beating heart of development itself, an irreducible tension which provides the energy to fuel the process, a constant interplay between order and chaos, between form and flow. Which is one of the primary characteristics - according to recent advances in thinking prompted by the 'new sciences'-of all living systems (Kaplan2000:6).

To use the living organism metaphor for development is useful because it deals with the complexity and lack of clarity that are the reality of working in the field. The anarchy which Kaplan describes of itself means that what NGOs do can never be tidily packaged into one neat philosophical framework. In addition, this anarchy also brings the almost unrealistic challenge to quantify, to identify, and to account for the donors' funding. Most of the supervisory hierarchy of development funding veers towards the need to count up identifiable inputs/outputs of the project process rather than recognise the organic growth of real development. The project process simply does not fit into this anarchic set up. But in order to fund development the project process is the fuel line that all NGOs use. I would like to suggest that the best development often occurs when the local population, to further its own agenda, subvert the project. The very real limitation to this idea is that development fails when the project is merely hijacked by the local elite and the resources are siphoned away from the community to serve the needs of the majority. The case study included in this paper illustrates positive subversion of the project process.

Within The Salvation Army three-quarters of the development activity would be in community development. For these activities, within certain broad guidelines, it is possible to see where a clinic has been built or a well has been dug, and the input/output pattern is suitable. But in addition HIV/AIDS community counselling and facilitation work is undertaken; this is far less concrete. It is not possible to measure whether a community now has more positive attitudes towards the person living with AIDS. The donors who support this work can see the vital nature of the work, and accept that it cannot be measured in an input/output fashion.

A further complicating factor in defining a coherent development philosophy is the conflict arising from describing the current economic reality in which development occurs. Nugent and Yatopoulos write: 'The ruling paradigm of the economics of development rests on the

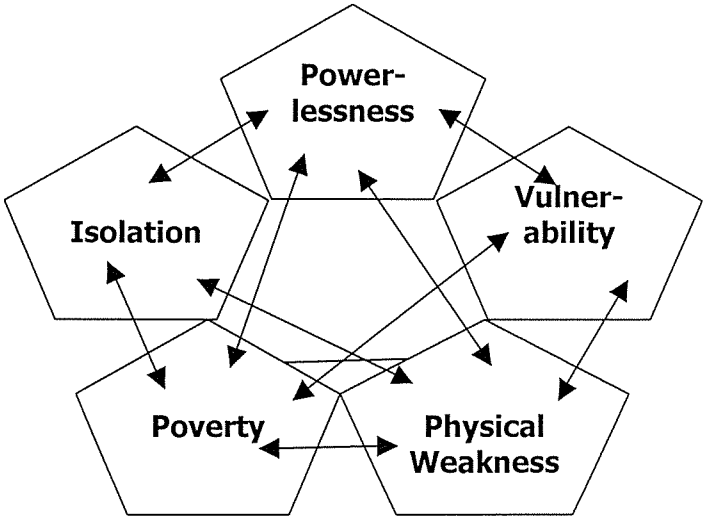
classical–neoclassical view of the world in which change is gradual, marginalist, non-disruptive, equilibriating, and largely painless. Incentives are the bedrock of economic growth.

Contrast this paradigm with another borrowed from Physics in which the second law of thermodynamics holds centre stage. The moving force in this case is not the invisible hand, which strives to bring order out of disorder, but of entropy which represents disorder, loss of information, and unavailability of energy. The second law of thermodynamics states that the universe is constantly and irreversibly becoming less ordered than it was. While the neoclassical paradigm views development as a cumulative process ruled by equilibrating mechanisms and centripetal tendencies, an application of the entropy law emphasises the centrifugal forces, the jolt and backwash effects of development. Instead of the optimistic mechanisms of the melting pot or the communicating vessels that lead to uniformity and homogenisation, the disequilibrium paradigm suggests that economic development, at least in its early stages, acts like the suction principle in inducing biformity. It nourishes the towering heights of polarity at one extreme, at the same time it creates marginalisation at the other extreme. Just as cream rises to the top, development trickles up for a while to benefit those who are well-endowed; and as sediment becomes mired at the bottom, the victims of development are crowded into the periphery' (Nugent and Yatopoulos 1979:452).

This picture of market forces being responsible for the increasing levels of poverty accurately describes the reality found by development NGOS. But this view of Nugent and Yatopoulos is not the majority view. This view is closely aligned to Chamber's useful poverty diagram (Chambers1983:112)

Figure 2

THE DEPRIVATION TRAP



All of the five elements are interlinked. The poor's isolation leads to their powerlessness, which in turn adds to their vulnerability. This vulnerability is linked to their poverty and their poverty impacts on their physical health. The net effect of such a construct on the issue of poverty is that no simple, single-issue development activities are going to be effective. A holistic integrated approach to the total needs of a community is an ideal, recognising that no community is an island and that holistic development at times must seek to change constraining influences far beyond the individual community. The progress out of this deprivation trap is not a simple one, and some writers would suggest that it is an impossible dream. Ferrnandez writes: 'The social organisation is rigid and strengthened by class factors. This has resulted in certain unintended effects of otherwise good intentions to help the poor. As a result the poor have not only remained poor, but the large majority of them are finding it increasingly difficult to rise above the so-called poverty line and remain there. The poverty line has not become a finishing tape towards which the poor are racing; rather it resembles more a sound barrier; to break it requires technology, organisation, resources and risks.' (Fernandez 1987:40). Rondinelli confirms Fernandez's analysis, 'Former USAID administrator Alan Woods noted that of 95 less developed countries that his agency had assisted, only 19 maintained consistent economic growth from 1950 to 1987' (Rondinelli 1993:2). The modern view of development was one of catch up. In other words the southern world could speed up its process of development to reach the stage of development enjoyed by the northern countries. Fernandez's concept is of a rapidly-increasing distance between the southern and northern countries. The case study featured in the paper shows an increase in illiteracy in East Africa. This decreasing access to education is an example of Fernandez's concept. True development would show an increased access and quality of education, for example, in southern countries. This decrease indicates the marginalisation and impoverishment process which is occurring. The challenge is to find a satisfactory philosophy in a post-modern environment. In fact to use the term 'developing countries' is a misnomer as it indicates an unrealistic vision for the future. The terms 'Northern' and 'Southern' are more useful to indicate the respective repositories of wealth and deprivation.

In conclusion, Kaplan sees development as being an organic, somewhat anarchic process. The fieldwork reality of this is that it is very hard to measure accurately true development in terms of the binary input/output system. In addition, the milieu in which development is occurring is described in mutually exclusive fashions. On one hand the Neoliberals believe in the 'invisible hand' of market forces bringing prosperity to all. And on the other hand theorists concerned with the increasing demonstrable impoverishment of the poorest sectors of the community see that those very same market forces are those that impoverish. Chambers aptly describes the inextricable quality of this poverty in his deprivation trap and Fernandez articulates the hopelessness of the poor ever being able to extricate themselves from this complex imprisoning social reality.

Chapter 3. Sustainable Development

Into this complex and demanding mix here are some of the elements writers see as essential to sustainable development. Sithembiso warns against simplistic solutions. She says that despite all the writing on sustainable development: 'A suitable and effective methodology for such development remains elusive for governmental, multilateral and non-governmental (NGOs) alike'(Sithembiso 1987: 51). Given the huge emphasis on sustainable development Sithembiso's statement would indicate that the discussion of sustainable development has not easily led to a methodology of implementation. This is the crux of the search for a workable philosophy: namely that the respective arenas of the theorists and the practitioners of sustainable development are far apart.

Chambers has a pragmatic approach to the issue. He sees that it is vital that the poor themselves gain control over the resources they need. But they don't need to do this on their own. There is a place for outsider assistance; he says: 'The aim is to transfer more and more of the power and control to the poor'(Chambers 1983:147). One of his emphases is that of power. Powerlessness is more a crucial issue for poverty then scarcity of economic wealth. Powerlessness need not be real, although often the poor have no strength. All that is needed to keep people impoverished is the mindset that they can't make a difference and that they are powerless. Korten sees that the future crucial development issue is that of transformation rather than growth. He sees there are three aspects of this: justice, sustainability and

inclusiveness (Korten 1990:4) Justice is the ability for everyone to have a minimum decent livelihood, sustainability is the recognition of the need to be stewards of the environment and inclusiveness is,as Korten explains for; 'everyone who chooses to be a productive, contributing community member has a right to the opportunity to do so and to be recognised and respected for these contributions' (Korten 1990:5). The problem with this vision is that if Korten advocates transformation rather than growth, then this implies a reduction of demand on world resources by the northern in favour of southern countries. The recent lack of progress in Nice over the issues of global warming would indicate that if northern countries are unlikely to sacrifice anything, even when it is in their interests such as in the case of global warming, then it is extremely unlikely that any kind of sacrifice in the interests of justice, sustainability and inclusiveness for southern countries is probable. It is not that Korten's ideas are unsound; the question is whether an NGO in search of a workable philosophy can use these ideas when they are describing an unattainable ideal, far beyond the compass of any organisation to effect such a transformation.

Korten also makes a differentiation between all the poor and those who are slothful and those who may not be motivated to help themselves. From my experience in the field, the extremely poor are often not in a position psychologically to feel that they are able to make a difference to their environment. The group which was involved in the case study, was, to some extent, typical of the extremely poor. The people see the main aspect of their life is to endure the hardships which fate brings their way. They have no concept that they can be agents of change. The role of the outsider in this situation is to bring hope of change. The psychological work of bringing about a change of thinking from patient endurance to questioning and modifying the status quo often must come as a necessarily foreign input, which catalyses change within the community. It is not something that naturally arises out of the extremely impoverished environment. As a faith-based NGO (FBNGO) it is not possible for The Salvation Army merely to assist those who are ready to develop, for all members of the community are people with value. The more hopeless and fatalistic members could be seen as our special constituency.

This bringing of realistic hope into seemingly hopeless situations is a key element in our work in the HIV/AIDS field. We are involved in motivating communities to care for their own members who are living with AIDS and by so doing provoke a discussion on the meaning of the pandemic and the ways the community can confront and control the pandemic's spread. In every community where we commence this work we encounter a fatalism that the pandemic is either God's punishment upon them, or some foreign invasion that simply cannot be stopped. To provoke communities to discover hope even when living with the pain of bereavement and loss requires a primary invasion of hope, which then can be rediscovered in the local situation.

Chapter 4. Implications for NGOS

Despite some of the above shortcomings of Korten's analysis, he does give a useful checklist of what he terms people-centred development. This is based on the idea that the earth is like a spaceship with finite resources. And we can use the earth's resources, but their use must be within limits. Korten is fairly suspicious of government as he sees that it serves those who control power, and that economic and political power are linked, in that possession of one facilitates the acquisition of the other. The market as an allocation mechanism, according to Korten is useful, but it does work in the favour of the wants of the rich over the needs of the poor. Korten does maintain that: 'Just, sustainable and inclusive communities are the essential foundation of a just, sustainable and inclusive global system' (Korten1990:68).

It is at the local level that the NGO does the most effective development, and it is at this local level that Korten's theory can be of use to the NGO. Edwards gives some supplementary advice: 'NGOs know how to facilitate effective grassroots development work; take your time, understand the situations, build on local knowledge and understandings, combat discrimination, develop strong local institutions, let things develop organically, etc' (Edwards1997:242). But learning is not a strong factor with many NGOs. There tends to be a stronger activist than a theoretical emphasis. Edwards comments on this: 'Activist cultures often see learning as a luxury, separate from and secondary to "real work", so time and space for learning is difficult to protect' (Edwards 1997:239). Edwards goes on to say that learning does require openness and an ability to learn from mistakes. This runs counter to

much NGO culture where failure can be punished. This is true especially in the realm of development. If a project is a failure and funds are usually accessed from a government donor agency, then failure in one project can have a global impact on the NGO's standing with that respective government donor. This can lead to a blue-print approach to project reporting in which the outputs reported on are too close to the project proposal. The need for success every time does offer huge incentives to a conspiracy of silence over the inevitable failures. The huge downside of this is that the NGO cannot learn from its mistakes, as it doesn't admit to having any.

A vital aspect for NGOS to consider when formulating their development policy is that even the large, multinational NGO's most successful work is at the grass roots. Korten talks about re-creating society from the bottom up. As the NGO continues its work, it should pass over the local functions to a people's organisation (Korten 1990:110).

A people's organisation, according to Korten, is one that is a mutual benefit society; it must have a democratic structure that gives the members ultimate power over the leaders; it must not be dependent on outside funding sources. Korten sees that the people's organisation is different from the NGO. He terms NGOs as third-party organisations in that while they work in partnership with local people, the local population does not ultimately control them. The local people's organisation can offer the best development as Korten sees that even organisations close to the grass roots will still continue to serve those who control them. Hence it is only the people's organisation, with its control over its leadership, which can most closely implement re-creation of society from the bottom up.

This re-creation of society is not a politically neutral activity, according to Farrington and Lewis (Farrington and Lewis 1993:326). They comment: 'It is possible to conceive of a continuum of NGO activities in terms of their increasing political sensitivity, with 'non' radical NGOs at one end and 'radical' NGOs at the other'(Farrington and Lewis 1993:326). They explain that non-political activities include the delivery of inputs and services with the development of new social innovations; lobbying of land reform; and grassroots organising for a variety of human rights as becoming more political. They conclude by saying that: 'There are no blueprints for success, but experience so far suggests that NGOs are at their

most useful as facilitators, encouraging the emergence of local initiative on one hand and enhancing the responsiveness of government services on the other' (Farrington and Lewis 1993:PXX).

Another key element to successful NGO involvement in development according to Rondinelli is: 'the ability to innovate, experiment, modify, improvise, and lead - talents that are often discouraged or suppressed by rigid designs and centrally-controlled management processes' (Rondinelli 1993:103). The project format doesn't lend itself easily to such a flexible approach. The whole process of attracting donor funding is a competitive activity as NGOs are faced with lowering development assistance grants. One side-effect of this is to ensure that the project proposals indicate clear levels of quantifiable results. This naturally leads to highly quantifiable input/output relationships. Such an original project design doesn't lend itself easily to an adaptive flexible learning approach in the implementation stage.

Chapter 5. NGOs and Partnerships

A key element in discovering a workable philosophy is to examine the nature of partnerships between northern and southern NGOs. The rhetoric speaks of equality and freedom within the relationship; the reality of this is much more complex. There is a Ghanaian proverb which says that 'the hand which gives is always higher than the hand which receives', and this typifies a high proportion of development partnerships.

Korten says of the partnership: 'More is not necessarily better, especially when the more is a gift from a foreigner'(Korten 1990:140). Korten goes on to explain that such gifts from the outsider create expectations of dependency within the community. This is a huge problem within The Salvation Army. Here the links between the partners are the long-term links of a branch church within the community of faith. It is not possible to break links with an unsatisfactory partner, as it would be in the usual northern and southern NGO situation. The very nature of the long-term relationship tends to result in the northern section of the organisation being seen, by both partners, as being the powerful benefactor. This can stifle local southern ownership of their problems as it is easier just to ask head office for help. The option to seek for local resources to solve local problems is not often taken.

The newsletter of the International NGO Training and Research Centre reinforces the unequal nature of the partnership relationship: 'At the heart of the debate is the contradiction between the implied mutuality and equality of the term 'partnership' and the fact that in reality partnerships between northern and southern NGOs are generally imbalanced in favour of the North, given its control over financial resources'(INGOTRC 2000). James goes one step further than this and says: 'For real development to occur, the deep-rooted attitudes of paternalism which are perpetuated by the aid chain must be challenged and changed on an organisational and individual level'(James2000:1). These qualities of dependency on the part of the southern partners and control and paternalism on the part of their northern counterparts describe a dysfunctional relationship.

In addition, such an unequal, somewhat dysfunctional, partnership can fail in reaching the most needy. An underlying premise for most development is that it should help the poorest members of a society, but Hellinger claims that this achievement is rare. He says: 'A look at U.S. PVOs indicates that many do not include or benefit the poorest 40 per cent of the population' (Hellinger 1988:100). Hellinger goes on to cite another researcher, Warren van Wicklin, who states: 'From his recent research in central America where he found projects of certain U.S. PVOs, their rhetoric notwithstanding, to be controlled by local elites' (Hellinger1988:102).

Kaplan pleads for an equality of partnerships to be restored to the relationship. Without this he says: 'If development interventions are designed by third parties, and not through the free interaction between development worker and client, then it must categorically be stated that the result is not development work; it becomes at best a patronising collusion, at worst a cynical manipulation'(Kaplan2000:5). Kajese goes one step further in that he lays the responsibility to effect a change at the doors of the southern NGO. He says: 'The burden of responsibility for development in the South lies ultimately with the southern countries and their indigenous NGOs' (Kajese 1987:80). But it requires strength which many southern NGOs do not possess to seek to rectify this situation. If the power balance is in favour of the northern partner, and if the southern partner feels dependent upon its wealthy northern patron, then it is obvious all parties need to address the issue.

How can this inequality be addressed? Chambers gives some useful pointers: 'In trying to see what to do,the outsider's unavoidable paternalism can be offset in two ways; first by starting with the priorities and strategies of the rural poor themselves. All share the same aim of a secure and decent livelihood; and second 'by concentrating on what outsiders and the rural poor agree in saying no to'(Chambers1983:140). This is contrary to the experience of many northern NGOs who have certain specialities which they want to share irrespective of the local need. Hellinger says: 'While not as directive as they once were, there is still a tendency on the part of many in the PVO community to control the development decision-making process and to identify projects and needs in sectors where they have expertise' (Hellinger1987:102). Not only is this true for NGOs, but also some donor governments will give special funds for water or HIV/AIDS etc. This restricts even further the possibility of responding to local demands. Because when a package is conceived in Canberra or Washington by the overseas development aid department of a donor government then pushed out to northern donors to compete for funding, it is very difficult to identify any southern partnership in the needs assessment. Experience has shown that when approached by a northern donor with funds for a specific theme, it is very difficult for the southern partner to refuse; but Kajese says this refusal is what must happen. However, given the fierce competition for funds amongst southern NGOs, the will to refuse may be there but the strength to do so may be very weak. Chamber's statement about starting with the needs of the poor is of paramount importance. In addition to this, Chambers says: 'Sustained participation in development demands transformation in three domains: methods and procedures; institutional cultures; personal behaviour and attitudes. All three are needed. Each reinforces the others. Each represents points of entry for change.

Of these, personal behaviour and attitudes are critical. Participation is about how people react; dominating behaviour inhibits participation; democratic behaviour to enable and to empower encourages it. For those with power and authority to adopt non-dominating, empowering behaviour almost always entails personal change' (Chambers1983:XV).

The time frame needed to elicit participation from the local population is very long. The travelling development consultant's time is short. The result of this can be superficial respect

being given to the principles of participatory development, but the end result is that the process is still dominated by the northern partner. Southern communities and northern agencies have different time frames, and the formers' time frames often are sacrificed to the need to present proposals within the northern time frame. Chambers also advocates the partnering with women as equal partners. The project in the case study illustrates the value of such partnering with women.

In conclusion the essential elements to consider in establishing positive partnerships between northern and southern partners are firstly to recognise the present power relationship: one in which the power is invested in the North as they control finances, and the southern counterpart does have dependency relationship with its northern partner. Chamber's call to start with the needs of the poor seems self-evident, but much of the organisational mindset of development agencies precludes that happening. Equal partnerships with women can lead to long-term sustainable development. Recognition of the role of local elites in preventing development benefits reaching the most needy members of society requires special attention. Northern NGOs should advocate against the thematic special grants given by northern governments and advocate for a southern-based development agenda. Even given these key principles, it is an extremely fragile process. Kaplan says: 'Development cannot be created or engineered. As a process, it exists independently of the development practitioner. All that we can do is facilitate processes which are already in motion. Where they are not in motion, it would be best and honest to refrain ....as development practitioners we can assist the flow of the process, but nothing more. It is not so much that we should not impose, but that we cannot witness the history of the development endeavour to date' (Kaplan2000:7).

Chapter 6. The place of Projects in the Development Process

Another serious cause of confusion for the NGO in search of a workable philosophy is the almost universal dislike within the community of development writers of the project system. This creates real conceptual confusion as funding cycles for all development work by NGOs is administered through the project system. Within The Salvation Army's work in facilitating people's movements to combat the spread of AIDS, the same anti-project bias is clearly evident. At a conference of the HIV/AIDS group I tired of listening to the anti-project

propaganda and asked if all those programmes with project funding in the future would prefer not to receive such tainted funds. The response was a curious one in that the whole process of distaining the project system receives its support through the very same system! In working with most of the major development agencies in the world I see no opportunities to access funding through non-project cycle means. In fact, the levels of technical expertise required to access these reducing funds necessitates more and more editing of local material to format into acceptable frameworks for northern agencies than at any time in the past. This editing function is potentially very dangerous, as the essence of the local ideas and initiative can get lost in the process. To have real intellectual integrity and consistency in the philosophical framework of the NGO, some realism must be given to incorporating an acceptance of the project system.

The anti-project bias is such an easy one to support. Rondinelli, in speaking of a review of USAID projects says: ' A study commissioned by USAID found that project sustainability - the degree to which assisted activities remained active or continued delivering benefits to people after the international funding ended - was extremely low. In a sample of 212 projects only 11 per cent had a strong possibility of being sustained after aid was terminated and 26 per cent had poor prospects for providing long-term benefits' (Rondinelli1993:2). Rondinelli goes on to cite UNDP projects for human settlement which indicated that less than 40 per cent of the projects were based on locally perceived needs (Rondinelli1993: 100). One factor which neither writer mentions which may be of note is the size of the projects under review. Both USAID and UNDP tend to implement large-scale projects in the field: often working through government departments and across a number of sectors. The long-term benefits of these large-scale projects certainly can be called into question. A problem is that by implication the grassroots, small scale, highly focused, NGO implemented project, which has totally different dynamics is also negatively implicated. Korten also sees little value in community development activity. He says: 'Second generation strategies differ in the extent to which they focus on human resource development or empowerment as the central issue. The rallying cry of the human resource development group had been the ancient oriental proverb:

"Give a man a fish, and you feed him for a day; teach him to fish, and you feed him for a lifetime."

Unfortunately, in practice, many second-generation programme interventions are little more than handouts in a more sophisticated guise. Too many of these interventions give little more than lip service to self reliance and, in fact, build long-term dependence on the assisting NGO' Korten1990:119). While this may have been a valid statement to make in 1990, I am uncertain that it is still relevant in 2001. As part of my role in assessing community development proposals presented by The Salvation Army for funding from most of the OECD /ODA vote, there is increasing attention being given both to local participation in control and design and in predicting levels of sustainability after the funding cycle ends.

Korten also sees that community development and empowerment activities are based on local inertia. He says: 'Second-generation strategies involve an implicit theory of village development that assumes local inertia is the heart of the problem. According to this theory the potential for self-advancement rests within the village community, but remains dormant because of the inertia of tradition, isolation and a lack of education and proper health care. The theory suggests that this inertia can be broken through the intervention of an outside change agent who helps the community realise its potentials through education, organisation, consciousness-raising, small loans and the introduction of simple new technologies' (Korten1990:110). This statement also seems a bit dated. Empowerment activities usually commence with the need to build possibility thinking within the community. The main constraints are not local inertia but the very real aversion to risks which the extremely poor need as a survival mechanism. To consider the problem is merely inertia implies that the community is merely lazy. Post-modern thinking recognises the skills and knowledge present in the local situation and realises that one of the basic components that is lacking is the financial resources to utilise the skills that are present. If poor communities had the funds they would undoubtedly improve their circumstances. The reason why intolerable conditions persist in many impoverished communities is because there are simply not the funds available to make a difference. This does not mean that merely throwing funds at a problem will make

it go away. On the contrary the infusion of funds needs real delicacy and care, but to think development is possible without the infusion of funds is also inadequate.

Kaplan recognises the key role of psychology in the development process he says: 'It was George Bernard Shaw who stated that: "Reformers mistakenly believe that change can be achieved through brute sanity". Processes of development are beset with unconscious factors, and realities of tradition, culture, motivation and resistances to change. We fool ourselves at our own peril, and we have been fooling ourselves for years.

People-centred development is about increasing, not decreasing, choice. If it is about enabling people to become more conscious, to understand themselves and their context such that they are better able to take control of their own future, if it "must leave people in more control of their circumstances, whatever those may be, and not subservient to those circumstances, however advantageous these may be", then it cannot narrowly define itself as poverty alleviation in the conventional sense'(Kaplan2000:15). Kaplan's emphases here are 'becoming more conscious', 'to understand themselves'; he sees that the process is not one of 'brute sanity'. The intangibles are the key to good community development and poverty alleviation.

One of the key intangibles, in my experience, is the local charismatic leader. Where this is present development is possible,' where it is absent, the best-made plans will fail. Hugh Thompson, writing for the London Daily Telegraph: 'Leadership is like sex appeal. We know it when we see it but we spend far too much trying to acquire it. And in both cases those people who have no chance of acquiring either, spend the most and sadly waste the most'(Thompson 2000). This does not denigrate the capacity development movement. But this development only works when the basic intangible leadership is present. This recognition of the natural leader and the nurturing of his/her skills should be a key function of development. But hierarchical systems tend to be threatened by the emerging natural leader, and rather than nurturing this rare gift these people are often crushed by the system.

Another coequally important intangible has to be the critical moment. There comes a time when a community is ready to adopt new ways and try risky development behaviour. When this time and the right leadership comes together then long lasting change is possible. This

was our experience in Rwanda and Kosovo, in Central America post Hurricane Mitch and Mozambique post Cyclone Celine, strangely post disaster reconstruction can be one of these times. When the disaster is a natural disaster this is more possible, where genocide has occurred, such as in Rwanda or Kosovo, the deeper issues of community reconciliation take a priority. But in the simple natural disaster new patterns are possible.

In Rondinelli's criticism of the project process (Rondinelli 1993:118) he cited a project in Tanzania which sought to fund housing for the working population of the new capital in Dodoma. He said that the local housing bank was too small to handle the task expected of it. The key point Rondinelli didn't explore sufficiently is that the main problem here was not the plan itself, but rather the scoping of the project. A project, which is too big for the capacity of the implementing agency is bound to failure. The same project on a more realistic scale could have been a resounding success.

Rondinelli does however prescribe ways to use the project system which are extremely helpful. He says: 'One way of coping with uncertainty, complexity and ignorance is to recognise that all development projects are policy experiments, and to plan them incrementally and adaptively by disaggregating problems and formulated responses through processes of decision-making that joins learning with action' (Rondinelli 1993:118). This incremental approach deals with the scoping issue in that projects expand in size, hopefully, in proportion to the implementer's capacity. Rondinelli goes on to describe a process in which projects commence as experiments, and expand through pilot, demonstration and replication phases. The danger in this approach is that while the local community may have been intimately involved in the design of the experimental or pilot stages, how is it possible to keep the same level of local ownership and design participation when the project reaches the replication stage? This was one issue that arose from the primary health project under review in this paper. The original project was designed in response to the expressed health needs of the women in the Machakos district of Kenya. However when the project came to be replicated to other places the new communities received what was, in effect a fait accompli; a total package in which all the lessons learned in Machakos with one tribal group were to be applied to other groups in Kenya and across into Tanzania. The challenge is not to

institutionalise the process as the project continues to expand, but to retain the flexible learning pattern throughout.

Rondinelli does acknowledge that when community development places a strong emphasis on sustainability, then such activity can truly be developmental. He notes the danger of the dependence this type of activity has on donor-funding, and the pressure this brings with fitting projects in the time frames of the donor funding cycle.

It still remains confusing when Kaplan, in writing for the United Nations NGO Liaison Service: a group totally committed and funded by the project system, says: 'The concept of the development project, then, with its beginning and end, its externally generated specifications, its notion of predictability and its lack of adaptability and mobility, has little to do with the effective development intervention, let alone with development itself. **Indeed, the concept of the development project is anathema to the concept of development** (*my emphasis).* It is a figment of an engineering mindset, at best a managerial tool used by a form of management inimical to development work, at worst a donor requirement to fulfil inappropriate financial control systems' (Kaplan 2000:20). This is not helpful as direction for an NGO. If the development NGO were to take this advice literally its effectiveness would cease as its vital sources of funding would cease. This illustrates a dysfunctional gap between the philosophy of the development movement and the way it does business.

In conclusion, the project cycle seems to be the unavoidable way development is organised, but it is a system held to be seriously in question. Projects which start with the needs of the poor; develop as learning activities with full flexibility for adaptation as they grow, which concentrate on ensuring sustainability and which increase people's choices have the possibility of being successful. The vital importance of the coming together of natural charismatic leadership at the right critical moment for a community is another element of the intangibles of development. An additional key element in the formula must be to ensure that people based development is people sized as well. The projects, which bring such a bad image to the project system, are those which are overly ambitious. In this case, small is beautiful, is vital in both project design and implementation.

Chapter 7. Implications for the Faith-based NGO

In the search for a workable philosophy for The Salvation Army as a faith-based NGO, are there any things which are different from other development NGOS? Salmon and Anheier have produced a chart indicating the relative usefulness of the various religions in nurturing NGO development. The Catholic and Protestant traditions both score highly in promoting development. Of interest are the columns headed 'Autonomy' and 'Hypothesised Encouragement to Non-profit Formation. The Protestant churches rate highly in this with high encouragement to both autonomy and NGO formation. It is of interest that the Catholic Church rates less highly. I would infer that this would be as a result of its hierarchical structure rather than its beliefs. In this case The Salvation Army, which still has strong hierarchical traditions, would be closer to the Catholic rather than its Protestant colleagues. It is also of interest that Salmons and Anheier place institutionalisation within the Catholic Church at a lower level than the Protestant community. Possibly they may have a specific meaning to this term, but if it denotes the development of institutions serving constituent communities then the Protestants and the Catholics would be equal. In fact the development of institutions within the Catholic Church could be higher than their Protestant colleagues.

Figure 3

Key Dimensions Of Religions With Implications For Non-Profit Development

Religion	**Emphasis on Charity and Philanthropy**	**Dimension Modularity**	Institutionalisation	Autonomy	Hypothesised Encouragement To Non-Profit Formation
Protesantism	High	High	High	High	High
Hinduism	Moderate	High	Low	High	High
Catholicism	High	Low- Moderate	Moderate	Moderate - high	Moderate - High
Buddism	Moderate	Low-Moderate	Moderate	Low - Moderate	Moderate – Low
Islam	High	Low	High	Low	Moderate – Low
African Religions	Moderate	Low	Low	Low	Low

(Salmon and Anheier 1999:67)

The expected role of the NGO has certainly expanded, and this is reflected in the expectation of the Faith-Based NGO to upscale their development activies. McMichael writes of this: 'Many

of the people left behind by the development and globalisation projects look to Non-Governmental Organisations, rather than to states to represent them and to meet their needs. Indeed we are currently in a phase of "NGOisation", in that national governments and international institutions have lost much of their legitimacy, and NGOs take considerable initiative in guiding grass-roots development activities'(Mc Michael 1996:239). In the local situation often the most obvious NGO is the church. Rather than development activities being a subsidiary activity to the church's main faith function, as communities are becoming more marginalised, the church must seek to reverse the impoverishment that it sees in its neighbourhood. McMichael's comments are certainly relevant: - I just hope the term 'NGOisation' remains uniquely his.

One change of significance for the faith-based NGO in a post-modern world is the increasing awareness within the wider development community of the importance of the spiritual component to humankind. Korten in 1995 writes of this new emphasis: 'The western scientific vision of a mechanical universe has created a philosophical or conceptual alienation from our inherent spiritual nature. This has been reinforced in our daily lives by the increasing alignment of our institutions with the monetary values of the marketplace. The more dominant money has become in our lives the less place there has been for any sense of the spiritual bond that is the foundation of community and a balanced relationship with nature. The pursuit of spiritual fulfilment has been increasingly displaced by an all-consuming and increasingly self–destructive obsession with the pursuit of money - a useful but wholly substanceless and intrinsically valueless human artifact' (Korten1995:7). This is a new direction in thinking for the development community. Throughout the whole modernisation era, the faith-based NGO had to ensure that its spiritual and its developmental work were to be kept totally separate. Development was seen to be about the material world and the spiritual was outside of the discipline. The new post-modern emphasis is rediscovering that humankind is profoundly spiritual and all development must include this element to be sound. A practical side effect of this has been recent overtures by the UNAIDS and the White House in Washington to the faith-based NGOs to come up with a faith-based response to the HIV/AIDS pandemic. A mechanistic search for vaccines and more programmes promoting

safe sex just simply are not enough. Unless we touch the deepest levels of humanity when we talk about HIV/AIDS we are missing the bedrock of human kind which is that we are also spiritual beings.

Illich, writing in 1970, is partly a product of his time and partly a predictor of a post-modern era. He writes of the place of the church in development and says: 'It is my thesis that only the church can "reveal" to us the full meaning of development. To live up to this task she must recognise that she is powerless to orient or produce development. The less efficient she is as a power the more effective she can be as a celebrant of the mystery.' He goes on to say that: 'Applied to development, faith in Christ means the development of humanity'. He concludes by saying: 'Thus the church does not orient change, or teach how to react to it. It opens a new dimension of specific faith to an ecumenical experience of transcendent humanism'(Illich1971:85). Illich's thinking links, in some respects to McMichael's,

when he says 'that faith in Christ means development of humanity'. He comes closest to a post-modern position when he speaks of faith 'opening the experience of transcendent humanism.' The exclusively Christological comments are less helpful in the current era, but those elements which link to the spiritual development of transcendent humanism provide links to interfaith-based responses to development. Illich is also a product of the modernisation era in that he reflects the sacred/ secular divide in development by saying the church should not be involved in development directly. It is the very interaction with the basic human needs, and their provision in a faith-based context, which is so appropriate to post-modern development.

What are some of the constraints faced by the Faith-based NGO (FBNGO)? I mentioned earlier that the FBNGO works best at the local community level. One of the problems is that the local situation is often impacted by the national and even international situation. Korten writes: 'Second generation strategies are developmental in concept, but it has become increasingly evident that their underlying assumptions are often overly simplistic .... Even NGOs engaged in more empowerment-orientated local organising that acknowledges the political dimension of poverty, commonly assume – at least by implication - that village organisations of the poor, by their own initiative, can mobilise sufficient resources to change

the relevant power structures. It has become evident to many such NGOs that local power structures are maintained by protective national and international systems against which even the strongest village organisations are relatively powerless'(Korten1990:120).

Here is an example of this from the survey. The Bungoma survey site is an area of very good agricultural land. Yet the women complained of insufficient food to feed their families. One of the problems is that much of the arable land is used to cultivate sugar cane. This is vital to the district sugar factories, to the national economy and possibly to the debt repayments programme through its export. To wrest land back into subsistence food production would be an impossible task.

Another major constraint is the hierarchical nature of The Salvation Army. Both Korten and Fernandez write on this. Korten writes: 'Hierarchy is the organisational mode of control and stability and bureaucratisation. It inhibits the flow of the information and the creative voluntary energies on which rapid social learning depends. Networking is the organisational mode of lateral communication, self-direction, rapid adaptation and social movements. It frees the flow of creative and voluntary energies and unlocks the barriers to change imposed by hierarchy' (Korten1990:106). Fernandez writes: 'The third major group of non-governmental organisations (NGO) that played a public role was the Christian churches. Their efforts were devoted to the poor, the aged and the handicapped with a major emphasis on education and health - fields to which they brought a high degree of professionalism. They did not, however, evolve new institutions in which people could participate as partners. Their programme was to build Christian communities, which were held together by a religious system that was hierarchical, and in which sanctions and rewards originated from the religions source'(Fernandez,1987:41). It is fashionable to deride hierarchical systems, and in many respects they are outmoded. It is good to see a democratisation of formerly autocratic systems but still a lot remains be done. However, the autocratic system is useful for rapid mobilisation of effort, particularly in terms of response to humanitarian disasters, and a centralised coordination of personnel and resources is essential. In every other aspect of development democratisation and local networking must be encouraged. Fernandez

comments on the failure to establish institutions for local participation is fair comment. The tension for the multinational FBNGO such as The Salvation Army is to promote local and bilateral initiatives, whilst at the same time seeking to keep some equity of resource flows to all centres of operation.

Another major constraint is the activist culture. Korten gives a good illustration of this: 'If you see a baby drowning you jump in to save it; and if you see a second and a third, you do the same. Soon you are so busy saving drowning babies you never look up to see if there is someone there throwing those babies into the river' Korten 1993:113). The Salvation Army often prides itself on dealing with the symptoms, and in Korten's terms having a world-class baby life-saving team! We are struck by the dilemma in that rescuing the babies in itself is an important activity. It was the kind of ethical dilemma we faced when deciding whether or not The Salvation Army should become involved assisting the huge refugee influx into Tanzania after the 1994 Rwanda genocide. Médecins Sans Frontiers, at one point in the emergency, refused to offer medical assistance in the camps because of the presence there of perpetrators of the genocide. The dilemma faced by all the NGOs involved, including the UNHCR, was which was the correct response? To join MSF on their moral high ground and leave the refugees to their deserved fate, or to see that whilst there were guilty members of the group present, the rest had the right to the usual assistance as refugees. As an organisation the Salvation Army chose not to be heavily involved in the camps but rather to move into Rwanda and assist in the post-war reconstruction. The conflict in those camps was what level of assistance should the refugees be given? If the conditions became too good in the camps a huge dependant community is established outside the borders of Rwanda. The political solution with the subsequent return of the people to Rwanda was the sustainable option. The challenge for the FBNGO is to make psychological space for itself through action/ reflection to reflect constantly on the underlying issues. Korten goes on to say that unless this type of reflection is done, then the NGO is in danger of perpetuating the 'very forces responsible for the conditions of suffering and injustice that it seeks to alleviate through its aid' (Korten 1990:114).

In conclusion the opportunity for constructive involvement in development has never been better for the FBNGO. The post-modern search for spirituality enables FBNGOs to mainstream their development work as central to their overall activities. There are some very real constraints for the FBNGO: its emphasis on grass-roots activity can mean that its voice to effect change at wider fora is not heard. There is still much to rid the FBNGO of inhibiting hierarchy and networking skills need to be more fully developed. The final major constraint is the FBNGO's strong activist culture, which can obstruct an action/reflection process on the deeper issues which give rise to community impoverishment.

Chapter 8. East Africa Survey

Chama cha Wanawake Health Education Project Evaluation, East Africa

July 10- 31 2000

Objective:

By surveying 600 breastfeeding mothers an assessment will be made as to whether any changes in knowledge beliefs and practices in selective child-care practices could be attributable to the long-term effect of the project process. An evaluation will be made as to whether any sustainable change to those practices could be the result of a Primary Health Education programme, which was implemented by The Salvation Army in connection with the Chama cha Wanawake, the organisation's women's division in Kenya and Tanzania. The project commenced in some of the survey areas as early as 1987 and is still running.

Background

The Salvation Army commenced operations in Kenya in 1896. By 2000 it had 768 ministers, 237 employees, 219,390 members and 468 parishes (Sutherland 2000:98). It is the numerically largest Salvation Army in the world. Women's activities are organised through the Chama Cha Wanawake (Women's Group) and there are groups in all 468 centres of operation. Since the 1970s various expressions of development programmes have been implemented through the CCW. The Primary Health Project has been the latest in these initiatives.

The pilot project commenced in Machakos, Eastern Kenya, in 1987. The project was a trainer of trainers in primary health education and used the CCW to teach the lessons based on the World Health Organisation's G.O.B.I.F. model. Its main features were: growth monitoring and child nutrition; oral rehydration; breastfeeding; immunisation; and family planning. Additional lessons were incorporated into the base programme on sanitation and HIV/AIDS. In each of the three districts a full-time health professional was hired. This staff member then trained pastor's wives. These in turn formed groups of eight to ten women from their women's groups to teach primary health lessons in a visitation programme to households. The projects were funded for a three-year programme by AUSAID, CIDA and USAID. Apart from the first pilot project, there was little consultation with the local women's groups as to whether they saw that the project was a top priority for them. Most of the decisions as to where the project was to be implemented were made by the national offices of The Salvation Army in Kenya and Tanzania, the women were merely implementers of the project. The method of teaching that was taught involved using flip charts, which could be used for illiterate groups. The local church was used as a base to which women from the village could come to have their babies weighed. After this different health-related lessons were taught to the mothers. Another aim of the project was to refer women to hospitals and clinics for immunisation and related health services such as family planning.

Using volunteers was seen as a problem because this community service role added to the women's burden of reproductive and productive activities and so the groups suggested a variety of income-generating activities. These were funded outside the mainstream of the project from other funds, but were seen as crucial to ensuring that a regular programme of visitation was carried out. The objective for these income-generating activities was to reimburse the trainers for the time they spent on visitation and education.

The pilot project was in the Eastern Kenyan district of Machakos. When the replication of the project extended to the Bungoma district in western Kenya in 1995, a base line survey was conducted to assess child-rearing practices. The survey undertaken in June 2000 included

three of the original survey sites, it also included sites in the original Machakos district and a district in northern Tanzania, where I had been involved in the facilitation of the project when I was coordinating development work in Tanzania from 1987- 1998.

Methodology

The 1995 exercise had used a survey, which was originally formulated at the Private Voluntary Organisation Child Survival Support Programme of the John Hopkins University. The objectives of the survey were to obtain information on the health knowledge and practices and immunisation coverage of mothers with children under two years of age. This survey was modified in Kenya and translated into Kiswahili . The original survey was a very extensive document, this caused real logistical problems with the tabulation of results and so the 2000 survey used some of the same questions and adapted the Kiswahili to a more modern style. In Bungoma the 1995 survey sites provided half of the 2000 sites. In Machakos and Tarime Tanzania sites were chosen where the original project had taken place. In each survey village between 10 and 40 women were surveyed, with the mixture of remote rural localities, semi-urban and small-town locations. The total group surveyed was 582 women, all of whom had children less than two years of age. At each site training sessions were held with the volunteer survey teams. The volunteers were mainly women of a similar age group to those being surveyed. The survey in each location took place over a four-day period. After each survey was completed there was a report back session with the survey team on the anecdotal information gathered. During the survey time I was able to visit communities where the health education work was still being carried out. In each community discussions were held with the women's groups as to the long-term effects of the primary health programme on their lives. Some of the groups provided me with written reports of their work and this was used to record their impressions of the project.

Major Outcomes

The survey sheds light on some interesting changes in social patterns.

The same target group was used for both the 1995 survey and the 2000, namely women with a child under the age of two years.

Age Range of Motherhood

In 1995 91% of all women in the sample were between 20 and 30 years of age.

In 2000 this age range had fallen to only 53% and the 30 to 40-age-range had increased from 8% in 1995 to 29% in 2000. This would tend to show that women are spreading their child-bearing wider and possibly starting child-bearing later.

Education Opportunities for Women

There is significant decline in accessibility to education. The percentage of women with no education has risen from 5.3% to 9.28%. This may be partly explained by the fact that the 1995 figures were only taken for Bungoma in Kenya, whereas the 2000 figures are an aggregation of Tanzania and Kenya, with the illiteracy rate in Tarime Tanzania being 20.5 %. However even comparing Bungoma's figures for 1995 and 2000 the rate of illiteracy has risen from 5% to 10%.

Employment Patterns

A major change has occurred in the five years under review. In 1995 33% of the sample described themselves as having no occupation. This was not a category stated in 2000 with the entire sample stating their sources of income. This would indicate a major shift in women's perception of themselves as having a productive as well as a reproductive role. Whether the change of role is different in reality is a moot point, what does show is a change in their perception of their role.

Immunisation

There is an increase overall of child immunisation from 61% in 1995 to 95.9% in the target group. Whilst this programme did not carry out immunisations its importance was emphasised.

Growth Monitoring

An important activity, which has survived in the survey area, has been the practice of women bringing their babies to the church for monthly weighing. This has shown a huge change in behaviour from only 3% taking their babies for weighing in 1995 to 66% doing so in 2000.

Pregnancy

The rate of breastfeeding women who were pregnant has dropped from 26% in 1995 to 14.6% in 2000.

Contraception

The rate of contraception has changed from 31% in 1995 to 15% in 2000. Part of the reason may be that in 1995 those practising natural methods of birth control were also included whereas the 2000 survey only asked if any modern methods of contraception were being used. So this result is a little difficult to quantify.

Location of Giving Birth

Of interest is that in 2000 the majority of women, 55%, still give birth in their homes and only 35% use hospitals. This would indicate a need to ensure that traditional birth attendants are well trained to offer a safe service.

Knowledge of HIV/AIDS

Sixty-six per cent of those surveyed knew what HIV/AIDS was. The detailed breakdown showed that witchcraft, mosquitoes, caring for the sick, and uncertain responses totalled 14% of the responses. Given the age group this lack of basic knowledge is of serious concern. It would seem that of those who lived in urban and semi urban-areas 78% of them knew about HIV/AIDs with only 61% of those from rural areas. It illustrates Chambers principles of tarmac based development. (Chambers 1983:12).

Survey Conclusions

There are certainly some discernible changes in the behaviour of the target group. Some of these changes do reflect the lessons taught by the Primary Health Education Project. The huge increase in the percentage of mothers who bring their children to be weighed each month could be attributable to the free weighing service that the project established and which is now run as part of the regular women's group activities. Immunisation rates have risen from 65% to 95% in the survey period. As the project did not provide immunisations, but merely taught its importance, whether the project can claim credit for this is moot. The halving of pregnancy rates for breast-feeding mothers from 26 per cent to 14 per cent certainly was in line with the project's teaching. However, this is complicated by the fact that the contraception rate has decreased from 31 to 15%; these two factors would seem to be contradictory. A possible relevant factor could be the change from one third of the women in 1995 who classified themselves as unemployed, with all women in 2000 considering themselves as working full time. Possibly the change in pregnancy levels could be attributable to women concentrating more on productive work.

The most outstanding and concerning finding of the survey was that only 66% of those surveyed said they understood what HIV/AIDS is. In other words one-third of the women between 20 years and 40 felt that they lacked a basic understanding of what HIV/AIDS is. This was further reinforced by the complex range of possibilities that the sample felt may be

the cause of the pandemic. It was also noticeable that the knowledge in the towns was better than the rural areas. This would indicate that even basic information sharing is still needed in the rural communities. Before any change to safe behaviour is possible, women need to know the basic facts of the disease. The anecdotal reporting back of the survey teams was that when those surveyed were asked the question many of them expressed a keen desire to learn more about HIV/AIDS. Somehow the message is simply not being transmitted in ways that can be understood by those in the rural areas.

To draw any statistical concrete conclusions from the survey that would indicate a sustainable change in the knowledge beliefs and practices has resulted from the Primary Health Education Programme would be to deny the complex availability of information today. Changes have occurred which would indicate an overall improvement in most primary health practices. The most that could be said is that the project undoubtedly has contributed to the overall education programme.

Institutional Conclusions

The Primary Health Education Project was a project within the Chama cha Wanawake. This is the women's group that is associated with the local churches. The Chama cha Wanawake has four objectives: worship, fellowship, education and service. It is a group that is open to both members of The Salvation Army and the wider community. It was from the Chama cha Wanawake that the trainers groups of eight women in each church were chosen. The project funded their activities and education for three years, after which it would seem reasonable that the activity would cease. In many places that was the case. But in some communities the health trainers became a permanent group seeking to better the health of women in their communities. This seemed to be most successful where there were strong charismatic local leaders. Where this leadership was not present the project followed a traditional pattern of ceasing its active functions once the project cycle finished.

One of the strongest elements that survived was the micro-credit activities which were set up to offer some payment to the volunteers. The groups reported to me a whole range of

income-generating activities, which commenced with the establishment of the project. In some centres the women's groups had obtained assistance from the District Health authorities for a mobile clinic to call monthly at the church. Two groups had raised funds to build a stone clinic. One group had decided to hire a nurse and raise chickens to pay for her services.

Another common feature was the continued monthly meeting to weigh babies in the church. This could be seen to be responsible for the high percentage of women taking their children for monthly weighing. One group has established a local GRO called Chama Afya(Health Club) with its own savings account and development plans. This group reported to me that the Health Club started once the project had finished. They saw the period of project funding as being the training period with the real activities commencing later.

The project was imposed on the women, and current thinking would conclude that such an approach would not lead to any long-term development, but the opposite is true in this case. The current thinking on the need for the local group to own the whole process from design to completion of the project misses the impact that a project may have to assist women to move from passive resisters to agents of change.

A key factor in the project was the way that, although the lessons taught through the trainer of trainers approach were all standardised and in no way adapted to the local context, the trainers themselves subverted the means of delivery of the messages. It is uncertain that very many visits were made with the issued flip charts to teach with. What was seen was that the women designed role plays, composed songs, wrote in local poetry the health messages and delivered it in ways that their audiences would understand. The delivery was often spiritual in content even though the instruction was purely secular. For the women, the training was perceived as empowerment through knowledge, rather than merely a scientific understanding about how oral rehydration prevented diarrhoea for example. The plays that were performed often dealt with gender issues in which women needed to battle against

conservatism from mother-in-laws and husbands in order to improve the health of their families. The plays were universally satirical in their content and in the performance and reception women were empowered as they laughed at the situations presented.

The second institutional outcome of the project was that the pastor's wives who were the group trainers were transferred in the course of their work to new areas. Some were transferred to the seminary and the teaching of the Health Education Programme was adopted into the seminary curriculum. Unlike other churches, all the Salvation Army officers (pastors) are trained as married couples with the wives and husband both being ordained. Hence the women teachers changed the seminary curriculum so that all newly-ordained pastors go out with the expectation that they should get involved in Primary Health Education. One of the centres I had visited had an enthusiastic group commenced by a newly- ordained couple. So the mainstreaming of this health education has a long-term future within the institutional framework of women's groups in East Africa.

The long-term nature of the women's groups is a key factor in the sustained behaviour change the community has derived from the project.

Major Recommendations

Survey results

It is requested that the survey results are returned to each survey site. The women in each group want to know the results of the survey. I would also request that they also be given the opportunity to report back on their views of the way forward for their group and these ideas are forwarded through to the International Development Office.

Illiteracy

The issue of literacy training as a basic human need needs to be considered. A project, which included this, could offset the disturbing trend of the difficulty of girls getting education or remaining in education. In addition to this, the programme should encourage women to keep their own girls in schooling for as long as possible.

HIV/AIDS Education

The concerning levels of ignorance of this issue need to be addressed by the Chama cha Wanawake. The new AUSAID funded HIV/AIDS awareness project needs to focus strongly on the remote villages as this seem to be where the greatest ignorance remains. A trainer of trainers approach in home visits may need to be carefully considered for the future. One idea that emerged from the community discussions was the possibility of creating age and gender specific accountability groups for the promotion of safe behaviour. An approach of individualistic instruction, as has been the paradigm in HIV/AIDS instruction, must be replaced with systems that use the power of the collective to reinforce safe behaviour.

Traditional Birth Attendants

The very high percentage of women who still give birth at home needs to be addressed. It is recommended that a survey is done through the Chama cha Wanawake to determine the spread and availability of TBAs in the community. If there is a need for further coverage, then possibly a project could be considered for TBA training.

The International Development Office is ready to give assistance in the preparation and processing of any plans, which arise from this process. Please pass on the following recommendations to each respective community.

Detailed outcomes

(a) Tanzania Tarime

The Tarime district forms the border between Tanzania and Kenya. There are two tribal groups in the survey area: the Bakuria, a group who are close kinsmen of the Maasai tribe and the Wajuluo tribe, a Nilotic group from the Lake Victoria area. The area near the border is closely aligned with Kenya and so reflects the Kenyan reality rather than the Tanzanian one.

Sirari is a small town on the Tanzania/Kenyan border,and Kemange is a semi-urban area on the edge of the district headquarters town of Tarime. Magoto and Kitagutiti are more remote but very close to the Kenyan border. Randa is some 15 kilometres from Tarime and is the most remote. Randa village is the home of the Wajuluo and the other four places are predominantly Bakuria.

Magoto

Magoto has double the survey average for illiteracy. The relatively good health indicators for the village would be in part a result of the Primary Health Programme. The village is far from clinical facilities, but still the levels of growth monitoring, immunisation and pregnancy levels are all more favourable than the survey averages. Considering the usual pattern of areas where high illiteracy usually results in lower primary health conditions this village is a positive deviance.

Randa (Bukine)

Randa Village, whilst more remote than Magoto or Kitagutiti, has a lower rate of illiteracy than the survey average. This community is the least favourable for agriculture yet education is seen as being more important and higher than the survey averages. The Primary Health Group here is the most active in the Tarime area. They have particularly focused on a successful goat-rearing income generating activity. They were at the forefront of requesting and designing a follow-on project from the Primary Health project and have received a bore hole which is also a fee-charging activity with the funds going to the local health club.

Kitagutiti

This village was the office for the Primary Health Project. It has very fertile soil and there is a strong emphasis on agriculture. This may account for the reluctance to educate girls as shown in the high illiteracy rate. The village's isolation would account for the high percentage of births that occur in the home. The Bakuria are a very patriarchal tribe and those primary health issues which are under the women's control: ie growth monitoring, diarrohea prevention, and immunisation - show an improving trend, possibly due in part to the Primary Health Education Project. But those primary health elements which men are involved in - pregnancy rates, contraception rates, access to education - women are in less favourable position in comparison with their colleagues from other survey areas. The percentage of mothers in the 15–20 years age group is double the survey average.

Sirari

Both Sirari and Kitagutiti have over 40% of the mothers with less than three years' education. This is double the survey average. Sirari is a border town with a great emphasis

on trading activities. Sirari is on a major truck-driving route between Kenya and Tanzania and is the main route from the coast to Rwanda and the Democratic Republic of Congo. The Kenyan and Tanzanian national HIV/AIDS programmes have concentrated on these locations. To find that 14% of the women still have not received HIV/AIDS information in an easily understood manner is a cause of great concern.

Kemange

Kemange is also on the truck-driver route although not as important a stopping-off place as Sirari is. However, again here the best knowledge of HIV/AIDS - namely that it is transmitted by sexual intercourse and contaminated blood - was only identified by 24% of the sample. Kemange has the district base hospital, but even so still 39% opted to have their children at home. This was the lowest percentage for the district but still a sizeable group considering the near-by facilities.

(b) Bungoma Kenya

Bungoma is situated in Western Kenya not far from Lake Victoria, and is an extremely fertile part of the country. This is an area of a high population density. Copestake writes of the Kenyan rural population: ' More than 60 per cent of Kenya's population are situated in the high potential areas that comprise 12 per cent of land area. Land shortage and the danger of land degradation arising from overcultivation are important issues, with rural population densities in excess of 300 per square kilometre not uncommon'(Copestake1993:88).

This area has one of the largest concentrations of The Salvation Army in the world, with it being one of the major denominations in the area. Within one government district there are some 56 churches. The survey plan had been to do the survey in five locations in each district, but here there was such competition for the survey to be done in each strong centre of the primary health movement, I was forced to do the survey in eight centres. This area was surveyed in 1995 and the results here show the most precise change in primary health indicators. The main tribe in this area is the Luhya, one of the major tribal groups in Kenya. According to the area coordinator, the Salvation Army Primary Health Training Project merely

started off the women in health education. Since the initial training they have also accessed government health training in:

Family planning, breastfeeding, weaning, growth monitoring, immunisation, traditional birth attendants, acute respiratory infection, first aid, malaria, HIV/AIDS and training on how to start a primary health programme. In the words of the co-ordinator, Nancy Asimeto: 'The women have proven beyond doubt that it is possible to run health education programme outside of established health facilities. More than that, they are providing that service with very simple materials and equipment with good co-operation from the health authorities' (Asimeto 2000:2).

Kimatuni

As in Tanzania, one of the major concerns in Kimatuni has to be the paucity of knowledge regarding HIV/AIDS. Only 27% of the sample cited sexual intercourse as being one of the contributors to AIDS spread. However in this community the health education group was responsible for establishing a self-support clinic. The district visiting nurse comes to their centre to offer vaccinations once a month. This is a fairly remote area and some of the educators have walked for 27 kilometres to visit remote areas to teach the women there.

Kamusinde

In contrast in Kamusinde, no one seems to know the first thing about AIDS, but in the supplementary question regarding possible causes 100% cited sexual intercourse as the main means of spreading the disease. I think there may have been some problems with the survey effectiveness here.

Kaptanai

This survey site has the highest percentage of participants with some secondary education. It also has the highest percentage of contraceptive use. These two variables have a positive relationship. Hence primary health education, whilst it has some value, is not as effective in promoting healthier communities as access to education for girls. Despite the factors, even this more-educated sample has poor information on the causes of HIV/AIDS. It is interesting that the group's reports on its activities, while emphasising the role of education, did note that the group income-generating activities were equal importance to the women. They had a

good progression of group activities from growing vegetables to buying a group cow and now they are planting maize. The group has a dynamic that is far beyond the sphere of the Primary Health Project per se. In the words of their co-ordinator: 'Finally special commendations go to the Salvation Army officers for enlightening us over the importance of working in group shape'(Kaptanai 2000:2).

It is their growth in the realisation that they have the potential for unified action which is the greatest value accruing from the project. Whilst this reflects the political rhetoric of the KANU ruling party, the reality of it happening in communities is rare and so for this to be identified as the most important benefit from the project is significant.

Lulcusi

In many of the social indicators Kaptanai and Lulcusi are very similar, except for the knowledge of HIV/AIDS. Lulcusi obviously has some effective primary health education being conducted here.

Mahanga

Again the main emphasis in the group reports are the economic activities they have commenced. The group has progressed from raising chickens to purchasing one sheep, now they have five. They have started a screen-printing activity to raise further funds. The group collected funds and have had a well dug and are raising funds for a hand pump. In addition the group has a monthly weighing session of babies once a month.

Webuye

Webuye was one of the original survey sites. Whilst the group has tried a number of activities, according to their reports they have been fairly unsuccessful. I was very aware of a dependency mentality amongst the group. The survey indicators showed a good grasp of primary health knowledge, but the group's development to becoming agents of change, which has occurred in other areas, was not as evident here.

Bungoma

This group is based in the district town. Some members of the group are government employees, with one doctor being a leading influence in the group. There is evidence of a strong education programme still occurring, however the group has also moved on here to

economic self-support activities as the primary focus. The diverse nature of the group is typified in their objectives

1. "To apply knowledge learnt by visiting different homes, giving health lessons to non and Salvation Army members
2. Build people spiritually both youth and adult
3. Making bricks
4. Poultry keeping
5. Table banking and borrowing
6. Farming on a small scale
7. Business on a small scale.'

This unselfconscious fusion of health education, expression of their Christian faith and economic activities is a great example of a holistic approach to development that touches all the essential areas of their lives.

The benefits they have listed are:

1. The project has created love among family members, hospital, neighbours and children.
2. It has eliminated illiteracy in most of our teachers who are now able to teach and explain.
3. It has enabled the group to get money to buy clothes for the needy and send eggs to the hospital to feed the sick.
4. It is able to get money through selling eggs. They can pay a workman, buy feed and drugs for the chickens.
5. A house for poultry keeping being built.
6. A pit-latrine for the church being constructed.

Here the three roles of women are touched: their reproductive role is enhanced through more love in their families, the productive role of creating income for themselves and their community role of caring for the sick in hospital. Their future plans are to start a tailoring school for their children who are unemployed.

Kiswayi

This group has a far lower than average level of education. Thus results of the health indicators should accordingly be poor. However, they have one of the best levels of knowledge of primary health issues. This may be attributed to the Primary Health Programme as a major factor.

(C) Machakos

The third district to be surveyed was Machakos. This was where the original programme commenced in 1986. In contrast to Tarime and Bungoma, Eastern Kenya and Machakos in particular suffers from a lack of consistent rainfall. Copestake in writing of Machakos says: 'Average rain fallranges from around 1,000 mm to 500 mm in low lying south and southeast of the district. Whilst soils on the hill masses are fairly fertile, soil erosion is a major threat'(Copestake 1993:111). During my visit, the area had not had a significant rainy season for two years. Emergency feeding programmes were occurring in the primary schools. This was part of the Horn of Africa 2000 drought. After my return to London we were able to develop a feeding programme for 100,000 people in the Rift Valley and a nation-wide programme of feeding 19,000 school children as part of the government initiative. However despite the emergency conditions it was possible to see the progress that had been made in the area of primary health. The Health Education Project was one that was designed in Machakos and then replicated to the wider community i.e. Bungoma and Tarime. It is of note that the enthusiasm for the programme and its adoption by the community was no more forceful in Machakos than it was in the replication sites. My conclusion is that whether it was designed by the women themselves, as was the case in Machakos, or as it was merely implemented, as it was in the replication areas, the project was meeting basic health needs in the community and hence it found a ready acceptance and an enthusiasm by the participants.

Itetani

Itetani was receiving governmental assistance feeding programme for schoolchildren at the time of the survey, which would indicate a high level of vulnerability because of the

drought. The Primary Health Programme here relies on the energy of the leader and has little formation beyond her. Weighing of babies is said still to continue, but there were few signs that the programme has had a very profound effect on the community.

Kavyuni

This group started in 1986. During the project period the group built a stone-block clinic. The government mobile clinic calls once a month. The patients all pay for the consultations. The local community development committee has strong links to the primary health programme, and both have a strong commitment to self-help development. A key factor here is the group leader who is focused, articulate and able to continue to motivate the group members after some 13 years of operation.

Machakos

This urban study shows the local level of health indicators. The survey group is within easy access of the district hospital. Its grasp of HIV/AIDS information is higher than more remote areas. Emphasising again that rural locations still have not been sufficiently covered with HIV/AIDS information.

Ngoleni

This site was the most isolated centre. The programme had commenced there as a result of the present officers being taught the primary health information at the Officer Training College. This programme is a second-generation programme that is replicated entirely beyond the project perimeter. Primary Health Indicators indicate there is still a lot to be done to educate the community. Of interest is that the correct knowledge of HIV/AIDS is far better in this community than the average. This could be connected to the fact that the officer has been trained as the HIV/AIDS coordinator for the district. Again the issue of motivational leadership is a crucial element.

Masii

Masii is a dairy cattle area. There are some beautiful cows in the area. The people seem to be surviving the drought better than others here. But once the cattle feed finishes the situation could be very difficult. The Primary Health Education Programme does still

continue each month to weigh children at the hall. But apart from this there is little further effort. Health indicators in the community are good, with one of the lowest pregnancy rates of the entire survey.

Conclusions

The survey does indicate a positive change in the Bungoma area in the primary health practices from the original survey in 1995 until 2000. Whether these changes are directly attributable to the project is uncertain as there are many sources of information outside of the project sphere. What is clear, though, is that for the trainers involved in the original project, a transformation has occurred. Through the training process they saw that it was possible to change their family in a positive manner. Some emphasis has been kept in health issues, but they have moved on to tackle the basic poverty issues. Hence present efforts are now concentrated on self-help economic activities. Those aspects of health that the women themselves could control - growth monitoring, immunisation - have found a ready acceptance of the new approaches. Those aspects such as contraception are more difficult as it impacts on the patriarchal nature of their societies.

The survey shows some real weaknesses, which could be addressed by the women's groups. Firstly illiteracy is on the increase. Research has shown that women's literacy has many positive impacts on poverty alleviation. In order to retain the present advances and to improve further, literacy training should be considered. Secondly, there is a dangerous lack of knowledge about HIV/AIDS. Serious efforts need to be made to give the women the basic information and skills in avoidance of infection. The level of ignorance is amazing considering the amount of efforts made through government and private agencies to spread HIV/AIDS awareness. The more remote a location the higher is the lack of knowledge about the disease. Thirdly, the percentage of women choosing to give birth at home would indicate there is an urgent need to ensure there is a good coverage of Traditional Birth Attendants. Such a programme would ensure that antenatal check ups would reveal birth complications and women at risk could ensure that they are referred to a hospital for delivery. This

emphasis on home births is not necessarily one of choice, but may rather indicate a lack of financial resources to pay for hospital services.

Implications for Sustainable Community Change in Project Design

A key implication for successful sustainable community change is to work with a traditional grouping within the society. The project is part of the Chama cha Wanawake programme of The Salvation Army. There is a long-term commitment to the Chama cha Wanawake and so lessons can continue to be passed on because the project has enhanced the life of the group. The project was not the sole reason for the group's existence. Where a project forms a group to carry out its programme, the reason for its existence ceases when the funding finishes.

The current need for participants to be involved in the design of the project is questionable. This was a programme that was imposed from the outside, but it still was assimilated into the context. All development agencies struggle with the theory of grass-roots participation in the design process; more lip service is paid to this interaction than most agencies will admit. The sheer logistics of spending the time in the communities and the willingness of the extremely poor to take the time to sit through the design process all converge to make the reality of this grass roots design practically difficult. Further, it is in the replication stage that the project risks becoming an imposition. The communities in the second or third stage had had no input in the initial design. However, the project found ready acceptance because it met clearly understood needs in the community.

The participants had the freedom to take the key concepts and make them their own and to communicate those principles in media that had a resonance. It is interesting that even today there are still large supplies of the original flip charts still stored at the national headquarters. The formal flip chart approach was replaced by a more contextually appropriate system.

A trainer of trainers approach can empower women. Many of the original trainers were illiterate village women. Becoming trainers gave them power to communicate knowledge. When it was demonstrated that the new knowledge also resulted in healthier families, they

portrayed their work as a sharing of power rather than a sharing of knowledge. Once they saw that they could effect changes to their environment they started asking questions. This led them to set their own agenda for tackling the poverty issues. This project is a good example of Chambers' pattern, mentioned earlier, of outsiders partnering with the local community. The local community took the concepts out of the project and then translated them into media of communication which were appropriate. The process of becoming teachers also empowered the women so that the trainers' groups are now developing into people's organisations with their own agendas. This was specifically seen in Bungoma, where one group had incorporated itself into the Health Club (Chamafya). As mentioned earlier, we do not start development, we can assist it when it is happening. In the case of this project, the Primary Health Project did not need to conscientise women on the need to care for their children. This would be one of their main preoccupations given the levels of child mortality in the area. Did the project help? Yes it did increase awareness of the women's choices for good family health. Did the project contribute to sustainable development? Probably it did, in that the lessons learned continue to be taught, new centres continue to start. The inclusion of the teaching material into the seminary should mean that future generations of pastors will be trained in these skills.

Chapter 9 Conclusion

At this point in the discussion it is vital to comment on whether it is possible to synthesise a coherent working philosophy for a faith-based NGO. Certainly there are key elements that seem to have clear acceptance by both the theorists and practitioners and there is an imperative to have a guiding philosophy. Korten who has contributed so much to my thinking on the subject says: 'The conflict between moving money and building capacity becomes particularly critical at this point in history when the transformation of institutions must be the central agenda. The more the assistance money that is poured through existing agencies without a clear strategy of using money to support transformation of resource management systems, the more those agencies are likely to resist substantive reform'(Korten1990;141).

Dichter confirms this need for reform: 'During this decidedly transitional stage, we northern NGOs need encouragement to do our own research in order to truly approach a "lessons learned" stage. We must also work to establish some norms and standards that are quantitative in nature. However difficult and distasteful this work proves, it will nonetheless allow us to better answer, first for ourselves, questions about how well we do' (Dichter1988:186). Edwards (Edwards et al:1998:13) joins in the plea for reformation when he said that if we wish others to adopt democratic and participatory methods in their operations, then these features must be present in our own structures. The reality is that neither in our internal management nor in our relationships between northern and southern partners is the FBNGO democratic; paternalism and dependency are present and they describe a dysfunctional relationship. Korten's calls for transformation not growth are as equally relevant to the search for a working philosophy as it is for development itself. The dominant theme must be to put people at the centre of all we do in development. Freire says 'Human beings are not built in silence, but in word, in work, in action-reflection' (Freire 1970:69). Dialogue on how we do the business of development is the starting point. To achieve a quality of dialogue is difficult because it entails looking courageously at the dysfunctional elements of our working patterns.

An emerging trend is to see that development issues are problems without borders. The Salvation Army as an example is promoting south/north learning on the means to confront the HIV/AIDS pandemic. Lessons that have been learned in the high-prevalence areas such as Africa can be shared as northern countries face up to the pandemic. This very process has the potential to redress the inequality of the development relationship which has always been the northern partners helping the southern to solve their problems. Now the problems are universal and learning is possible for all partners.

Another key element is Korten's call for social movements that are not driven by money. It was mentioned earlier in the paper that communities remain poor because they simply lack the funds to fix the things that are needed. But Korten's comment must assist in a search for finding the appropriate place for funding. How can funding be injected into a programme without creating inequalities and dependency? Chambers has a useful approach when he says

to start with the needs of the poor. Edward's advice to take your time, understand the situation and build on local knowledge is sound practical advice. This would be the pattern that is possible for the FBNGO. The case study of the primary health project shows an activity where a project started in the health area, but then took off on a local agenda. This transferring of power to the poor is another way of working advocated by Chambers. The project didn't initiate development: it merely built on development that was already happening. The formation of the Chama cha Wanawake as a local women's group preceded the project and continues after the project period. In this way the lessons learnt have enhanced the life of the group. The groups, which are formed for establishment of a project, have little reason to continue after the funding period is finished. The potential of such women's groups for sustainable development is considerable.

A serious constraint to development which the FBNGO needs to look at is the issue of advocacy beyond the grass-roots to redress the unjust systems which contribute to the forces which marginalise the poor. The activist tendencies of the FBNGO tend to see that grass-roots community development has a greater attractiveness than the more abstract advocacy for legislative and regulatory reform.

The paper commenced with asking the question: is it possible to have a unified global strategy for all the various activities undertaken by the multinational FBNGO? The answer is I do not think it is possible. The very desire to adopt such a policy is a construct of the modernisation era, when global quick-fix methods were sought. A post-modern approach is to see that the whole process of development is complex and essentially anarchic. In certain situations a welfare approach is essential, at other times a community development programme, such as the case study is successful. When faced by the global AHIV/AIDS pandemic the promotion of a people's movement is essential. All approaches have their value and their limitations and are appropriate in specific contexts.

For the FBNGO the post-modern reaction against the materialistic modernisation era opens new arenas to explore. The need to incorporate the spiritual needs of humankind is an area where the FBNGO has positive inputs to share with the wider development community. In the

case study the womens' groups did not differentiate between health, poverty and spirituality, all were seen as part of the holistic aspects of community life.

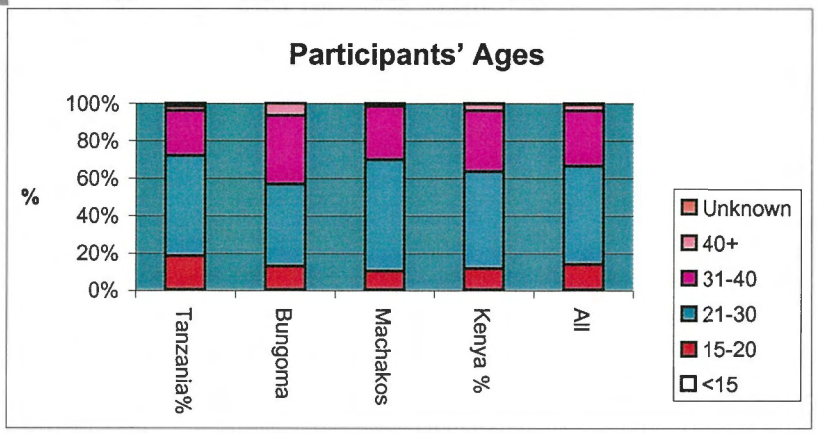
There is a real need to come to terms with the project process. Within the development community it is the nourisher that all theorists love to deride. The project mechanism does have limitations but if Rondinelli's ideas of the potential of projects being policy experiments are explored then the project process still has a useful place. At the lowest level, there is no other viable mechanism for obtaining funding except through project system and so it must be adapted to meet the needs of the poor. This may sometimes mean that the poor, to satisfy their own agenda, will subvert the whole process.

The tool-box approach to using the most appropriate tools to suit the context seems to be the direction FBNGOs should explore.

Health Survey East Africa July 2000 Summary

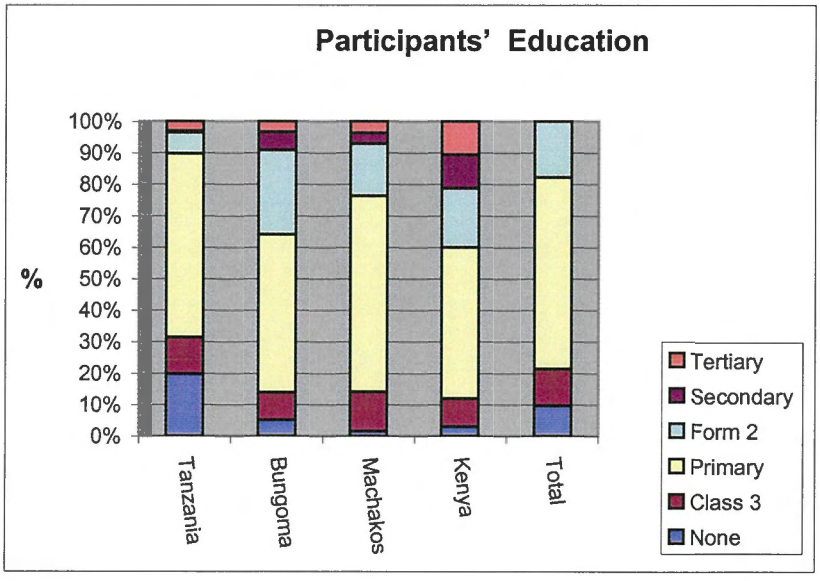
Participants' Age

	Tarime	Tanzania%	Bungoma	Machakos	Kenya %	All	%
<15	1	0.5	1	1	0.52	3	0.5
15-20	36	18	23	20	11.26	79	13.6
21-30	107	53.5	80	118	51.83	305	52.4
31-40	48	24	67	57	32.46	172	29.6
40+	5	2.5	12	2	3.66	19	3.3
Unknown	3	1.5		1	0.26	4	0.7
Totals	200	183	199	582			



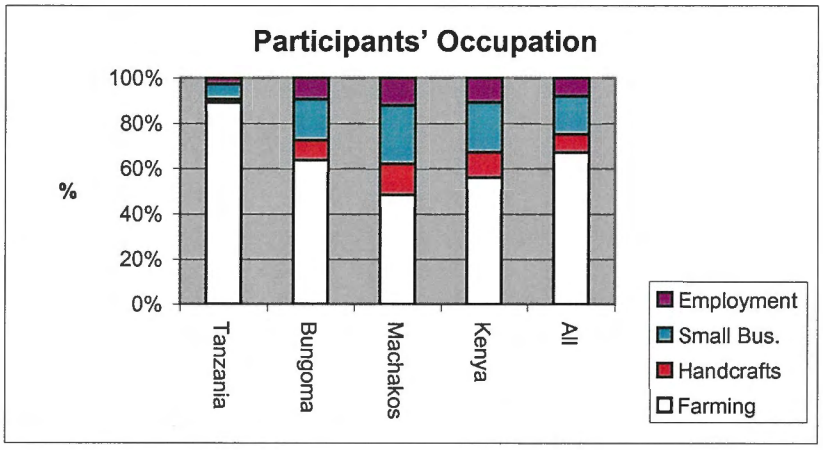
Participants' Education

	Tarime	Tanzania	Bungoma	Machakos	Kenya	All	Total
None	20.5	20.5	5.3	1.5	3.56	54	9.28
Class 3	12	12	9.1	12	11.05	65	11.17
Primary	60.5	60.5	52.1	60	58.69	338	58.08
Form 2	7	7	27.9	16	22.98	99	17.01
Secondary			0.5	6	3.40	13	2.23
Tertiary			3.2	3.5	3.51	13	2.23
Total			183			582	

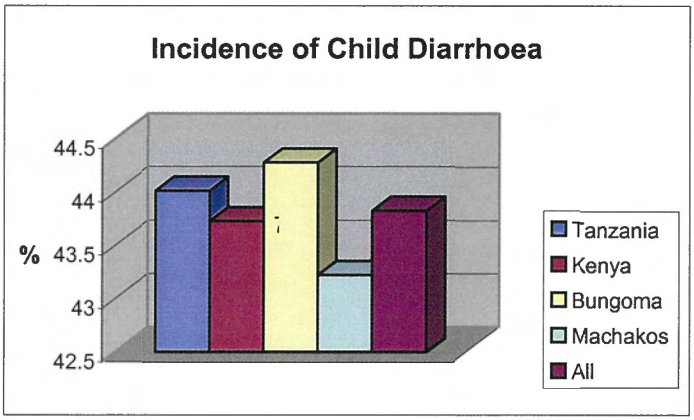


Health Survey East Africa July 2000 Summary ctd.

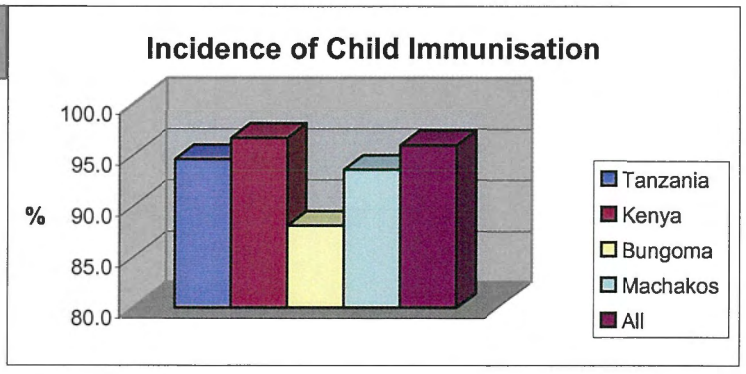
Participants' Occupation	Tarime	Tanzania	Bungoma	Machakos	Kenya	All	%
Handcrafts	3	1.5	16	27	11.26	46	7.90
Farming	179	89.5	117	97	56.02	393	67.53
Small Bus.	13	6.5	33	51	21.99	97	16.67
Employment	5	2.5	17	24	10.73	46	7.90



Incidence of Diarrhoea in Children		%
Tarime	88	44.0
Tanzania	88	44
Bungoma	81	44.3
Machakos	86	43.2
Kenya	167	43.7
All	255	43.8

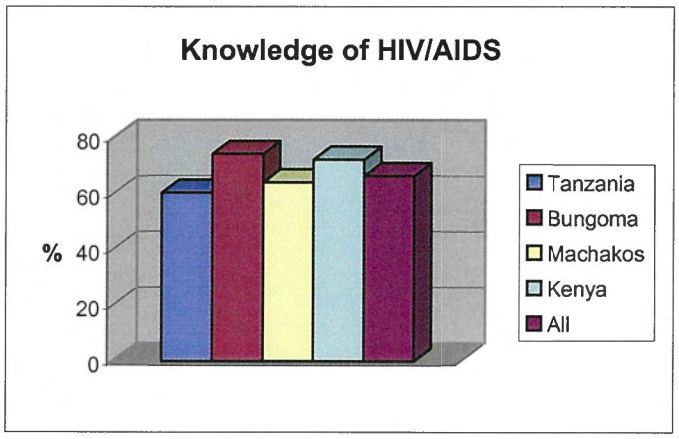


Incidence of Immunisation in Children		%
Tarime	189	94.5
Tanzania	189	94.5
Bungoma	183	88.0
Machakos	186	93.5
Kenya	369	96.6
All	558	95.9



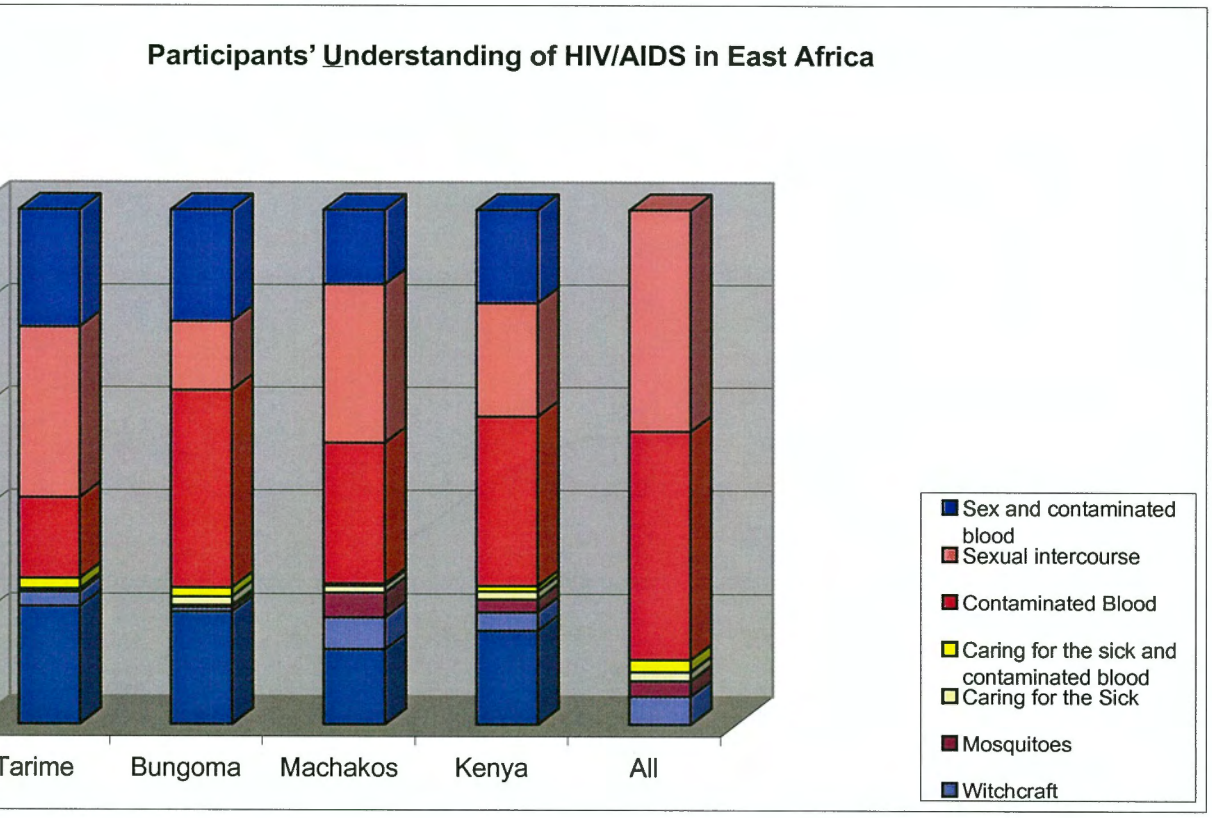
Health Survey East Africa July 2000 Summary Ctd.

Knowledge of HIV/AIDS		%
Tarime	110	55
Tanzania	110	60
Bungoma	148	74
Machakos	127	64
Kenya	275	72
All	385	66



Perceived Understanding of the Causes of HIV/AIDS in East Africa

	Tarime	Tanzania	Bungoma	Machakos	Kenya	All
	7	3.50	2	14	4.19	3.95
	1	0.50	1	11	3.14	2.23
	1	0.25	4	3	1.83	1.29
and contaminated blood	5	2.50	4	1	1.31	1.72
d	39	19.50	88	62	39.27	32.47
	83	41.50	31	70	26.44	31.62
ted blood	57	28.50	50	33	21.73	24.05
	7	3.50	3	5	2.09	2.58



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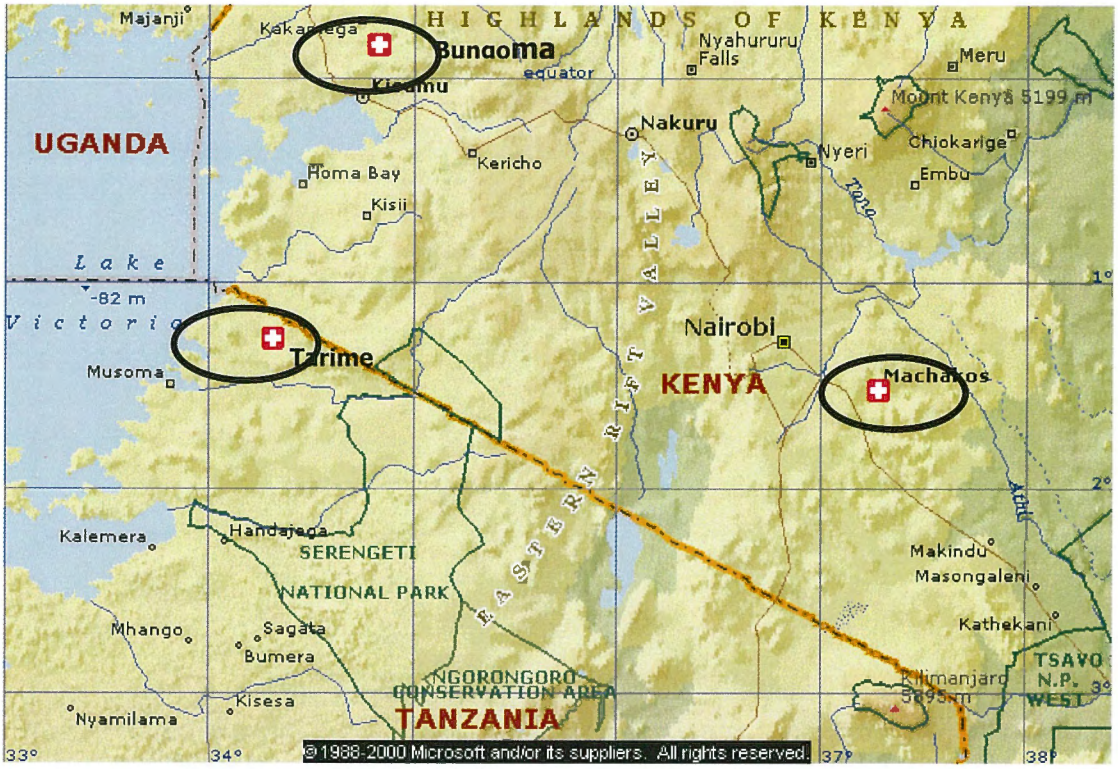
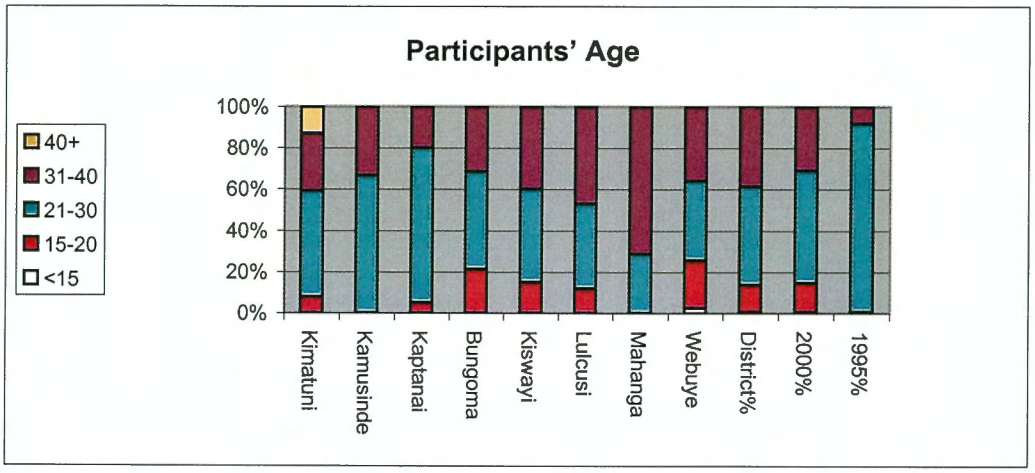


2. Health Survey Bungoma Kenya July 2000

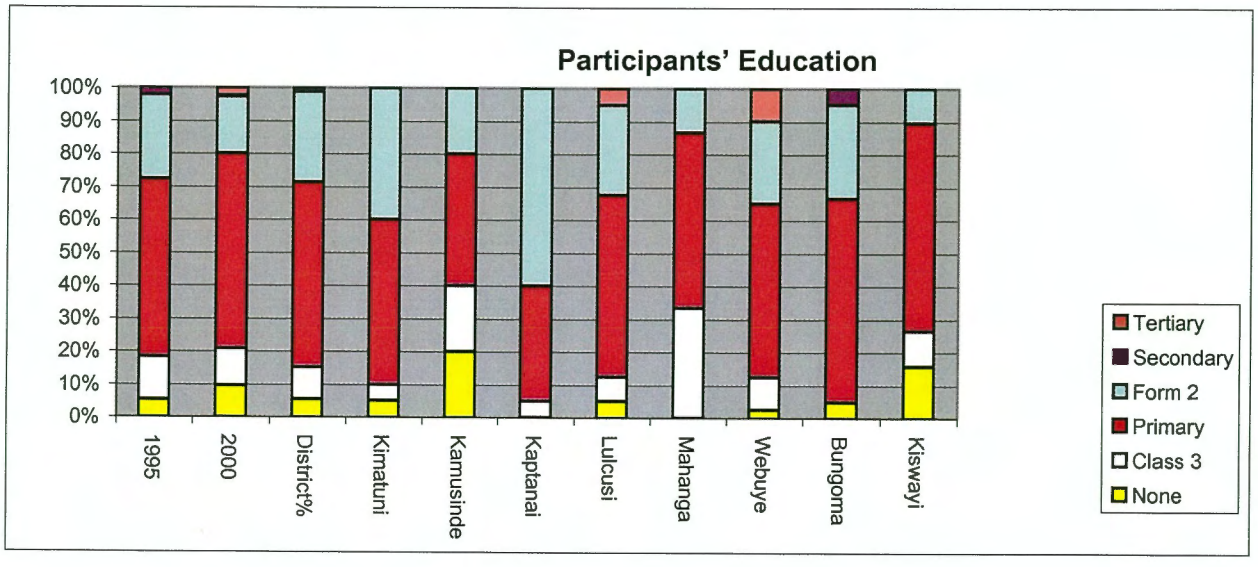
Participants' Age Bungoma

	Kimatuni	Kamusinde	Kaptanai	Bungoma	Kiswayi	Lulcusi	Mahanga	Webuye	All	District%	2000%	1995%
<15								1	1	0.5	0.5	
15-20	2		1	4	3	4		9	23	12.4	13.6	0.6
21-30	13	4	15	9	9	14	4	15	83	44.6	52.4	91.4
31-40	7	2	4	6	8	16	10	14	67	36.0	29.6	8
40+		4		1		6		1	12	6.5	3.3	
Unknown												



Participants' Education

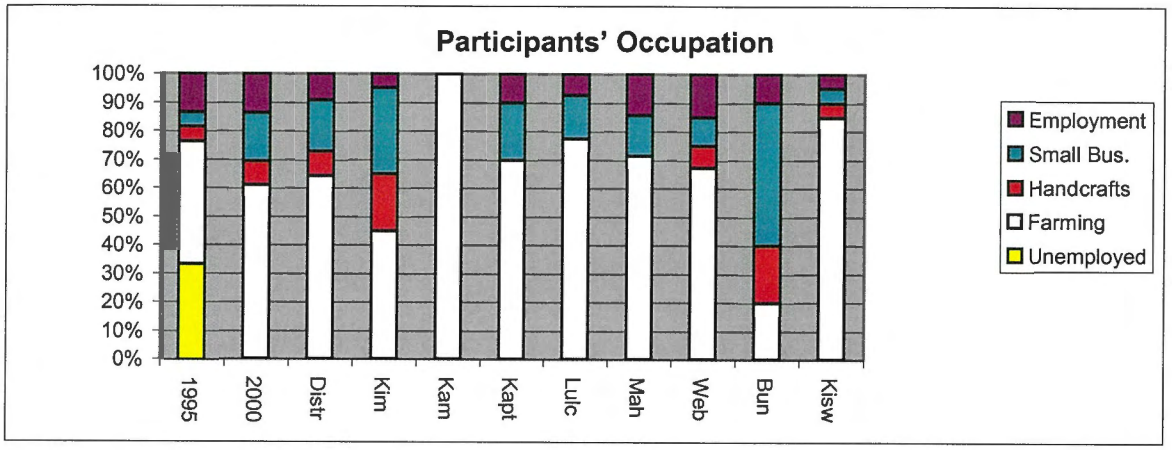
	1995	2000	District%	Kimatuni	Kamusir	Kaptanai	Lulcusi	Mahar	Webuye	Bungoma	Kiswayi
None	5.3	9.28	5.4	1	2		2		1	1	3
Class 3	13.3	11.17	9.7	1	2	1	3	5	4		2
Primary	55	58.08	55.9	10	4	7	22	8	21	13	12
Form 2	26	17	27.4	8	2	12	11	2	10	6	2
Secondary		2.23	0.5								1
Tertiary		2.23	1.1				2		4		
				20	10	20	40	15	40	20	20



2. Health Survey Bungoma Kenya July 2000 Ctd.

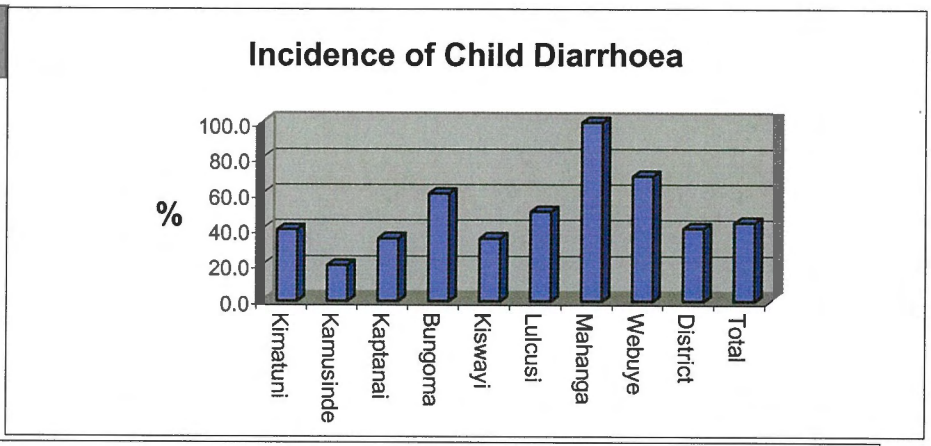
Participant's Occupation

	1995	2000 District%		Kimatuni	Kamusind	Kaptana	Lulcusi	Mahanga	Webu	Bungoma	Kiswayi
Handcrafts	5	8	8	4					3	4	1
Farming	43.5	60	60	9	10	14	31	10	27	4	17
Small Bus.	5	16.5	16.5	6		4	6	2	4	10	1
Employmer	13.5	13.5	8.5	1		2	3	2	6	2	1
Unemploye	33										



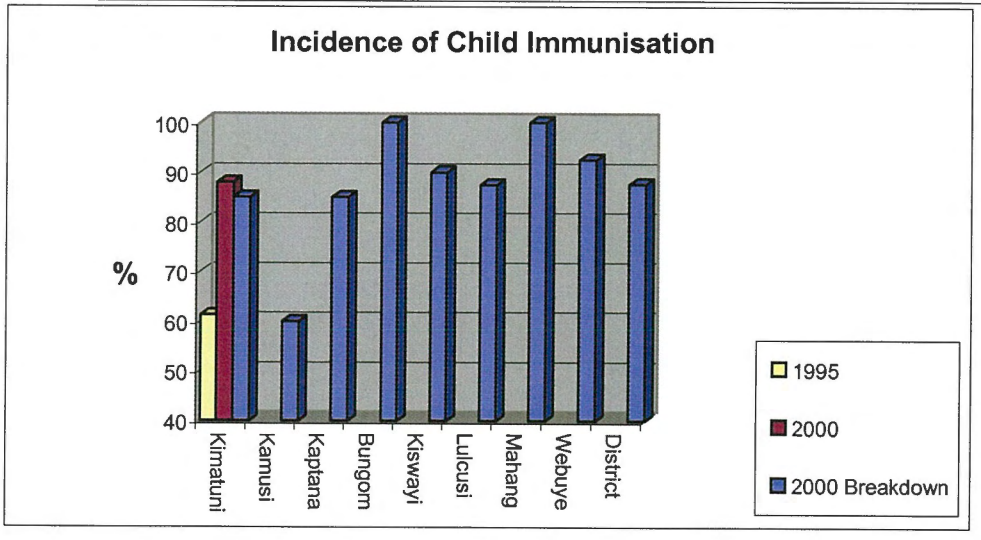
Incidence of Diarrhoea

in Children		%
Kimatuni	8	40.0
Kamusinc	2	20.0
Kaptanai	7	35.0
Bungoma	12	60.0
Kiswayi	14	35.0
Lulcusi	7	50.0
Mahanga	14	100.0
Webuye	14	70.0
District	81	40.5
Total		43.8



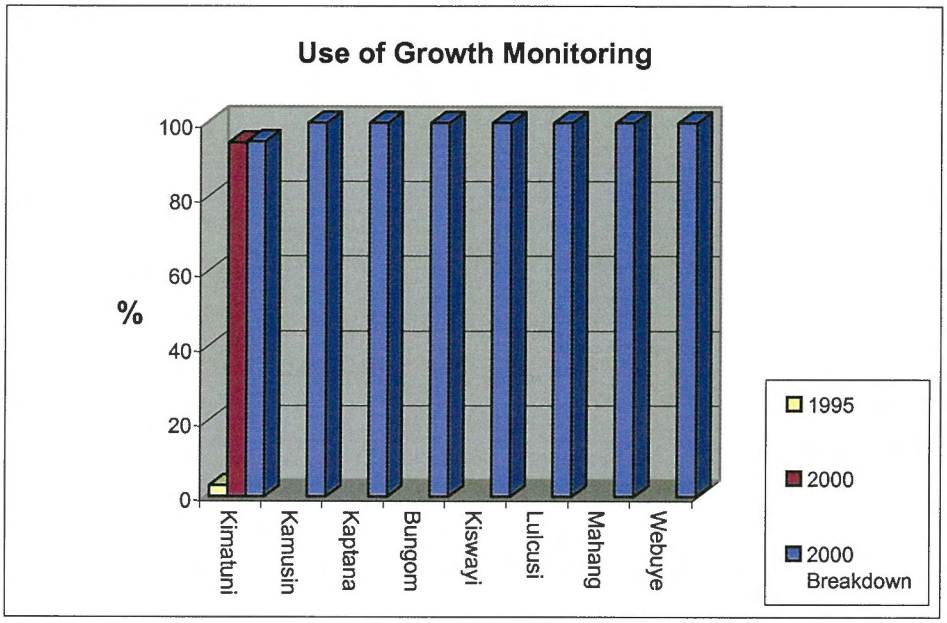
Incidence of Child Immunisation

		%
Kimatuni	17	85
Kamusinc	6	60
Kaptanai	17	85
Bungoma	20	100
Kiswayi	18	90
Lulcusi	35	88
Mahanga	14	100
Webuye	37	92.5
District	163	88
2000		88
1995		61.3

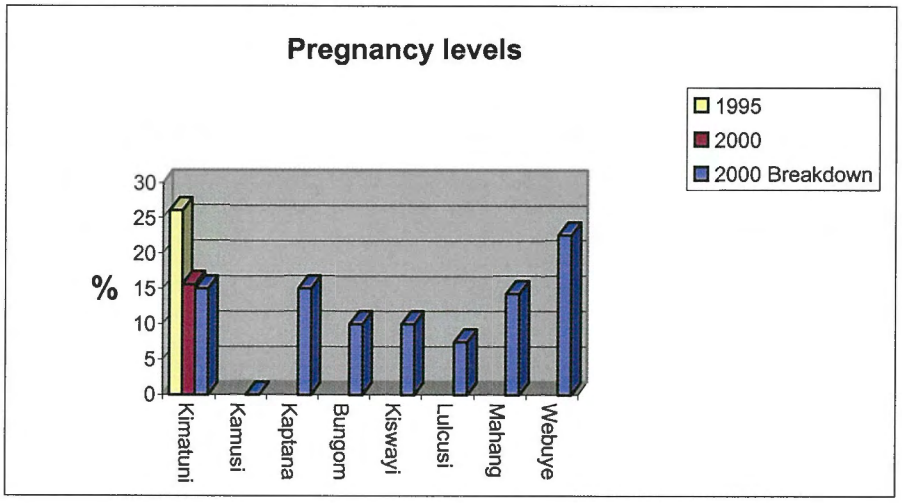


2. Health Survey Bungoma Kenya July 2000 Ctd.

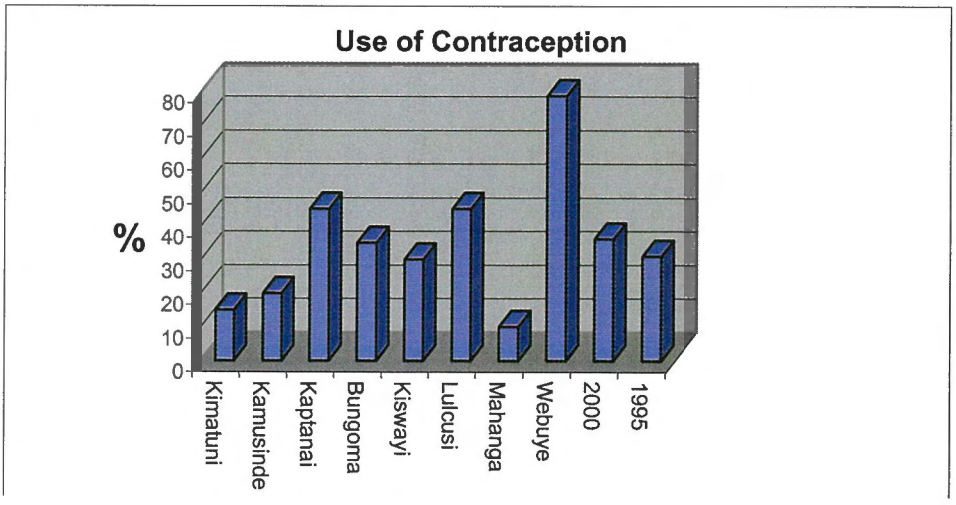
Use of Growth Monitoring	%	
Kimatuni	19	95
Kamusinc	10	100
Kaptanai	20	100
Bungoma	20	100
Kiswayi	20	100
Lulcusi	40	100
Mahanga	14	100
Webuye	40	100
2000	176	95
1995		3



Pregnancy Levels	%	
Kimatuni	3	15
Kamusinc	0	0
Kaptanai	3	15
Bungoma	4	10
Kiswayi	2	10
Lulcusi	3	8
Mahanga	2	14
Webuye	9	23
2000	29	16
1995		26

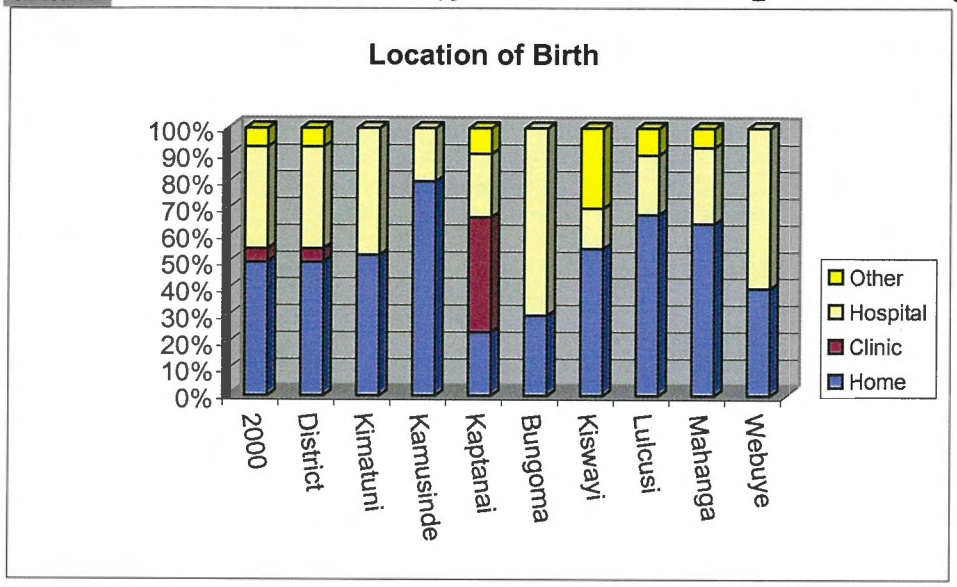


Use of Contraception	%	
Kimatuni	3	15
Kamusinc	2	20
Kaptanai	9	45
Bungoma	14	35
Kiswayi	6	30
Lulcusi	18	45
Mahanga	4	10
Webuye	11	79
2000	67	36
1995		31



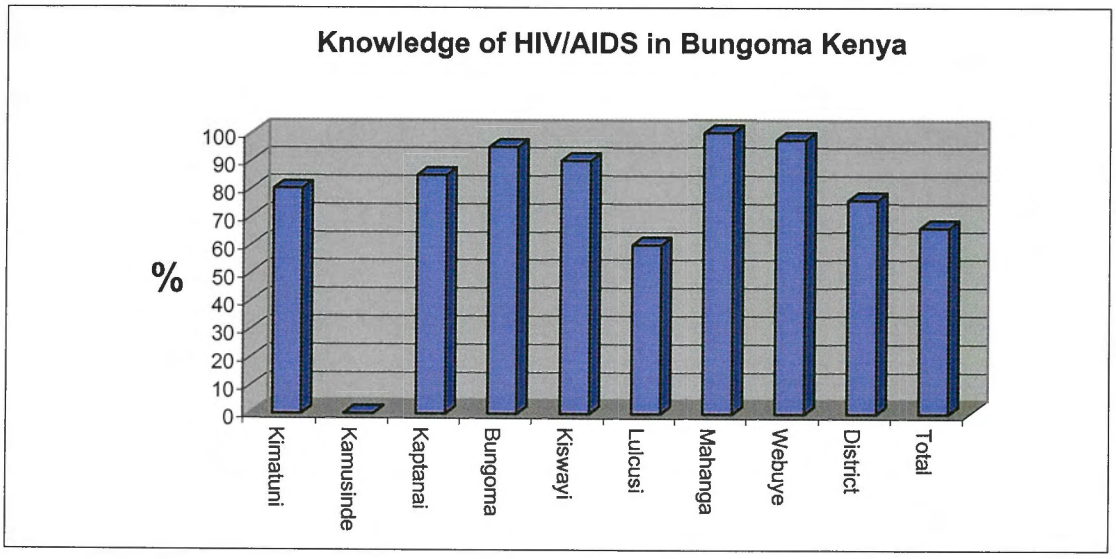
2. Health Survey Bungoma Kenya July 2000 ctd.

Location of Birth	2000	District	Kimatuni	Kamusin	Kaptan	Bungom	Kiswayi	Lulcu	Mahanga	Webuye
Home	49	92	10	8	5	6	11	27	9	16
Clinic	5	9			9					
Hospital	38	70	9	2	5	14	3	9	4	24
Other	7	13			2		6	4	1	



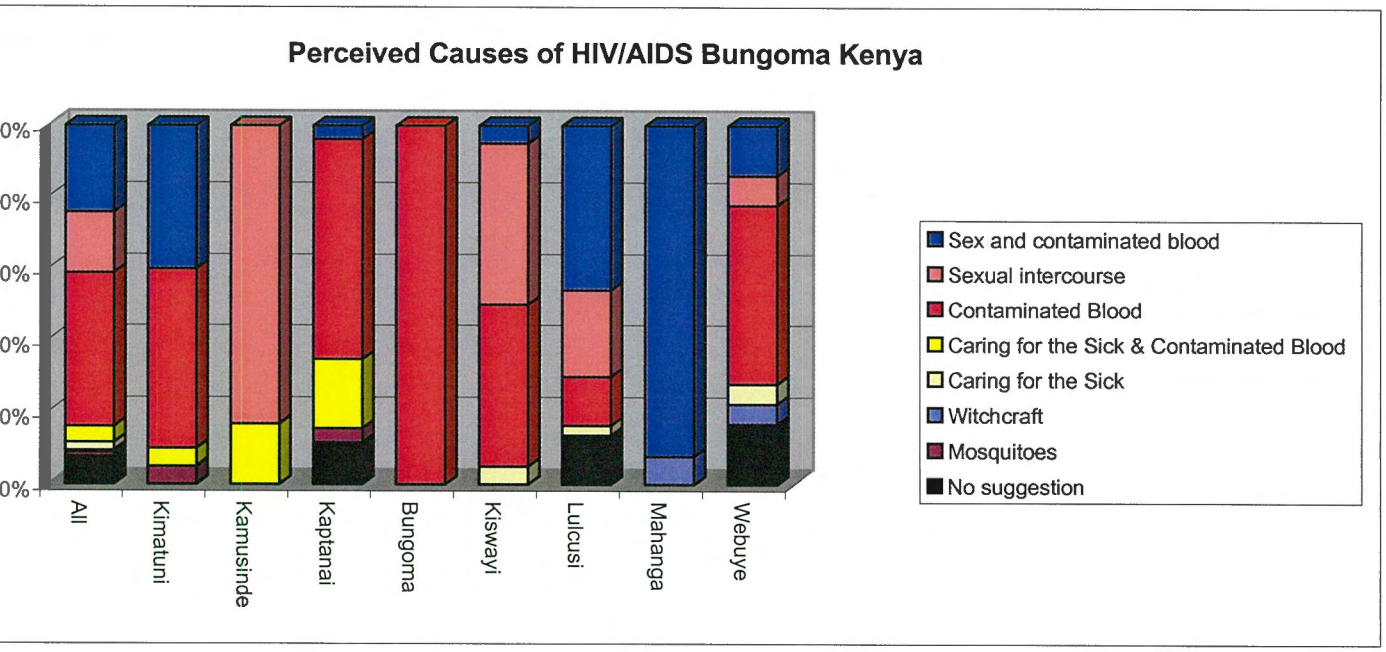
2. Health Survey Bungoma Kenya July 2000 ctd.

Knowledge of HIV/AIDS		%
Kimatuni	16	80
Kamusinde	0	0
Kaptanai	17	85
Bungoma	19	95
Kiswayi	18	90
Lulcusi	24	60
Mahanga	14	100
Webuye	39	98
District	141	76
Total		66



Perceived Understanding of the Causes of HIV/AIDS

	All	%	Kimatuni	Kamusinde	Kaptanai	Bungoma	Kiswayi	Lulcusi	Mahanga	Webuye
	2	1.08	1							1
	2	1.08						1		1
	4	2.15					1	1		2
& Contaminated Blood	8	4.30						1	2	5
od	78	41.94	10		16	20	9	5		18
	31	16.67		10			9	9		3
ated blood	44	23.66	8		1		1	17	12	5
	14	7.53			3			5		6
	183	98.39	19	10	20	20	20	39	14	40



2. Health Survey Bungoma Kenya July 2000 Ctd.

2.1 Kimatuni Report	%	Total	%
Education			
None		5	5
Class 3		5	10
Primary		50	56
Form 2		40	27
Secondary			1
Tertiary			1
Incidence of Diarrhoea		40	41
Immunisation		80	88
Growth Monitoring		95	95
Pregnancy Levels		15	15
Use of Contraception		15	36
Place to Give Birth			
Home		52	49
Clinic			5
Hospital		47	38
Other			7
Knowledge of HIV/AIDS		80	76
Causes of HIV/AIDS			
Witchcraft		5.2	1.09
Mosquitoes			0.55
Caring for the Sick			2.19
Caring for the Sick & Blood			2.19
Contaminated Blood		52	48.09
Sexual Intercourse			16.94
Sex and Cont. Blood		42	27.32
No Suggestion			1.64

2.2 Kamusinde Report	%	Total	%
Education			
None		20	5.4
Class 3		20	9.7
Primary		40	55.9
Form 2		20	27.4
Secondary			0.5
Tertiary			1.1
Incidence of Diarrhoea		20	40.5
Immunisation		60	88.0
Growth Monitoring		100	95.0
Pregnancy Levels		0	15.0
Use of Contraception		20	36.0
Place to Give Birth			
Home		80	6
Clinic			0
Hospital		20	14
Other			0
Knowledge of HIV/AIDS		0	76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes			0.55
Caring for the Sick			2.19
Caring for the Sick & Blood			2.19
Contaminated Blood			48.09
Sexual intercourse		100	16.94
Sex and Cont. Blood			27.32
No Suggestion			1.64

2. Health Survey Bungoma Kenya July 2000 Ctd.

2.3 Kaptani Report	%	Total	%
Education			
None			5
Class 3		5	10
Primary		35	56
Form 2		60	27
Secondary			1
Tertiary			1
Incidence of Diarrhoea		35	41
Immunisation		85	88
Growth Monitoring		100	95
Pregnancy Levels		15	15
Use of Contraception		45	36
Place to Give Birth			
Home		25	49
Clinic		45	5
Hospital		25	38
Other		10	7
Knowledge of HIV/AIDS		85	76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes			0.55
Caring for the Sick			2.19
Caring for the Sick & Blood			2.19
Contaminated Blood		80	48.09
Sexual Intercourse			16.94
Sex and Cont. Blood		5	27.32
No Suggestion		15	1.64

2.4 Lulcusi Report	%	Total	%
Education			
None		5	5
Class 3		7.5	10
Primary		55	56
Form 2		27.5	27
Secondary			1
Tertiary		5	1
Incidence of Diarrhoea		17.5	41
Immunisation		87.5	88
Growth Monitoring		100	95
Pregnancy Levels		7.5	15
Use of Contraception		45	36
Place to Give Birth			
Home		68	49
Clinic			5
Hospital		23	38
Other		10	7
Knowledge of HIV/AIDS		60	76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes		2.5	0.55
Caring for the Sick		2.5	2.19
Caring for the Sick & Blooc		2.5	2.19
Contaminated Blood		12.5	48.09
Sexual Intercourse		22.5	16.94
Sex and Cont. Blood		42.5	27.32
No Suggestion		12.5	1.64

2. Health Survey Bungoma Kenya July 2000 Ctd.

2.7 Bungoma Report	%	Total	%
Education			
None	5		5
Class 3			10
Primary	65		56
Form 2	30		27
Secondary			1
Tertiary			1
Incidence of Diarrhoea	60		41
Immunisation	100		88
Growth Monitoring	100		95
Pregnancy Levels	10		15
Use of Contraception	14		36
Place to Give Birth			
Home	30		49
Clinic			5
Hospital	70		38
Other			7
Knowledge of HIV/AIDS	95		76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes			0.55
Caring for the Sick			2.19
Caring for the Sick & Blood			2.19
Contaminated Blood	100		48.09
Sexual Intercourse			16.94
Sex and Cont. Blood			27.32
No Suggestion			1.64

2.8 Kiswayi Report	%	Total	%
Education			
None	15		5
Class 3	10		10
Primary	60		56
Form 2	10		27
Secondary	5		1
Tertiary			1
Incidence of Diarrhoea	70		41
Immunisation	90		88
Growth Monitoring	100		95
Pregnancy Levels	10		15
Use of Contraception	30		36
Place to Give Birth			
Home	55		49
Clinic			5
Hospital	15		38
Other	30		7
Knowledge of HIV/AIDS	90		76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes			0.55
Caring for the Sick	5		2.19
Caring for the Sick & Blood			2.19
Contaminated Blood	45		48.09
Sexual Intercourse	45		16.94
Sex and Cont. Blood	5		27.32
No Suggestion			1.64

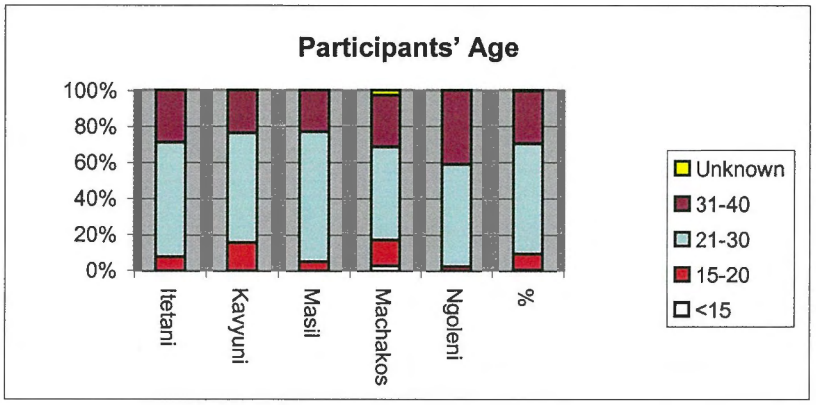
2. Health Survey Bungoma Kenya July 2000 Ctd.

2.5 Mahanga Report	%	Total	%
Education			
None			5
Class 3		33	10
Primary		53	56
Form 2		13	27
Secondary			1
Tertiary			1
Incidence of Diarrhoea		100	41
Immunisation		100	88
Growth Monitoring		100	95
Pregnancy Levels		14	15
Use of Contraception		10	36
Place to Give Birth			
Home		64	49
Clinic			5
Hospital		28	38
Other		7	7
Knowledge of HIV/AIDS		100	76
Causes of HIV/AIDS			
Witchcraft			1.09
Mosquitoes			0.55
Caring for the Sick			2.19
Caring for the Sick & Blood		14	2.19
Contaminated Blood			48.09
Sexual Intercourse			16.94
Sex and Cont. Blood		85	27.32
No Suggestion			1.64

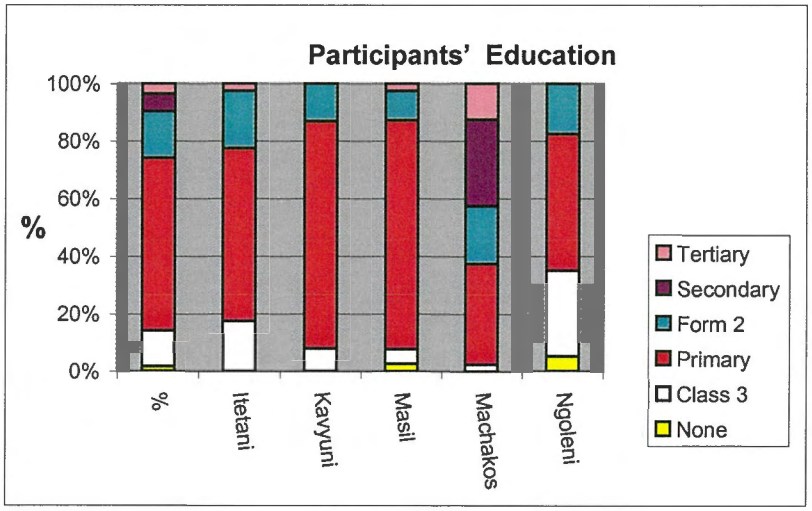
2.6 Webuye Report	%	Total	%
Education			
None	2.5		5
Class 3	10		10
Primary	52.5		56
Form 2	25		27
Secondary			1
Tertiary	10		1
Incidence of Diarrhoea	35		41
Immunisation	92.5		88
Growth Monitoring	100		95
Pregnancy Levels	22.5		15
Use of Contraception	27.5		36
Place to Give Birth			
Home	40		49
Clinic			5
Hospital	60		38
Other			7
Knowledge of HIV/AIDS	98		76
Causes of HIV/AIDS			
Witchcraft	2.5		1.09
Mosquitoes	2.5		0.55
Caring for the Sick	5		2.19
Caring for the Sick & Blooc	12.5		2.19
Contaminated Blood	45		48.09
Sexual Intercourse	7.5		16.94
Sex and Cont. Blood	12.5		27.32
No Suggestion	15		1.64

3. Health Survey Machakos Kenya July 2000

Participants' Age Machakos	Itetani	Kavyuni	Masil	Machakos	Ngoleni	All	%
<15				1		1	0.52
15-20	3	6	2	5	1	17	8.90
21-30	24	23	28	18	22	115	60.21
31-40	11	9	9	10	16	55	28.80
40+	2					2	1.05
Unknown				1		1	0.52
Total	40	38	39	35	39	191	

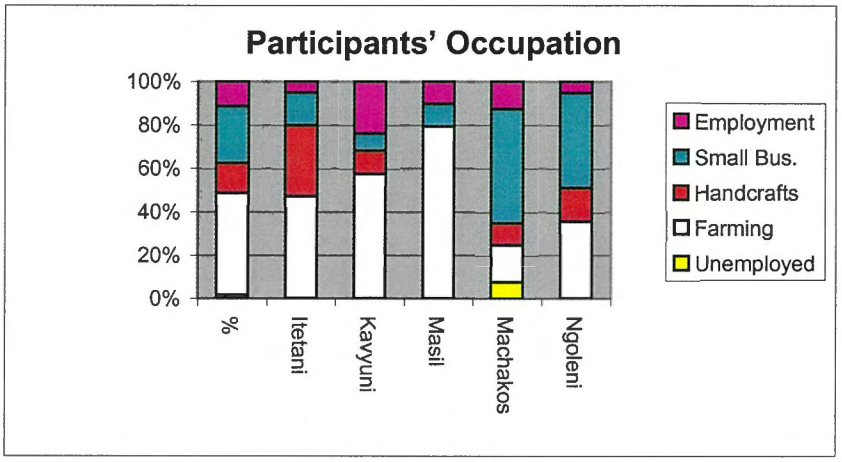


Participants' Education	All	%	Itetani	Kavyuni	Masil	Machakos	Ngoleni
None	3	1.5				1	2
Class 3	25	12.7	7	3	2	1	12
Primary	118	59.9	24	30	31	14	19
Form 2	32	16.2	8	5	4	8	7
Secondary	12	6.1				12	
Tertiary	7	3.6	1		1	5	
total	197		40	38	39	40	40

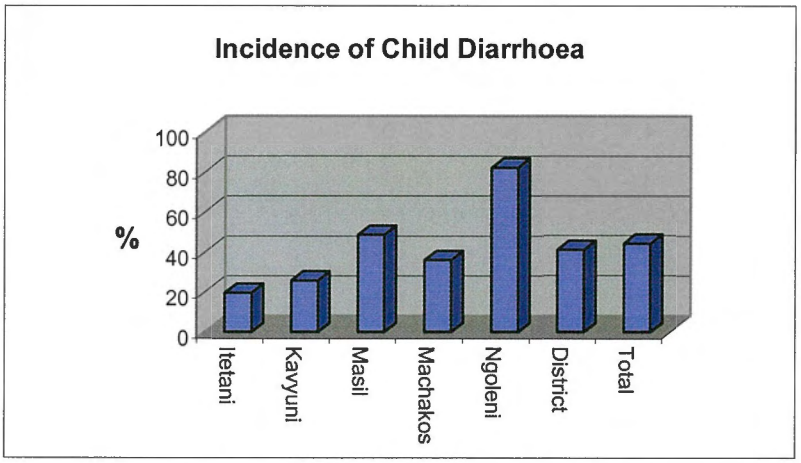


3. Health Survey Machakos Kenya July 2000 Ctd.

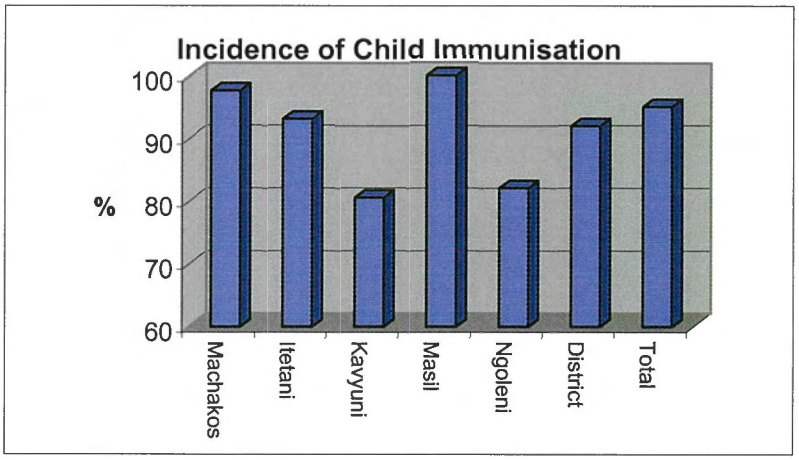
Participant's Occupation	All	%	Itetani	Kavyuni	Masil	Machakos	Ngoleni
Handcrafts	27	13.78	13	4		4	6
Farming	93	47.45	19	22	31	7	14
Small Bus.	51	26.02	6	3	4	21	17
Employment	22	11.22	2	9	4	5	2
Unemployed	3	1.53				3	



Incidence of Diarrhoea in Children		%
Itetani	8	19.5
Kavyuni	10	25.6
Masil	17	48.6
Machakos	14	35.9
Ngoleni	32	82.1
District	81	40.7
Total		43.8

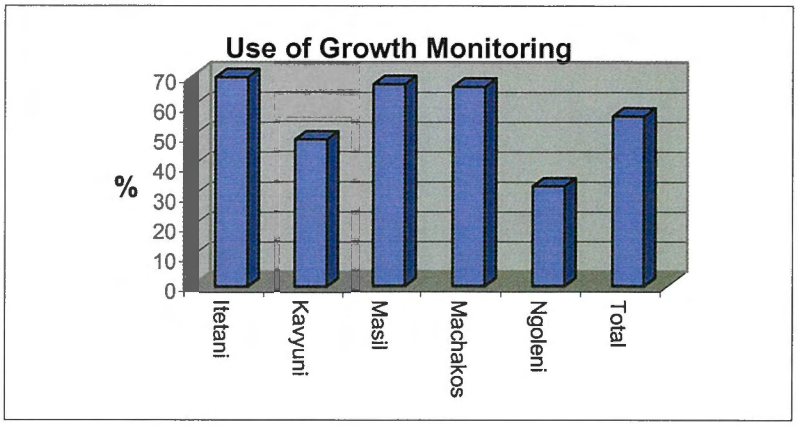


Incidence of Child Immunisation		%
Machakos	39	98
Itetani	40	93
Kavyuni	33	80
Masil	39	100
Ngoleni	32	82
District	183	92
Total		95

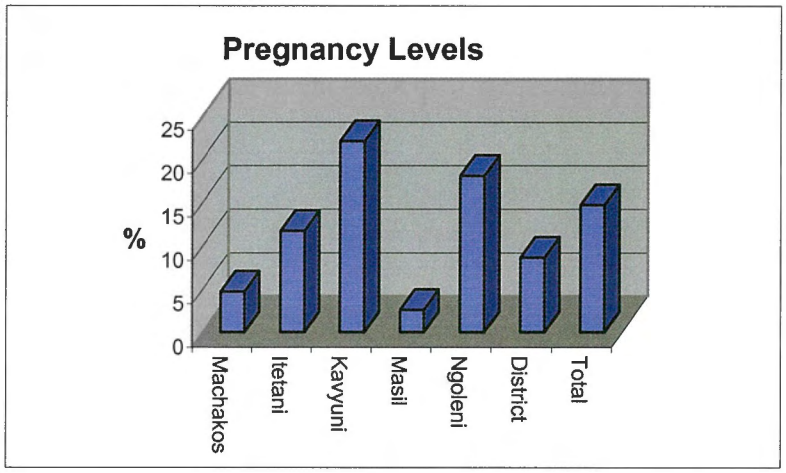


3. Health Survey Machakos Kenya July 2000 Ctd.

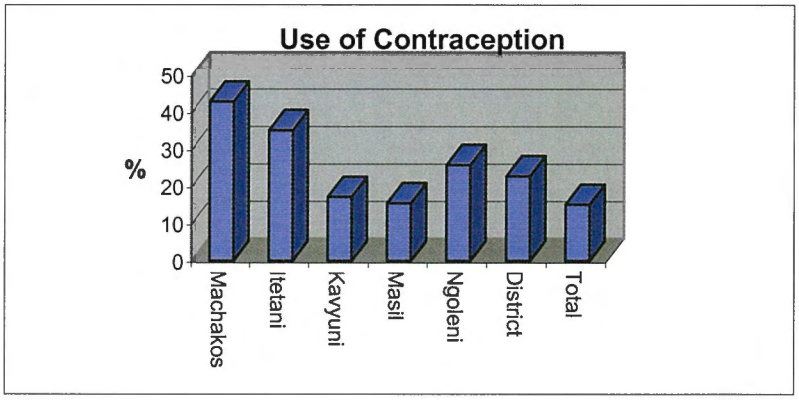
Use of Growth Monitoring		%
Itetani	30	70
Kavyuni	20	49
Masil	27	68
Machakos	26	67
Ngoleni	13	33
Total	113	57



Pregnancy Levels		%
Machakos	2	5
Itetani	5	12
Kavyuni	9	22
Masil	1	3
Ngoleni	7	18
District	17	9
Total		15

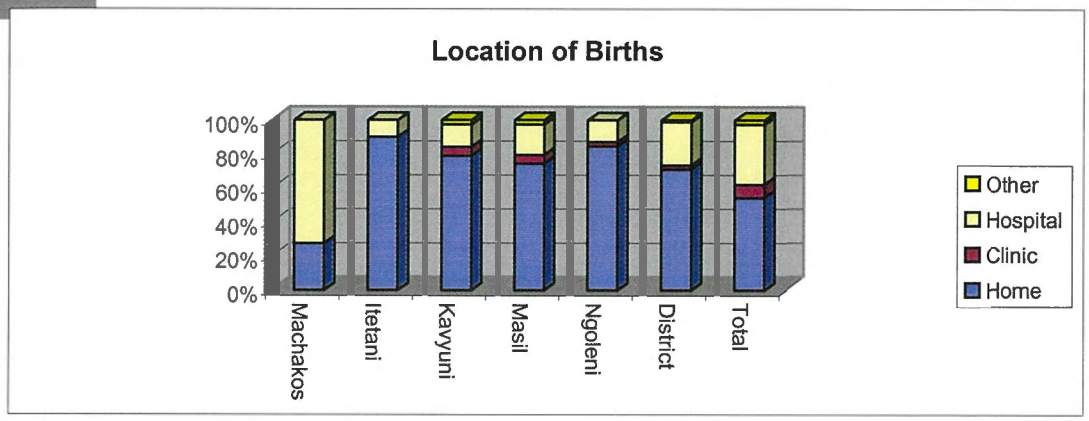


Use of Contraception		%
Machakos	17	43
Itetani	15	35
Kavyuni	7	17
Masil	6	15
Ngoleni	10	26
District	45	23
Total		15

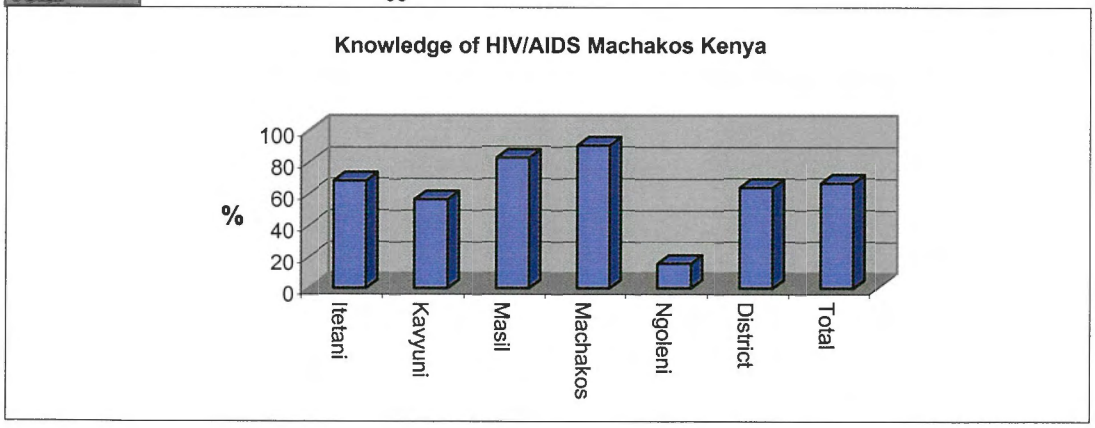


3. Health Survey Machakos Kenya July 2000 Ctd.

Location of Birth	Machakos	Itetani	Kavyuni	Masil	Ngoleni	total	District	Total
Home	11	36	30	29	33	139	70	55.3
Clinic			2	2	1	5	3	7.9
Hospital	29	4	5	7	5	50	25	35.91
Other			1	1		2	1	2.58

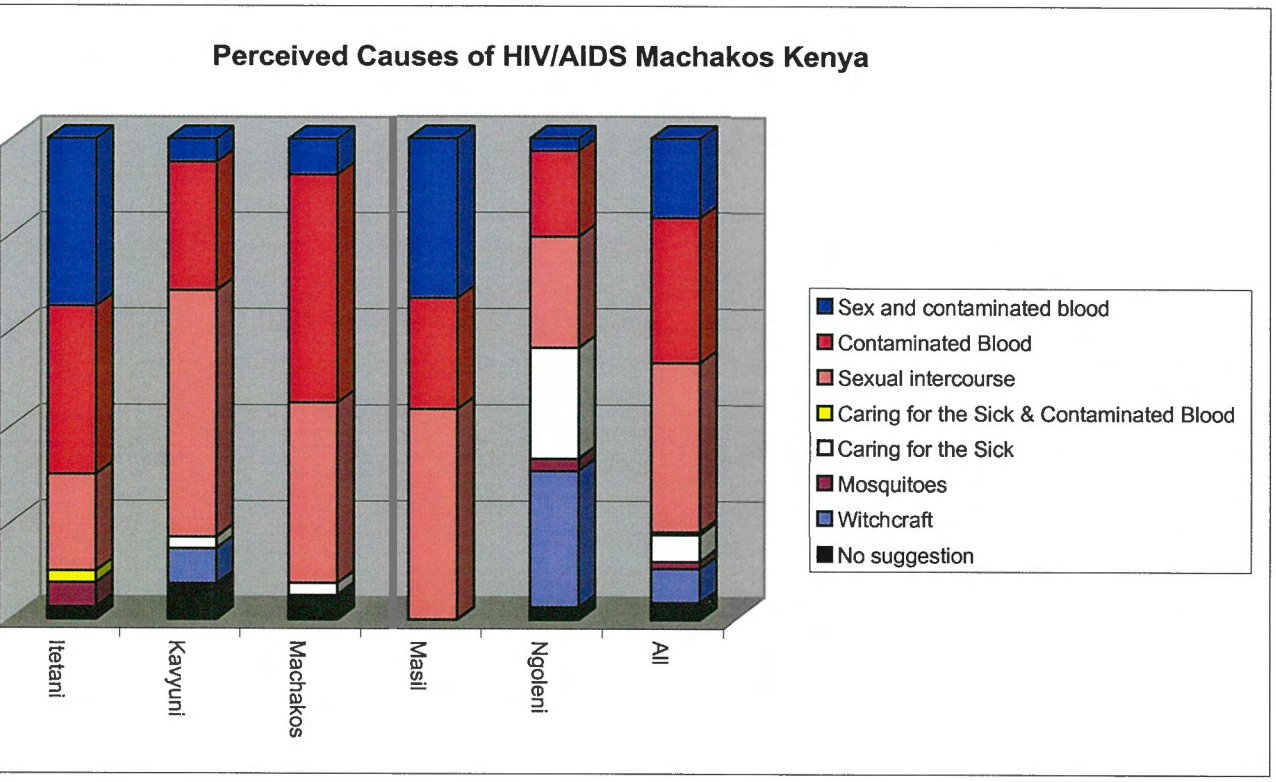


Knowledge of HIV/AIDS		
Machakos	%	
Itetani	29	67
Kavyuni	23	56
Masil	32	82
Machakos	36	90
Ngoleni	6	15
District	126	63
Total		66



Perceived Understanding of the Causes of HIV/AIDS Machakos Kenya

	Itetani	Kavyuni	Machakos	Masil	Ngoleni	All	%	
		3			11	14	7	
	2				1	3	2	
		1	1		9	11	6	
& Contaminated Blood	1					1	1	
d	14	11	19	9	7	60	30	
	8	21	15	17	9	70	35	
ted blood	14	2	3	13	1	33	17	
	1	3	2		1	7	4	



3. Health Survey Machakos Kenya July 2000 Ctd.

3.1 Itetani Report	%	Total	%	3.2 Kavyuni Report	%	Total	%
Education				Education			
None			1.5	None			1.5
Class 3		18	12.7	Class 3		14	12.7
Primary		60	59.9	Primary		56	59.9
Form 2		20	16.2	Form 2		21	16.2
Secondary			6.1	Secondary			6.1
Tertiary		2	3.6	Tertiary			3.6
Incidence of Diarrhoea		20	40.7	Incidence of Diarrhoea		25.6	40.7
Immunisation		93	92	Immunisation		80	76.0
Growth Monitoring		70	57	Growth Monitoring		49	57.0
Pregnancy Levels		12	9.0	Pregnancy Levels		22	9.0
Use of Contraception		35	23.0	Use of Contraception		17	23.0
Place to Give Birth				Place to Give Birth			
Home		90	70	Home		78	70
Clinic			3	Clinic		5	3
Hospital		10	25	Hospital		13	25
Other			1	Other		2	1
Knowledge of HIV/AIDS		67	63	Knowledge of HIV/AIDS		56	63
Causes of HIV/AIDS				Causes of HIV/AIDS			
Witchcraft			7	Witchcraft		7.14	7
Mosquitoes		5	2	Mosquitoes			2
Caring for the Sick			6	Caring for the Sick			6
Caring for the Sick & Blood		3	1	Caring for the Sick & Blood			1
Contaminated Blood		35	30	Contaminated Blood		45.23	30
Sexual Intercourse		20	35	Sexual Intercourse		35.7	35
Sex and Cont. Blood		35	17	Sex and Cont. Blood		7.14	17
No Suggestion		3	2	No Suggestion		4.76	2

3. Health Survey Machakos Kenya July 2000 Ctd.

3.3 Machakos Report	%	Total	%	3.4 Ngoleni Report	%	Total	%
Education				Education			
None			1.5	None		5	1.5
Class 3		3	12.7	Class 3		30	12.7
Primary		35	59.9	Primary		47.5	59.9
Form 2		20	16.2	Form 2		17.5	16.2
Secondary		30	6.1	Secondary			6.1
Tertiary		13	3.6	Tertiary			3.6
Incidence of Diarrhoea		35	40.7	Incidence of Diarrhoea		82	40.7
Immunisation		98	76	Immunisation		82	76.0
Growth Monitoring		67	57	Growth Monitoring		33	57.0
Pregnancy Levels		5	9.0	Pregnancy Levels		18	9.0
Use of Contraception		43	23.0	Use of Contraception		26	23.0
Place to Give Birth				Place to Give Birth			
Home		27	70	Home		83	70
Clinic			3	Clinic		3	3
Hospital		72	25	Hospital		13	25
Other			1	Other			1
Knowledge of HIV/AIDS		90	63	Knowledge of HIV/AIDS		15	63
Causes of HIV/AIDS				Causes of HIV/AIDS			
Witchcraft			7	Witchcraft		28	7
Mosquitoes			2	Mosquitoes		3	2
Caring for the Sick		1	6	Caring for the Sick		23	6
Caring for the Sick & Blood			1	Caring for the Sick & Blood			1
Contaminated Blood		48	30	Contaminated Blood		18	30
Sexual intercourse		38	35	Sexual intercourse		23	35
Sex and Cont. Blood		7	17	Sex and Cont. Blood		3	17
No Suggestion		5	2	No Suggestion		3	2

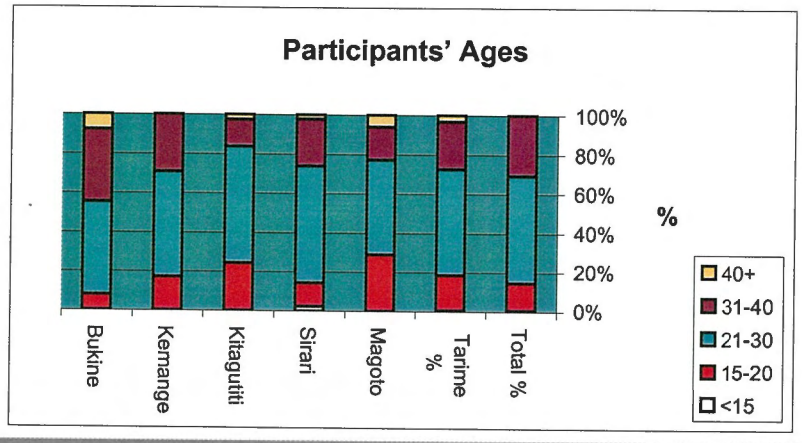
3. Health Survey Machakos Kenya July 2000 Ctd.

3.5 Masili	Report	%	Total	%
Education				
None			3	1.5
Class 3			5	12.7
Primary			79	59.9
Form 2			10	16.2
Secondary				6.1
Tertiary			3	3.6
Incidence of Diarrhoea			48	40.7
Immunisation			100	76
Growth Monitoring			68	57
Pregnancy Levels			3	9.0
Use of Contraception			15	23.0
Place to Give Birth				
Home			74	70
Clinic			5	3
Hospital			18	25
Other			2	1
Knowledge of HIV/AIDS			82	63
Causes of HIV/AIDS				
Witchcraft				7
Mosquitoes				2
Caring for the Sick				6
Caring for the Sick & Blood				1
Contaminated Blood			23	30
Sexual Intercourse			43	35
Sex and Cont. Blood			33	17

1. Health Survey Tarime Tanzania July 2000

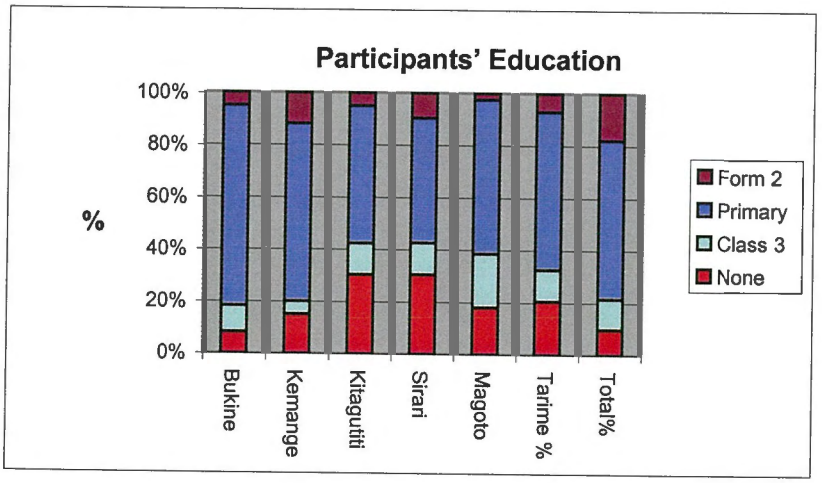
Participants' Ages

	Bukine	Kemange	Kitagutiti	Sirari	Magoto	All	Tarime %	Total %
<15				1		1	0.5	0.5
15-20	3	7	9	5	12	36	18.0	13.6
21-30	18	22	22	25	20	107	53.5	52.4
31-40	14	12	5	10	7	48	24.0	29.6
40+	3		1	1		5	2.5	3.3
Unknown			3			3	1.5	0.7
Totals	38	41	40	42	39	200		



Participants' Education

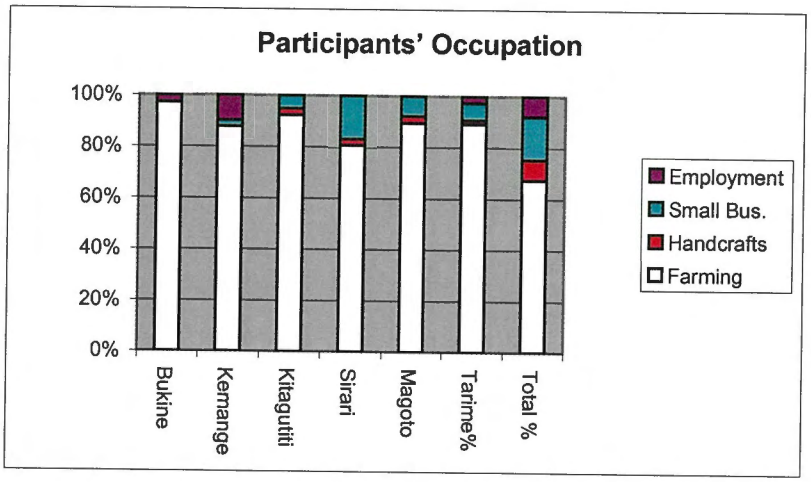
	Bukine	Kemange	Kitagutiti	Sirari	Magoto	All	Tarime %	Total%
None	8	15	30	30	17.95	41	20.5	9.28
Class 3	10	5	12	12	20.51	24	12.0	11.17
Primary	76	68	52	47	58.97	121	60.5	58.08
Form 2	5	12	5	9.5	2.5	14	7.0	17.01
Secondary								2.23
Tertiary								2.23
Total								



1. Health Survey Tarime Tanzania July 2000 Ctd

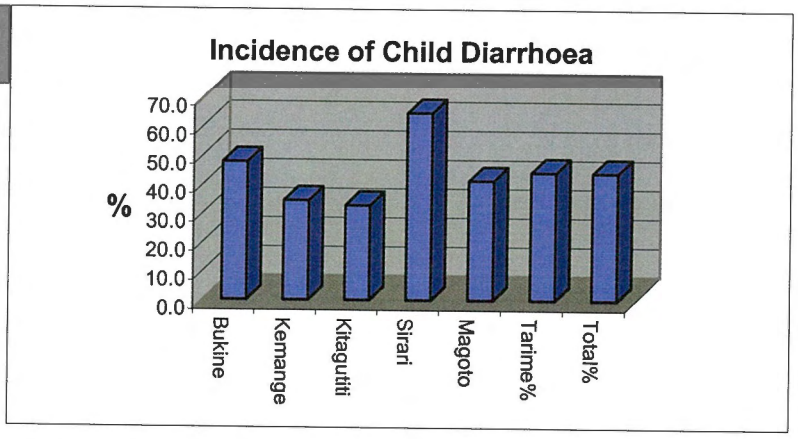
Participants' Occupation

	Bukine	Kemange	Kitagutiti	Sirari	Magoto	Tarime%	Total %	Total %
Handcrafts			1	1	1	3	1.5	7.9
Farming	37	36	37	34	35	179	89.5	67.53
Small Bus.		1	2	7	3	13	6.5	16.67
Employme	1	4				5	2.5	7.9
Total	38	41	40	42	39	200		



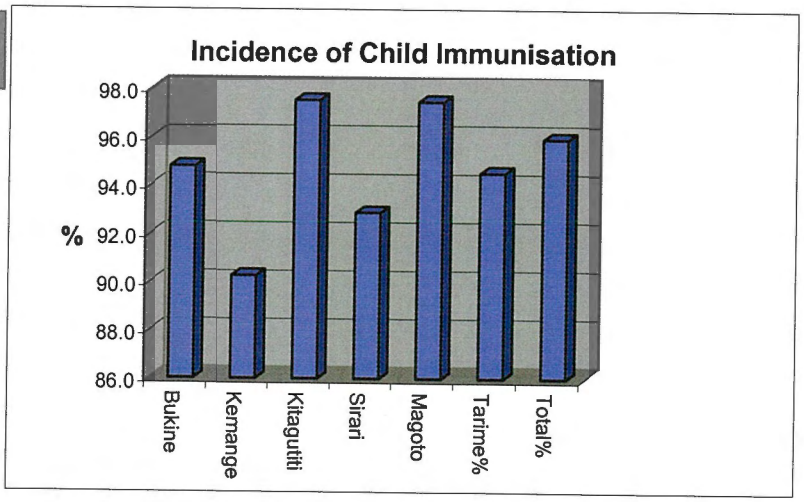
Incidence of Diarrhoea in Children %

Bukine	18	47.4
Kemange	14	34.1
Kitagutiti	13	32.5
Sirari	27	64.3
Magoto	16	41.0
Tarime%	88	44.0
Total%	255	43.8



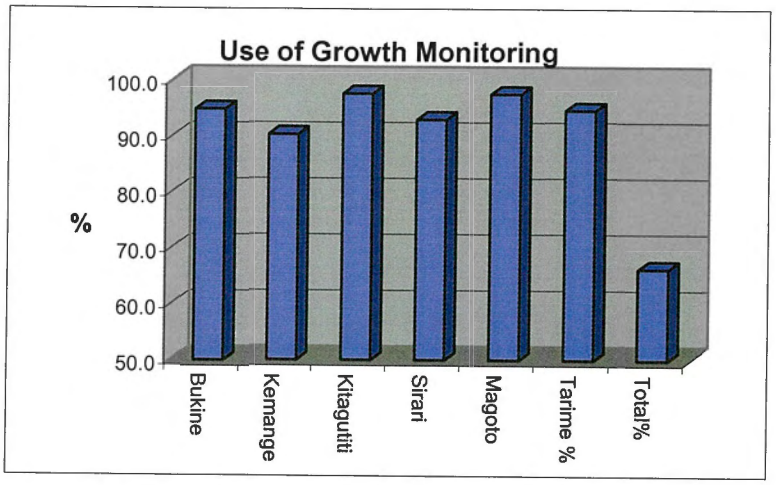
Incidence of Immunisation in Children %

Bukine	36	94.7
Kemange	37	90.2
Kitagutiti	39	97.5
Sirari	39	92.9
Magoto	38	97.4
Tarime%	189	94.5
Total%	558	96

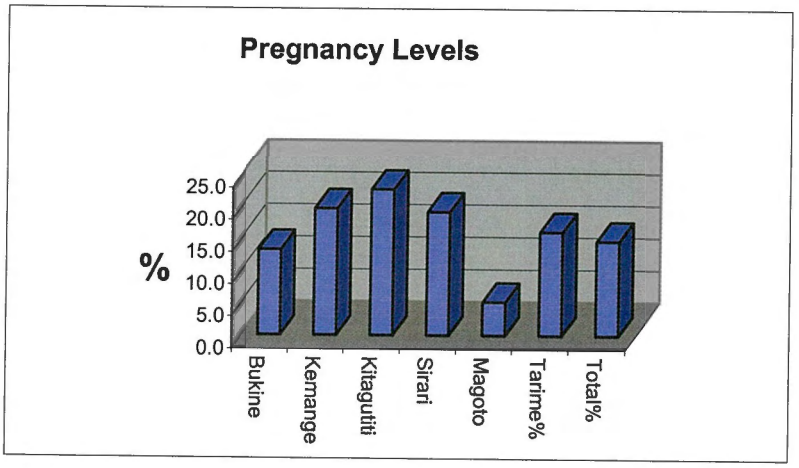


1. Health Survey Tarime Tanzania July 2000 Ctd

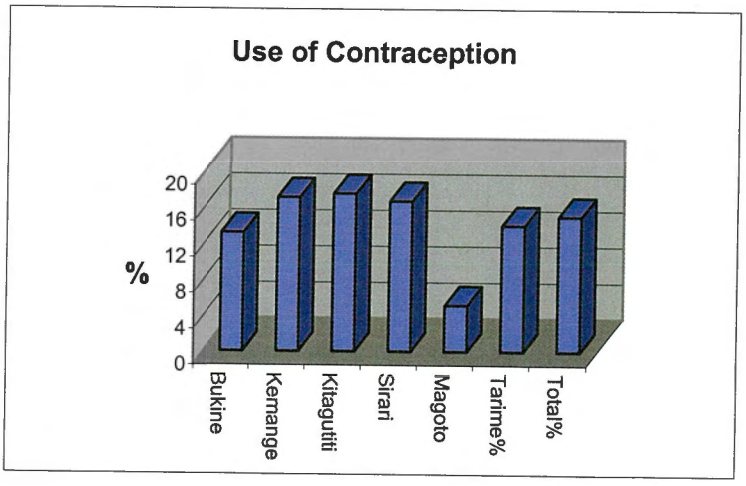
Incidence of Growth Monitoring of Children		%
Bukine	36	94.7
Kemange	37	90.2
Kitagutiti	39	97.5
Sirari	39	92.9
Magoto	38	97.4
Tarime %	189	94.5
Total%	385	66



Pregnancy Levels		%
Bukine	5	13.2
Kemange	8	19.5
Kitagutiti	9	22.5
Sirari	8	19.0
Magoto	2	5.1
Tarime%	32	16.0
Total%	85	15

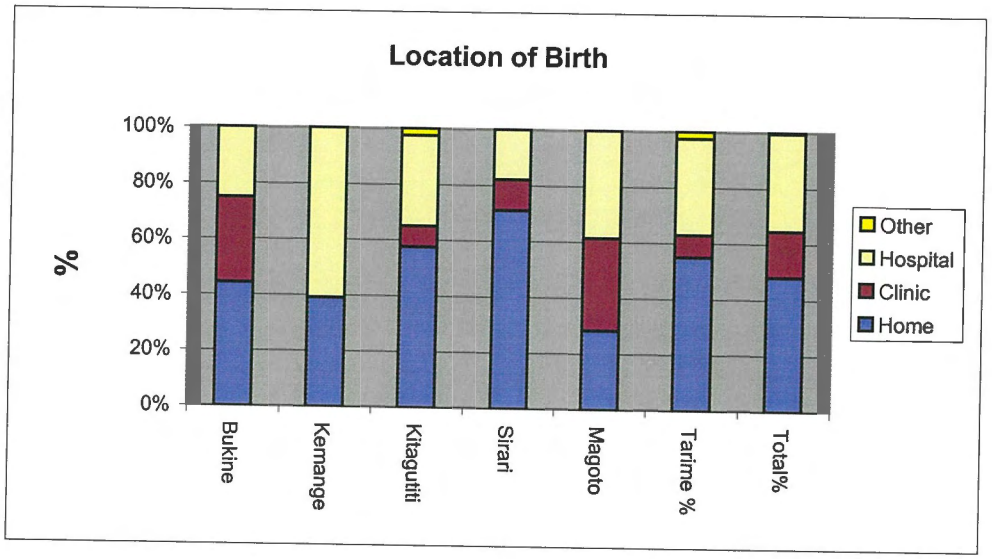


Use of Contraception		%
Bukine	5	13
Kemange	7	17
Kitagutiti	7	18
Sirari	7	17
Magoto	2	5
Tarime%	28	14
Total%	85	15

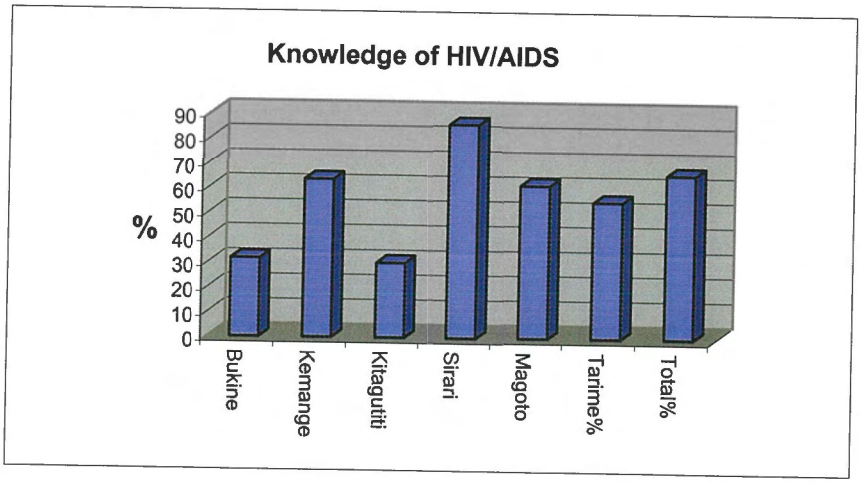


1. Health Survey Tarime Tanzania July 2000 Ctd

Location of Birth	Bukine	Kemange	Kitagutiti	Sirari	Magoto	All	Tarime %	Total%
Home	42	39	57.5	71	28.2	96	48	55
Clinic	29		7.5	11	33	33	17	7.9
Hospital	24	61	32.5	18	38.46	70	35	34.6
Other			2.5			1	1	2.5

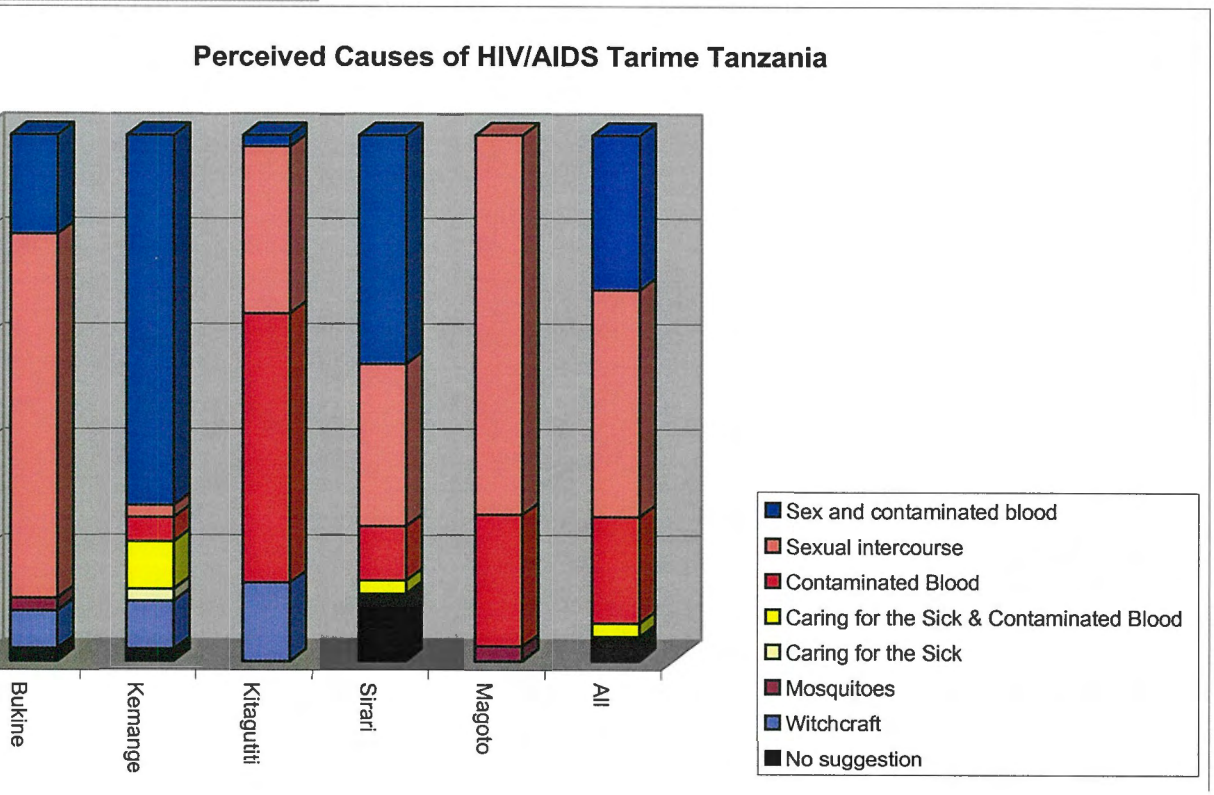


Knowledge of HIV/AIDS		%
Bukine	12	32
Kemange	26	63
Kitagutiti	12	30
Sirari	36	86
Magoto	24	62
Tarime%	110	55
Total%	385	66



Perceived Understanding of the Causes of HIV/AIDS in Tanzania

	Bukine	Kemange	Kitagutiti	Sirari	Magoto	All	%	
				3	4	7	3.50	
		1				1	0.50	
		1				1	0.50	
& Contaminated Blood		4		1		5	2.50	
d		2	24	4	9	39	19.50	
	29	1	15	12	26	83	41.50	
ted blood	8	31	1	17		57	28.50	s
	1	1		5		8	4.00	



1. Health Survey Tarime Tanzania July 2000 ctd

1.1 Magoto Village Report		
Education	%	Total
None	18	9.28
Class 3	21	11
Primary	60	58
Form 2	2	17
Incidence of Diarrhoea	41	49
Immunisation	97	92
Growth Monitoring	85	66
Pregnancy Levels	11	14
Use of Contraception	16	26
Place to Give Birth		
Home	30	55
Clinic	30	8
Hospital	30	33
Knowledge of HIV/AIDS	68	66
Causes of HIV/AIDS		
Witchcraft	10	4
Blood	23	32
Sex	60	31

1.2 Randa Village report		
Education	%	Total
None	7.8	9.28
Class 3	10.5	11
Primary	76.31	58
Form 2	5.26	17
Incidence of Diarrhoea	47	49
Immunisation	94	92
Growth Monitoring	86	66
Pregnancy Levels	10	14
Use of Contraception	15	26
Place to Give Birth		
Home	41	55
Clinic	30	8
Hospital	29	33
Knowledge of HIV/AIDS	68	66
Causes of HIV/AIDS		
Blood	76	32
Sex	21	31
No Suggestion	2.6	4

1.3 Kitagutiti report		
Education	%	Total
None	30	9.28
Class 3	12	11
Primary	52	58
Form 2	5	17
Incidence of Diarrhoea	33	49
Immunisation	98	92
Growth Monitoring	78	66
Pregnancy Levels	17	14
Use of Contraception	14	26
Place to Give Birth		
Home	60	55
Clinic	10	8
Hospital	30	33
Knowledge of HIV/AIDS	30	66
Causes of HIV/AIDS		
Caring for the Sick		
& Contaminated Blood	60	5
Blood	37.5	32
Sex	2.5	31

1.4 Sirari report		
Education	%	Total
None	30	9.28
Class 3	11	11
Primary	47	58
Form 2	9	17
Incidence of Diarrhoea	64.3	49
Immunisation	92.9	92
Growth Monitoring	92.9	66
Pregnancy Levels	19.0	14
Use of Contraception	17	26
Place to Give Birth		
Home	71	55
Clinic	12	8
Hospital	17	33
Knowledge of HIV/AIDS	86	66
Causes of HIV/AIDS		
Witchcraft	7.1	6.7
Blood	9.5	32
Sex	28	31
No Suggestion	12	2.4
Caring for the Sick	2.4	1.37
Sex and Blood	40	24.05

1. Health Survey Tarime Tanzania July 2000 Ctd

1.5 Kemange Report	%	Total
Education		
None	14	9.28
Class 3	4	11
Primary	68	58
Form 2	12	17
Incidence of Diarrhoea	34	49
Immunisation	90	92
Growth Monitoring	78	66
Pregnancy Levels	14	14
Use of Contraception	19	26
Place to Give Birth		
Home	40	55
Clinic		8
Hospital	60	33
Knowledge of HIV/AIDS	63	66
Causes of HIV/AIDS		
Mosquitoes	2.4	2.23
Caring for the Sick	2.4	1.29
Caring for the Sick & Blood	9.7	1.72
Contaminated Blood	4.8	32.47
Sexual Intercourse	4.8	31.62
Sex and Cont. Blood	75	24.05
No Suggestion	2.4	2.58

SURVEY DIARY

I received survey forms from Faye Hannah initially prepared by John Hoplins University and used in the original 1995 survey in Bungoma. I modified these for ease of use with multiple choice questions, to ease future tabulation of the results. There was some need to correct the Kiswahili translation of questions.

11th July 2000

Arrived in Nairobi from London, was met by Salvation Army driver and taken to SA compound. At 9.00pm returned to the Bus Station, Nairobi: a notorious place for thieves and was extremely grateful when the bus left at 10.00pm.

12th July

Arrived 7.00am in Tarime Tanzania without incident and went to the District Officer's home. At 10.00am and I met with the survey volunteers. Two came from each survey site and we discussed the survey procedure. They returned to their home areas to carry out the survey.

13th July

Wednesday travelled to Magoto and instructed two more volunteers. When we left two hours later left two hours later, we met one of the volunteers on the roadside conducting the survey.

I have undertaken to send a report to the survey sites to enable them in their development planning. The volunteers are eager to learn the results of the survey. This morning I met with a fellow researcher at the hotel. She is an anthropology PHD student and has been in Tarime for one month but has yet to get into the field. She has no network to link into. This is a fairly lawless area and without an entry to the community any kind of research will be extremely difficult to manage. I discussed this with the D.O. and he agreed to help her gain entry to the communities.

14th July

On Friday I was able to visit Bukine by local transport. This was something of an adventure, but it helped me to appreciate the way the local people travel. As a sequel to the Home League Health Education project, a VASS-funded Women's Project has been implemented there and the new well is a real benefit to the community. The commitment to tree planting and gardening seems a bit spasmodic. Already the women have 20,000/- collected from sales of water. This will be used for repairs to the pump and various women's projects.

When asked what they wanted to do in the future they replied that they want a maize mill as it is a long way to the nearest maize mill.

I talked to Peragia, the agricultural extension officer about this and she will help them in their planning. The good news was that the small livestock handling programme (goats) that was started as an aside to the Home League Health Education Programme is still running. The people in this area understand livestock but agriculture is unfamiliar. Two evangelists in the area said that their advice on another project, an AUSAID youth agriculture project, was for livestock rather than agriculture. The project manager insisted on agriculture, which failed. It behoves us outsiders to listen to local advice; this is the essence of participatory development.

15th July

On Saturday I collected the survey forms. All of the forms had been completed. The volunteers had enjoyed the experience and had learnt a lot about their own communities. I had some time with Peragia and talked to her about relations with donors and the need for prompt reporting. I advised her, together with the local communities to make a district development plan.

It has been good to return to Tanzania, and it is most gratifying to see the advances that are being made.

16th July
Sunday involved the long trip from Tarine to Bungoma. This involved a taxi to the bus stop. A bus to the Tanzanian border. A taxi to Migori in Kenya. A bus to Kisumu a bus to Bungoma and a bicycle to the hotel! En route I was wedged into the smallest places. Eight people in a small saloon car., twenty-two in a mini-bus provided close contact with the locals.

Two exciting moments occurred when the police caught a young man on the bus carrying Marijuana - he escaped by running off into the sugar cane! The whole bus cheered his daring.

The second was on my final mini-bus journey. The rear door of the vehicle was roped closed so as to put the luggage behind the back seat. As we went over a bump the door opened and all the bags went skidding over the ground. For some agonising seconds I watched my suitcase skidding along. It remained intact and the only damage was a punctured tube of sun protector.

I arrived in Bungoma tired, dirty and very hungry and was taken to the Divisional Commander's house for a huge meal.
17th July
Monday we visited three survey sites: Webuye, Mahanga, Lukosi. At each site we had a community meeting. The dominant theme was the underlying poverty of the people. Bungoma in Western Kenya is a very fertile place, but agricultural prices are too low for a family to pay for all their needs and have sufficient food. There also seems to be a dependency mentality. They are looking for a sponsor and the heritage of authoritarian, paternalistic leadership in Kenya leads naturally to dependency, especially when faced by a potentially wealthy source of funding.

Despite my incipient cynicism there is a great deal of self-reliant development occurring. A dominant request is for hand pumped water wells. This is in an area of abundant water. The demands in the arid Eastern part next week will be more insistent.
All of the surveyors received the survey forms and it is hoped they will return them on Friday.
18th July
On Tuesday we visited a Salvation Army sponsored school called Makutano. It is about 1 km from the divisional headquarters but the DC had never visited nor had anyone from THQ. The process whereby a school becomes "sponsored" is a little problematic.

The sponsorship is definitely a grass-roots initiative. A local retired chief who is a Salvationist decided to start a Salvation Army school. Apart from himself a local officer from Bungoma Corps sits on the committee. Hence the link to organisation is rather tenuous.
In the afternoon we visited Kimatuni, which is the site of the Joy Valley/Kimatuni OD project. The DC, who is not on the steering committee, has distanced himself from the project. However, Captain Karemi, the Kimatuni Corps Officer, seems to be very focused and, if given sufficient support, will see the project through.

One real concern voiced was over the need to recruit and pay for a nurse for the clinic. It was noted in the 1999 report that no recruitment expenses will be covered. It is improbable that the government would second and pay a nurse for the centre.

The last place to be visited was Bungoma Corps. Here is a strong group of *Chama Afya* (Health Club) members. They continue to engage in visitation and have initiated a number of self-help projects. They expressed the wish to establish a women's centre in the town and start a tailoring school there. Other centres had all insisted on clinics, which are inherently not self-sustaining.

I would encourage Bungoma Corps to make some definite plans, as this seems a useful grass - roots initiative.

Saturday 22nd

I had to leave Bungoma at around 6:00 am to catch the first bus to Nairobi. It is about half a mile from the hotel to the bus stop and my suitcase is very heavy with survey materials. Additionally, I felt rather exposed as a European on my own. Fortunately, as I was about to leave the hotel, a car pulled up and the driver offered me a lift to Eldoret – a good hour's journey on my way to Nairobi. I caught a bus in Eldoret and arrived safely in Nairobi. The Boulevard Hotel was a welcome break and gave me a chance to ring home. Being out of touch for two weeks is not easy.

23rd July

Transport to Machakos was smooth. This time I travelled in an ancient Peugeot estate. These are a distinctive long-distance taxi. I was given the seat of honour – in the front with no seat belt! The Garden Hotel is very pleasant and clean. The resident band was a less welcome addition.

24th July

I met with the survey volunteers; they will return the forms on Thursday. There was ample opportunity to talk with people regarding their development needs. The obvious need was water. The pattern of assisting officers to have a residential water tank is not good development as the community receives minimal value. Water tanks are also of marginal value if the rainfall is infrequent. A plan to prioritise the driest places for assistance with this would be a worthy project. The provision of water to all corps in arid conditions would take approximately 10 years with considerable effort. But as an essential community needs it cannot be overlooked.

25th July

Visited Kayvani and Itetani. The countryside is scorched earth. There have been no significant rains for two years. Unlike other areas of Africa, here all the hills have well-made terracing and little signs of erosion are seen. Kayvani is an active corps. They are building a large corps officer's house. They have a large hall, a big water tank that had been built with funding from USA Western. The corps has started a school and the *Afya ya Jamii* Primary Health Education group have built a three-roomed stone clinic. It is not yet finished but the government supplies a mobile clinic once a month. They have asked for furnishings for the clinic.
Itetani is not as well organised. The *Afya ya Jamii* group comprises the Home League. They do continue a monthly weighing of children. One of their number is a traditional birth attendant of some interest is a village based health co-operative. This is a mixture of some 40 women from the village they raised 200,000 shillings to purchase a building in the village centre. This could be used as a clinic.

Both places expressed the need that water is their top priority. The children at the Itetani School are receiving government food aid which would indicate an objective level of food scarcity in the area.

26th July

Visited Masii and Ngoleni.

Masii Corps has a beautifully built nursery school. It is possible that it was part of a different village polytechnic. They are building a large new hall. The *Afya ya Jamii* still continues but its work is fairly weak in its overall impact. Some 20 women each month come to have their babies weighed. Their number one development priority is water.

There is a large water tank foundation which was started some years ago. The plan is to build their tank and link it to a government pipe.

The women's main source of livelihood comes from dairy cattle. There are some beautiful cows and well organised feeding systems there.

Ngoleni

A large enthusiastic crowd was at this new corps. The corps have built a lovely stone house. I was asked to officially open this. In addition they have commenced a large hall. The foundations are extensive owing to the sloping land and they have already spent K Shgs750,000 (USD10,000) on the hall. They want to build an *Afya ya Jamii* clinic. This programme started as a result of the lieutenants being taught *Afya ya Jamii* at the Training College. This ensures future officers will be taught these skills. The lieutenant is both the divisional youth officer and the HIV/AIDS coordinator. The two major problems the community faces are water shortage and HIV/AIDS. Their suggested plan to solve the water shortage involves constructing a series of small dams on a local river. The whole group said they would provide labour and materials for such a project. This could serve as a pilot in the water provision project. Leadership seems to be strong here.

27th July

I collected in all the surveys. The young volunteers were so enthusiastic in this work. They are a group of secondary school leavers who have few prospects, but are intelligent. One hopes that they will find meaningful employment. In the late afternoon I visited Gideon Muthuka's home. Both Gideon and his wife are trained foresters. They were involved in the implementation of an Ausaid-funded tree project.

Trip Recommendations

Tanzania	-	Tarime prepare additional well projects for Bubombe and two other sites in Bukine Section submission to UK 2001. This could be combined with sites in the Serengeti.
Kenya	-	Bungoma. Bungoma Corps to design a Tailoring School project as part of the Chamafya activities
Eastern Kenya		Consider long-term plan of providing wells for those corps in the driest Areas.

REPORT ON BASELINE SURVEY

MATCHING GRANT IV/GHANA
Child Survival VIII Project

August 14, 1995
Faye Sheehy-Hannah
Program Consultant
SAWSO/Kenya

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Special thanks go to the Home League Members and Community Volunteers who have waited so long and worked so hard to make this project a reality in their communities.

BASELINE SURVEY

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EXECUTIVE SUMMARY

INTRODUCTION

A Knowledge,Practice and Coverage survey (KCP) was carried out encompassing eight Salvation Army Divisions and Districts in Eastern, Western and Central Kenya catchment areas between July 10-21,1995. This work was achieved in cooperation between the private voluntary organization SAWSO, USAID Mission, CIDA Canada,the Kenya Ministry of Health and the PVO Child Survival Support Program (PVO CSSP), Institute for International Programs of The Johns Hopkins University School of Hygiene and Public Health.

The objectives of the survey were to obtain information on the knowledge and practices of the mothers of children under two years of age in the Start-up year of a proposed 7 year grant concerning maternal child health activities, and to identify health care factors most commonly involved at the household level for childhood illness. The objectives of the survey were accomplished within two weeks. Under the direction of the SAWSO program consultant, The Salvation Army field staff and volunteers tabulated the results and held preliminary discussions of the findings. Follow-up discussions with implementing field staff will be held in order to evaluate project plans (as outlined in the long term proposal) and to provide background information for the refinement of project implementation plans.

HOME LEAGUE HEALTH EDUCATION PROJECT

The Home League Health Education project is being implemented by The Salvation Army in Kenya at 74 Sites (Corps/Church Centers) in the following Salvation Army Divisions and Districts: Bungoma, Embu, Kakamega, Mbale, Thika, Kisumu, Nairobi and Nakuru. The start up year, including part of the KPC Survey and an evaluation has been funded by the Kenya USAID Mission. CIDA Canada contributed substantially to the KPC survey costs and have made a 3 year commitment to implementation support in their areas. AUSAID has also made a 3 year commitment to their geographic sites: i.e. Bungoma, Kisumu and Kakamega, AUSAID; Mbale, Nakuru and Embu, CIDA Canada. Technical support has been provided by the SAWSO program consultant and by the CIDA and AUSAID representatives. The KPC Survey was implemented in all of the current project areas. The project in Kenya will serve a potential beneficiary population of 75000.

QUESTIONNAIRE

The survey questionnaire was initially designed at the PVO/CSSP office in Baltimore, MD in consultation with SAWSO and then refined in Nairobi, Kenya. The Salvation Army and MOH staff and volunteers participated in a four day training program in how to conduct a WHO 30 cluster sample survey methodology so that the 27 member group could competently conduct this type of survey as a routine activity to measure project progress. Nine three-person teams of interviewers and a supervisor, conducted the 30 cluster survey. The SAWSO consultant and the Project Coordinator provided additional supervision during the survey. Each cluster included 10 cohort household survey interviews of mothers with children less than 2 years of age. A total of 300 households were interviewed.

MAJOR FINDINGS

Major findings include the following health indicators:

Nutrition:

Initiation of Breastfeeding: 87.2% of infants were breastfed within the first eight hours of birth.

Exclusive Breastfeeding: Only 36.4 % of the (55) infants under four months were being exclusively breastfed. Of those in this age group who were **not** being exclusively breastfed (35 infants), 77 % were being given water in addition to breast milk, 60% were being given Super Uji (a weaning food), and 45.7% were being given fruit; **Introduction of Foods**

95.8 % of the (47) infants between five and nine months, were being given solid and/or semi-solid foods;

Persistence of Breastfeeding:

25% of the (32) children between the ages of 20 and 24 months were still being breastfed (and being given solid/semi-solid foods).

Diarrhoea (Children less than 24 months)

Continued Breastfeeding:

74% of (116) infants/children with diarrhoea in the previous 2 weeks were given the same or more of breastmilk.

Continued Fluids:

71.6% of infants/children with diarrhoea in the previous 2 weeks were given the same amount or more of fluids other than breastmilk;

Continued Foods:

51.7% of infants/children with diarrhoea in the previous 2 weeks were given the same or more food;

ORT Usage:

68.9% of infants/children with diarrhoea in the previous 2 weeks were treated with ORT. It is significant, however, that the treatments did not include home available fluids except for the ingredients for SSS. For example:0% named teas, coconut milk, rice water and the like.

Pneumonia Control: Medical Treatment

79% of mothers sought medical treatment for the (100)infants/children with cough and rapid, difficult breathing in the previous 2 weeks;

Immunisation(136 Children between the ages of 12 to 23 months):

EPI Access

58.8 % of the children had received DPT 1;

EPI Coverage

48.5% of the children had received OPV 3;

49.8% of the children had received all of their immunisations;

MAJOR FINDINGS (Continued)

EPI Measles Coverage

49.3% of the children had received measles vaccine;

EPI Drop Out Rate

There was a 21.2 % change between DPT 1 and DPT 3 for children in this age group;

Maternal Care

Maternal Card

Only 36% of the 300 mothers interviewed had an Antenatal Card;

Tetanus Toxoid Coverage (by card inspection)

81.6% of the (98) mothers who had Antenatal cards had received two doses of tetanus toxoid vaccine;

Antenatal Visits

81.6% of the mother who had cards had at least one visit prior to the birth of their child ;

Modern Contraceptive Usage

92% of the 268 mothers who were not pregnant at the time of the survey, stated that they did not want another child in the next two years;

Of these (247)mothers only 31.9% (79 mothers) were currently practicing family planning;

Mothers who said they were practicing family planning were asked what contraceptives they used. Multiple answers were possible.

Of 136 replies:

92 (67.6%) named modern contraceptive methods, primarily pills and injections; 38

(27.9%) listed natural methods, i.e. breastfeeding and rhythm method;

Condoms were mentioned only twice (1.4%).

SURVEY DESCRIPTION and METHODOLOGY

INTRODUCTION

In 1991, A.I.D. required PVOs with new FHA/PVC Child Survival grants to conduct a 30-cluster baseline survey using a standardized questionnaire developed by JHU. Although the Home League Health Education Grant was not a CSI grant, the CSI 30-cluster survey was chosen as the baseline instrument,in part because the SAWSO program consultant who provided the Survey Training in Kenya was familiar with the KPC survey and felt that the field and volunteer staff involved in the Kenya project were capable of accurately implementing a survey of this kind.

SAWSO TRAINING OF TRAINERS

Johns Hopkins University Survey Trainers had provided a training of trainers seminar for SAWSO program staff and selected field staff in December of 1994. The seminar's purposes were: (1) to explain the organization of the standardized questionnaire, as well as the purpose of each question, (2) to train SAWSO staff the conduct of a standard W.H.O. 30-cluster survey, and (3) to train SAWSO staff to manually tabulate, analyze, and develop a report from the completed survey questionnaires. JHU paid the costs of the survey trainer's salary and the trainer's office costs. Subsequent to the training, SAWSO staff journeyed to Bangladesh, Ghana, Zambia and Indonesia, where they trained clinic staff, survey supervisors and interviewers in how to conduct a 30 cluster WHO survey as part of their Matching Grant start up activities.

The SAWSO program consultant for Kenya implemented the survey in Ghana after the completion of the SAWSO TOT. She trained the Core Survey teams, monitored the progress of the survey and facilitated the tabulation and analysis.

B. Objectives of the Survey

The method of choice for these kind of surveys is a 30 cluster sampling technique. The study population consists of mothers of children under the age of 24 months living in the PVO project area. By restricting the sample to mothers of children less than 24 months of age, repeat surveys can ascertain the project's ability to reach children born during the life of the project, and establish whether the project was successful in communicating to the mothers, through village based volunteers, certain action messages about key MCH interventions.

A population based sample survey is one method of obtaining rates; i.e. data relative to denominators, which are an important part of project's health information system. The data collected from a sample survey can be used for project design, management information and evaluation purposes.

The objectives of the survey are to provide SAWSO/SA Kenya with information about the following issues:

- Knowledge of mothers of children under two years of age about: major threats to infant, maternal and child health; ways to prevent immunizable diseases; proper treatment of diarrheal diseases (ORT); the

value of growth monitoring; appropriate nutrition/weaning practices; and information about child spacing

- Actual practices of mothers with regard to the intervention areas mentioned above
- Target groups for health education action messages
- For children aged 12-23 months: the coverage rates of BCG, DPT3, OPV3, measles vaccines and drop out rates between series antigens

The survey establishes estimates of MCH/child survival knowledge and assesses the extent of practices (K & P) of the project's primary health care interventions. The data collected will help SAWSO/SA Kenya to do two things: 1) evaluate and refined project objectives; and 2) plan, manage, and assess project activities targeted towards changing behaviors at the household level.

C. Schedule of Activities in Kenya

June 1995	Review of Questionnaire and Translation of Questionnaire into Kiswahili
July 10-13	Training of supervisors and interviewers
July 14-17	Conduct of survey interviews
July 19-20	Manual tabulation of questionnaires
	Preliminary Group discussion of results and implications
July 21-August 7	Review of tabulation and findings by SAWSO program consultant
August 13-16	KPC Report written by SAWSO Consultant
August 20-September 15	Feedback to KMOH, USAID, District Health Councils and local communities
September 18-21	Review of Findings with Selected Project Field Staff by SAWSO Program Consultant and Project Coordinator during technical assistance visits.

II. METHODOLOGY

A. The Questionnaire

The questionnaire, which contains 52 questions, was designed to collect information from mothers of children under 24 months of age. The questions were based on a standardized survey format which A.I.D. requires of all PVO CSVIII projects. The standardized survey instrument was developed by the staff at PVO CSSP, with the assistance of US and international experts for the various intervention areas. SAWSO, in cooperation with The Salvation Army health services team in Ghana (KPC Core Team) further customized the standardized survey questionnaire making the finalized questionnaire appropriate to the actual MGIV project interventions and the project area.

The first two questions ask about the age of the respondent (mothers) and her youngest child under 24 months of age; questions 3 - 6 collect data regarding mother's literacy, employment, and who cares for the child when the mother is away from home; questions 7 - 13 deal with breast-feeding and other feeding practices; questions 14 - 15 ask questions concerning the child's attendance at growth monitoring sessions; questions 16 - 25 refer to mother's response to diarrheal disease and management of the child with diarrhea; questions 26-30 concern respiratory infection;questions 31-36 concern the immunization status of the child; and finally, questions 37-48 are about pre-natal care, family planning, and maternal nutrition.
Questions 49-52 are about Malaria.
The questionnaire was originally written in English and carried to the Salvation Army project office in Kenya.After the questionnaire was refined and customized by the Project Staff, it was translated into Kiswahili. Although several tribal languages are spoken in the project areas, it was decided to translate the questionnaire into Kiswahili only. The reason for this was that Salvation Army indigenous officers are very much accustomed to having Kiswahili translated by community church members into local languages (as they get transferred from one locality to another) until they learn the tribal language. They were comfortable with this system and so were the health staff volunteers who assisted with the survey. Although it seemed an unusual way to do things, in fact it worked quite well. Survey interviewers felt that consistency of questionnaire content was maintained and that with few exceptions no irregularities in translation occurred.

B. Determination of Sample Size

Sample sizes were calculated with the following formula:

$$n = z^2(pq)/d^2$$

where **n** = sample size; **z** = statistical certainty chosen; **p** = estimated prevalence/coverage rate/level to be investigated; **q** = 1 - **p**; and **d** = precision desired.
The value of **p** was defined by the coverage rate that requires the largest sample size (**p** = .5). The value **d** was depends on the precision, or margin of error, desired (in this case **d** = .1). The statistical certainty was chosen to be 95% (**z** = 1.96).

Given the above values, the following sample size (**n**) needed was determined to be:

n = (1.96 x 1.96)(.5 x .5)/(.1 x .1)
n = (3.84)(.25)/.01
n = 96

It takes much time to randomly select an identified individual from the survey population, and then perform this selection 96 times to identify a sample of **n = 96**. Time can be saved by doing a 30 cluster sample survey in which several individuals within each cluster selected to reach the required sample size. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of **p, d, and z** above (Henderson, et. al., 1982). In general, when using a 30 cluster sample survey, the sample size used should be approximately double the value **n**, when: **n = (z x z)(pq)/(d x d)**. In this case, a sample size of 300 (10 per cluster) was selected so as to ensure that sub-samples would be large enough to obtain useful management type information.

The estimates of confidence limits for the survey results were calculated using the following formula:

95% confidence limit = p $\pm$ z(square root of {pq/n})

where: **p** = proportion in population found from survey; **z** = statistical certainty chosen (if 95% certainty chosen, then **z** = 1.96); **q** = 1 - **p**; and **n** = sample size

EXAMPLE: If the proportion of children in the survey who were completely and correctly immunized is 37% and **n** = 297:

95% confidence limit = .37 $\pm$ 1.96(square root of {.37 x .63/297})
(z = 1.96)

1.96 = .37 $\pm$ .03 (or, 34% to 40%)

In other words, we are 95% sure that the actual proportion of children in the survey area who are completely and correctly immunized is between 34% and 40%.

C. Selection of the Sample

The sample consisted of 300 women with children 0-23 months of age in eight catchment areas in the Eastern, Western and Central Regions of Kenya.
Ten women were selected in each of 30 randomly selected *kindred* (cluster sites) following the process described in The EPI Coverage Survey training manual (WHO, Geneva, Oct. 1988).

Once the survey teams reached the designated *cluster site*, the initial household

surveyed within the cluster, as well as the direction from the initial household, was randomly selected.

D. Training of supervisors and interviewers

The SALVATION Army program staff had pre-selected supervisors and interviewers for training from among the Divisional and District leadership and from nearby MOH health staff volunteers. At the start of the training, participants were allowed to determine for themselves about the makeup of each team. They chose to form teams according to the area they came from and they stuck to that system even though the actual survey might have been easier to implement had they chosen to break up their team and get more people involved in the survey. The training of supervisors and interviewers took place in four days. During the training, the SAWSO program consultant delegated responsibility for various activities that the SA Core team members could conduct themselves.
The first training day was dedicated to survey administration and methodology.
The SAWSO Survey Trainer presented the following topics:(a) purpose and objectives of the survey, (b) selection of the sample size, (c) selection of the starting household and survey direction, (d) community protocols and taboos, and (e) review of the customized questionnaire.
The second day of training concentrated on interviewing techniques, further familiarization with the questionnaire through role play, and the roles of the supervisor and interviewers. Interview practice sessions were held using a triad system, i.e. one supervisor, one interviewer and one person pretending to be a mother. Interview roles were rotated so that each person had a chance to play each role at least once. supervised by person each team selected. The SAWSO program consultant facilitated the interview practice sessions, but each team chose its' own supervisor to comment on their performance.
The third and fourth days of training were spent drawing maps and practicing household selection. Training in tabulation was deferred until after the survey was completed and the teams returned to Nairobi.

A local field test had been planned as part of the survey training but it was eliminated in favor of taking an extra day for travel to distant survey sites.

E. Conduct of the interviews
The survey was conducted over four consecutive days; July 14-17. Thirty survey areas (kindreds) which had been previously selected using random selection methods as specified.

The supervisors of each team were responsible for the selection of the starting household and survey direction. The supervisors observed at least two complete interviews by each surveyor each day. Each questionnaire was checked for completeness before the survey team left the survey area, so that, in the case of missing or contradictory information, the mother could be visited again the same day.

In many countries it is very difficult to determine exact ages for many individuals. This is particularly true in those countries where birth registration is not common and where the exact birth date is rarely required for official documents. To reduce the importance of age misreporting we have limited the tabulations to broad age groups. In most cases, the tabulations are for all children under age 2 (that is, 0-23 months). In cases where a child is "about one year old" or "about 2 years old" the interviewers have been trained to probe to try to determine whether the child is past its first (or second) birthday.

In order to ensure consent and confidentiality, consent was obtained from each mother. Supervisors assured the mother that all information would be held in confidence, and that the information would be used to help health workers plan health activities. The potential respondent was advised that she was not obligated to participate in the survey, and that no services would be withheld from her if she chose not to participate.
A "tick mark" was placed beside the mothers name after her consent was obtained and before commencing with the survey. In order to ensure confidentiality SAWSO consultant and the SA Core team agreed that all identifiers on the questionnaires be erased/destroyed upon completion of the survey.

F. Method for Data Analysis

July 19-20 were dedicated to manual data tabulation and preliminary analysis. The SAWSO consultant supervised the hand tabulation, with the assistance of the team supervisors. Presentation of key survey findings were made by 3 teams. Issues, root causes and suggestions for project activities related to the findings were discussed.
Eight teams, made up of core team interviewers and supervisors, were available full-time for hand tabulation. Manual tabulation required the whole day dedicated to tabulation. The hand tabulators sat around tables in the corps hall on the SA training center compound. The questionnaires were organized by cluster site, and each cluster of questionnaires was circulated between each of the tabulators. The tabulators each recorded the responses to one question at a time going through each of the 300 survey questionnaires until all the responses to that particular question had been tabulated. The tabulators were trained to analyze the results of the questions they had each tabulated and then write out a short analysis on the bottom of the hand tabulation sheets.

For the first draft of the survey report, the SAWSO consultant obtained frequency distributions for each of the questions and a few key cross tabulations.
Once the frequency tables and some cross tables were finalized, the results of the survey were compared to the Kenya MOH and UNICEF/WHO health messages, Home

League Health Education Project objectives, and the results of the KPC survey in order to develop the first draft of the survey report.

III. RESULTS

In addition to the data collected about the primary health indicators, the following additional information was gathered from the questionnaires. 300 questionnaires were manually tabulated. Nine extra questionnaires were initially included in the counts for the first six questions, but they were removed from the survey and their answers deleted before the final tabulation was done. A few of the questions had slightly different values for N because not all mothers answered the questions. The range for N was between 297 and 300.

Identification Module

Q.1. The median age reported by mothers surveyed was 24 years, 11 months. 0.6% of mothers surveyed (2 out of 300) were under 18 years. 8% or 24 mothers were over 35 years.

Q.2. 18.33% (55) infants in the survey were under four months of age. 49.65% (149 out of 300) children in the survey were under the age on one year,i.e. children 0-11 months. 45.33% (136 out of 300) of the children in the survey were 12-23 months of age. The median age of children in the survey was 10.25 months.

AGECHILD	Freq	Percent	Cum.
0	08	2.7%	2.7%
1	18	6%	8.7%
2	14	4.6%	13.3%
3	15	5%	18.3%
4	15	5%	23.3%
5	15	5%	28.3%
6	11	3,7%	32%
7	08	2.6%	34.6%
8	13	4.3%	38.9%
9	15	5%	43.9%
10	16	5.3%	49.2%
11	16	5.3%	54.5%
12	23	7.7%	62.2%
13	15	5.0%	67.2%
14	13	4.3%	71.5%
15	13	4.3%	75.8%
16	09	3%	78.8%
17	10	3.3%	82.1%
18	12	4%	86.1%

19	09	3%	89.1%
20	07	2.3%	91.4%
21	07	2.3%	93.7%
22	11	3.8%	97.5%
23	07	2.3%	100.0%
Total	298	100.0%	

Mother's Education and Occupation Module

Education:

Q3. 5.33% of mothers surveyed reported that they had no formal education;
13.3% reported that they had attended primary school, but could not read;
55% reported that they had attended primary school and could read;
26.3% reported that they had either a secondary or higher level of education. In sum, **81.3% of mothers in the survey stated that they could read.**

Occupation:

Q4. **232 mothers (78%) reported that they were not generally away from home during the day.**
The remaining 68(22%) worked away from home.

Q5. 200 mothers answered the question about what kind of work they did to earn an income. Multiple answers were possible.

43% (86 mothers) stated that they earn income from harvesting;
15% (30 mothers) reported that they earn income from selling agricultural products;

13.5%(27 mothers) stated that they earn income from selling handicrafts;

7.5% (15 mothers) stated that they earned income as street vendors;

6% stated that they were salaried workers;

7.5% (15 mothers) reported earning income from categories not listed in the questionnaire;

7.5% (15 mothers) stated that they earned income as servants.

100 mothers (33%) stated that they had no income generating work;

Child Care:

Q6. 290 mothers answered this question.

42,4% (123 mothers) took the child with them when they left home.
18.3% of mothers (53) reported that older children took care of the child when the mother was away from home.
22.7% (66 mothers) left their children with relatives.
7.5% (22 mothers) left their children with a maid servant.

Breastfeeding/Nutrition Module

Breastfeeding

Q7. **88.3% (265 mothers) reported that they were breastfeeding their child at the time of the survey.**

Q8. Of the 35 mothers who were not breastfeeding their child, 92% reported that they had breastfed the child in the past.

Initiation of Breastfeeding

See Health Indicators in Executive summary

Exclusive Breastfeeding

See Indicators

Introduction of foods

Q12.When asked when a mother should start giving a child foods in addition to breastmilk:
48.3% (145 out of 300) mothers responded with an **age between four and six months**;
41.3% (124 mothers) indicated an age earlier than four months;
3.3% (10 mothers) indicated an age six months or later.

In sum, 44.6% did not know that mothers should give their children food in addition to breastmilk **between four and six months** of age.

Introduction of weaning foods

Q13. When asked what the additional foods to breastmilk should be:
13.1% responded with a food **rich in iron;**
34.2% responded with a food **rich in vitamin A.**
11.1 stated that a mother should add **oil** to the child's food.
30,2% responded with **high energy foods** i.e super uji, potatoes.

Feeding Practices

Q10. In the 5-8 month old age group (47 children):
21.2% were being given a food enriched with **vitamin A,**
61.7% were being given a food enriched with **protein**, either meat, fish or beans.
91.0% were given **high energy foods** i.e. Super Uji.

How to keep breastfeeding(Care of the breasts)

Q 11. Mothers did not seem to understand this question. It needs to be rewritten for the next survey. Of the 353 answers given to this question (Multiple answers were possible) however:

34% said that **frequent sucking** was action a mother could do to continue to breastfeed;

13.3% said that **breastfeeding exclusively for the first 4 months was helpful.** asked

4.8% said to **avoid bottle feeding** was a help.

Growth Monitoring Module

Q14. **78.3%** of mothers (235) in the survey said that they **had a growth monitoring card** for their child;

64% of those with weighing cards (162) **had been weighed in the four months** prior to the survey;

Diarrheal Disease Module

Q16. See Indicators in Executive Summary.

Breastfeeding during diarrhoea

Q17. See Indicators as above.

Acute Respiratory Infection

Q26. 150 children in the survey had a cough or cold in the previous 2 weeks.

ARI Symptoms

Q27.100 of those children,(66.7%)experienced **fast and difficult breathing.**

Q30. 287 mothers answered the questions about what signs and symptoms would cause them to seek help for a child with ARI:

36.5% said difficult breathing

25.7% said fever

28.5% said cough

Implied in these answers may be overuse of health centers, as cough alone does not require professional help.

ARI Treatment

Q28. 79% of the mothers whose children had rapid and difficult breathing sought treatment.

Q29. Of the 79 mothers who sought treatment for their child with ARI:

40.66% went to a hospital,

22% went to a clinic

16% went to see a Traditional Birth Attendant. **treatment from for their child:**

83.3% Sought treatment from a hospital, a health center or an outreach clinic;.

26.6% sought treatment from a drug store.

Immunization:.(Children 12-23 months old,

See Indicators in Executive Summary.

Measles

Q 32. Only 11.7% of mothers surveyed knew the age at which measles vaccine

should be given. It can be assumed therefore, that mothers may not know the immunisation schedule for other antigens.

Tetanus:
Q 33. 46.6% of mothers surveyed thought that TT vaccine protected both the mother and the newborn
16/1% thought that it protected infants only
4% thought it protected the mother only
33.2% didn't know the answer to that question.

Q34. **52.9% knew** that **a pregnant woman needs two or more tetanus toxoid injections** to protect the newborn infant from tetanus.

Q35. 184 **mothers (61.3%) had an immunization card** for their child.

Q36. The immunization status for children 12-23 months of age is based on the immunization card actually seen by the interviewers. There were 136 children in the survey 12-23 months of age. See Indicators in Executive Summary for Immunisation coverage percentages.

Maternal Care Module

See Indicators in Executive Summary.

Q39. Of the 98 maternal health cards looked at by interviewers in the survey, all had space to record ante-natal care visits;

80 Mothers(81.6%) had made **two or more ante-natal visits;**
21 mothers(22.8%) had made **one ante-natal visit.**

Family Planning
Q40. 32 mothers (26%) stated that they were pregnant.

Q41. **Of the 268 mothers who** stated that they **were not pregnant,**
247 stated that they did not want to have a child in the next two years.

Contraceptive Use
Q42.**of the 247 mothers who did not want to have a child in the next two years:**
Only 79 (31.9%) were currently using any methods to keep from getting pregnant;

Q43.All mothers who said they did not want to have another child in the next two years were asked what kinds of contraceptives they preferred/used at some time.
37.1% of the answers indicated the **use of modern methods,** primarily tablets and injections;
15.3% of the answers given indicated a preference for "**natural family planning**", i.e

breastfeeding and the rhythm method.

Maternal Care

Q44.When asked how soon after a woman knows she is pregnant should she see a health professional:

22% of (300) mothers asked this question said **indicated a time period within the first trimester** of pregnancy;

62%) mothers indicated a time period within the second trimester;

9% **indicated a time period within the third trimester.**

Q45.When asked **what foods are good for a woman to eat to prevent pregnancy anemia:**

56% **indicated a protein food rich in iron;**

47%) **indicated a green leafy vegetable rich in iron.**

Q46.**Prenatal Care**

300 Mothers were asked whether they visited any health center for prenatal care while they were pregnant:

231 mothers(77%) said yes;

69 mothers(**23%**) said no.

Food during pregnancy:

Q47.58% of mothers surveyed said that they **ate the same or more food than usual** during pregnancy;

39% stated that they **ate less than usual during pregnancy.**

Person present at birth

Q48. When asked who tied and cut the cord at the child's delivery:

147 mothers(**49%**)**indicated a health professional** (physician, nurse or midwife);

74 mothers (25%) **indicated a traditional birth attendant;**

37 mothers (12%) **indicated a family member;**

27 mothers (9%) tied the cord themselves.

MALARIA Questions

Q.49-52:

87 % of 300 respondents knew what malaria was;

65% of their children had malaria in the previous two weeks;

Treatments for the children who had malaria included (Multiple Answers possible):

Hospital Medicine, 69.2%

Dispensing Medicine, 78%

Local treatment and "Other" treatments, 7.2%

BCG Status

AGEGROUP	NO BCG	YES BCG	TOTAL
0-23 MONTHS	47 (15.7%)	252(84.2%)	299 CHILDREN

OPV Status

OPV 1,2,&3: 113 children 0-23 months of age

OPV 1		OPV 1,2		OPV 1,2,3		Drop Out	
Freq. #	Percent %	Freq. #	Percent %	Freq. #	Percent %	D.O. Frequency (# OPV1 - # OPV3)	D.O. Rate $\frac{\#OPV1 - \#OPV3}{\#OPV1}$
219	73.2%	174	58.2%	133	44.5%	86	39.3%

DPT Status

DPT 1,2,&3: 113 children 12-23 months of age

DPT 1		DPT 1,2		DPT 1,2,3		Drop Out	
Freq. #	Percent %	Freq. #	Percent %	Freq. #	Percent %	D.O. Frequency (# DPT1 - # DPT3)	D.O. Rate $\frac{\#DPT1 - \#DPT3}{\#DPT1}$
215	71.9%	165	55.2%	126	42.1%	89	41.4%

Measles Status

AGEGROUP	NO MEASLES	YES MEASLES	TOTAL
9-23 MONTHS	199(66.5%)	100 (33.4%)	299 CHILDREN

Fully Immunized Status

(BCG + OPV123 + DPT123 + Measles)

AGEGROUP	NOT FULLY IMMUNIZED	FULLY IMMUNIZED	TOTAL
0-23 MONTHS	199(66.6%)	100 (33.3%)	299 CHILDREN

DISCUSSION AND RECOMMENDATIONS

AGE DISTRIBUTION

Facts for Life published UNICEF, WHO, and UNESCO states that the risks of child-bearing are greatest when the mother to be is under 18 years or over 35.

A bias in the methodology is presented because interviewers were trained to ask mothers questions about the youngest child if she had more than one child under the age of 24 months.

In summary, SAWSO will continue emphasis on birth spacing at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35 to reduce the dangers of child bearing.

EDUCATION/OCCUPATION

70% of the mothers surveyed can read, however, of those the majority can read only at the primary level. Two different groups will be targeted: those that can read at the primary level and those that cannot read. For those mothers that can read, SA/GHANA will develop simple written health messages both in English,Twee and Ewe. For those mothers that cannot read, SA/Ghana will train CHWs in counseling techniques. This group will also be reached by the CHWs using adult learning methodologies, for example demonstrations, role plays, pictorial presentations and through discussions.

Over 54% of the mothers are away from home during the day. Many of these mothers leave their children with older siblings . Other caretakers mentioned by mothers were husbands and maid servants. In order for CHWs to reach mothers, home visits need to take place in the evenings or on "free" days when mothers are at home. In order for CHWs In order for health messages to reach older siblings... mothers can afford primary health care (PHC) services. project, however, will intensify activities that promote awareness regarding child and maternal care. These activities include: adequate nutrition for mother and child including exclusive breastfeeding, maternal care, immunizations, family planning/child spacing, home management of diarrhea, and growth monitoring.

Breastfeeding/Nutrition

Facts for Life breastfeeding messages state: that mothers should exclusively breastfeed during the first four to six months of life, that mothers should introduce foods in addition to breastmilk between four to six months of age, that infants should start to breastfeed as soon as possible after birth, and that breastfeeding should continue well into the second year of a child's life and for longer if possible.

0% of the children in the 0, 1, 2, and 3 month age group in the survey were being exclusively breastfed.
100% of the 59 children in the 5, 6, 7, and 8 month agegroup had been given solid or semisolid foods. About % of mothers, when asked, did not know that children should be introduced to foods other than breastmilk between four and six months of age; over 50% indicated an age for food introduction earlier than four months. The biggest problem regarding breastfeeding practices, therefore, is the early introduction of food and fluids other than breastmilk in the project area. SAWSO will emphasize the benefits of exclusive breastfeeding during the first four to six months by targeting mothers, CHWs, TBAs, and professional health workers.

77% of mothers breastfed their child within the first eight hours after birth. SAWSO will continue emphasis on benefits of early initiation of breastfeeding after delivery

during the training of TBAs, CHWs, and both private and public health workers.

All of the children in the survey had been breastfed at some time, however, at the time of the survey 77% were still being breastfed. Of the 23 children in the 20, 21, 22, and 23 month agegroup, only one was still being breastfed. Mothers will be encouraged to continue breastfeeding up to the child's 24 month of age. will reinforce the benefits of prolonged breastfeeding during training of CHWs, TBAs, the communities themselves. All health workers in the project area (private and public) will receive instruction on the benefits of breastfeeding for the first two years of a child's life.

Another Facts for Life breastfeeding message is that to ensure the regular supply of breastmilk the mother should: breastfeed as soon as possible after birth, care for her breasts/nipples, allow frequent sucking to stimulate production, exclusively breastfeed for the first four months of life, avoid bottle feeding of the baby, and to attempt to relactate if she had stopped breastfeeding. Of these actions to ensure the supply of breastmilk, about 40% of mothers knew to care for breasts/nipples, and about 25% knew to allow frequent sucking to stimulate production. Few mothers knew about the other actions to ensure the supply of breastmilk. Many mothers mentioned eating good foods and drinking palm wine as actions to ensure the regular supply of breastmilk. Mothers in the project area need to hear and understand the benefits of this health message. CHWs, TBAs as well professional health workers will be encouraged to bring this message to mothers and to the community as a whole.

It appears that most mothers are giving their children foods enriched with calories, protein, vitamin A and iron. It is not clear from the survey, however, the quality and quantity of foods given to the children. therefore, will continue to work towards promoting and encouraging mothers to provide adequate foods of good nutritional value. For example, relatively few mothers knew that they should give their child an extra amount of oil with their foods. SAWSO and the Ghana project staff will promote the daily administration of one teaspoon of palm oil to children under two years of age.

Growth Monitoring

Approximately half of the mothers in the survey had a growth monitoring card for their child. Of the children with growth monitoring cards, few had been weighed in the four months preceding the survey (3% of 300). The project objective as stated in the proposal is that at least 50% of children 0-3 years of age in the surveyed communities will be weighed once every two months.

will provide cards to all children under the age of five years in the project areas through community household registration, and will encourage mothers to safeguard the cards. also will train health workers and encourage policy makers to ensure that all children under two years are weighed and that weights are recorded on the child's growth monitoring card. Professional health workers need to trained to better coordinate PHC activities to assure that children are weighed and that weights are

recorded.

Diarrheal Diseases

Facts for Life diarrhea messages stress the importance of giving extra fluids and continued feeding during the diarrhea episode, and providing extra foods when the child is recovering from diarrhea.
Approximately 25% of the children in the survey were given more breastmilk than usual during the diarrhea episode, and close to 30% of the children were given more fluids than usual during diarrhea. 60% of children were given more or the same amount of foods as usual during diarrhea, and 80% of mothers knew that a child should receive more foods or high calorie foods after the diarrhea episode. SAWSO will provide messages for CHWs to bring to mothers in the project areas that stress the importance of giving more fluids and continued feeding during a child's diarrhea.

One of the project objectives outlined in the proposal is that 40% of mothers will use ORT to treat their children's diarrhea. Facts for Life also stresses the dangers of using medicines to treat diarrhea. Approximately half of the mothers in the survey were giving ORT to their children during diarrhea. Half of the mothers also were giving their child medicine for the diarrhea. Of those mothers giving ORT about one-third were giving a sugar-salt solution (SSS); the rest were providing ORS or other kinds of home available fluids. In the project areas, SAWSO will place special emphasis on the use of SSS to treat diarrhea and on the dangers of using medicines for diarrhea. This will include organizing training/workshops for local chemists as well as health workers.

Few mothers in the survey (11%) stated signs or symptoms related to dehydration as those that would cause them to seek advice or treatment for their child's diarrhea. Signs and symptoms most frequently mentioned were weakness or tiredness (53.3%), fever (27%), vomiting (21.7%), blood in the stool and loss of appetite (16.7% each). Facts for Life stresses in order dehydration, fever, loss of appetite, vomiting, passing several watery stools in one or two hours, and blood in the stool as signs that a mother should seek qualified medical help for her child. Health messages will be provided by SAWSO emphasizing signs related to dehydration as the most important signs that a child needs medical help during diarrhea. SAWSO plans to train CHWs and TBAs to emphasize this message to mothers.

Immunizations

60% of 300 mothers had an immunization card for their child and 18% stated that they had lost their child's card. 95 of the 113 mothers with children aged 12-23 months (84%) reported that their child had received at least one vaccination.

Antigen-specific immunization coverage rates for the 12-23 month agegroup are: BCG 63.7%, OPV123 44.2%, DPT123 44.2%, and Measles 43.4%. These percentages represent population based coverage rates for the surveyed children, as recorded on the immunization card. The rate of children fully immunized (BCG + OPV123 + DPT123 + Measles) in the CSVIII baseline survey (37.2%) is lower than the 60% national EPI coverage estimate of 1991. The national objective for full

immunization coverage of children during the first year of life is 80%. The SAWSO project objective as stated in the proposal is for 70% of children in the each project area to be fully immunized by the end of the second year of life.

In the surveyed population, the difference between the first and third OPV is about 32%. and between the first and third DPT is approximately 30%.

The high percentage of mothers who reported that their child had received immunizations and who had in their possession immunization cards for their children contrasts with the low coverage rates found in the survey. This may suggest that vaccinations given during immunization campaigns are not reaching children the number of times required to fully immunize in the first year of life. SAWSO will work in collaboration with private and public health institutions in the project areas to provide routine immunization services. SAWSO will train health staff of these institutions and provide cold chain equipment. Also, SAWSO will train CHWs/TBAs to counsel mothers and reinforce the message on the importance of completion of the EPI schedule during a child's first year of life, if possible.

Overall knowledge of mothers about the timing and purpose of immunizations is quite good. For example, 94% of mothers stated that a pregnant woman needs at least two TT injections to protect the newborn infant. SAWSO will continue to reinforce messages about the timing and benefits of immunizations for both the mother and child.

Maternal Care

Less than 30% of mothers surveyed had maternal health cards. Of those mothers with cards, however, most had received two TT injections, and all had received at least one TT injection. All mothers with cards with spaces to record ante-natal visits had made ante-natal visits. Possession of maternal cards appears to be a good indicator of access to ante-natal care. It should be noted that over 90% of mothers reported having visited a health site for ante-natal care. In order to better estimate access to ante-natal care and TT coverage of pregnant women all women of child-bearing age in the project will receive primary health care cards.

Only 13% of mothers who did not want to have more children within the two years following the survey, or did not know if they did, were using a modern method of family planning. (Only 28% were using any method of family planning at all, modern and traditional). Looking at the 300 mothers in the survey, 6% are using a modern method of contraception. The CSVIII project objective as stated in the proposal is to increase modern contraceptive usage from 2% to 5%. The national objective for modern contraceptive usage is 10%.

Mothers' knowledge of appropriate maternal nutrition practices is high. Close to 90% of mothers knew that foods rich in iron were good for a woman to eat during pregnancy, and more than 75% of mothers stated that they ate either more or the same as usual during pregnancy. SAWSO will continue to promote maternal nutrition in its PHC activities in order to maintain high levels of knowledge and practices

regarding appropriate maternal nutrition.

A high percentage of deliveries (92%) were attended by a health professional. This highlights the importance of incorporating both public and private health institutions into the area primary health care system. For example, SAWSO can use the opportunity of health professionals attending deliveries to ensure that mothers breastfeed as soon as possible after birth.

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   Joan Robinson
   * Alex Costas
   * Faye Hannah
   * Rosemary Regis
   * Bramwell Bailey
   * Kim Green
   * Tony Tolosa
   * Grace Herring
   * Mary Bryant

OUR CHIEF GUEST OF HONOUR INTERNATIONAL LEADER
FOR HOMELEAGUE HEALTH EDUCATION PROJECT (CAPTAIN SETHLELU)

It gives me pleasure to be associated with our Community Health Workers who had undergone and successively completed an intensive course in Community Health Care through Salvation Army Effort. THE SALVATION ARMY In its efforts of not only providing spiritual guidance, but the total growth of individuals has been actively collaborating with the Government to bring health services closer to the people and we leaders , we are happy for that. These trainers they have undergone an intensive Government approved course to enable them to work in the community in which they live to provide health education together with other personnel in the community to provide information on Baby Care- preventing diarrhoea in children family planning, nutrition, and cleanliness both in the home and in the neighbourhoods they live in.

The Guest these Health Education team of Bungoma Division - they have trained into two groups, some trained at Roosterm (Kakamega) and the rest trained at Webuye.

THEY HAVE UDNERGONE GOVERNMENT RECOGNISED COURSES FOR HOMELEAGUE HEALTH EDUCATION

1. Family Planning
2. Breast Feeding
3. Weaning
4. Growth monitering
5. Immunisation
6. Traditional Birth Attendants
7. Acute Respiratory Injection
8. FIrst Aid
9. Malaria
10. Aids
11. How to start a programe

Finally I take this opportunity to thank the International leaders to send Captain Sethlelu as a leader of this project to survey Bungoma Division on Health Education Programme

I also thank to all officers and all those who have made this occassion possible and to urge the Homeleague Health Education Team to continue to spread all that th have learnt to the community and also evangelise to those who are spiritually weak so that they achieve a whole some growth both spiritually and physically.

At this juncture I call upon the international leader for this project, Captain Sethlelu to make a presentation.

Thank you and may GOd bless you all.

Yours sincerely,

LT COLONEL NANCY ASIMETO (DDWO)
BUNGOMA DIVISION

HOMELEAGUE HEALTH EDUCATION RPOGRAMME IN BUNGOMA DIVISION

Bungoma Division: We ahve Health Education Programme going on this is Kimatuni Salvation Army Clinic, Tulienge Salvation Army Clinic and also Wabukhonyi Women Group.

The community has been going to far health centres to attend clinics and treatment but due to the Salvation Armys introduction of this Health Education Clinic, they are now very happy and have appreciated their service to them. What they need mostly is the support from Friends.

Yet the problems do not diminish the womens and community members enthusiasm for their project. The plain fact is this centre works and if the management is poor we usually apoint the new management under leadership of the officer in charge.

The driving forces to the clinics is Captain Naomi Karimi of Kimatuni Corps and Envoy Mary Onyango of Tulienge Corps and Major Rosebella Abuli of Wabukhoyi Corps. These are supported by the (DDWO) Lt. Colonel Nancy Asimeto Bungoma Division with Homeleaque members. They have good co-operation from the nurses of Bumula Health Centre and Sirisia Health Centre brings Vaccinations once per month.

The centres provides other medicines and equipment for daily treatment. THe nurses from the nearest hospital and Homeleague members walks to outposts and wards some 27 kilometres away to treat and advise patients and teach the people in the communities.

The centres offer growthmonitoring, prenatal check-ups, breastfeeding, nutrition, family planning, Aids, malaria, oral rehydration and acute respiratory infection.

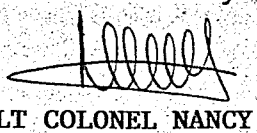
Patients who are able pay a small fee which is used to supplement the medicines box.

In Bungoma we have malaria, typhoid, cholera and aids (all aggravated) by the lack of clean drinking water.

The women have proven beyond doubts it is possible to run health education programme outside the established health facilities. More than that, they are providing that service with every simple material and equipment with good cooperation from the health authorities.

Thank you and God bless the Salvation Army.

Yours sincerely



LT COLONEL NANCY ASIMETO (DDWO)
BUNGOMA DIVISION

K.P.C SURVEY TO 8 DIVISIONS AND DISTRICTS

BUNGOMA DIVISION BEING INVOLVED 1996

TRAINING OF SUPERVISORS AND INTERVIEWERS

The Salvation Army Programe Staff had pre-selected supervisors and interviewers for training from among the divisional level leader and from near by M.O.H health staff volunteers. At the start of the training participants were allowed to determine for themselves about the make up of each team. THey chose to form teams according to the area they came from and they stuck to that system even though the actual survey might have been easier to implement had they chosen to break up their team and get more people involved in the survey. The survey was done by Paye Hannah .

1.

The first training day was day was dedicated to survey administration and methodology.

THE SAWSO SURVEY- PRESENT THE TOPICS

a) Purpose and objectives of the survey.

b) Selection of the sample size

c) Selection of the starting household and survey direction

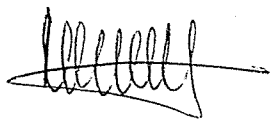
d) Community protocal and taboos

e) Reviews of the customized questionnaire

2. The second day of training concentrated on interviewing techniques, further familiarization with the questionnaire through role play and the roles of the supervisor and interviewers.

3. The third and fourth days of training were spent drawing maps and practicing household selection and training in tabulation was deferred until after the survey was completed.

REPORT FROM THE (DDWO)



LT COLONEL NANCY ASIMETO
BUNGOMA - DIVISION

THE SALVATION ARMY.
KAPTANAI S.A CORPS

AFYA YA JAMII PROJECT

The Primary Health Care Organization was started at Kaptanai in 1995. The Pioneers who underwent the one year training at Rosterman Hotel in Kakamega were, MRS Ogendo (Officer incharge during that time), Agnes Silicho, Sellah Wanyanyi and Florence Sirengo.

After training, we quickly embarked on sensitization of people over the demands of the project.

Through motivation of lesos and nice budges given, the group gained momendum and by the end of the year - 1996 - membership had risen to fourty, thereby enhancing the establishment of the initial Project which dealt with weighing and child's growth monitoring.

After a successful performance over-that, we embarked on small scale farming by Planting Vegetables & groundnuts and Poultry keeping. Yields from that gave us a stride to start animal husbandry - sheep.

After a short spell of time, and with its good Performance, it has managed to make us expand to dairy farming. Thus we now have a dairy animal (a young (calf) worth shs 5000/=.

Along with that we have maize in a half acre Plot which is also doing well.

Hopefully, we anticipate to expand our dairy field which is our main

BUNGOMA SALVATION ARMY

CHAMAAFYA WOMEN GROUP-BOX.319,BUNGOMA-KENYA

This project started in 1998 and continued till 1998 March when members graduated as full members of Afya ya Jamii. They were under Lt.Colonel Cheroben.

We learned many things by different teachers. The members learned in groups at different stations.

First Group - Nairobi, Second Group - Bungoma Coprs, Third Group at Webuye Corps.Some of the things we learnt were Breast Feeding,ORS, Aids,First Aid,Malaria,Immunizations,Diarhea,Family Planning,Dotge(Paji Balanced Diet,Songs.

All learners liked the Education and prayed for the S.A. to prosper. After graduation,we formed a project called Bungoma Chamafya Women Grou with 24 members. We chose the leaders who are capable- Chairlady-Margar Siboe,Secretary - Dina Makokha, Treasurer - Malisellina Luketelo plus 4 Committee members.

This team came up with many projects as such we decided to contribute 500/=(Five hundred shillings only). We raised 12,396/=cash. We decided to make Bricks which we sold at Shs.40,000/=(Forty Thousand Only). We bought Chicks feeds and drugs. We have distributed money to some member to run small scale businesses and small scale farming.

OBJECTIVES

Chamaafya came up with many intensions:-

1) To apply knowledge learnt by visiting different homes,giving health talks to non and S.A.members
2) Build people spiritually both youth and Adult.
3) Making Bricks
4) Poultry Keeping
5) Table Banking and Borrowing
6) Farming on small Scale
7) Business on a small scale.

BENEFITS OF THE GROUP

1. The project has created love among family members,Hospital,Neighbou and children.
2. It has eliminated illiteracy in most of our teachers who are now able to teach and explain.
3. It has enabled members to buy clothes for the need and send eggs to hospital to feed the sick.
4. It is able to get money through selling the eggs. They can pay a workman,buy feeds and drugs for the chickens.
5. Have build a house for poultry keeping.
6. Have constructed a Pit-Latrine for the church.

...../2.

PROBLEMS

As the project grows as problems arise:-

1. Lack of enough money rather capital to enable us buy enough chicks feeds and drugs for poultry.

2. Lack of place-Plot to work freely as it is just run at a members home.

3. Lack of more seminars from T.H.Q for more moderations and co-ordinations.

FUTURE DREAMS

1. Members dreamers are that if ever they could get capital they could buy a plot and construct a workshop for tailoring school.

2. To fight poverty the members pray that God send them a sponsor one day to make them be strong.

SECRETARY-
DINAH N. MAKOKHA (MRS)

WEBUYE S.A AFYA YA JAMM I GROUP

The group was started in 1996 by 30 members. The Organizer was Major Rodah Onyango. The Officials were

1. Janet Sirengo was our teacher
2. Jemimah Kajaira The Secretary.
3. Elizabeth Peka the Treasurer.

Rose Kisakamutu.

Im The year 1996 we had a project of Chickens, they were 90 in number and we were short of finance for treatmentm they all died. We again contributed 1500/= we bought a Sheep. After some time it died. Thus which each member contributed 50/= to buy it.

Although that We did not give up. The members decided to have a native Cattle. They contributed a nother money to buy it. Where of each member contributed Kshs. 200/= and We bought it for Kshs. 6,000 We bought a heifer for that much. It was kept by our teacher Janet Sirengo.

We need to hire a plot to plant nappier grass for grazing. For now we do not have the mohey. But our Cattle has got a Calf now. For now we want to start to do zero grazing.

We have now started a nother project at the Church. Which is Water project. We hired the people to dig the Well, and each member Contributed Kshs. 200/=. We have reached where it is now, and we have come short of money. Because we need a pumping machine.

Now th at we have ru n short of money, if we had some one to assist we could complete our Water Project.

Thank you.

Janet Sirengo.

Major Margaret Shilisia.

MAHANGA CORPS FAMILY LIFE

PROJECTS:

1 POULTRY KEEPING — LOCAL BREED

(a) We started this project in 1997. We started by keeping five chickens of the local breed with the purpose expansion through laying eggs and of hatching of more young chicks. Eventually the number increased. Out of which we raised a sheep. From one sheep we now have 5.

(b) Through joint efforts we managed to raise a heifer which is now maturing. Future plans are that each member gets a cow from the one we have now

2. TEXTILE PRINTING PROJECT:

This project began in August 1997. The project is well sustained and the activeness depends on that demand as per time:

Future plans are that we train the Youth, especially school leavers, to venture in this project, as it is quite viable.

4 WATER PROJECT.

This was started in February 2000. Each on is 1999, we had dug the borehole with the aim of providing water to the church. In the cause of time we decided to give the borehole a face lift, by making it permanent. To where we are now, we have spent Kshs 40,000 = (Forty thousands only).

Health Survey

Mahali_____

1. What is your name? **Jina lako ni nani?**_____

2. What is your age? **Umri wako ni ngapi?**

   a. chini 15 ☐
   b. 15-20 ☐
   c. 20-30 ☐
   d. 30-40 ☐
   e. Zaidi 40 ☐

3. What is your child's name? **Jina lake ni nani?**_____

4. What is his/her age? **Umri wa mtoto chini ya miezi ishirini na nne?**

   a. chini miezi 3 ☐
   b. 3-6 ☐
   c. 7-9 ☐
   d. 10-12 ☐
   e. 13- 15 ☐
   f. 16-20 ☐

5. What was the highest educational level you attained? **Kiwango cha juu cha elimu ulichopata ni kipi?**

   a. Sija soma ☐
   b. Darasa 3 ☐
   c. Darasa 7 ☐
   d. Form 4 ☐
   e. Form 6 ☐
   f. Chuo ☐

6. What work do you do? **Unafanya kazi gani?**

   a. kilimo ☐
   b. bisahara ndogo ndogo ☐
   c. kazi ya mkono ☐
   d. kazi ya ajira ☐

7. Are you breastfeeding (.....) ? **Unanyonyesha (.....)?**

   Ndio ☐
   Hapana ☐

7.a Are you giving (.....) water or herbal teas?
Je unampatia (.....) maji au madawa ya miti shamba?

Ndio ☐
Hapana ☐

7.b Are you giving the child supplementary milk?
Je unampatia (.....) maziwa ya Maziwa ya mkebi ?

Ndio ☐
Hapana ☐

7.c Are you giving (.....) semisolid foods such as Super Uji, Ceralac, or mashed potatoes?
Je unampatia (.....) vyakula nyororo kama, supa uji, chakula kilizo changinyishwa na vyazi vilivyopondwa?

Ndio ☐
Hapana ☐

8. What can a mother do in the baby's first four months of life to keep on breastfeeding?
Mama anaweza kufanya nini katika miezi minne ya kwanza ya maisha ya Mtoto ili aendelee kunyonya?

_____

_____

9. Has (.....) had diarrhoea during the last two weeks? **Je (.....) amekuwa wa ugonjwa wa kuhara kwa wiki mbili zilizopita**?.

Ndio ☐
Hapana ☐

10. During (.....)'s diarrhoea, did you breastfeed (.....)?
Je wakati (Jina la mtoto) alipokuwa anahara likuwa ukim-nyonyesha?

Ndio ☐
Hapana ☐

11. During (name of child)'s diarrhoea, did you provide (.....) with fluids other than breast-milk?
Je wakati (Jina la mtoto) alipokuwa akihara ulimpatia maji mbali na kumnyonyesha?

Ndio ☐
Hapana ☐

12. During (.....)'s diarrhoea, did you give the child solid/semi-solid foods?
Je wakati (Jina la mtoto) alipokuwa anahara, ulimpatia vyakula vigumu?

Ndio ☐
Hapana ☐

13. When (.....) had diarrhoea, what treatments, if any, did you use?
Wakati (.....) alipokuwa na ugonjwa wa kuhara ni matibabu gani ulimpatia?

sikutumia dawa ☐
dawa ya kinyenji ☐
dawa ya kisasa ☐

14. When (.....) had diarrhoea, did you seek advice or treatment for the diarrhoea?
Wakati (.....) alipokuwa akihara, je ulitafuta ushauri?

Ndio ☐
Hapana ☐

15. What important actions should you take if (.....) has diarrhoea?
Ni hatua gani za muhimu ungechukua (jina la mtoto) anapokuwa na ugonjwa wa kuhara?

Kufunga dawa ☐
Kuendele na kunyonyesha ☐
Kumlisha mtoto ☐
Kumpeleka hospitali ☐
Kumpatia maji maluum ☐

16. Has (.....) ever received any immunization? **Je (.....) amewahi kupata chanjo yo yote?**

Ndio ☐
Hapana ☐

17. May I see (.....) Road to Health Card? **Je naweza kuona kadi ya kupimia (Jina la mtoto)?**

Ndio ☐
Hapana ☐

18. Look at the Growth Monitoring part of the card and record the following information: has the child been weighed in the last four months? **Tazama kadi y ukuaji wa mtoto na auandike habari yake. Je mtoto amewahi kupimwa kwa miezi minne iliyopita?**

Ndio ☐
Hapana ☐

19. Do you have an Ante-Natal Card ? **Je una kadi iliyotumia kuhudhuria kliniki ulipokuwa mja mzito**

Ndio ☐
Hapana ☐

20. Are you pregnant now? **Je wewe ni mcha mzito kwa sawa?**

Ndio ☐
Hapana ☐

21. How many children do you have? **Una watoto wangapi?**

1 ☐
3 ☐
5 ☐
7+ ☐

22. Are you currently using any method to avoid/postpone getting pregnant? **Je kwa sasa unatumia njia yo yote ya kuzuia kupata mimba?**

Ndio ☐
Hapana ☐

23. Where did you give birth? **Ulijifungua wapi?**

Nyumbani? ☐
Zahanati ☐
Hospitali ☐
Mahali pengine_____ ☐

24. Do you know what HIV/AIDS is ? **Unajua virusi ya ukimwi ni nini?**

Ndio ☐
Hapana ☐

25. Do you know how people get HIV/AIDS? **Unajua vile watu hupata ukimwi?**

Uchawi	☐
Mbu	☐
Kumtunza mgonjwa	☐
Matendo ya ndoa	☐
Damu yalioambukiswa	☐