

3. ミニッツ（合同評価報告書付）

MINUTES OF MEETINGS
BETWEEN
THE JAPANESE TERMINAL EVALUATION TEAM
AND
THE AUTHORITIES CONCERNED OF
THE GOVERNMENT OF THE REPUBLIC OF KENYA
ON THE JAPANESE TECHNICAL COOPERATION FOR
THE INTERNATIONAL PARASITE CONTROL PROJECT

The Japanese Terminal Evaluation Team (hereinafter referred to as “the Team”), organized by the Japan International Cooperation Agency (hereinafter referred to as “JICA”) and headed by Dr. Akira HASHIZUME, visited the Republic of Kenya from 24 January to 18 February, 2006. The purpose of the Team was to confirm the achievements made during the five year’s cooperation period, and to make the terminal evaluation for the International Parasite Control Project (hereinafter referred to as “the Project”).

During its stay, both the Team and authorities concerned of the Republic of Kenya (hereinafter referred to as “both sides”) had a series of discussions and exchanged views on the Project. Both sides jointly monitored the activities and evaluated the achievements.

As a result of the discussions, both sides agreed upon the matters referred to in the documents attached hereto, and the result of evaluation was compiled in the Evaluation Report with mutual understanding.

Nairobi, 17 February, 2006

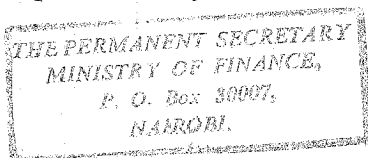
Dr. Akira HASHIZUME
Leader
The Terminal Evaluation Team
Japan International Cooperation Agency
Japan

Dr. Davy KOECH
Director,
Kenya Medical Research Institute
The Republic of Kenya

Countersigned by:

Mr. Joseph K. KINYUA
Permanent Secretary,
Ministry of Finance
The Republic of Kenya

Dr. Hezron O. NYANGITO
Permanent Secretary,
Ministry of Health
The Republic of Kenya



EVALUATION REPORT
ON THE JAPANESE TECHNICAL COOPERATION
FOR THE INTERNATIONAL PARASITE CONTROL PROJECT

JAPAN INTERNATIONAL COOPERATION AGENCY
JAPAN

KENYA MEDICAL RESEARCH INSTITUTE

AND

MINISTRY OF HEALTH
OF THE REPUBLIC OF KENYA

17 FEBRUARY 2006

Handwritten initials: HW, OK, JK, and a signature above JK.

1. Introduction

1-1 Evaluation Study Team

JICA (Japan International Cooperation Agency) dispatched the Terminal Evaluation Team (hereinafter referred as “the Team”) to Kenya from 24th January to 18th February 2006 for the International Parasite Control Project (hereinafter referred as “the Project”). The Team was headed by Dr. Akira HASHIZUME, Senior Advisor for Director General, Human Development Department, JICA. The Team reviewed the achievements made in the past five-year cooperation period of the Project and prepared this Evaluation Report in collaboration with Project implementers, to summarise the achievements of the Project and to report the lessons learnt for future cooperation in this field.

The members of the Japanese Evaluation Team were as follows:

	Name	Designation	Affiliation	Duration of Stay
1	Dr. Akira HASHIZUME	Team Leader	Senior Advisor for Director General, Human Development Department, JICA	10-18 Feb. 2006
2	Dr. Tsutomu TAKEUCHI	Parasite Control	Chairperson, Advisory Committee, Professor, Department of Tropical Medicine and Parasitology, School of Medicine, Keio University	10-18 Feb. 2006
3	Mr. Kohei TAKIMOTO	Evaluation Planning	Staff, Infectious Disease Control Team, Group IV, Human Development Department, JICA	10-18 Feb. 2006
4	Ms. Keiko KITA	Evaluation Analysis	Researcher, Global Link Management, inc.	24 Jan.-18 Feb. 2006

1-2 Background and Summary of the Project

In response to Global Parasite Control Initiative (Hashimoto Initiative), “ the Eastern and South Africa Centre of International Parasite Control (ESACIPAC) was established at the Kenya Medical Research Institute (KEMRI) as one of the three global centres to build human capacity and promote human/information network in school-based parasite control among the Eastern and Southern African region.

The Project was originally launched as “the Research and Control of Infectious Parasitic Disease Project” on 1st May, 2001. The Project accommodated two components: one the last phase of the Research Control of Infectious Diseases Project and the other Global Parasite Control Initiative. In March 2003, after two years from the commencement, the International Parasite Control Project was separated from the Research

and Control of Infectious and Parasitic Diseases Project for more effective management of the Project. The PDM for the Project was accordingly modified.

The Overall Goal, Project Purpose, and Outputs for the modified PDM were as follows:

Overall Goal	Control programmes and applied field research on parasite control are strengthened through capacity building of human resource development and research activities in Kenya and participating countries
Project Purpose	ESACIPAC performs the role of the centre for human resource development and human / information network establishment in Kenya and participating countries in order to strengthen effective control of the targeted Parasitic Diseases (Malaria, Geohelminthiasis, Filariasis and Schistosomiasis)
Output1	ESACIPAC as an international centre is strengthened to carry out its mandates effectively
Output2	Appropriate strategies for control of targeted parasitic diseases, for which school health-based model is being established in Kenya, are developed
Output3	Policy makers and concerned members of the participating countries are sensitized and committed to the project
Output4	Appropriate training to enhance human capacity is undertaken
Output5	Information and human network on parasite control is developed with the participating countries, ACIPAC, WACIPAC, international organizations and other institutions
Output6	Applied field research activities are undertaken, including application / development of appropriate tools

2. Methodology of Evaluation

2-1 Method of Evaluation

The Evaluation Team conducted the evaluation in line with the Project Cycle Management (PCM) method as follows:

- 1) The Team assessed the degree and prospects of achievement of the Project Purpose and Outputs based on the Project Design Matrix (PDM) attached as Annex I.
- 2) The implementation process was assessed and evaluated from the aspect of the project management.
- 3) The Team analysed and evaluated the Project from the viewpoints of “Relevance”, “Effectiveness”, “Efficiency”, “Impact” and “Sustainability”.
- 4) The Team made the conclusion and recommendation of the Project, and also identified lessons learnt from the Project.

2-2 Data Collection Method

- 1) Review of existing document reports related to the Project implementation
- 2) Interview of the Kenyan counterparts engaged in the Project, Japanese experts, and other stakeholders.
- 3) Field visits in Mwea division.
- 4) Analysis of questionnaire from Japanese experts, Kenyan C/Ps and training participants from eight countries.

2-3 Five Criteria of Evaluation

1) Relevance

Relevance of the Project is reviewed as the validity of the Project Purpose and the Overall Goal in connection with the development policy and needs of Kenya and participating countries as well as Japan's ODA policy.

2) Effectiveness

Effectiveness is assessed by evaluating the extent to which the Project has achieved and contributed to the beneficiaries.

3) Efficiency

Efficiency of the Project implementation is analysed focusing on the relationship between outputs and inputs in terms of timing, quality and quantity.

4) Impacts

The question on what changes, whether positive/negative or anticipated/unanticipated, have been produced as a result of the implementation of the Project.

5) Sustainability

Sustainability of the Project was forecasted in organizational, financial and technical aspects by examining the extent to which the achievement of the Project would be sustained or expanded after the

Project is completed.

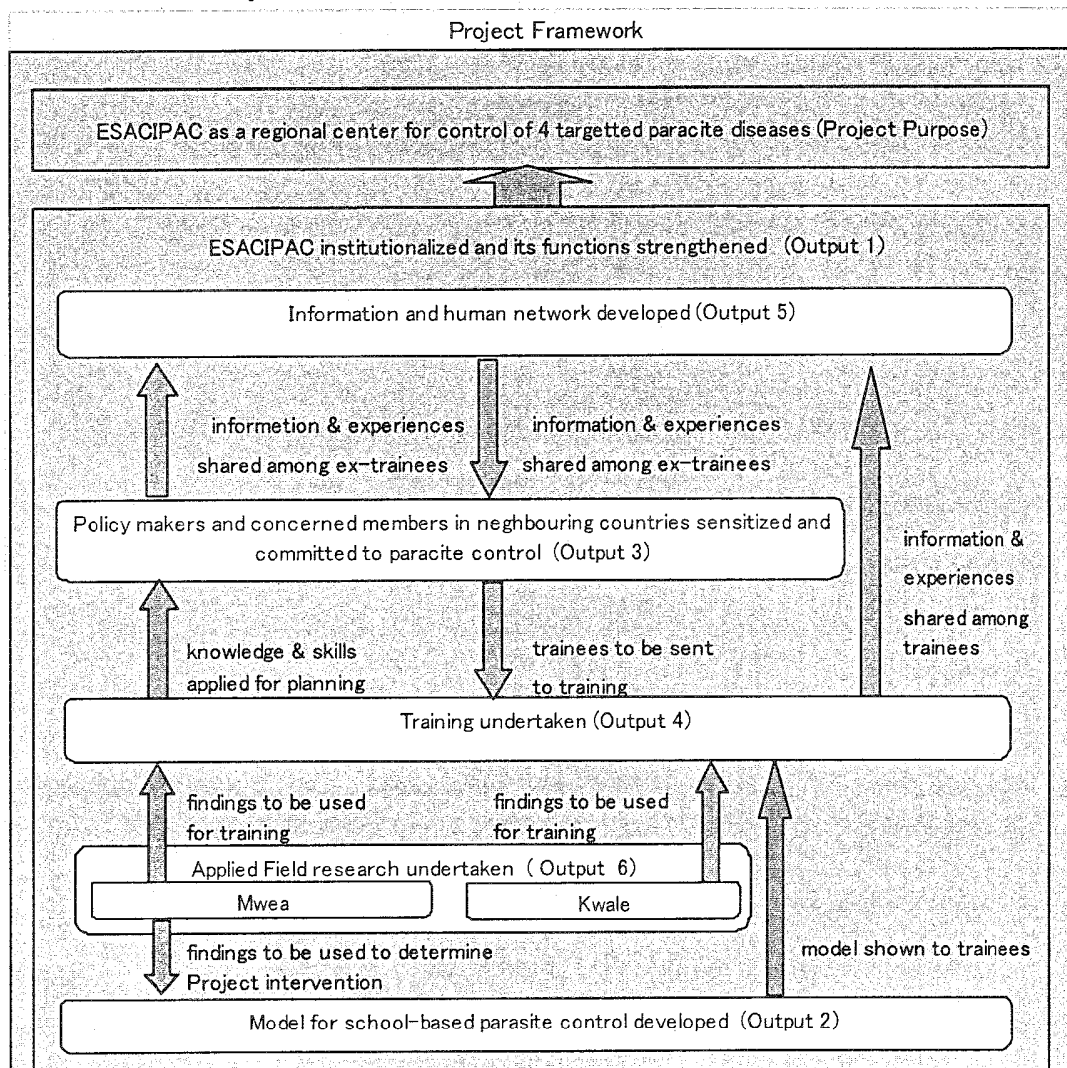
2-4 Scope of Terminal Evaluation

2-4-1 Target Period of the Terminal Evaluation

The terminal evaluation was carried out based on the PDM made in March 2003, when the Project was separated from the Project for Infectious Diseases Control. However, the review of the Project implementation process covered the whole five years.

2-4-2 Framework of the Project

Framework of the Project shown in the PDM can be summarized as follows.



* There are two sites for applied field research (Output 6): Kwale for filariasis (to assess the National Programme for the Elimination of Lymphatic Filariasis), schistosomiasis and STH and Mwea, which is a model site for school-based parasite control, for malaria, STH, and schistosomiasis.

3. Project Performances and Implementation Process

Accomplishment of the Project was measured in terms of inputs, activities, outputs and project purpose, all of which were based on the Project Design Matrix.

3-1 Input

3-1-1 Japanese Contribution

1) Long and Short-Term Experts

The list of experts is shown in ANNEX II.

A total of 9 Long-Term Experts totalling 230.2 MM, will have been assigned by the end of the Project. The areas of expertise include Chief Advisory, Project Coordination as well as various sub-disciplines in Training Administration and Management, Medical Entomology, Parasite Control, Public Health and Parasite Control/School Health.

A total of 12 Short-Term Experts in 14 visits, totalling 14.1 MM, will have been dispatched by the end of the Project. Average duration of stay per visit was 1.0 MM, ranging from 0.3MM to 4.9MM. The fields of expertise include Parasitology, Parasite Control/School Health, Control of Filariasis, Donor Collaboration, Project Cycle Management, Project Management and Public Health.

2) Provision of equipments

The list of equipments provided to the Project is shown in ANNEX III. The equipments included those brought by Long and Short-term Experts, worth 46,315,816 Kshs.

3) Training for Counterparts and Management Consultation Missions

The list of training activities for the Counterparts as well as of the Management Consultation Missions is shown in ANNEX IV.

A total of 5 persons, with an average duration of 45.7 MM and 91MM, will have been trained under the Counterpart(C/P) training scheme by the end of the Project. The areas of training include Networking and GIS system, Medical Entomology, Parasitology and Information Network.

Under the training programmes supported by non-Project sources from JICA, one C/P benefited from long-term PhD training programmes in the field of Malaria and 3 C/Ps joined Workshops on Global Parasite Control Initiatives through Group Training Scheme.

In addition, the C/Ps have benefited from an exposure to international courses conducted by the other CIPACs and other international conferences as well in which a cumulative sum of 31 MM had participated. Among them were:

<International courses/ symposiums by CIPACs >

1. WACIPAC International Course on GPCI for Health Policy Makers, Ghana
2. WACIPAC International Course on Planning, implementing and monitoring of the school based parasitic diseases control, Ghana
3. ACIPAC International Course on School-based Malaria and Soil-transmitted Helminthiasis Control for Programme Managers, Thailand
4. ACIPAC Final Symposium on School Health-based Approach for Malaria and Soil-transmitted Helminthiasis Control, Thailand

<International Conferences>

1. African Health Science Congresses in Uganda, Ethiopia, Kenya and Egypt
2. WHO/AFRO, World Bank, CIPACs Conference, Zimbabwe
3. IVM Course of WHO/Ghana University, Ghana
4. 2nd Meeting of the Partnership for Integrated Vector Management in Africa, Cameroon
5. Danish DBL International Workshop on strengths, limitations and knowledge gaps for evidence-based integrated helminth control in Africa, Zambia

The Project also received one Management Consultation Mission in which the overall direction of the Project was given.

4) Operational Cost for the Project

Annual Operational Cost from the JICA Project fund is shown in ANNEX V.

A total of 68,557,740.Kshs have been expended for local operational costs by the Project fund from April 2003 to January 2006.

3-1-2 Kenyan Contribution

1) Appointment of core Counterpart personnel

The name list of C/Ps in KEMRI is shown in ANNEX VI.

2) Facilities and Office space for Japanese experts

As per the R/D, 1) space for implementation of the Project, 2) offices and other necessary facilities for the Japanese Experts, 3) facilities and services such as the supply of electricity, gas and water, sewerage systems, telephones and furniture necessary for the activity of the Project, and 4) other facilities mutually agreed upon as necessary, have been provided in sufficiency. Among them, major activities have occurred in the KEMRI buildings, which were built through the Japanese Grant Aid scheme.

3) Allocation of Budget to Project Activities

A table showing annual Operational Cost from KEMRI budget is shown in ANNEX VII.

A total of 15,983,566 Kshs will have been allocated and expended for the Project by the end of the Project. The expenses include these for traveling and accommodation for Kenyan C/Ps, telephones, research materials and stationeries.

3-2 Output

The degree to what each Output has been achieved is as below.

Output 1: ESACIPAC as an international centre is strengthened to carry out its mandates effectively.

The basic management structure of the management has been established with three divisions (Training, Applied Field Research and Information Networking), but observations and the results of interviews during the terminal evaluation led to the conclusion that additional efforts need to be done.

The number of full-time staff has increased gradually from the time when ESACIPAC was launched in August 2002 to more than 20 as of January 2006, but the results of the questionnaire survey indicate that responsibilities of some staff are not explicitly defined. A Training Committee and an Information Committee were established within ESACIPAC, but their operations were not clearly organised.

In interview with KEMRI Director, ESACIPAC was defined as one of KEMRI's centres, but there is no written document that identifies ESACIPAC as KEMRI's 11th centre. In KEMRI's Strategic Master Plan (2005-2015), which was issued in May 2005, ESACIPAC was categorized as a training program but not a research centre. ESACIPAC Director, who was officially appointed in June 2003, has been an official member of KEMRI's chief officer meeting since August 2004.

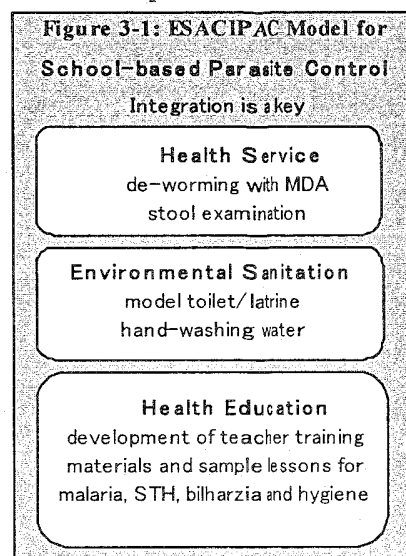
Indicator	Results
1-1 Centre activities are institutionalized.	<ul style="list-style-type: none"> ➤ ESACIPAC appears not to have been officially designated as the 11th KEMRI centre. The ESACIPAC Director has been an official member of KEMRI's chief officers meeting since August 2004. ➤ KEMRI Strategic Master Plan (2005-2015) says that KEMRI hosts two training programmes – ESACIPAC and the Institute of Tropical Medicine and Infectious Diseases (ITROMID).
1-2. Terms of reference are clearly defined.	<ul style="list-style-type: none"> ➤ There were no written Terms of Reference for the three divisions.
1-3 Steering Committee is constituted.	<ul style="list-style-type: none"> ➤ It was an original agreement with KEMRI and ESACIPAC to set up a steering committee composed of the Director of 4 KEMRI centres from which staff was sent to ESACIPAC. The steering committee was not constituted and it was replaced by the Project Implementation Committee, including ESACIPAC, Directors of 4 KEMRI centres (CMR, CBRD, CPHR and CVBCR) and the JICA project team. The Committee was held quarterly in 2001, 2002, 2003 and 2005.
1-4 Fulltime personnel are identified, assigned and appreciated.	<ul style="list-style-type: none"> ➤ First ESACIPAC Director was officially appointed in 2002 on attendance from CMR. The current Director was officially appointed in July 2003, exclusively for ESACIPAC by KEMRI Director on the behalf of KEMRI's management board. Two researchers (including the ESACIPAC Director) and 6 technologists were working on full time basis at the time of terminal evaluation. 15 members of staff are for administration/logistics. ➤ Nine researchers and four technologists are sent from other KEMRI centres and DVBD, Ministry of Health.

Output 2: Appropriate strategies for control of targeted parasitic diseases, for which school health-based model is being established in Kenya, are developed.

With all completed activities, Output 2 is acknowledged widely as the biggest success in the Project. Key points for success are summarized as follows:

<Key Point 1: Integrated intervention for school-based parasite control is in process>

As shown in Figure 3-1, the development of the ESACIPAC model in Mwea for school-based parasite control is in process, and the integration of the three components has not been strong enough: health service for de-worming against schistosomiasis and soil-transmitted helminthiasis (STH) and stool examination; environmental sanitation with focus on toilet/latrine construction; and health education. The integration of these three components was not initially planned. De-worming activities were initiated prior to other two activities. The integration of health education with de-worming was based on the recognition that control of parasitic diseases could not be achieved only with mass drug administration (MDA) for de-worming and that re-emergence

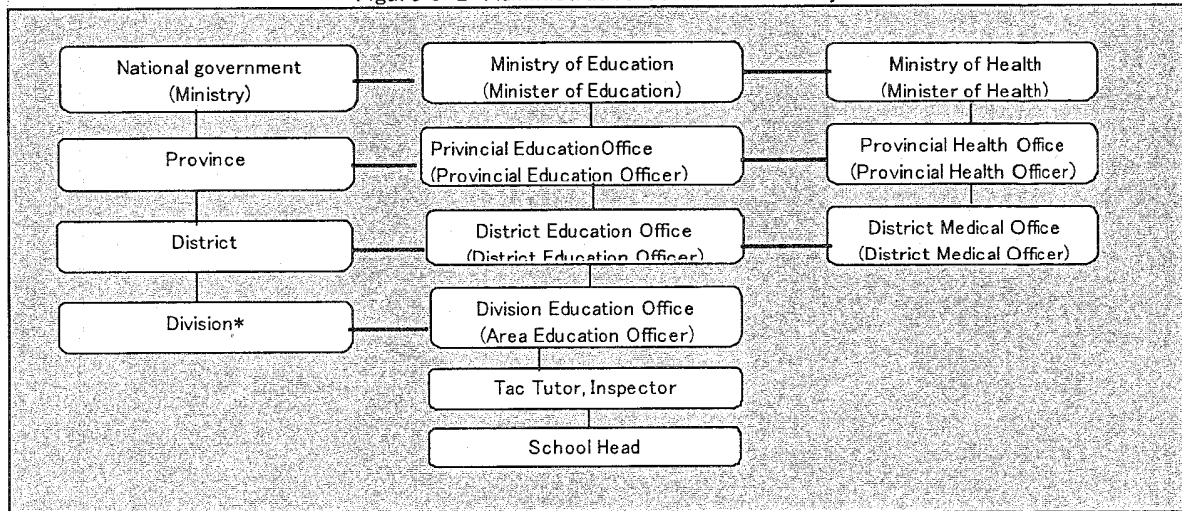


would occur soon after the MDA activities were terminated unless health education/promotion activities were introduced. On the other hand, the integration of environmental sanitation into the model was not included in the original framework of Output 2 and it is the product of flexible response to the needs of beneficiaries with their leadership and full participation of the communities throughout the process. One school at each of the three educational zones in the division was chosen for toilet/latrine construction.

<Key Point 2: Pilot project targeting the administrative unit is driven to faster duplication>

Mwea was chosen as a model division among 4 divisions of Kirinyaga district covering *all* 92 schools of Mwea division for de-worming/stool examination and health education. Starting a pilot project with one administrative unit (division in case of Kenya) is basically the same approach that was applied to WACIPAC's pilot project. On the other hand, it was the ACIPAC approach in which several schools in the administrative unit were targets for demonstrating in the international course. The ESACIPAC/WACIPAC approach costs more in terms of project funds as well as time to establish the process of model building with larger number of stakeholders involved. However, once the model is established in one division, it could be expected that duplication of the model to other divisions in the district is driven faster as the district as well as the targeted division has already been advocated and mobilized in the process.

Figure 3-2 Administrative Structure in Kenya



ESACIPAC Approach to mobilize stakeholders (Formation of district/division team)

Advocacy/Sensitization at National Level	Advocacy/Sensitization at District/Division Level
① Advocacy on Global Parasite Control * International Symposium (Aug. 2002 and Oct. 2004)	
② Promotion of Cooperation between MoE and MEST a) School Health National Committee (SH-NSCC) meeting to discuss on development of national health policy and formulation of School Health Inter-Agency Committee (SH-ICC). (March 2003) ⇨ SH-ICC formulated.	① A series of meetings with heads of the district office of education and health and the manager of National (April 2003) ⇨ The idea agreed among stakeholders.
b) 1st SH-ICC Meeting to advocate the importance of school-based parasitic diseases control with de-worming as an entry point (June 2003). ⇨ Program of the school-based parasitic diseases control adopted in the draft of the 5-year strategic plan of MoH and MOEST.	② A series of meeting with district and division education and health officers (May 2003). ⇨ Ageement on mass treatment at school in Mwea made.
c) 2nd SH-ICC Meeting (Sept. 2003) ⇨ Formulation of the district team was officially decided.	③ Sensitization meeting with distict and division education and medical officers as well as school masters (Sept. 2003). ⇨ Collaboration between MoH and MOEST at the district and division level agreed.
	④ Division team formulated (November 2005)

< Key point 3: Process to involve entire stakeholders in activities established >

ESACIPAC successfully established the “process” of mobilization of stakeholders, which accordingly formulated an intersectoral team at district level and division level for school-based parasite control and promoted community participation in health promotion and construction of toilets at school.

1. Process to formulate intersectoral team: Having considered administrative structure and system of Kenya

(as shown in Figure 3-2), ESACIPAC first formulated district team and then division team whose members were both from education and health sectors in order to implement de-worming activities and promote health education.

2. Process in de-worming, health education and provision of sanitary facilities: Table 3-1 shows the process of mobilization of stakeholders in three activities. Activities in each component were in accordance with respective plan, but not within the unified action plan. This weakness has been rooted in non-harmonious management within ESACIPAC.

Table 3-1: Process of De-worming/ Health Education/Provision of Sanitary Facilities

De-worming/Stool examination	School Health Education	Provision of Sanitary Facilities
1. Base line survey for deworming (July 2003-Feb.2004) (demographical & parasitological)	1. Formation of health promotion team (Oct.2004)	1. Baseline survey on sanitary situation (Sept. 2003)
2. Sensitization to school head and teachers (Sept. 2003)	2. Development of health education materials skeleton	2. Selection of 3 pilot schools (April 2004)
3. Community sensitization (parents) (Oct. & Dec. 2003)	3. Workshop for teachers, health personnel and parents' representative in 6 pilot schools	3. Start of meetings with schools
4. Teacher training for deworming (March 2004 & Feb.2005)	4. Pre-test period in 6 pilot schools	4. Plan of model toilet and cost estimates
5. De-worming by trained teachers (March 2004& Feb.2005)	5. Workshop for finalizing materials	5. Meeting with parents
6. Post-deworming surveys (Coverage and Stool Exam)	6. Workshop for expanding division-wide (Sept.2005)	6. Signature of MoU witnessed by FHO (Jan. 2005)
7. Meeting with district team (Reporting and planning for next year)	7. Monitoring on usage and impact	7. Completion of the construction (June 2005)
		8. Handing over ceremony (July 2005)
		9. Monitoring of usage and impact (Planned)

3. Process to train teachers and representatives of parents as key players to disseminate messages of school-based parasite control:

Guideline on de-worming was developed and distributed to all primary schools in the division, while basic health education materials were developed and distributed in September 2005 to all primary schools in the division. Teacher training for de-worming has been conducted annually since 2004 and health education for teachers was conducted several times in 2005. It should be noted that one parent from each school was also invited.

Teacher training on de-worming was conducted in March 2004 and March 2005 one week before the mass treatment. Training curriculum included: (a) introduction of the concept of school health (b) prevalence of parasitic diseases in Mwea and how to avoid infections (c) introduction of de-worming drug and instruction on how to store and distribute the drug and (d) record of the provided medicine for evaluation. The district team facilitated the training. The number of trained teachers was 174 for the first training and 144 for the second training.

Half day teacher training on health education for parasite control in Mwea division was held 15 times in September 2005 and January 2006, covering all primary schools in the division: 262 teachers from 83 schools were trained. District/division team becomes facilitators for the training. Training curriculum included: (a) introduction of the concept of health education, (b) introduction of materials on health

education for children and teaching guidelines (c) samples of integration of health education topics into syllabus (d) sample of teaching methods (e) samples of lesson schedule (f) concept and method of community mobilization for health promotion. The same training was held in January 2006 for 7 schools which had not been able to participate in the previous training. Out of expected 28 participants attended the training.

Indicator	Results
2-1 Guidelines for parasite control are developed.	<ul style="list-style-type: none"> ➤ ESACIPAC developed de-worming guidelines for district managers and teacher training kit for de-worming with instruction on drug distribution in 2003. In July 2004, the modified de-worming guideline was officially adopted as the national guideline for mass de-worming by the Permanent Secretary of Ministry of Health and Ministry of Education, Science and Technology. ➤ In order to prevent infection and re-infection of the parasitic diseases, ESACIPAC in collaboration with MOH and MOEST at the national, district and divisional level also developed educational materials in 2005 with the existing school syllabus. For this purpose, two workshops were organized in 2005 with more than 30 teachers from 6 pilot schools. Health promotion was emphasized with regards to safe water, environmental sanitation and hygiene for control of infectious diseases including parasitic diseases.
	<ul style="list-style-type: none"> ➤ De-worming have been implemented in all 92 schools in Mwea division, teachers training for health education in 83 schools, the toilet construction was completed as a model for others in 2 schools and is in process in 1 school. ➤ De-worming for soil-transmitted helminthiasis and schistosomiasis was conducted in March 2004 (43,928 children covering 98% of enrolled children and 6,000 non-enrolled children) and March 2005 (4,3959 children – 97.8%) in Mwea, Stool examination of all class 3 children in 92 schools in Mwea was done. ➤ The average infection rate for schistosomiasis in Mwea declined from 36.0% in 2004 to 11.4% in 2005. The rate for STH also decreased from 13.3% in 2004 to 3.0% in 2005. ➤ De-worming activities in Mwea were demonstrated to participants to the second and the third international training courses. Copies of de-worming guidelines for teachers and district managers were given to international course participants for use in their countries. The participants also learnt the process and strategies of advocacy and sensitization of stakeholders, formation of intersectoral team composing of MOH and MOEST at national, district and division level, development of guidelines for parasite control and conducting teacher training for de-worming and school health education. ➤ De-worming was also conducted in Ndia division in 2005 for 42,146 children by the district team with support from ESACIPAC.

Output 3: Policy makers and concerned members of the participating countries are sensitised and committed to the project.

All activities under Output 3 were completed, but the Output was on the half-way achievement. Neither have there been parasite control projects in 7 neighboring countries under the Global Parasite Control Initiative yet, nor has ESACIPAC received official progress reports from these countries. ESACIPAC's

contribution to neighboring countries is limited to advocacy and human networking in the country. Unlike ACIPAC's and WACIPAC's PDM, ESACIPAC's PDM did not set the indicator as the number of pilot projects launched by ex-trainees in their country upon their return, and therefore it is not reasonable to evaluate the quality of the country visit. Yet it is still regretted that having set the less aggressive indicator (the number of visited countries) in PDM by its own, the ESACIPAC Project team remained passive and eventually could not utilize the allocated budget for the fiscal 2005 to be used as a seeds fund for pilot project(s) in neighboring countries.

On the other hand, ESACIPAC's intervention to Kenya is more direct and practical. More Kenyan officials both from MoH and MoEST were invited to the international training than other countries, which was more effective to mobilize the two ministries towards Global Parasite Control Initiative (GPCI). As already described, the creation of the partnership between the two ministries is one of the key factors for the success in the model building for school-based parasite control in Mwea. Continuous efforts are required to stimulate dialogue between the two ministries at the national level to realize the development of a national school health policy in near future.

Indicator	Results
3-1 Country visits are carried out.	<ul style="list-style-type: none"> ➤ ESACIPAC visited neighboring countries three times: <ul style="list-style-type: none"> - The 1st visit (December 2001- February 2002), targeting 6 countries except Zimbabwe, was with the purpose of advocating the Global Parasite Control Initiative (GPCI) and introducing ESACIPAC to MoH, JICA country office and Embassy of Japan in each country. Situation analysis of each country was also conducted. - The 2nd visit (November 2002-January 2003) to 6 countries, except Malawi, resulted in identification of participants from each country to ESACIPAC 1st international training. - The 3rd visit (June-July of 2005) targeting 6 countries, except Uganda, aimed at monitoring and follow-up of ex-trainees of the international training.
3-2 International symposium is held.	<ul style="list-style-type: none"> ➤ ESACIPAC held symposium to advocate the Global Parasite Control Initiative (GPCI) twice. <ul style="list-style-type: none"> - The 1st symposium (August 2002), targeting policy makers mainly from Ministry of Health, brought about 60 participants (including facilitators) from Kenya and seven neighboring countries, mostly from MoH. International organizations and NGOs, including WHO/HQs, WHO/AFRO, World Bank, UNICEF/ESARO, USAID, DFID and CDC were also invited . - The 2nd symposium (October 2004) was held with ESACIPAC-supported 20 participants both from Health and Education Ministry of Kenya and six neighboring countries. WHO/HQs, WHO/AFRO, World Bank, UNICEF, WFP, CTC and PCD were also invited. ➤ Besides international symposium, ESACIPAC held 2 international workshops on curriculum development in June 2003 and September 2003 and a refresher course on schistosomiasis, STH and filariasis for consultants in September 2004 in collaboration with WHO/AFRO. About 60 consultants participated in the course. ➤ In-country workshop was also held in February 2002 with

	<p>participants mostly from KEMRI.</p> <p>➤ ESACIPAC funded three Africa Health Science Congress to advocate GPCI: April 2002 (Uganda), November 2003 (Ethiopia) and November 2004 (Kenya).</p>
3-3 Participants of (international) training course are nominated.	Participants for three international training courses were identified. The number of participants for training was 17 at the 1 st training (February 2003), 16 at the 2 nd training (March 2004) and 23 at the 3 rd training (February 2005).
3-4 Trained participants are assigned to parasite control program in their countries.	<p>➤ Ex-participants sent ESACIPAC a draft proposal or guideline on which they had worked upon their return, and ESACIPAC commented on their works. ESACIPAC intervention was not led to the start of pilot project in their country, however.</p> <ul style="list-style-type: none"> ● Kenya: ① MoH and MoEST jointly drafted policy on school health which includes malaria control and soil-transmitted helminthiasis and schistosomiasis control. ② Two ministries also drafted school health program with support from JICA Kenya office in March 2004. Ex-trainees have been fully involved in both initiatives. ● Uganda: ① School health guideline have been developed. ② With support from SCI, de-worming was conducted to 8,000,000 children. Ex-trainees took an initiative for the activity. ③ Proposal on school health project, including community safe water, de-worming, sanitation and health education, was submitted to JICA. Towards the finalization of the proposal, ESACIPAC played a coordinating and consultation roles. To this end, country visit was made in 2004. ● Tanzania: ① With support from SCI and Global Fund, de-worming was conducted to 5,000,000 children. Ex-trainees were in charge of the activity. ● Zanzibar: ① MoH and MoE signed MoU in 2005. ② De-worming is planned with support from SCI and WHO. Ex-participants from both ministries have been involved in the plan. ● Zambia: ① With support from SCI, schistosomiasis control program is in process. ② Ex-trainees from MoE took a leading role to prepare proposal on school health project which is now positively considered by JICA Zambia office. ● Malawi: ① There has been no specific school-based parasite control program, but with support from WFP, ex-trainees from MoE recently have been working on the district-level school health program. ● Botswana: ① No specific school-based parasite control program exists. ② Ex-trainees recently have been reviewing school health policy which was stipulated in 1980s. ● Zimbabwe: ① With support from WHO/AFRO, ex-trainees from MoH conducted mass treatment for schistosomiasis and STH at three pilot schools.

Output 4: Appropriate training to enhance human capacity is undertaken.

All planned activities under Output 4 were completed, except 4-5 (Setting-up/utilize of training facilities).

The training centre was established on Japanese grant aid in November 2005 and awaits the opening in March 2006.

International training courses have been held once a year since 2003, and 56 participants, obtained opportunities for training on parasite control by the end of 2005. The training contributed to establish partnership between MoH and MoEST. The target of the training was limited to policy makers and program managers at national level so far.

When the latest PDM was designed, "training" under Output 4 implied (a) International training courses on school-based parasite control, targeting Kenya and 7 neighboring countries and (b) in-country training for senior technologists at national/district level and university/training colleges staff. Training (b) was included in the former PDM attached to R/D signed in May 2001 and modified as shown in the latest PDM. Training (b) was included in the current PDM under the presumption that the training centre mentioned above would be used for the Project. It was reported by the Project team that no single in-country training was conducted as had planned because of unavailability of the training centre. However, the terminal evaluation team attributed the incompleteness to management reasons: it is true that the presumption was not met, but it was responsibility of the Project team to monitor the presumption during the Project period and take necessary action when difficulties arose. With the delay of the construction, the Project team could have considered using other training facilities as an alternative venue. Therefore, it is more reasonable to see the reason of the incomplete activity in the fact that the Project team could not start the in-country training for technologists.

Indicator	Results
4-1 Training curricula and materials are developed and utilized.	<ul style="list-style-type: none"> ➤ The first curriculum/module for the international training course was developed in 2002 in collaboration with WHO/AFRO and adopted in 2003. Curriculum/module on school-based parasite control includes applied field research, planning, implementation, monitoring and evaluation. ➤ ESACIPAC has not developed training material for the international training course by its own partially because training facilitators/instructors for the last three trainings prepared materials and partially because the method of training is based on experience sharing through country report and discussions.
4-2 The centre offers at least one international and one in-country course each year.	<ul style="list-style-type: none"> ➤ As mentioned in 3-3 above, ESACIPAC organized international training annually since 2003 and brought 56 participants in total from 8 countries including Kenya. The international training originally targeted policy makers and program manager during the first stage of Project period, and planned to target technologists at district level later. ➤ No in-country training for technologists was conducted as planned.
4-3 The field sites for (international training course) are established and utilized.	<ul style="list-style-type: none"> ➤ Mwea Division in Kirinyaga District was selected as a model project site for ESACIPAC as the division has suffered from high prevalence rate of water borne infectious diseases, mainly malaria and schistosomiasis, due to rice farming irrigation system. ➤ The project site in Mwea was not ready for the first international training course in 2003 and therefore Kisumu was used as the field site for the international training course. During the second

	<p>international training course in 2004, the project site in Mwea was ready for demonstration of mass treatment only. It was only at the third international training course in 2005 when the Mwea model could be shown to participants of the course.</p> <p>➤ Training centre in Mwea, which was constructed for the irrigation project in 1991 on Japanese grant aid, was utilized for training activities by ESACIPAC, and lab facilities were provided by DVBD for stool examination. Also, as mentioned Output 2, toilets/latrines were constructed as one of the models to improve environmental sanitation and shown to participants of international training course.</p>
--	---

Output 5: Information and human network on parasite control is developed with the participating countries, ACIPAC, WACIPAC, international organizations and other institutions.

All four activities under Output 5 were completed, but the achievement of Output is relatively low. Information network has not functioned well, yet. Difficulties in the network development were influenced by the fact that the infrastructure for Internet operation/maintenance in neighboring countries is not enough. Another way of developing information network is publication and distribution of newsletters.

The 15th issue of newsletter has been published by the end of January 2006 and distributed during the country visits and the international symposium/training programmes. ESACIPAC has a technical capacity of updating its web page on its own since October 2005, but its contents have little been updated.

There is also room for improvement in human network development. Information/experiences sharing between ESACIPAC and ACIPAC/WACIPAC were done through mutual participation to international symposium (Output 3) and international training (Output 4). ESACIPAC C/Ps participated in 8 WACIPAC or ACIPAC international symposium/training and ESACIPAC received WACIPAC/ACIPAC C/Ps to an international symposium and 3 international training. The practice has hardly given ESACIPAC benefits in development of training module/curriculum. Methods of human network building between ESACIPAC and 7 neighboring countries are limited to country visits by ESACIPAC (Output 3) and international training (Output 4). Partnership between ESACIPAC and WHO/AFRO, especially in training activities, has become stronger during the Project period.

Indicator	Results
5-1 Web page is uploaded and maintained.	<p>➤ ESACIPAC Website (www.esacipac.org) was established in February 2003 but its contents have not been updated regularly. The latest update was done on 31 January 2006 with 2 ESACIPAC news letters.</p> <p>➤ The Web has approximately 70 accesses per day, and the total access number from May 2005 to January 2006 is 15,000 or more. The daily access number is more than the access to KEMRI home page.</p> <p>➤ ESACIPAC web page is connected to that of international organizations such as WHO, World Bank and CPC, but not vis-à-vis.</p>

5-2 Visits among CIPACs exchanged.	<ul style="list-style-type: none"> ➤ ESACIPAC C/P participated in WACIPAC's workshop in October 2001, July 2003 and July 2004. ➤ ESACIPAC C/P participated in ACIPAC's international training course in June 2001, August 2002, July 2003, June 2004 and final symposium in January 2005. ➤ WACIPAC and (or) ACIPAC participated in ESACIPAC's international workshop in August 2002 and international training courses in February 2003, March 2004 and March 2005. WACIPAC participated in 2 international workshops in collaboration with WHO/AFRO on curriculum development in February 2002 and September 2003.
5-3 Visits to international organizations and institutions.	<ul style="list-style-type: none"> ➤ ESACIPAC visited WHO/AFRO in June 2003, which resulted in an agreement on collaboration in curriculum development in October 2003. The second visit in May 2005 led to the basic agreement with WHO/AFRO that ESACIPAC would be a collaborating partner for its training. ➤ Other organizations/institutions where ESACIPAC visited include Makerere University Medical School (three times) and Division of Vector Borne Diseases (three times) in Uganda, National Institute of Medical Research (twice) in Tanzania, University Teaching Hospital (three times) in Zambia and Medical Technical College (twice) in Malawi.
5-4 Newsletters are published	<ul style="list-style-type: none"> ➤ ESACIPAC's publication started as a quarterly magazine in October 2003 and three magazines two additional ones were published. The first newsletter was published in June 2005, and the 15th Issue of ESACIPAC Newsletter has been published by the time of the terminal evaluation and distributed to participants of international symposium/training and to ministries of health and education and other relevant organizations on visits of neighboring countries. ➤ The newsletters are also circulated to MoH and MoEST of Kenya and in Kirinyaga and Kwale district offices, other KEMRI centres, research institutes and international organizations stationed in Kenya.
5-5 Information between participating countries and ESACIPAC is exchanged.	<ul style="list-style-type: none"> ➤ ESACIPAC exchanged information/experiences with Ministry of Health and Ministry of Education on occasion of visits to 7 neighboring countries. ➤ The report of the international training included the list of participants with contact address, summary of lecture and country report. The report of the third training (February 2005) has not been issued as of February 2006. ➤ Database of contact resource persons has been established and updated. The list of contact resource persons is increased to 245 from 8 countries by the end of January 2006.

Output 6: Applied field research activities are undertaken, including application / development of appropriate tools.

Two activities under Output 6 have been undertaken. Operational research using already developed tools has been conducted over the 3 years in Mwea (for malaria and STH) and Kwale (for filariasis). Findings have also been presented in scientific meetings, and manuscripts are being sent to relevant journals for publication after being reviewed by Japanese experts and cleared by KEMRI.

Indicator	Results
6-1 Research tools are applied/ developed and used for parasite control.	➤ Applied field research undertaken includes ¹ : <ul style="list-style-type: none"> (a) Evaluation of treatment effect for schistosomiasis & STH in Kwale and Mwea schools. (b) Entomological studies for malaria in Mwea. (c) Filariasis activities in Kwale to determine treatment coverage, monitoring effect of MDAs in sentinel sites & spot-checks (in collaboration with DVBD and MoH) (d) Schistosomiasis vector-snail survey to determine breeding sites in Mwea (e) Evaluation of people's attitudes, perceptions & knowledge of parasitic diseases after de-worming in Mwea.
6-2 Findings are disseminated.	➤ Eights manuscripts have been authored, 4 of which have been approved by KEMRI's publications committee for publication: <ul style="list-style-type: none"> (a) Drug efficacy of praziquantel & albendazole in Mwea. (b) Primary school children's perception of cleanliness of school latrines. (c) Correlation between prevalence & intensity of schistosomiasis & STH in Mwea. (d) Risk factors of Schistosomiasis mansoni infection among adult population in Mwea. (e) Relation of school latrine-related perception & practices of children with diarrhoeal episodes in Mwea. (f) The adverse effect of Albendazole and Praziquantel on mass drug administration for parasite control. (g) Effect of albendazole, a combination therapy for LF on STH in Kwale. (h) Prevalence and intensity of schistosomiasis & STH in school children in Mwea ➤ Ten presentations have been made during African Health Sciences Congress in Uganda in 2002, Ethiopia in 2003, Nairobi in 2004 and Cairo in 2005.

3-3 Achievement of Project Purpose

Project Purpose: ESACIPAC performs the role of the centre for human resource development and human/information network establishment in Kenya and participating countries in order to strengthen effective control of the targeted parasitic diseases

With successful move toward the integrated model building for school-based parasite control in Mwea division which required the involvement of entire stakeholders at different levels to the implementation process, it is reasonable to conclude that ESACIPAC has performed a leading role in human resource development and networking within the Kenyan context. It is too early to assess the impact of ESACIPAC activities on the other 7 countries. ESACIPAC's intervention to start model projects in the region is indirect, and therefore to make it happen in each participating countries, it is critical that key stakeholders be fully convinced with effectiveness of school-based parasite control and come to take strong leadership for the realization, favorably with support from donor agencies in their countries during the initial stage of the challenges. To this end, ESACIPAC would be able to (a) hold international training course for TOT for

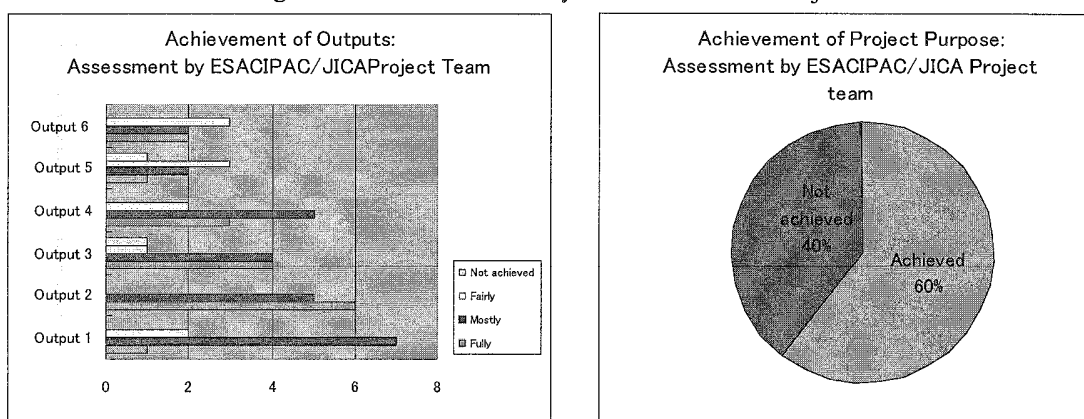
¹ (d) and (e) were conducted with non-project fund.

technologists while continuing to target policy makers/managers and (b) focus more on in-country training in the region by utilizing Kenyan human resources who have already been trained under the Project. At the same time, ESACIPAC continues to support activities in Mwea in order to develop the integrated model for school based parasite control. When the Mwea model with mature integration is shown to participants of the international training course, along with the evidence gained through operational research, then the Mwea model would be acknowledged as the effective and applicable model, which eventually would result in duplication to other division/district with mainstreaming to nationalization in Kenya and expansion to the region.

Figure 3-3 below shows self-assessment by ESACIPAC Project team on achievement of 6 Outputs and Project purposes. The result is based on 11 responses to questionnaires to the Project team. The result implies that the degree of satisfaction is relatively high with Output 1, 2 ,3 and 4, and that there is a room for the improvement in Output 5 and 6 to achieve the Project purpose.

Indicators	Results
1. The personnel in-charge of parasite control programmes in Kenya and participating countries have been successfully trained by the centre.	<ul style="list-style-type: none"> ➤ Fifty-six participants from eight countries, including Kenya have been trained for three years. The participants were mid-level policy makers and program managers both from MoH and MoEST, but not technologists as originally planned. ➤ In Kenya, development of model of integrated school-based parasite diseases is in process in Mwea division. On the other hand, no pilot project has yet to be launched in other 7 countries. Yet the proposal on school health, which was prepared by ex-trainees from Uganda in close consultation with JICA Uganda office, has been approved. ESACIPAC provided advice on its visit in February 2005.
2. The personnel in-charge of parasite control programmes in Kenya and participating countries have been successfully trained by the centre.	<ul style="list-style-type: none"> ➤ PCM workshop as a part of the 3rd international training course in March 2005 has provided participants with new perspective of program management, but follow-up is necessary to enable ex-participants to utilize knowledge and skills in problem analysis and planning properly.
3. Information collected by ESACIPAC from established network activities is well used for effective parasite control	<ul style="list-style-type: none"> ➤ Database of contact resource persons has become available and information on ESACIPAC activities have been disseminated through website, newsletters, country visits. However, information exchanges among eight countries in the region are limited.
4. School health guideline is developed based on the model parasite control and are adopted by the concerned ministries in Kenya	<ul style="list-style-type: none"> ➤ De-worming guidelines have been developed and signed by Permanent Secretaries from MoH and MoEST. ➤ School health guidelines is in its 3rd draft. The draft was first prepared by JICA consultant and then developed by Kenyan stakeholders, including MoH and MoEST.
5. Applied field research activities for parasitic diseases control are carried out as stated in the ESACIPAC document.	<ul style="list-style-type: none"> ➤ Baseline survey and KAP survey in Mwea were used to determine Project intervention to control Malaria, Geohelminthiasis and Schistosomiasis effectively. Findings through applied field researches were also used to scale the impact of Project intervention and determine follow up activities. ➤ Besides Mwea, the Project has supported KEMRI to conduct applied field research on Filariasis in Kwale.

Figure 3-3: Self-assessment by ESACIPAC/JICA Project Team



3-4 Implementation Process of the Project

3-4-1 Formation of Original Master Plan/Project Design Matrix and Its Revision

The International Parasite Control Project was a part of the Research and Control of Infectious and Parasitic Disease Project (May 2001-April 2006) before March 2003. The formulation process of the Research and Control of Infectious and Parasitic Disease Project accommodated two factors: continuation of research activities from the last phase of the Research and Control of Infectious Diseases Project (1995-2000) and integration of Global Parasite Control Initiative (Hashimoto Initiatives). Two components (establishment of an international training centre for Parasitic Control and capacity development of infectious diseases control and research) were integrated under one project management structure with two separate PDMs.

After two years from the commencement, the International Parasite Control Project was separated from the Research and Control of Infectious and Parasitic Disease Project on the visit of the Project Management Consultation Mission on March 2003. The practice is considered appropriate because objectives of the component for parasite control became more defined as the Project developed and it became evident that managing two components with different orientations under one structure was not adequate. When the current International Parasite Control Project became an independent project, the original PDM was modified with minor changes in contents. If the logical sequence at Output, Project Purpose and Overall Goal levels had been adequately established with clearly defined result-based indicators, management of the Project could have been easier.

3-4-2 Adequacy of Implementation Process

< Project Period from May 2001 to March 2003 >

Looking at the whole five-year period of the Project (May 2001-April 2006), the first two years when the recent International Parasite Control Project (hereafter, the Project) was incorporated with the Research and Control of Infectious Diseases Project, the implementation was slow. Main reasons include::

- (a) Japanese project leader, who was to be in charge of both parasite control and infectious disease control, was on duty only after August 2001 and the dispatch of long-term experts delayed as well;
- (b) it had been several months before Kenyan C/Ps engaging in logistics in training activities were identified; and
- (c) Kenyan Coordinator for parasite control activities took study leave in Japan in July 2001 for other research purposes, two month before her appointment. On her return, she was appointed to ESACIPAC Director (June 2002) as well as Director of Centre for Microbiology Research (July 2002). It was only in July 2003 when the current ESACIPAC Director/coordinator was appointed on full-time basis to make ESACIPAC ready to fully commit to commence the Project.

The Project was in the preparatory phase for the first two years, putting focus on activities for collection of data/information on parasite control in neighboring countries as well as preparation and implementation of international symposium/training to advocate on GPCI and ESCIPAC's role to this end. Two long-term experts for parasitology and training administration/management and two short-term experts for parasitology and parasite control /school health were sent during the period.

< Project Period from April 2003 to April 2006 >

Having been separated from the original Research and Control of Infectious and Parasitic Diseases Project, the Project was ready to get into the actual implementation stage with newly appointed full-time ESACIPAC Director/Coordinator, and the Project implementation was in full gear by the time of the visit of the Project Management Consultation Mission in October 2004. For one-and-half years before the Mission, the Project activities were limited to training and international symposium for policy makers in Kenya and the neighboring 7 countries under Output 4 and surveillance activities for de-worming in Mwea under Output 2. It was in May 2003 when JICA and KEMRI finally reached an agreement to select Mwea as a pilot project site while Kwale remained as the site for applied research. It took almost two years to select the pilot project site, but activities in Mwea have been implemented smoothly. To catch up for the delay in the process, 4 long-term experts and 12 short-term experts have been sent during the period. Assigned areas include medical entomology, parasitology, parasite control, applied epidemiology, filariasis control, school health, public health, project management and Project Cycle Management (PCM). Among the 6 important assumptions identified in PDM, the assumption "ESACIPAC training facility is available on time" was not met.

3-4-3 Monitoring of the Project Implementation

Monitoring of the Project implementation has been regularly carried out through Joint Coordination Committee (JCC) and the Project Implementation Committee (PIC). JCC has been organized once a year

since 2001 and PIC meetings were held three times in a year in 2001, 2002, 2003 and 2005. The progress review through JCC and PIC was carried out in light of PDM. The questionnaire survey and interviews to the Japanese Project team and core C/Ps implies that consensus on direction of the Project among the ESACIPAC team was not built successfully, which more or less prevented from the smooth implementation of the Project. Nearly 90% of respondents to questionnaires said that the monitoring of the Project has been conducted regularly, but 65% do not believe that the implementation process was done smoothly. If weekly group meeting among ESACIPAC Project team had been held as stated in Minutes of Meeting signed between two governments in March 2003, the implementation process could have been smoother toward the common goal.

No joint evaluation between the two government in the middle of the Project was implemented as stated in R/D signed in March 2003. The Project Management Consultation Mission was conducted in October 2004, but no official record of the mission was prepared.

4. Results of Evaluation

4-1 Relevance

Relevance of the Project is high. The Project was coherent to the policy of Kenya and the 7 neighboring countries and the assistance policy of the Government of Japan. The purpose also met the needs of these 8 countries.

(1) Relevance to Japan's ODA policy:

The Project is relevant to Japan's ODA policy as the Project was launched in response to the agreement at the Birmingham G8 Summit in 1998 where Japan proposed promotion of Global Parasite Control (Hashimoto Initiatives) which focuses on control of parasitic diseases through human resource development.

(2) Relevance to needs of Kenya and 7 neighboring countries:

The Project is relevant to needs of Kenya and seven neighboring countries (Botswana, Malawi, Tanzania, Zambia, Zimbabwe, Zanzibar, Uganda) because malaria, STH and filariasis, which are target diseases of the Project, are main parasitic diseases in the countries. Before the initiation of the Project, national program/policy on parasite control and/or school health program were developed in some of these 8 countries, and the intervention of the Project would support on-going challenges. For instance, National Malaria Control Program, National Schistosomiasis Control Program and National Program for Elimination of Lymphatic Filariasis (NPELF) already existed in Kenya. So did in Zambia for malaria and lymphatic filariasis. Tanzania had National Program for Soil-Transmitted Helminthiasis Control Program (NSSCP) and Uganda had the national action plan on elimination of the disease. Tanzania and Botswana already had National Health Program.

(3) Comparative Advantages:

The Okinawa Infectious Disease Initiative (IDI) in 2000 addressed the effectiveness of Japanese experiences of parasite control and stressed the necessity of utilizing its experiences in the Global Parasite Control Initiative. During the postwar period, malaria, STH and filariasis were main parasitic diseases in Japan, but mass examination/selected treatment with health education was successfully eliminated STH. It is relevant to introduce the Japanese experiences on parasite control for effective training and control activities.

(4) Relevance to the Selection of the C/P Organization:

It was relevant to choose Kenya as a partner country of Japan for the promotion of GPCI in the Eastern/Southern African region because Kenya had an earlier technical cooperation and Third Country Training Program (TCTP) with JICA. The relevance of the selection of KEMRI as the C/P organization in

Kenya is fairly high. Advantages of partnership with KEMRI are seen in the fact that (a) KEMRI has numbers of parasitologists; (b) KEMRI has hosted the joint training program with the Institute of Tropical Medicine and Infectious Diseases (ITROMID) for MSc and PhD degree, and therefore training was not new to KEMRI; and (c) KEMRI can unite theory (operational research to design effective intervention on parasite control) with practice (training of a personnel to deliver integrated school-based parasitic diseases control in the region) within the Project framework.

4-2 Effectiveness

Momentum has been built for intensified progress to achieve the Project purpose since the Project was separated from the Research and Control of Infectious and Parasitic Disease Project in March 2003, but its influence is rather on the country context. More efforts are required to enable ESACIPAC grow into a regional centre for human resource development with the continuous support of KEMRI and the international society. At the same time, the priority for ESACIPAC should be put on the development of the Mwea model with mature integration of the three components (de-worming, health education and environmental sanitation) so that the model becomes the comprehensive school health program to be applicable to the region with evidence gained through operational research.

(1) Achievement of Project Purpose

< Institutional Capacity of ESACIPAC >

Main disadvantage ESACIPAC currently has faced is a shortage of staff who could be fully committed to the activity, and therefore its management and operation have depended more on capacity of limited number of individuals. The number of responsible staff is not so much the issue if the mechanism of the management cycle of the training program (planning, implementation, monitoring/follow-up) was established. From this point of view, two questions are raised to assess the institutional capacity of ESACIPAC. The questions are: (a) if the module for international training in which the concept of GPCI is incorporated has been developed; and (b) if ESACIPAC's staff would be able to facilitate the training with the developed module. At the time of the evaluation, the answer was not so optimistic, but the establishment of the regional training committee within KEMRI in 2005, headed by KEMRI deputy Director, can be well evaluated as the reflection of institutional commitment.

⇒ Capacity of ESACIPAC in management of International training: It could hardly be concluded that technical transfer by Japanese experts to Kenyan C/Ps in management of training was done satisfactory. This is because neither Japanese experts were identified explicitly for areas of management of training, nor Kenyan C/P(s) for technical transfer in the area identified. Management and operation of international training has been done with the initiative of the ESACIPAC Director in close consultation exclusively with Japanese team leader.

➤ **Quality of Module for International Training:** Three consecutive international training courses for mid-level policy makers and program managers were organized, and a total of 56 participants from 8 countries were trained in the past three years. However, the Terminal Evaluation Team found that the concept of GPCI has not been incorporated in the training module. This is mainly because (a) the Mwea model, composing of three components, did not exist at the time of the 1st international training and for the 2nd training, the de-worming activity could only be demonstrated to training participants. The 3rd training was conducted with the Mwea model for the first time; and (b) Neither ESACIPAC staff who have been committed to Mwea activities nor ex-participants to CIPACs trainings were involved enough in the process of curriculum/module development.

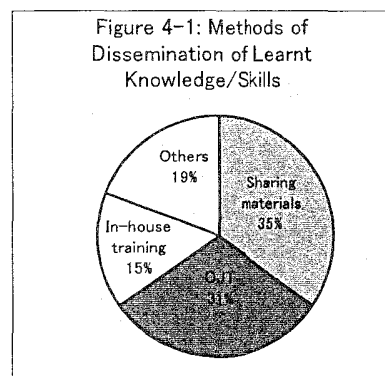
➤ **Capacity of ESACIPAC to Facilitate International Training with the Developed Module:** There has been limited number of ESACIPAC staff who could be identified as potential for future because the majority of sessions in the three international training courses has been facilitated by guest speakers from international organizations. The ESACIPAC Director/Coordinator and two other ESACIPAC/KEMRI researchers, who are in charge of Mwea activities, have facilitated the session of health promotion and environmental sanitation respectively, and therefore they are expected to play a leading role in facilitation of the international training course.

<ESACIPAC's Role of Capacity Building in the Region >

ESACIPAC's significant influence on the region has not been marked yet. It is reported and observed that ex-trainees have represented their countries in international conferences and meetings, including African Health Science Congress while some of them have worked on proposals on parasite control, but no pilot project supported by ESACIPAC has been launched in these seven countries.

Evaluating contribution of ESACIPAC training based on whether or not trained personnel have trained their colleagues on their return, it is reasonable to conclude that the Project has produced some degree of effectiveness in the regional context. As shown Figure 4-1, the questionnaire survey found that ex-trainees have disseminated learnt knowledge and skills to colleagues with various methods. Nearly half of respondents have shared acquired knowledge and skills at their work place either through on-job training or in-house training.

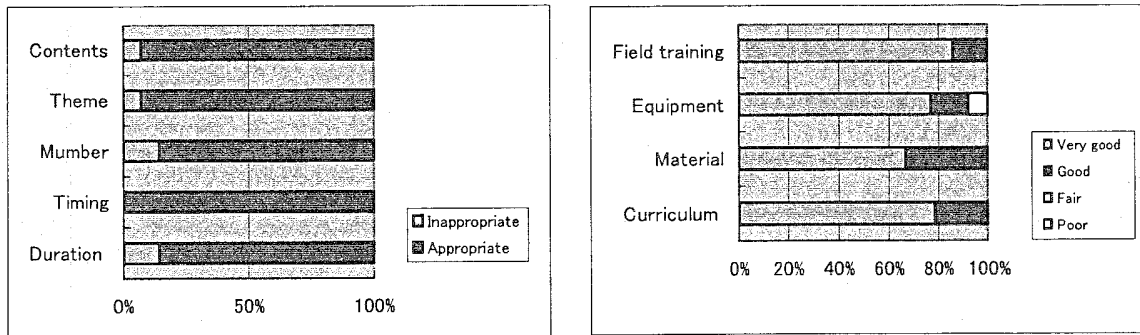
The result of the questionnaire survey to ex-trainees (Figure 4-2) explicitly shows that the international training course is well assessed by ex-trainees. This is evident from the responses to questionnaires by ex-trainees of ESACIPAC international training courses². Approximately 80% of the respondents said that they were very satisfied with the course and the rest said that they were satisfied with the course. Most



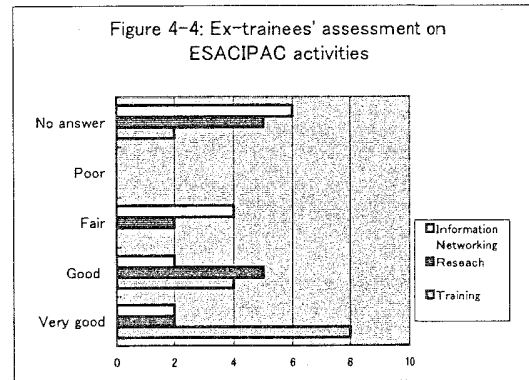
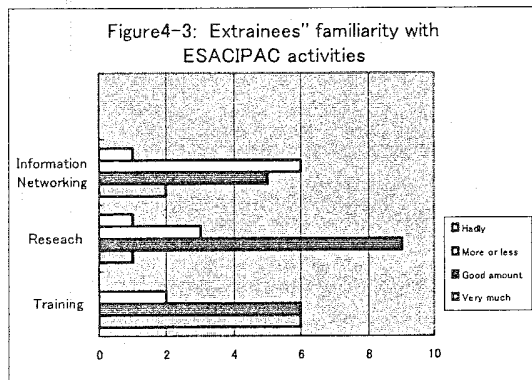
² Responses from 14 ex-trainees out of 56 from Kenya, Uganda, Tanzania, Zimbabwe, Zanzibar, Zambia and WACIPAC (Guana)

ex-trainees interviewed identified the session of Program Cycle Management as one of the best parts of the course and they have practiced the skill in their work. Some also pointed that the participatory approach learnt at the session was useful to involve the community and foster their ownership in the Project implementation in Mwea.

Figure 4-2: Assessment on International Training Course by Ex-trainees



The questionnaire survey also found that among three areas of ESACIPAC's activities, training, which is the biggest segment, is well assessed by ex-trainees in the region, but more intervention is necessary in information networking. The questionnaire survey found that more than 80% of the respondents have kept in touch with other participants and that e-mail is the major method of communication. A small number of ex-trainees interviewed said that they often visit ESACIPAC website.



(2) Promoting Factors and Hampering Factors:

Promoting Factors:

- (a) KEMRI's management support to ESACIPAC
- (b) Full commitment of the current ESACIPAC Director/Coordinator in ESACIPAC activities.
- (c) Harmonious working relations between ESACIPAC and other centres of KEMRI, especially Centre for Public Health Research (CPHR), Centre for Microbiology Research (CMR) and Centre for Biotechnology Research and Development (CBRD).

Hampering factors:

- (a) Initial change of ESACIPAC Director/Coordinator before 2003 and less number of full-time ESACIPAC staff than targeted.
- (b) Different level of understanding in the purpose of the Project (concept of GPCI) and ESACIPAC's mandate among ESACIPAC team members, including Japanese short-term experts and KEMRI staff on secondment to ESACIPAC.
- (d) Weak project management in such skills as planning, time management and risk management that caused the delay in the selection of the project site and the start of the international training course for district technologists.

4-3 Efficiency

Efficiency of the Project implementation is relatively low with provision of some equipment in more ad hoc manner and with a lack of managerial enforcement to coordinate dispatch of qualified Japanese experts for various specialized activities in a timely manner. Japanese inputs for C/Ps training in Japan and CIPACs produced less effective outputs as well. Despite such weakness in management, however, persistent efforts made by both Japanese experts and Kenyan C/Ps eventually led to fairly successful Outputs.

(1) Dispatch of Japanese Experts and Adequacy of C/Ps for Technical Transfer:

The questionnaire survey shows that the small number of Japanese long-term experts felt their expertise fully matched with Project needs and that the timing of dispatch and duration of their assignment were appropriate. Their assessment on dispatch of short-term experts is equally severer: the number of short-term experts and the timing of dispatch did not meet their needs and areas of expertise were inappropriate. Majority of C/Ps have similar dissatisfaction. The result of the questionnaire survey implies that both long-term and short-term experts were not fully utilized.³

Regarding the appropriateness of the allocation of Kenyan C/Ps in terms of the numbers, timings and areas of profession, there is a gap in assessment by both sides. Almost all Kenyan C/Ps responded to the questionnaire said that it was appropriate in all three categories, but less percentage of Japanese experts answered positively.

(2) C/P Training in Japan

The practice led to critical points of consideration. Five KEMRI/ESACIPAC staff have been sent to Japan during the 5-year Project period in areas of medical entomology, parasitology, networking and GIS system and Information network. Duration of training was approximately one year, except the training on information network which for about one month. The interview to three ex-trainees who have recently

³ List of Japanese experts which was attached to R/D signed in March 2003 between the two government said that fields of expertise for long-term experts would be Parasitology, Public Health/Health Education and other fields mutually agreed upon as necessary. Fields of expertise for short-term experts included Parasitology, Vector Biology and Information Network.

stationed in KEMRI/ESACIPAC found that all of them appreciated the training opportunities in Japan with appropriate timing and duration, and that upon return they shared new knowledge and skills with colleagues in KEMRI/ESACIPAC through in-house training session and OJT. Yet fields of training were not directly connected to ESACIPAC activities, and therefore relatively small benefits were brought to ESACIPAC to achieve the Project purpose. The Project could hardly benefit from one of the 5 ex-trainees as he had not been really involved in the Project before and after the training. The case was against the R/D signed in March 2003 between the two governments, agreeing that the Kenyan personnel sent for technical training in Japan would be required to serve in ESACIPAC upon return to KEMRI. The others have largely served in ESACIPAC activities.

The lesson learnt from the said example is that the Project-related TOR should be prepared before the training and expected commitment of trainees-to-be upon their return could be explicitly identified in advance. Secondly, trainees should be sent to Japan after his/her responsibilities within the Project were ensured. Lastly, critical assessment on the selection of trainees was brought from some of Project stakeholders: considering Project purpose routed in GPCI, it could be more practical and Project-oriented if at least one personnel had been trained in areas of public health.

(3) Study Tours to CIPACs

All respondents to questionnaires, both Japanese experts and Kenyan participants, marked that both timing and contents of the study tour was appropriate. Value of the tour was identified especially in opportunities to share similar problems on parasite control and learn lessons from the 2 CIPACs' challenges in development of integrated package of school-based parasite control which required full commitment of entire stakeholders. Participants interviewed said that they could explore the idea of school health and learnt how to involve ministries of health and education toward the goal, which led them to the success in Mwea. Majority of respondents believe, however, that the duration of the course was too long and that the learning opportunity should have been given more staff. More importantly from viewpoint of contribution of the study tour to the achievement of the Project purpose, ex-trainees should have been involved in the development of ESACIPAC training program.

(4) Provision of Equipment

Results of the questionnaire survey and interview found that most of Kenyan C/Ps were satisfied with the provision of equipment by the Japanese side in terms of quantity, quality, timing and kinds, but few number of Japanese experts saw the provision of equipment as appropriate. Special attention was drawn to the provision of weighing machines and height scales with cabinets for keeping data to all schools in Mwea in 2004 for the purpose of monitoring of development of children. The problem is seen in the fact that the provision was completed before the purpose was identified and that proper instruction of the measurement method and data keeping was not given at the time of provision. It is highly encouraged that ESACIPAC

makes the best use of those equipment for operational research.

On the other hand, Japanese experts appreciated the facilities and equipment provided by the Kenyan side, including set-up of the project office, establishment of Internet connection and allocation of full budget for internal travel of C/Ps.

(5) Local Cost by Japanese Side

The local cost support by the Japanese side was used to carry out the implementation necessary of all activities. There were no serious problems reported.

4-4 Impact

Through analysis of Project-related documents /reports, questionnaire survey, field observation, and interviews to stakeholders conducted during the terminal evaluation, the Team has confirmed that several positive changes have been noted as follows:

(1) Impact on Region

Evaluating the impact of the international training based on whether or not ex-trainees have launched pilot project(s) in their country, there was a small-scale initiative by ex-trainees in Uganda. However, it can be concluded that the Project has yet to give impact in the region. It was pointed out during the interview to stakeholders that if ESACIPAC had followed up more closely in the process and provided more enthusiastic intervention to and coordination with JICA Uganda Office on the right timing, the first contribution of ESACIPAC in the region would have been evident before the Project ends.

(2) Impact on Kenya

➤ Impact on Policy and Program

It is pointed out it was ESACIPAC that introduced the idea of health education in Kenya and that the country is going toward the comprehensive health program: (a) Development of school health policy is in the final phase; (b) Comprehensive school health program was included in the Kenya Education Sector Support Program (2005-2010) of Education Sector Support Program. In line with the plan, an annual lump sum of Kshs. 55,000 is allocated to all schools for the improvement of environmental sanitation such as safe water and toilets since 2005. The decision is not the direct impact of the ESACIPAC program, but according to AEO at Mwea, the Mwea model, in which the importance of hygiene is stressed, influenced the decision; (c) On the other hand, MoH will start de-worming at 6 districts in accordance with the Second National Health Sector Strategic Plan of Kenya (2005-2010); and (d) With MoEST fund, staff training on health education for MoEST and MoH at Kisumu was conducted in February 2006.

➤ **Impact on School Children and Community in Mwea**

- (a) De-worming has brought direct impact on school children: (a) The burden of parasitic diseases among school-aged children in Mwea reduced by more than 70% after one-year of de-worming. The infectious rate of shistosomiasis and STH declined from 36% in 2004 to 11.4% in 2005 and from 13.3% in 2004 to 3.0% in 2005 respectively; (b) Children have physically become stronger, leading to less number of absentee rate; (c) Academic performance of pupils has been improved.
- (b) Health education has caused behavioral changes in school children and their parents: (a) The number of children with shoes has increased. So has their parents; (b) Pupils currently wash their hands before eating and after toilet. Some households have made a leaky tin water container with a small hole at the bottom making a restricted water flow and (c) Pupils now use clean toilets.
- (c) Teachers who are the key role players for health education have been well motivated and it is observed that some schools have organized a health club with action plan. Also health day is set for the exhibition of health promotion to all schools in the educational zone and community. The school is the entry point for health education to the community.
- (d) The entire community was mobilized to construct toilets in 3 schools in Mwea and in the process the community people was sensitized on the importance of basic hygiene.

(3) Unexpected Impact:

No negative impact has either been reported or observed. Positive impact includes (a) de-worming covering non-schooling children, which has improved their health condition; (b) the success of Mwea produced similar interests from other divisions in Kirinyaga district and (c) teacher training manuals on de-worming currently in use by UNICEF and International Christian Services (NGO), which is the evidence that the contribution of ESACIPAC has been acknowledged.

4-5 Sustainability

Basis of institutional and technical sustainability to maintain the benefits of the Project has been established. Support from KEMRI and international society is a key for the future of ESACIPAC.

(1) Policy Support and Financial Sustainability:

It is highly possible that policy support to ESACIPAC will be sustained after the Project is completed because parasite control is one of the key strategic objectives identified in KEMRI's Strategic Master Plan (2005-2015) that is tied up with National Health Sector Strategic Plan II(2005-2010).

Financial sustainability is fairly high as well. As shown in Figure 4-5, the budget allocation to ESACIPAC activities has grown for the past 3 years and will be growing for future based on the scope of its activities, including activities in field sites. According to KEMRI Director, KEMRI would be able to provide financial support to ESACIPAC for in-country training but expect financial support from the

international society for international training.

Figure 4-5: Budgetary allocation for ESACIPAC (KSHs)

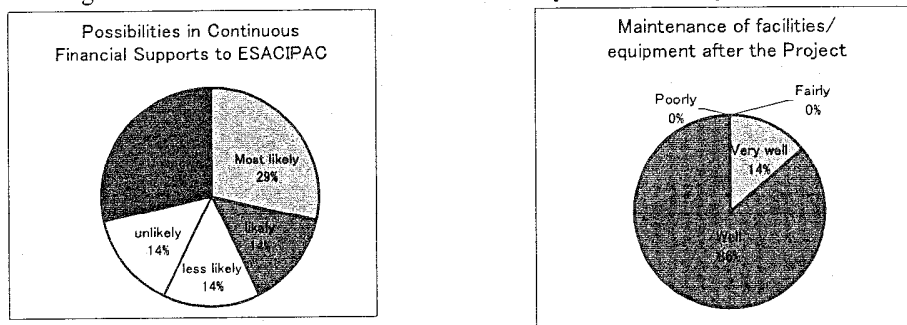
	Budget for the last 3 years (Actual)			Projected budget for the next 3 years		
	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009
Transport Operating Expenses	150,000	55,000	300,000	360,000	432,000	518,400
Local Travel & Accommodation	1,600,000	2,665,000	1,500,000	1,800,000	2,160,000	2,592,000
Telephone Expenses	40,000	96,000	150,000	180,000	216,000	259,200
Expenses of Board & Conferences	2,500,000	2,000,000	2,800,000	3,360,000	4,032,000	4,838,400
Drugs & Dressings	75,856	242,710	300,000	360,000	432,000	518,400
Research Materials	49,000	40,000	100,000	120,000	144,000	172,800
Purchase of Consumable Stores	20,000	20,000	80,000	96,000	115,200	138,240
Purchase of Stationery	25,000	30,000	150,000	180,000	216,000	259,200
Computer Stationery	40,000	15,000	200,000	240,000	288,000	345,600
Miscellaneous/other expenses	20,000	20,000	100,000	120,000	144,000	172,800
Maintenance of Equipments			600,000	720,000	864,000	1,036,800
Total	4,519,856	5,183,710	6,280,000	7,536,000	9,043,200	10,851,840

Sources: KEMRI (The budget does not include expenses for personnel, service/utilities and plant service/maintenance).

Looking at KEMRI's annual budget for the fiscal year of 2004/2005, only 1% of the total KSh.3.0 billion (US\$37,500,000) was raised from KEMRI's own internal sources. 53 % was allocated by the Government of Kenya and 56% was from externally sourced grants. KEMRI plans to increase the portion of internally generated revenue up to 15 % by the fiscal year of 2014/2015⁴.

Figure 4-6 below shows the perspective of ESACIPAC's core C/Ps on financial sustainability of ESACIPAC and its capacity of maintenance facilities/equipment without external supports after the Project ends in April 2006. The questionnaire survey reveals that staff are not sure about financial credibility of ESACIPAC, but that most of C/Ps are confident of maintenance of facilities and equipment. Japanese experts have similar perspective.

Figure 4-6: ESACIPAC's financial sustainability: assessment by ESACIPAC core C/Ps



⁴ Strategic Master Plan (2005-2015): Meeting the Health Challenges of the 21th Century, Kenya Medical Research Institute, 24th May 2005, P28

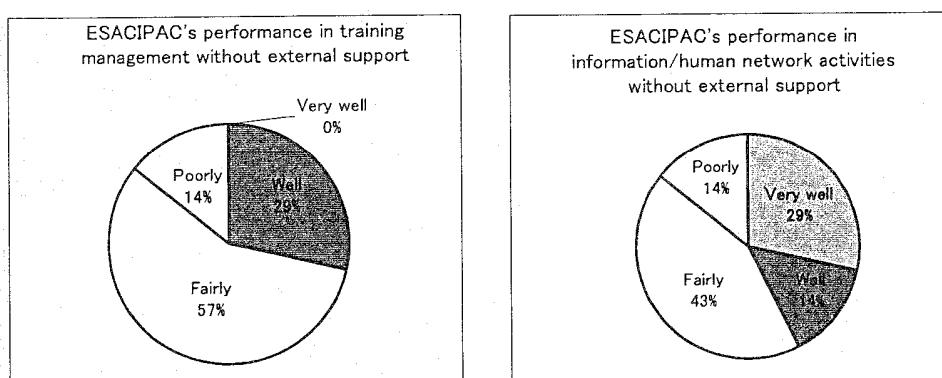
(2) Institutional Sustainability:

Unlike other KEMRI centres, ESACIPAC currently has certain unique features: it is expected to be one of the key KEMRI's centres and to grow up as a regional centre as well. In the current picture, the regional centre (ESACIPAC) is located within KEMRI. KEMRI is aware of its responsibility to support the newly born ESACIPAC to develop to be a regional centre, and the fact that the strengthening of ESACIPAC is marked as one of the institutes' key objectives for the following year⁵ is an evidence of KEMRI's serious commitment to the new challenge. To this end, recruitment of scientific and technical staff is in progress, the regional training centre was completed within KEMRI in 2005 and KEMRI has allocated an annual budget to ESACIPAC for the next 3 years as shown in Figure 4-7 above. With the training centre, which was established on Japanese grant aid and is scheduled to open in March 2006, ESACIPAC will enhance its status in Kenya and in the region.

To ensure ESACIPAC to fulfill the expected mandate as a centre of excellence in future, supports from international society is necessary at least during the transition period from the stage as a "national centre" to the stage as a "regional centre" in a long run. It is an advantage for ESACIPAC that it has successfully developed partnership with WHO/AFRO in training during the Project, but more collective action (donor coordination) is required to ensure its contribution to the region in line with Focus Resources on Effective School Health (FRESH) which was declared in 2000 by WHO, UNESCO, UNICEF and the World Bank.

Figure 4-7 below shows that the majority of ESCIPAC core C/Ps believe that ESACIPAC is capable of managing training and information/human network activities without external support. Japanese experts have reservations on whether their C/Ps who are currently working in ESACIPAC under fixed-term secondment will remain within ESACIPAC after the end of the Project.

Figure 4-7: ESACIPAC's Institutional Sustainability: Assessment by ESACIPAC core C/Ps⁶



(3) Technical Sustainability:

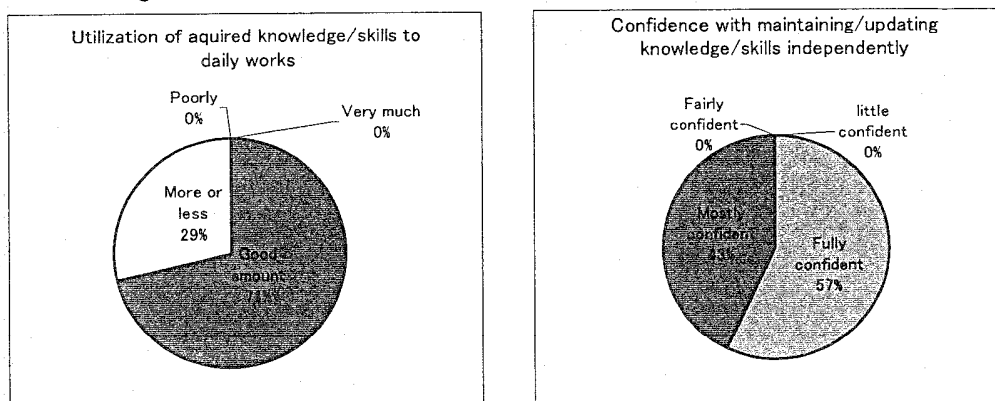
Responses from core C/Ps to questionnaires (Figure 4-8) shows that all C/Ps recently have utilized

⁵ Interviews on February 8, 2006 to KEMRI Director, Deputy Director and ESACIPAC Director/Coordinator.

⁶ Results of Questionnaire to ESACIPAC C/Ps: 3 researchers, 2 technologists, 1 communication officers and 1 admin. staff

knowledge and skills learnt through international training/symposium or/and technical transfer by Japanese experts, and that all of them are confident with maintaining and updating such knowledge and skills independently. Assessment by Japanese experts implies that there is some room for improvement in all three areas of activities: training, research and information networking.

Figure 4-8: Technical sustainability: self-assessment by core ESACIPAC C/Ps



4-6 Conclusion

Evaluation in accordance with PDM concludes that the Project was nearly successful with outputs and impact produced during the Project period with strong ownership of Kenyan C/Ps which leads to sustainability after the end of the Project in April 2006. However, the result of evaluation in line with the concept of GPCI could hardly come with the conclusion that the Project has contributed enough to strengthen parasite control in neighboring countries because the Mwea model of integrated school-based parasite control is still immature to be shown as an applicable model. Additional efforts to formulate the comprehensive package of school health is highly encouraged.

5. Recommendations and Lessons Learnt

5-1 Lessons Learnt

Based on experiences from Project's implementation, the following lessons are drawn:

- (a) It was well examined and evidenced at the Project site that the school-based approaches to control of parasitic diseases is effective;
- (b) With findings through operational research as evidential data of its effectiveness, the Mwea model could have been introduced to participants of the international training course;
- (c) When the Project gained momentum, PDM should have been carefully reviewed and revised with focus on effective support for neighboring countries to initiate school-based parasite control activities, along with strategic budget allocation;
- (d) Setting result-based indicators in PDM and conducting objective-oriented monitoring would be

- critical to secure effectiveness and efficiency; and
- (e) Timing of C/P training in Japan should be strategically coordinated in the overview of the Project plan and qualification of the nominees should be carefully considered so that experiences in Japan can benefit the Project.

5-2 Recommendations

In order to strengthen capacity of ESACIPAC as a centre for human resource development in the Eastern and Southern Africa for effective control of parasitic diseases, the Evaluation Team recommended that:

- (a) ESACIPAC Project Team should jointly review the current training module for the international training course and make a revised version in which the concept of GPCI is well incorporated before the end of the Project.
- (b) ESACIPAC should compile pilot experiences in Mwea into a document by the end of the Project and should establish explicit definition and roles of Mwea activities within the context of the international training course.
- (c) Observing that there has not been any significant impact of ESACIPAC on parasite control in the region, ESACIPAC should consider methods of replicating its pilot experiences in Mwea to other countries in the region, suitably in consultation with relevant international agencies.
- (d) Noting that one of the key objectives of ESACIPAC is human resource development, and using the new Regional Training Centre, there is need to enhance third country training programme on international parasite control.
- (e) ESACIPAC should consider effective strategies for follow-up of ex-trainees of the international training course.

ANNEX I	Project Design Matrix
ANNEX II	List of experts
ANNEX III	List of equipments
ANNEX IV	List of training activities for the Counterparts
ANNEX V	Operational Cost from the JICA Project fund
ANNEX VI	List of C/Ps in KEMRI
ANNEX VII	Operational Cost from KEMRI