RED/DQS TRAINING WORKSHOP

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Review of RED Approach and DQS

- Review PMTCT/MCH programme performance in Bondo
- Familiarize with the RED approach and its components
- Share experiences on feasible ways of reaching the pregnant women using RED approach.

EXPECTED OUTCOMES

At the end of the workshop, participants to be able to:

- ❑ Understand and apply the REC approach.
  - Describe ways and means of reaching target populations in their respective Facilities.
  - Identify effective methods for linking with communities
  - Outline steps for effective **supervision**
  - Understand the key issues in monitoring and using data for taking action
  - Appreciate the importance of good planning and management of resources
- ❑ Understand and apply the DQS methodology in improving MCH data quality.

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Overview of the Reaching Every District/ Pregnant Woman Approach

WHAT IS RED APPROACH?

What is RED Approach?

- **Prioritizing districts and health facilities by unreached pregnant women.**
  - Proportion
  - Total number
- **District and health facility focus**
  - Assessment and problem solving
  - Planning, budgeting, implementation, monitoring
  - Adequate funding and capacity for implementation
- **Annual milestones for unreached pregnant women.**

Five operational components needed to reach every district

- **Planning and managing resources**
  - ***better management of human and financial resources***
- **Re-establishing outreach services**
  - ***regular outreach for communities with poor access***
- **Supportive supervision**
  - ***on site training by supervisors***
- **Community links with service delivery**
  - ***regular meetings between community and health staff***
- **Monitoring and use of data for action**
  - ***DQS, chart doses, map population in each health facility***

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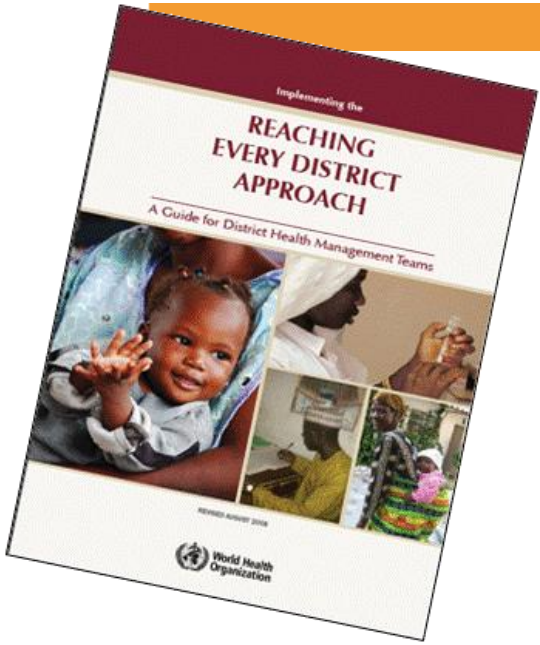
Enhanced RED Approach Framework emphasizes integration and targeting at health facility level



Essential Building blocks (Components) of 'RED' Approach

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IMPLEMENTING THE RED APPROACH

RED Approach Implementation Framework

Planning			Implementation	Monitoring & Evaluation
COMPILE (population and Coverage data)	**ANALYZE** (problems, causes and solutions)	**PRIORITIZE** (Where First, What First)	**IMPLEMEN-TATION** (Service delivery)	**MONITOR, REVIEW AND ACT** (Progress, Issues and Next Steps)

RED Activities at District level

Planning

Compile, Analyze and Prioritize

District Microplaning

District Level

Health Facility level

Health Facility Micro planning: Compile, Analyze Prioritize and Plan

THANK YOU!

FOR REACHING OUR DISTRICT AND VILLAGE

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Reaching The Target Population using the RED Approach

Target Population for RED Approach

- Unreached pregnant mothers
- Unvaccinated children
- Unvaccinated mothers

STEPS FOR REACHING THE TARGET POPULATION?

RED Approach Implementation Framework

Planning			Implementation	Monitoring & Evaluation
COMPILE (population and Coverage data)	**ANALYZE** (problems, causes and solutions)	**PRIORITIZE** (Where First, What First)	**IMPLEMEN-TATION** (Service delivery)	**MONITOR, REVIEW AND ACT** (Progress, Issues and Next Steps)

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COMPILE

Compile population and coverage data (District Level)

- List all the facilities
- Get the estimate target population of each facility
- Obtain the absolute figure of pregnant mothers accessing ANC 1 & ANC 4
- Calculate coverage for each health facility

Compile population and coverage data (District Level)

Draw a simple District map showing the following important information:

- Location of each Health Facility;
- Total population and target population of each Health Facility;
- all known high-risk or priority areas;
- Important roads and geographical landmarks (rivers, streams, mountains);

Compile population and coverage data (HF Level)

- List all the villages
- Get the estimate target population of each village
- Obtain the absolute figure of pregnant mothers accessing ANC 1 & ANC 4
- Calculate coverage for each catchment area

Compile population and coverage data (Health Facility Level)

Draw a simple map of the HF catchment area. Mark the following important information on the map:

- Location of each village;
- the total population and target population of each village;
- distances between village and health facility
- transport frequently used by HF to reach village and time (if known)
- all known high-risk or priority areas;
- roads and geographical landmarks (rivers, streams, mountains);

ANALYZE THE COVERAGE PROBLEM

Analysis of problems

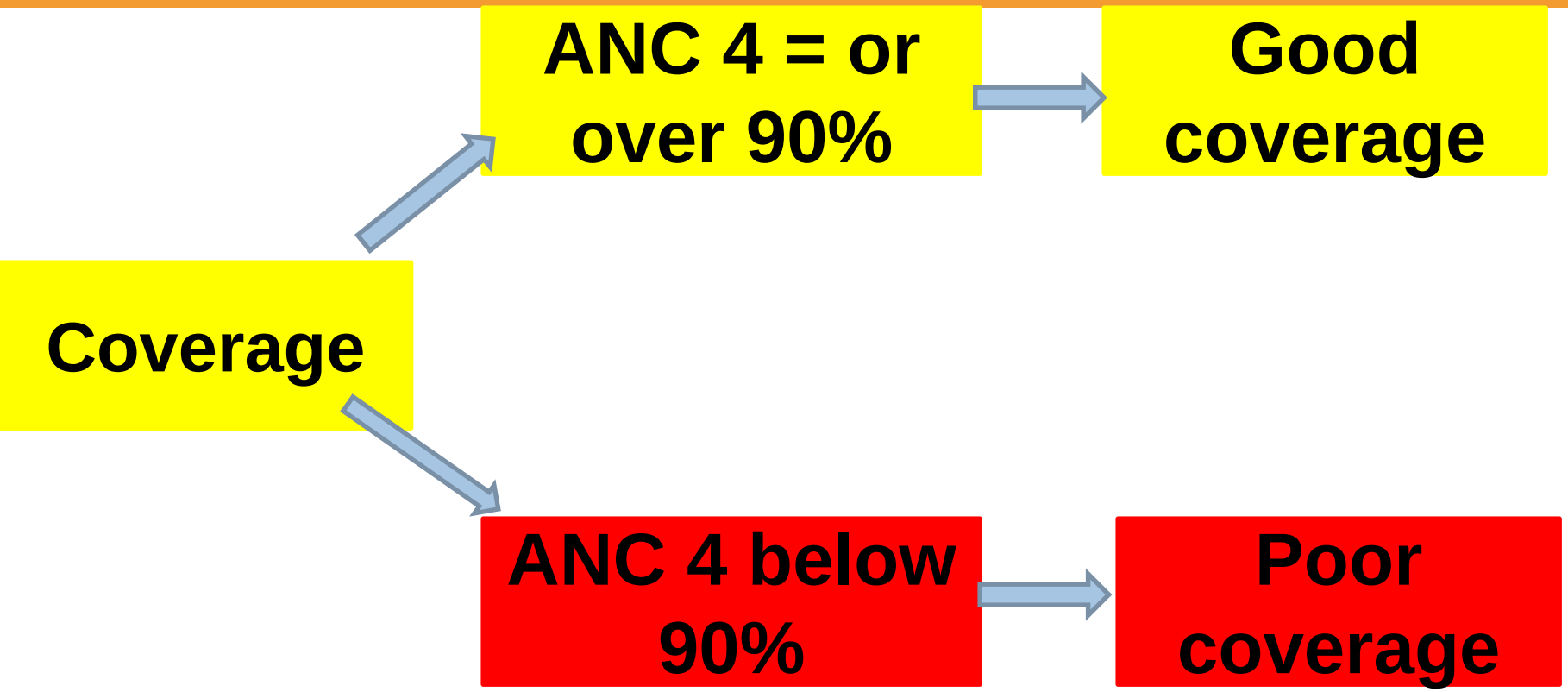
- Calculate Un reached pregnant mothers
- Calculate Drop-out rates
- Identify type of performance problem

Calculation of coverage

- Pregnant women accessing ANC 4
- Coverage of ANC 4

- **Low coverage of ANC 4 means there is problem of ANC services**

Categorization of *coverage*



ACCESS

- Possibility of the person reaching the intended place easily and getting service

- ANC access: determined by 1st ANC visit
  - Are they coming? Yes – access good
  - If not – Access poor.
  - Identify the reasons of not accessible

Utilization

- Continuation of using the services
- ANC utilization: determined by ANC 4 coverage
  - Do they continue to use the services? Yes, drop out is low.
  - If not -high drop out. They can not finish required scheduled visits.
  - Why?? Not utilizing the services
  - Identify the reasons of not utilizing services

Calculation of Utilization

- Pregnant women accessing ANC 1
- Pregnant women accessing ANC 4
- ANC 1 – ANC 4 = Pregnant women who have dropped out from the service
- Drop out rate: multiply 100 (standardization)

$$\frac{\text{ANC 1} - \text{ANC 4}}{\text{ANC 1}} \times 100$$

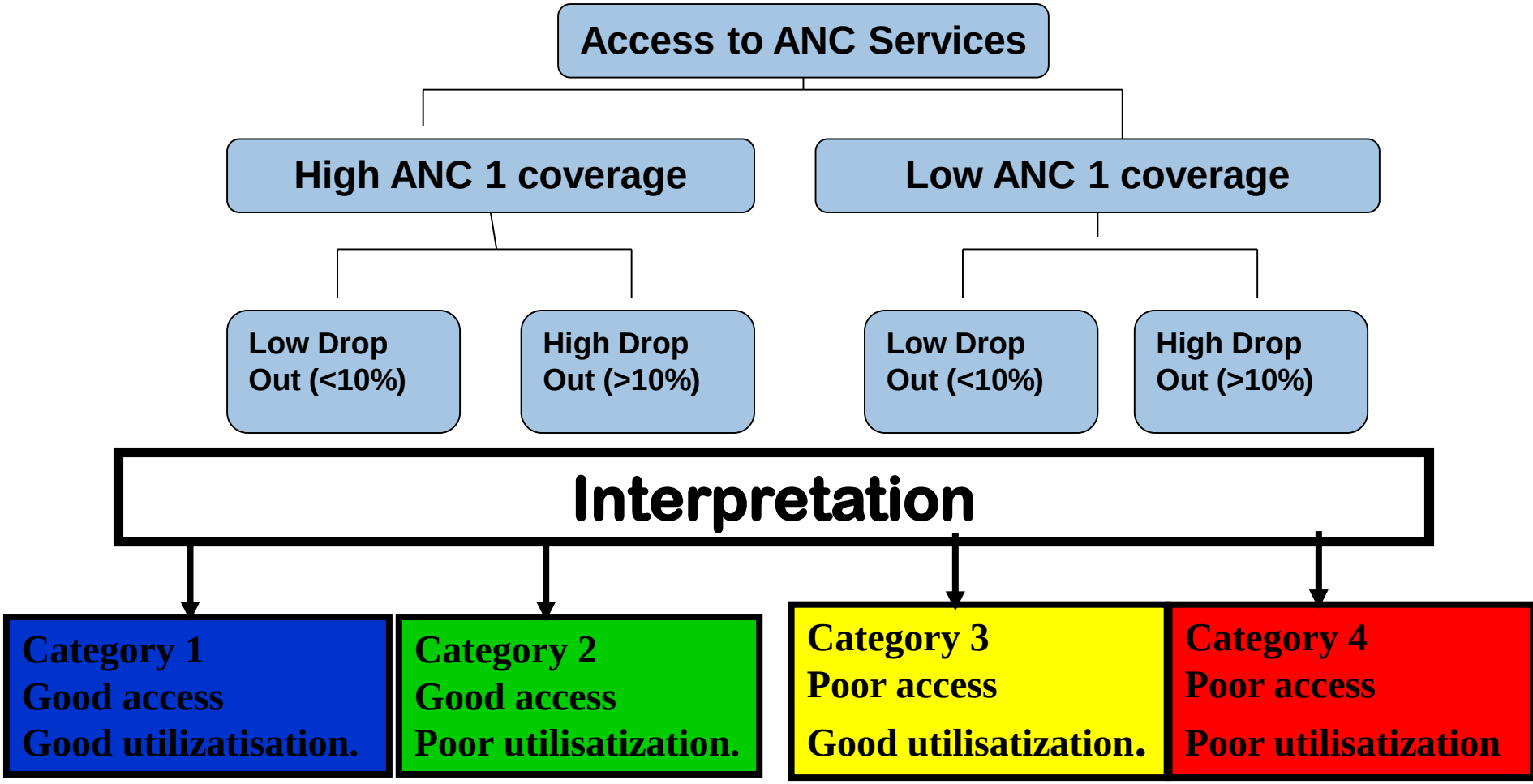
Categorization of *utilization*

Utilization

Drop out rate below 10% → **Good utilization**

Drop out rate = or above 10% → **Poor utilization**

Categorization of access and utilization



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PRIORITIZE

Limitation of using categorization in *reaching every child*

- Access / Utilization may not show the districts or health facilities with high number of un-vaccinated children

Health Facility	Target Pop	ANC 1	ANC 4	% ANC 1	% ANC 4	Unreached	Drop out	Access	Utilisation	Category 1,2,3,4
Kizumbi	358	287	254	80.2%	70.9%	104	11%	good	poor	Cat 2
Utinta	644	544	514	84.5%	79.8%	130	6%	good	good	Cat 1
Kazovu	359	259	240	72.1%	66.9%	119	7%	poor	good	Cat 3
Namansi	326	258	232	79.1%	71.2%	94	10%	poor	poor	Cat 4
Mandake	150	98	73	65.3%	48.7%	77	26%	poor	poor	Cat 4

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Limitation of using categorization in *reaching every child*

- Where do you focus to first in order to ensure that you reach every child with the little resources you may have???

Health Facility	Target Pop	ANC 1	ANC 4	% ANC 1	% ANC 4	Unreached	Drop out	Access	Utilisation	Category 1,2,3,4
Kizumbi	358	287	254	80.2%	70.9%	104	11%	good	poor	Cat 2
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THE RED APPROACH PLANNING TOOL

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Reaching the Target Population

Step 3: Develop individual microplans with health facilities

- Discuss with the facilities staff: Why are they not reached?
- Could it be:

Distance from health facility	**No outreach services**
Shortage of transport & fuel	**Non compliant care givers**
Staff shortage/knowledge gap	**Too many children/session**

Where to focus: Prioritize

- Select the facilities which are contributing a big number of unreached pregnant women
- Avoid to over stretch the resources
- To be realistic - 10 facilities
- Experience shows 10 facilities contribute more than 50% of unvaccinated children

Why are they not reached?

- Discuss with the facilities staff: Why are they not reached
- Example:
  - Distance from the health facility
  - Operational hours
  - Shortage of staff
  - No outreach services
  - Non compliance due to lack of knowledge
  - Long waiting time
  - Hard to reach

Reaching the Target Population

Step 4: Implement and monitor

- Coordinate with community leaders to prepare for outreach sessions (when, where, how community can contribute..)
- Conduct sessions as planned and monitor coverage
- Monitor whether sessions are being conducted as planned

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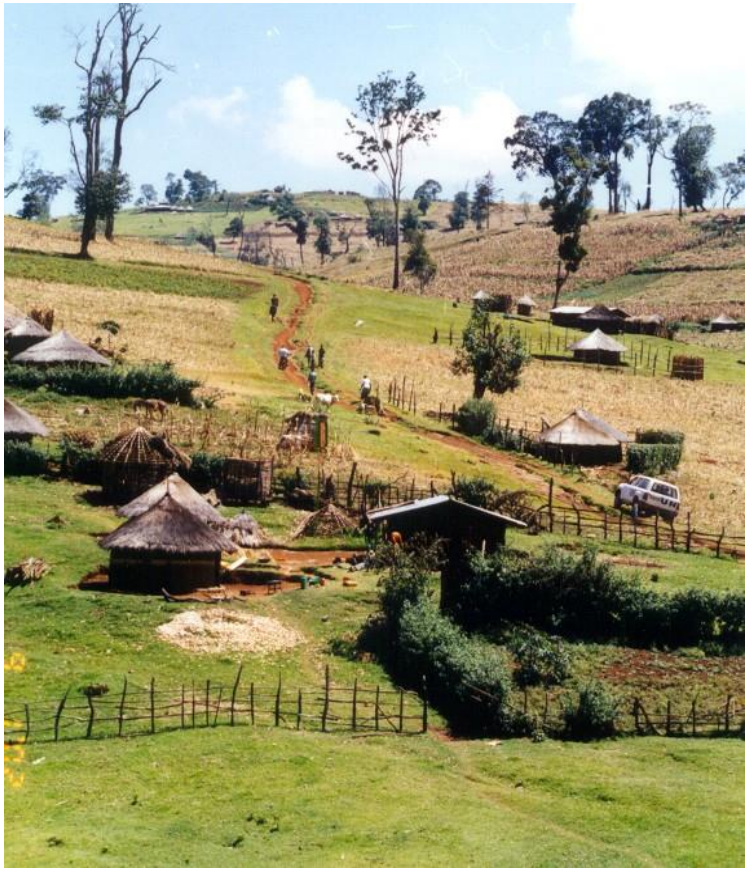
Reaching the Unreached…



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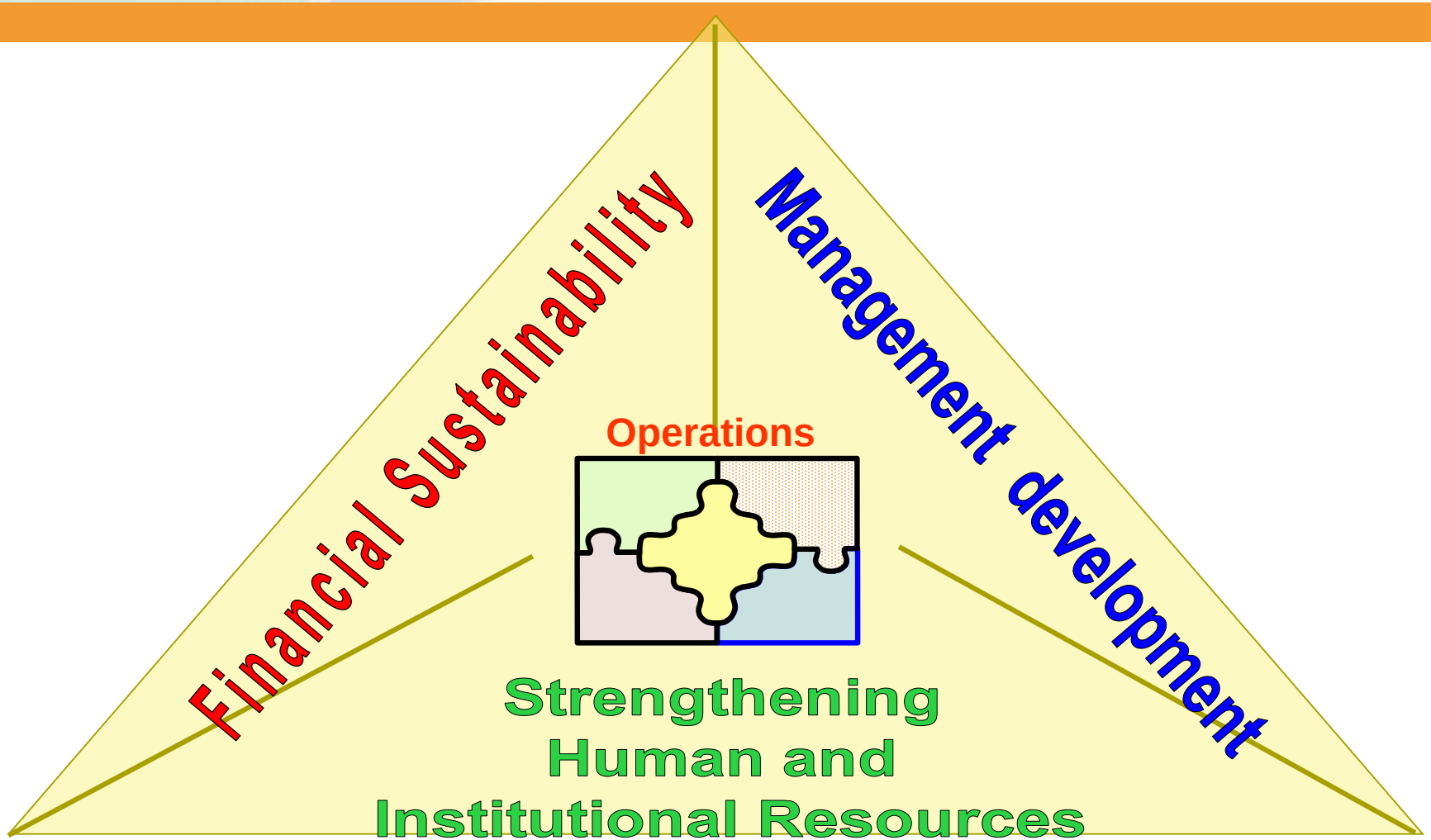
Planning and Management of Resources

Introduction

- Planning is a continuous process for analyzing data, evaluating achievements and constraints, and taking decisions to achieve the objectives.
- It is a process that helps to expose all the problems associated with integrated service delivery and to develop appropriate strategies for resolving them
- Planning is a vital management function that helps to systematically improve effectiveness of the RED Approach.
- Planning facilitates identification and prioritization of programme needs to improve performance.

Supporting elements of the health system.



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Types of plans

	Multi-year National (Strategic)	Operational
Frequency	3-5 years	1 year or less
Scope	All ANC activities	All ANC activities
Content	– Mission – Policies – Situation Analysis – Long-term goals and objectives – Strategies – Major activity areas – Timeline of implementation – M & E of implementation – Costing and financing – Resource requirements	- Situation Analysis - Objectives - Strategies - Detailed activities - Timeline of activities - Supervision - M & E of implementation - Detailed budget - Identifying resources

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Planning Process

SWOT

IDENTIFYING PROBLEMS & SELECTING PRIORITIES

- Where are we now?
- What are the most important issues to address?

Assessment

SETTING OBJECTIVES and TARGETS & DETERMINGING STRATEGIES and ACTIVITIES

- Where do we want to be?
- How do we get there?
- Who is responsible for what, when?

Developing Multi-year and Annual Plans

QUANTIFYING RESOURCES and BUDGETS

- What do we need?
- Where do we get it from?

Developing Multi-year and Annual Plans

USING THE PLAN

- Is all going as planned?
- Are we where we wanted to be?
- What changes are needed?

Implementing, Monitoring, Evaluating & Revising Plans

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Analysis of ANC coverage problems

What proportion of the pregnant women have ACCESS to ANC services?
(What is the ANC 1 coverage?)

HIGH coverage with ANC 1 (≥90%)

LOW coverage with ANC1 (<90%)

What proportion of pregnant women COMPLETE the 4 scheduled visits?
(What are the drop-out rates)

High coverage with ANC 4 (≥90%) and drop-out rate < 10%

High coverage with ANC 4 (≥90%) and drop-out rate ≥10%

Low coverage with ANC 4 (<90%) and drop-out rate < 10%

Low coverage with ANC 4 (<90%) and drop-out rate ≥ 10%

How should these RESULTS be interpreted?
(Action points to improve coverage)

- **Drop-out rates are low and coverage is high.**
- **Encourage the health facilities in this area to share successful strategies**

- **Reducing drop-out rates will result in rapid improvements in coverage**

- **Access to ANC services is limiting ANC coverage**
- **Review your outreach services strategy!**

- **Access to ANC services combined with high drop-out rates is resulting in low coverage**
- **Identify strategies to increase access.**

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SWOT analysis – a tool to analyze information

Impact	*Internal Environment*	*External Environment*
Positive	**Strengths**	**Opportunities**
Negative	**Weaknesses**	**Threats**

Indicators for Monitoring and Evaluation

- Timeliness and Completeness of reporting
- Coverage and the unvaccinated
- Dropout rate
- Monitoring Chart updated
- Outreach vaccinations in target groups
- DQS done in the last three months
- Number of defaulters traced

NB: these indicators to be submitted monthly by health facilities and quarterly by districts

Quantifying Resources and Budget

Quantify the following resources

- Human
- Material
- Financial
- Information
- Time

Budgeting tips

- Estimates should be realistic
- Avoid duplicating costs
- Be comprehensive but ensure the largest costs are most accurate.
- Separate recurrent from capital costs
- Strive to indicate sources of funding

Summary

- Planning is a continuous process, linking different levels in a country
- The planning process should as much as possible involve all partners/stakeholders
- It should be preceded by a situation analysis
- The plan should be based on a sustainable source of funding
- Implementation of the developed plan should be monitored and revised, when necessary

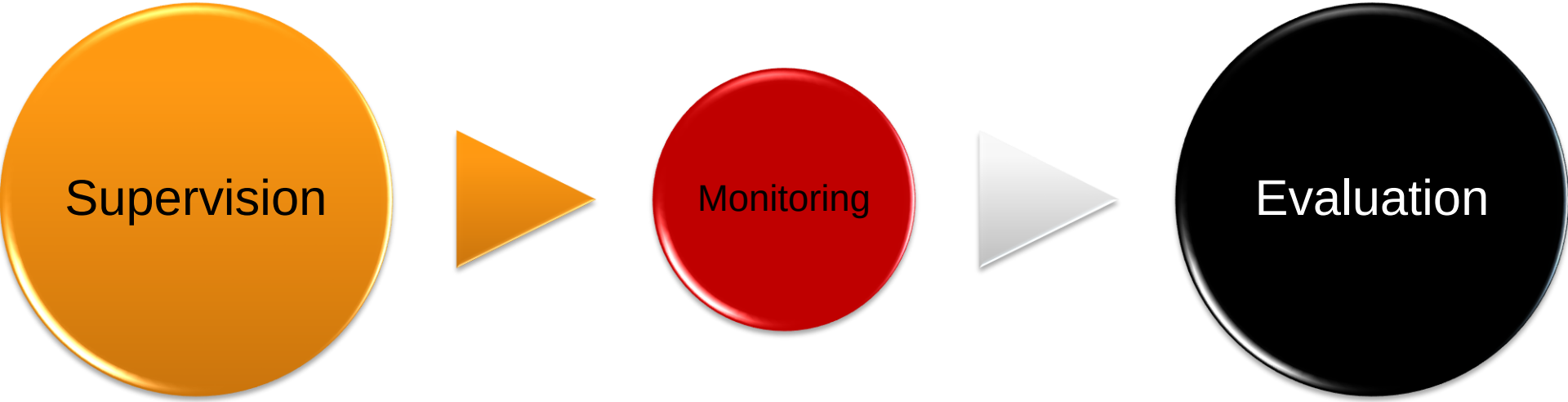
Supportive Supervision

Session Outline

- Supportive Supervision: What's new?
- The Supervision Process – Making it More Effective

SUPPORTIVE SUPERVISION FOR RED APPROACH: WHAT'S NEW?

SUPERVISION, MONITORING AND EVALUATION: Know the Difference?



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SUPERVISION, MONITORING AND EVALUATION: Some Key Words

Supervision

- On-site Training; Coaching, Capacity Building

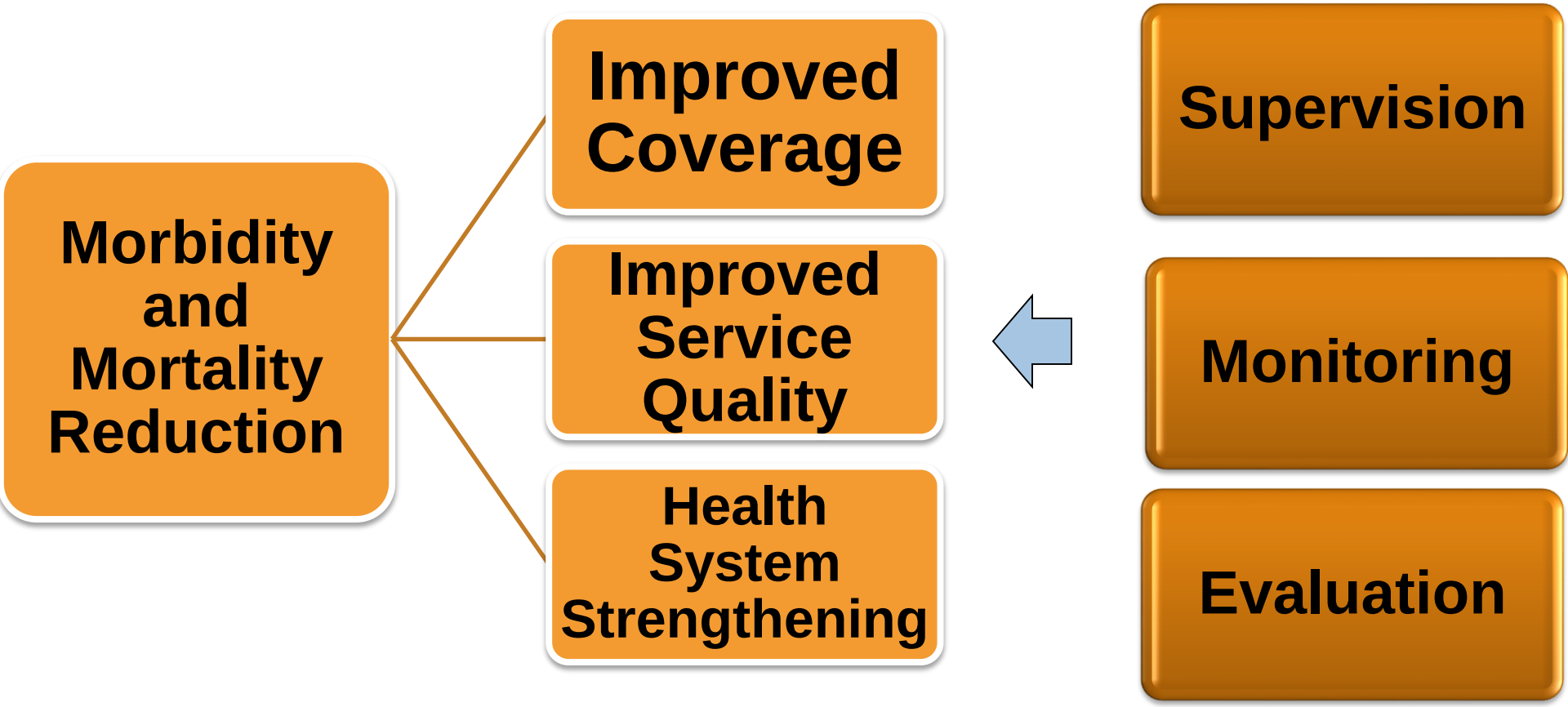
Monitoring

- Checking progress against plan

Evaluation

- Review effectiveness, Impact

Objectives of Supervision, Monitoring and Evaluation



COMPARISON OF TRADITIONAL AND SUPPORTIVE SUPERVISION

Parameters	Traditional supervision	Supportive supervision
Who conducts supervision	External supervisors	External supervisor, colleagues, staff themselves, community
Frequency of supervision	Periodic visits: monthly/quarterly	Continuously: routine work, team meetings + periodic visits
How supervision is conducted	Inspection, review of records, instructions by supervisor	Observation, dialogue, diagnosis, feedback, discussions, on-site training
After supervision	No or irregular follow-up	Recording, monitoring and follow-up

SUPERVISION- an OPPORTUNITY to…

- Identify problems and solve them
- Help service providers improve their performance
- Ensure uniform adherence to set standards
- follow up on decision reached during previous visits
- Identify staffing needs e.g. training and personal development
- Maintain and reinforce the administrative and technical link between high and lower levels

SUPPORTIVE SUPERVISION: Major Challenges?

- Lack of supervisory skills and knowledge
- Infrequent or irregular supervision due to lack of resources
- Narrow focus on inspection of certain areas
- Critical and Punitive approach
- Supervisor lacks authority to reward or sanction performance

THE SUPERVISION PROCESS – MAKING IT MORE EFFECTIVE

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Effective Supportive Supervision: the CHANGE required…

- **CHANGE:**
  - Need to change objectives of supervision
  - Need to change frequency, duration and nature of supervisory encounters
  - Need to make supervision more supportive and facilitative

Focus of RED Approach Supportive Supervison

- Focus on problem solving
- Collective responsibility of supervisor & supervisees
- Empowers health providers to monitor and improve their performance
- Review the quality & reporting of the available data
- Supervisor facilitates, trains and coaches
- Supervisees participate in supervising themselves and each other
- Decision-making is participatory

Style of Supervision

POLICE Vs COACH

Which one are you???

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Programme Management Framework

Plan	Supervision / Capacity Building	Service Delivery	Monitor	Evaluate
Planning	Implementation		Monitoring and Evaluation	

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The Supervision Process

Planning the Visit

- Supervision Action Plan and Budget
- Supervision Checklist
- Set objectives

During the Visit

- Observation
- Collecting Information
- Provide on-site training and Problem Solve

After the Visit

- Give Written Feedback
- Prepare Your Report
- Send Report to higher level
- Do Follow-up visits

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Elements of RED Supervision

- **Observation**
  - Health Facility Environment
  - Health facility staff – as he/she performs routine tasks,
  - Remember to praise performance in public and discuss poor performance in private.
- **Collecting Information.**
  - Interact with health workers
  - Review of available records
  - Talk with community members or clients to learn how they appreciate the services
- **Provide ON-SITE TRAINING to Clinic staff and help to SOLVE PROBLEMS**

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After the Visit: Making Your Visits Count

- **Provide Written Feedback on the Supervision Visit**
  - Use Supervision Book
- **Preparing a Supervision Report**
  - Performance of health workers
  - Creativity and capacity of staff to solve problems
  - End with the recommend improvements
- **Follow-up visits**
  - Conducted as often as required
  - Follow up on issues raised in previous supervision

Linking Services with Communities

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Outline

- Definition and significance
- Key issues to consider
- Implementation steps/process
- RED Approach Tools

The five RED components

- **The components are:**

- Planning and Management of resources
- Reaching Target Population
- Linking services with communities
- Supportive Supervision
- Monitoring for action

What is a community?

- Community is a group of people living in the same geographical area, also people identify strongly with the same religion, political party economic set-up etc

Significance of Community Linkage

- To partner with communities to promote and deliver ANC services.
- Health staff to work with communities to manage and implement MCH services and other health services through regular meetings.
- To create demand for ANC services
- To ensure that immunisation services are addressing community needs

Why community linkages?

The community members are the:

- Right holders for our services
- Change Agents
- Access to knowledge, information for improved awareness, decisions and development initiatives
- Encourage full commitment, participation and ownership
- Encourage voluntary demand for services
- Platform to measure the impact of services

Links between services and community

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What can be achieved through CL?

- Enhance community ownership by ensuring their involvement in planning and utilisation of ANC services
- Improve interaction of health workers and clients at every point where services are provided to the public
- Identify and develop links with community structures (e.g. religious groups, women's groups, NGOs, traditional leaders)
- Strengthen capacity of health workers to communicate effectively and actively with clients and the community

Which communities can contribute to unreached pregnant women?

- The religious groupings
- The elites
- Families on the streets
- The highly mobile populations e.g. fishing communities
- Refugee communities
- Geographically hard to access

What are the barriers to linking services with communities?

- Inadequate community involvement and interaction in planning right from inception of the process
- Absence of a well-defined communication strategy
- Suboptimal communication skills or practices of health care workers, community leaders and policymakers
- Competing health priorities and over-committed staff; reliance on volunteers; funds

Building effective community partnerships (1)

- **Generate support** for ANC services from political leaders and decision-makers, community groups, and household members.
- **Enhance community ownership** by ensuring its involvement in planning and utilization of ANC services.

Building effective community partnerships (2)

- **Improve the interaction** between HW and community/client at every point where "service" meets the public.
  - Fixed facility
  - Mobile/Outreach
- **Help to reach** the hard-to-reach and **convince** the hard-to-convince
- **Respond** to adverse events and rumors

Key Communication Components for RED

1. **Community –Social Mapping**

   Identify and develop links with community structures (e.g. religious groups, women's groups, CBOs/NGOs, traditional leaders) and involve them in planning for and supporting household use of ANC services.

Key Communication Components for RED

2. Health system – IPC Training

- Strengthen the capacity of health workers to communicate effectively with clients and community.

- Strengthen capacity of HWs in planning communication activities for ANC services.

Key Communication Components for RED

3. **Media – Community radios, drama, music, etc**

   Develop a media network that is informed on MCH issues so it can report accurately and be an effective ally of MCH service delivery and utilization.

Key Communication Components for RED

4. **Advocacy at community level**

   Develop and implement an advocacy strategy aimed at local political leaders, partners and stakeholders to promote long term commitment, community ownership financial support.

Compile: Social Mapping of Gate-keeper/Partner Analysis (Tool 3)

- To initiate community dialogue to discuss problem and propose solution.
- To obtain an understanding of the issues and commitment to solve problem.
- To ensure collective action - community participation
- To agree on role and contribution of the community

Tool 3: Social Mapping: Stakeholder/Partner Analysis

Province: _____ District: _____ Health facility: _____

Catchment Area Name (Village, Sublocation, Location	Community/Influential leaders		School		Religious Institutions (sect)/ Traditional Practitioner		NGOs / CBOs/ Extension Workers, Farmers & Business Name Others	
	Name	Title	Name of School	Focal person	Name	Focal person	Name	Focal person

Current strengths of key partners.
Opportunities and challenges;

Social Mapping - Get to know the community

- Where are they?
- What do they do?
- What is the best time to reach them?
- Where are the hard-to-reach?
- Who are they?
- Who are their leaders?
- Who do they listen to regarding health matters?
- What language/channel is best used?
- Who are the defaulters & Why do they default?

Activities for linking services with communities

- Training of community volunteers on Defaulter tracking
- Advocacy / Sensitization meetings with various groups (community and religious leaders, parents, teachers, NGOs, private health practitioners, special groups, local authorities etc)
- Inter-personal Communication skills training for health workers
- Sensitization & feedback on performance to community leaders

Analysis of Communication needs

- Possible scenarios:
  - 1. High Access/High drop-out
  - 2. Low Access/Low drop-out
  - 3. Low Access/High drop-out
  - 4. High Access/Low drop-out

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RED Approach Implementation Process

Health Facility

Planning

Compile, Analyze and Prioritize

District Micro planning

District Level

Health Facility level

Health Facility Micro planning: Compile, Analyze and Prioritize & Plan

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Health facility level: compile and analyze data analysis

- In collaboration with Health Facility staff review the available ANC administrative data
- Line list all villages/settlements/estates with
  - target population
  - Reached pregnant women
  - Unreached pregnant women
- Develop a map showing the catchment/service area of the health facility
  - Distance from the facility
  - Identify service (s) provided

Health facility level: prioritize the problems of health facilities

- Brainstorm with health facility staff problems leading to unreached pregnant women in the area
  - **Avoid prescription from DHMT**
- Use the tool as guide (Tool 1D)
- Prioritize the problems
- Identify maximum 5 key (major) problems
- ***Involve the community (through representative)***

Health facility level: Identify and prioritize solutions and plan

- Brainstorm the solutions with health facility staff in collaboration with DHMT
- Prioritize the solutions
  - Short term
  - Long term
- Identify solutions that can be **solved at health facility**
- Identify solutions that need to be solved at District level
- Identify solutions need to be solved at higher level
- Develop Health Facility micro plan/work plan

Health facility level: Solutions to be implemented immediately

We are working on Reaching Every pregnant woman:

- Identify solutions to be implemented immediately to reach every unreached pregnant woman
- Prioritize the solutions that can bring impact to be implemented at health facility

District

Planning

Compile, Analyze and Prioritize

District Micro planning

District Level

Health Facility level

Health Facility Micro planning: Compile, Analyze and Prioritize & Plan

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Programme Management Framework

Planning			Implementation	Monitoring & Evaluation
COMPILE (population & Coverage data)	ANALYZE (problems, causes and solutions)	PRIORITIZE (Where First, What First)	IMPLEMENTATION (Service delivery / Supervision)	MONITOR, REVIEW AND ACT (Progress, Issues and Next Steps)

Support for implementation

- Provide supportive supervision
  - During advocacy, sensitization and community dialogue
  - During the ANC session (fixed and outreach)

Programme Management Framework

Planning			Implementation	Monitoring & Evaluation
COMPILE (population & Coverage data)	**ANALYZE** (problems, causes and solutions)	**PRIORITIZE** (Where First, What First)	**IMPLEMENTATION** (Service delivery)	**MONITOR, REVIEW AND ACT** (Progress, Issues and Next Steps)

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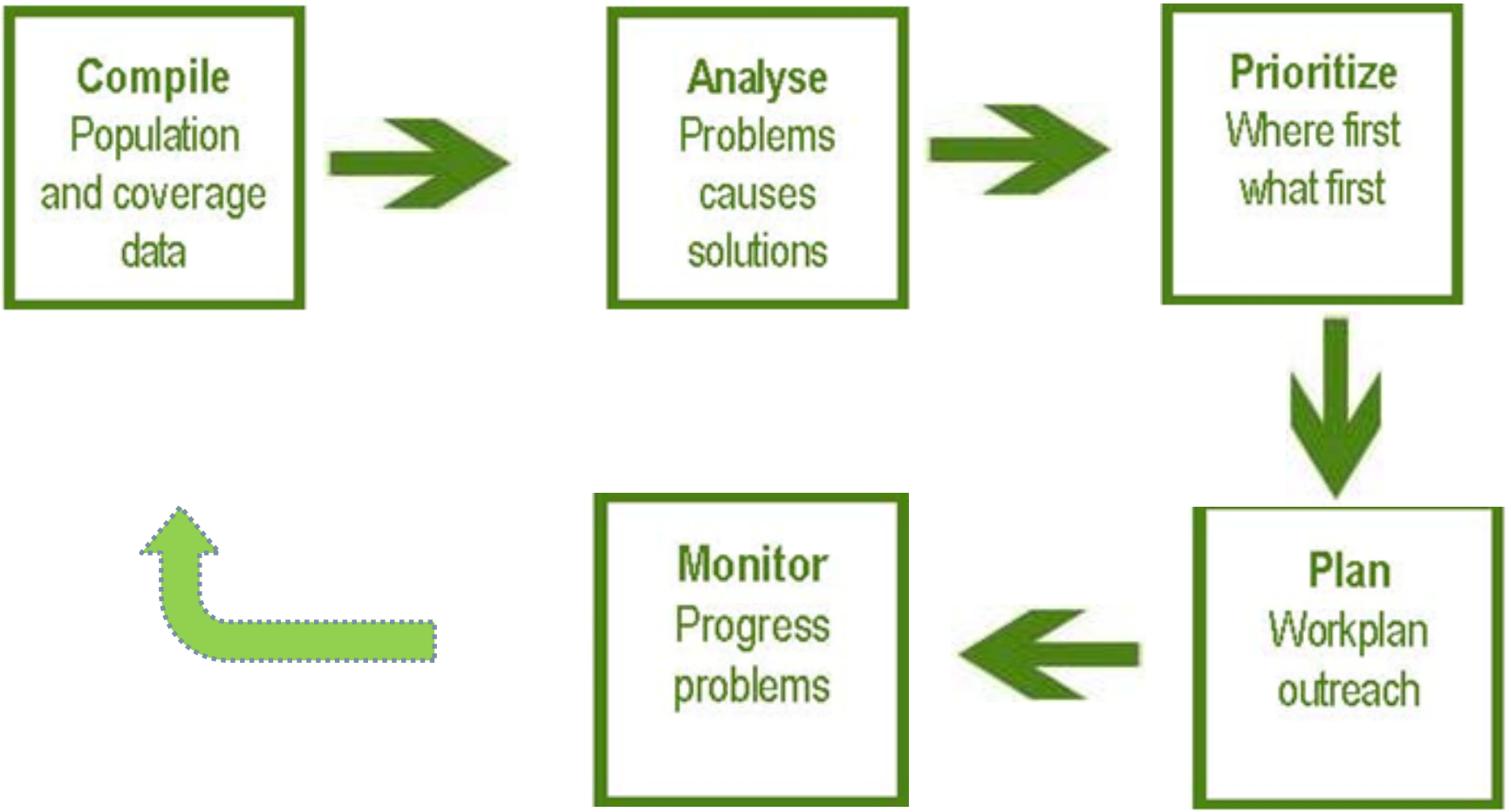
Monitor implementation

- Compile baseline data (before implementation)
- Monitor the progress
- Provide feedback
- Review progress
- Plan next actions

5 Steps – Flow chart



Integration Process at District and Health Facility Levels

INTEGRATION

What is integration??

Why Integration??

- Achievement of MDG 4/5
- Cost effective use of resources
- Community acceptability/fatigue
- Strengthening health systems

Advantages of delivering additional interventions

- More efficient use of scarce resources - reduction in operational costs and decreased competition
- Coverage rates for the linked intervention may rapidly increase to the levels of the MCH program rates
- Increased community acceptance of integrated interventions
- Opportunity for harmonization of national and district priorities

Potential challenges and risks of additional interventions-1

- Supplies: Maintaining adequate supplies
- Organization of activities: Failure to coordinate and adhere to set schedules
- Compatible: when some of the interventions are targeted at different age groups
- Resource allocation: In adequate resources
- Package: Lack of standard integrated package

Potential challenges and risks of additional interventions-2

- **Staff:** staff shortage vs workload
- **A reduction in coverage:** for some interventions
- **Difficulties with developing a clear social mobilization** message for several interventions at once

Elements of success

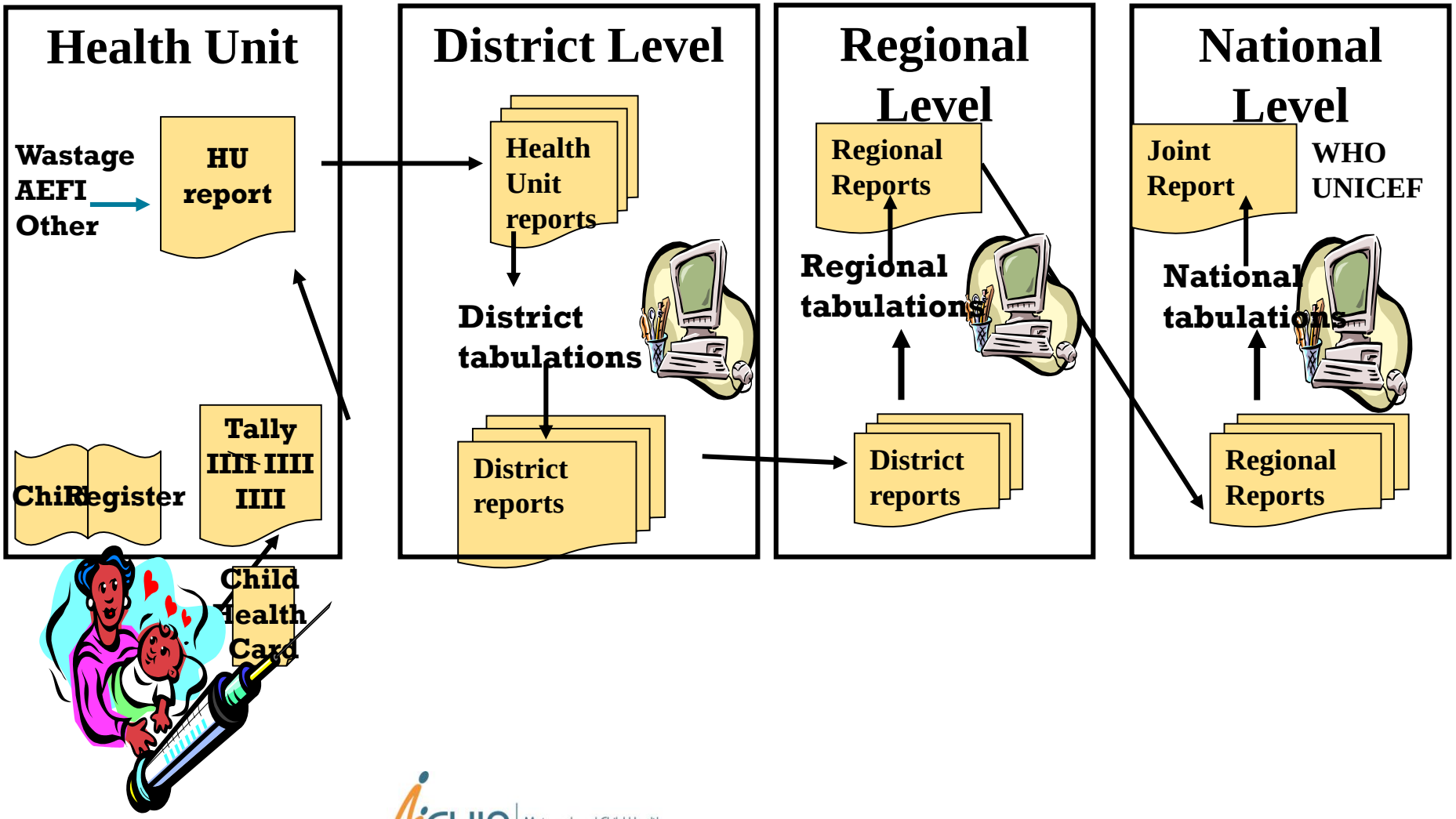
- Consensus-building in the district coordinating committee
- Development of clear implementation plan
- Timely implementation of the plan
- Appropriate advocacy and social mobilization messages

Possible Interventions to integrate

- ANC/PNC
- Immunizations; Measles, Hib, TT, BCG, Polio, DPT
- Management of minor illnesses: ARI/pneumonia, diarrhea (ORT, Zinc) etc
- Vitamin A supplementation
- Deworming
- Health promotion messages

Overview of Data Quality Self-Asssessment (DQS)

Reporting flow



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Data Worries…

Data Accuracy

- How accurate is the data

Quality of Reporting System

- What's the quality of the data 'vehicle'

(DQS)

A procedure and tools for assessing /verifying data and system quality

DATA QUALITY SELF-ASSESSMENT

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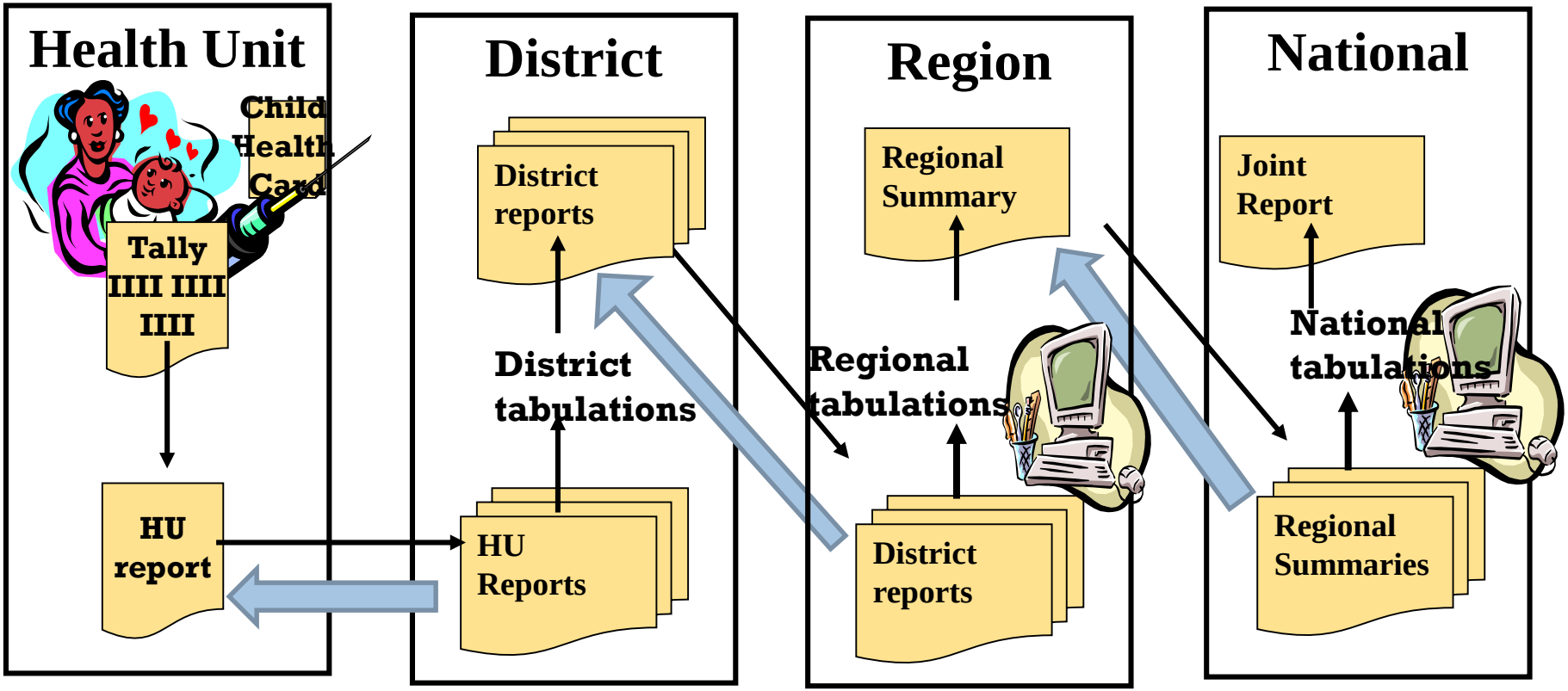
Data Quality Self-assessment (DQS)

- All countries can use the tool
- Countries design the questionnaire and the accuracy tool
- Countries conduct their own assessment and can choose the sampling method
- Countries do own analysis; draw conclusions and develop recommendations
- Can involve many staff in the EPI programme, at national, provincial/regional, district, and Health facility levels and is relatively cheap
- Takes a fairly short time to complete and results are immediately available

Data Quality Audit (DQA)

- Complex tool and only implemented in GAVI supported countries
- Initiated by GAVI and meant to assure international community that reported coverage is accurate
- Conducted by an independent external auditor appointed by GAVI
- Failure of DQA affects ISS rewards and countries have to pass before rewards can be given by GAVI

DQS Process: Following the Paper Trail



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DQS Process: the Assessment

- Review of data **accuracy** at different levels
- Use of a self-designed questionnaire to review monitoring **quality** issues:
  - Availability of vaccination cards
  - Use of tally sheets
  - Directly observed reporting and recording practices, etc
- Analysis, conclusions & recommendations to improve use of **accurate**, **timely** & **complete** data for action

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DQS Tools…

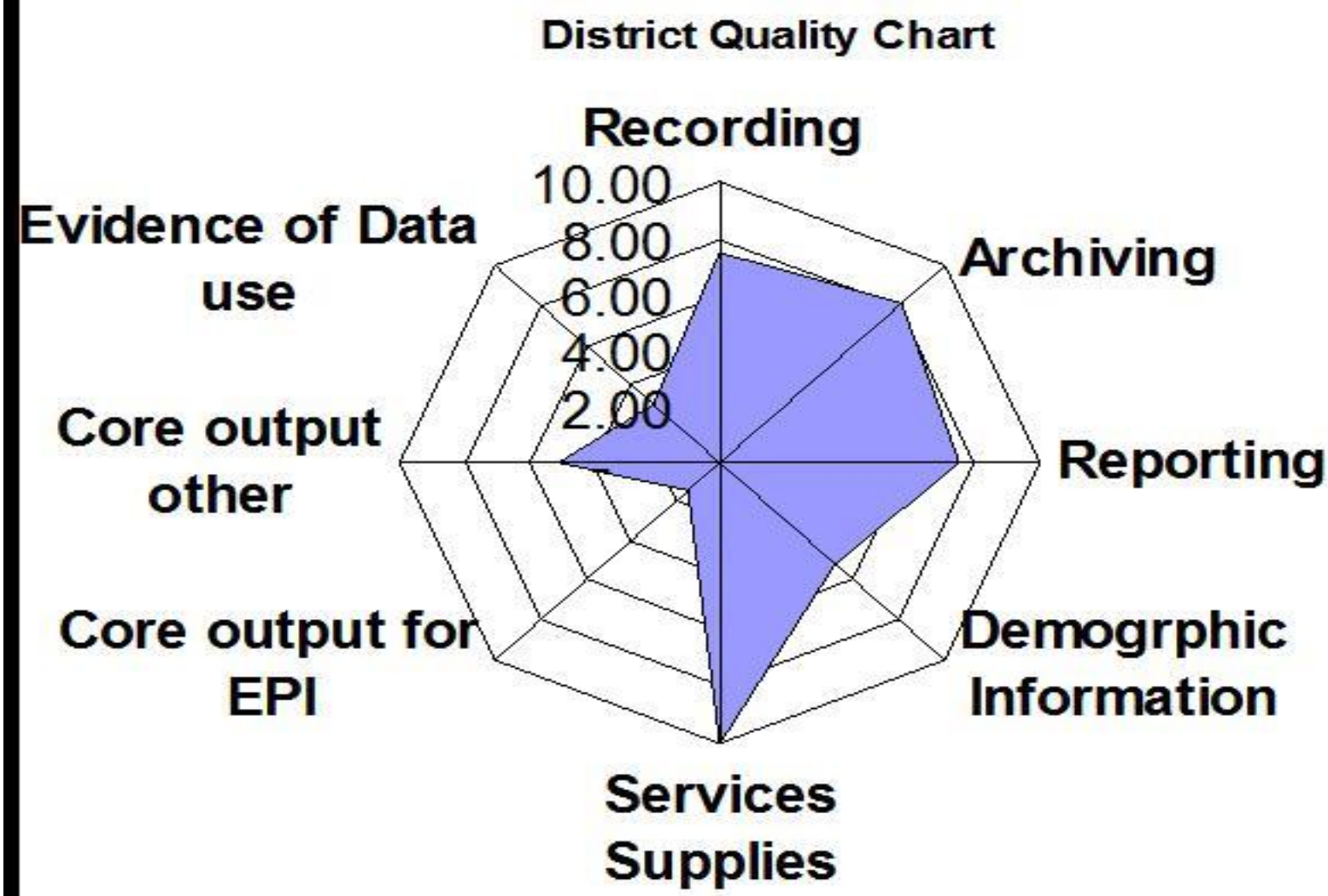
Data Accuracy

- Data Verification tool

Quality of Reporting System

- Data Quality Questions

DQS Results


District Quality Chart
Recording
Archiving
Reporting
Demogrphic Information
Services Supplies
Core output for EPI
Core output other
Evidence of Data use
10.00
8.00
6.00
4.00
2.00

Quantifying Data Quality

- **Data Accuracy**
  - Verification Factor
  - Discrepancy Ratio
- **Quality of Reporting System**
  - Quality Index

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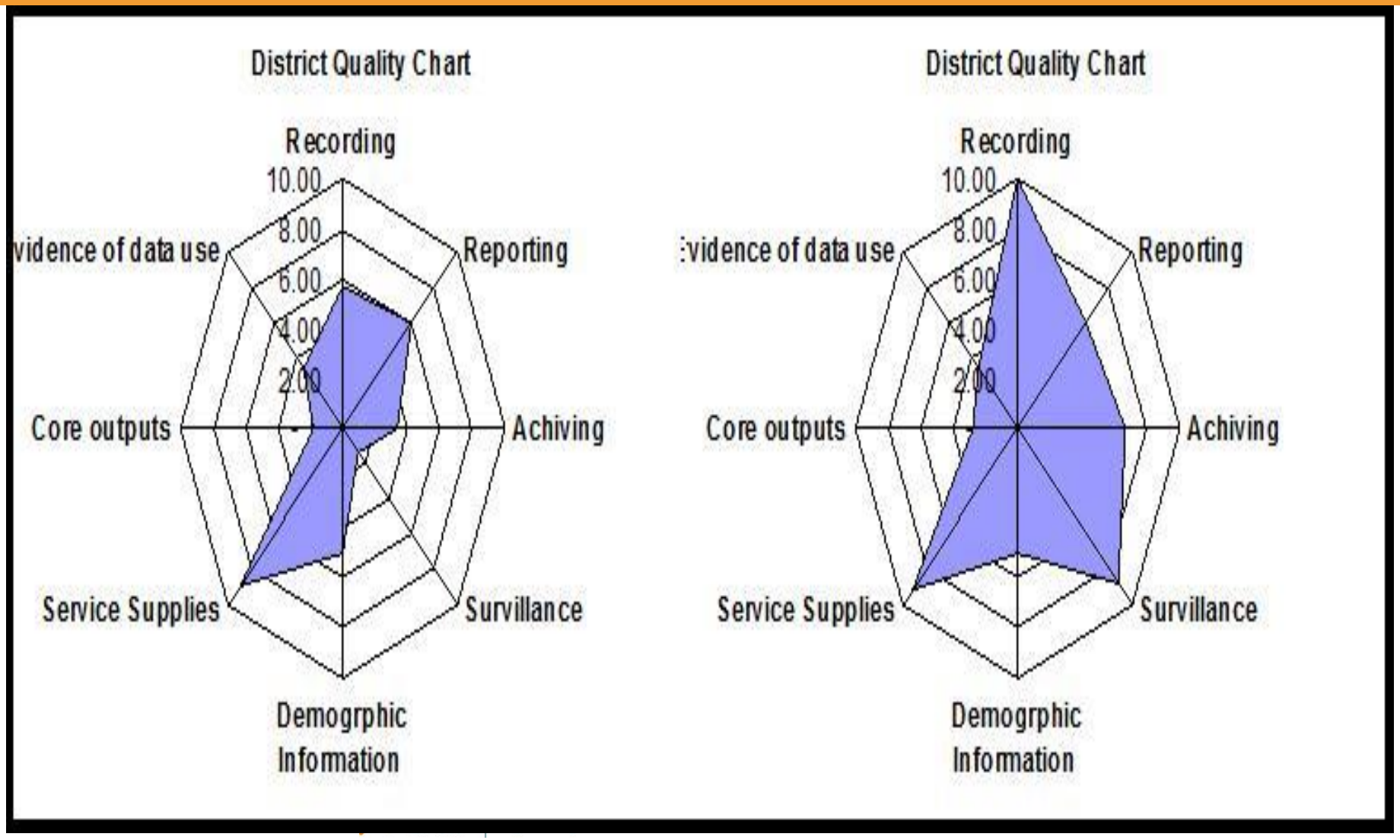
District Quality Graph



Data Accuracy

Verification Factor:

$$\frac{\text{Immunization recounted at lower level}}{\text{Immunization Reported at high level}}$$

Discrepancy Ratio:

$$\frac{\text{Sum of discrepancies X 100\%}}{\text{Sum of reported immunizations}}$$

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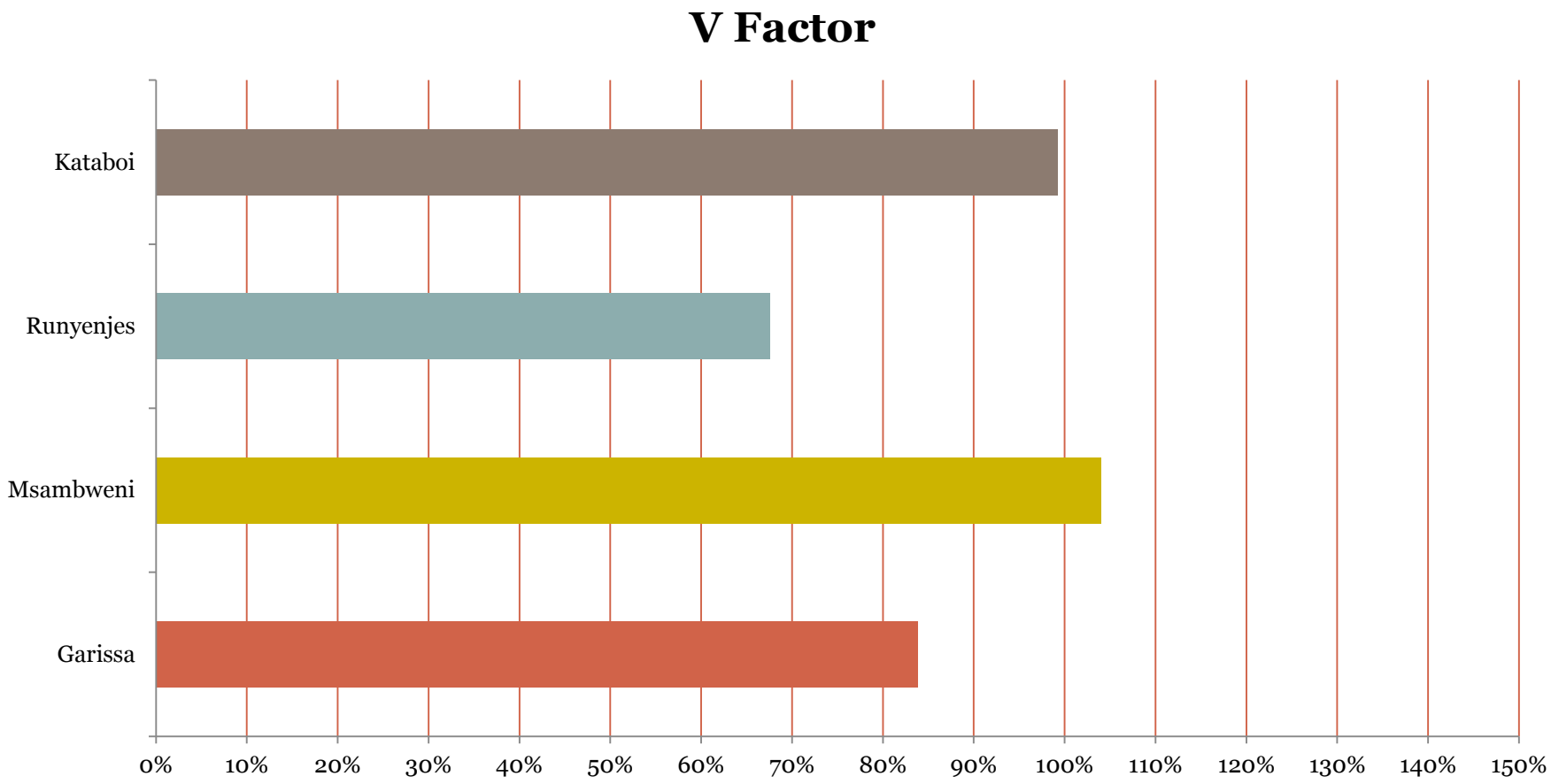
Verification Factor



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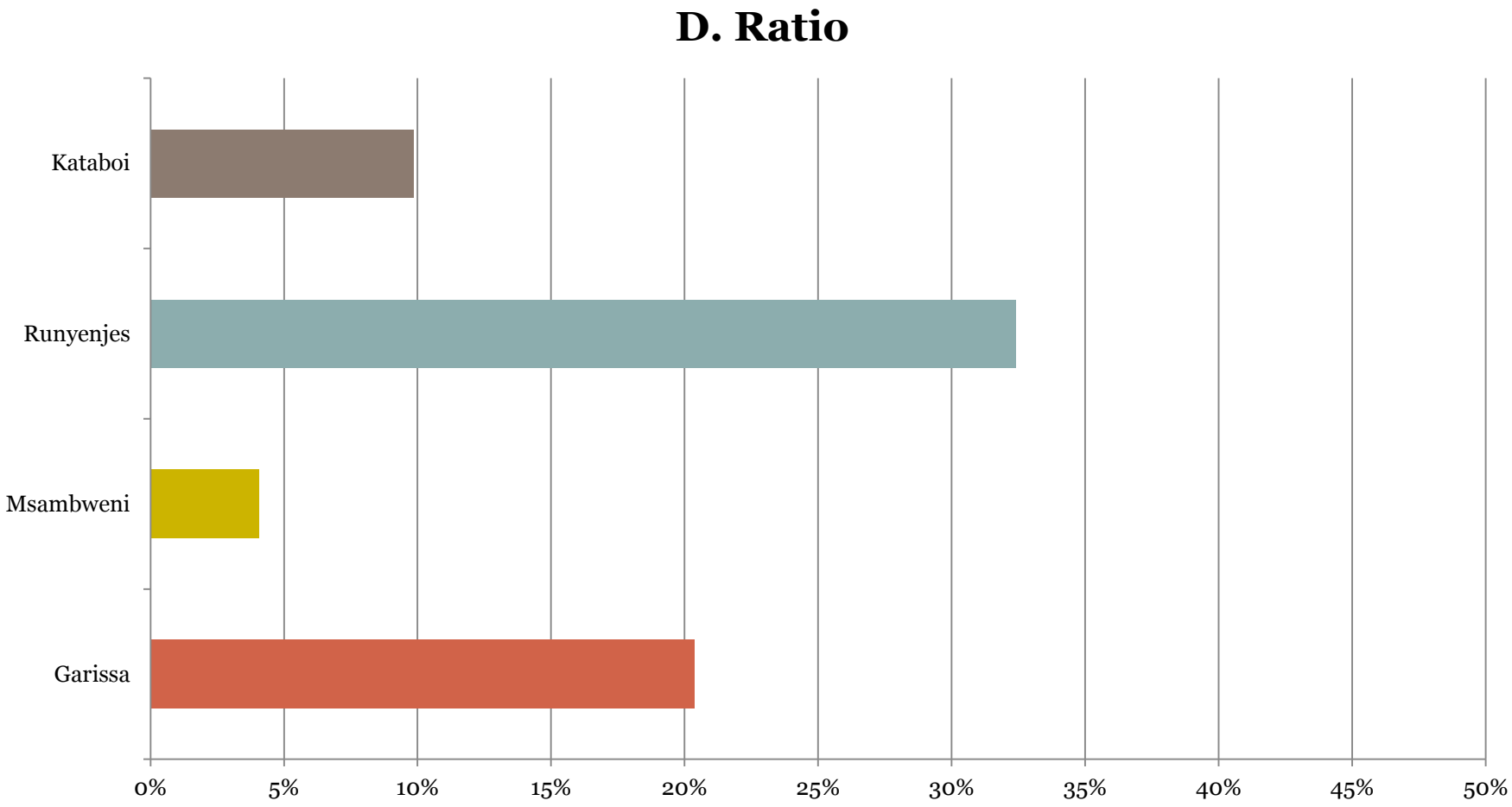
Discrepancy Ratio



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Some

	Population	Estimated pregnant women	Distance	ANC 1	%	ANC 4	%
Mutai	3200		6	80		53	
Ruto	848		4	19		18	
Chelimo	958		4	36		30	
Sunkuli	624		2	23		21	
Korio	585		3	20		15	
Kamau	1380		2	38		30	
Collins	1078		1	39		18	
Belinda	2800		3	89		78	
Baraza	888		4	30		20	
Matano	1580		3	53		20	
TOTAL							

Kiptoon

Village	Pop.	Estimated pregnant women	Distance	ANC 1	%	ANC 4	%		
Kamau	526		1	19		18			
Njoroge	386		2	15		14			
Mogaka	1021		2	35		16			
Onyancha	542		3	22		10			
Williams	440		4	19		11			
Johnson	380		3	14		6			
Obama	284		2	10		8			
Kogelo	741		6	18		15			
Kennedy	678		5	23		13			
Thuo	280		1	13		10			
	5278			188		121			

Kamau							
Villages	Population	Estimated pregnant women	Distance	ANC 1	%	ANC 4	%
Onyango	920		4	30		16	
Ogola	841		3	28		22	
Akoth	758		2	29		21	
Owino	584		1	18		15	
Aketch	476		1	19		10	
Odero	1000		5	30		20	
Odiero	1231		6	26		24	
Nyawiri	321		2	8		6	
Akello	434		3	14		8	
Waweru	318		1	10		9	
	6883			212		151	

Njenga

Village	Pop.	Estimated pregnant women	Distance	ANC 1	%	ANC 4	%
Rose	840		4	18		17	
Tom	678		4	26		20	
Mary	534		3	22		10	
James	848		3	25		5	
Bill	621		1	20		6	
Gates	728		2	25		10	
Dan	624		6	13		7	
Peter	431		5	14		7	
Imelda	763		1	29		16	
Caro	476		2	20		14	
	6543			212		112	

Hellon									
GROUP 5									
Villages	Population	Estimated pregnant women	Distance	ANC 1	%	ANC 4	%		
Omondi	1538		3	50		30			
Atieno	1320		1	42		20			
Achieng	1462		6	46		19			
Omollo	1874		9	54		30			
Kandiege	985		4	28		20			
Rabuor	1025		2	39		28			
Okiki	680		1	30		18			
Amayo	540		1	18		11			
Ramula	3200		3	70		64			
Kabondo	1800		3	67		44			
TOTAL	14424			444		284			

Village/estate	Population	Est PG women	ANC 4	Coverage	unreached pg women	% contribution	Ranking (in descending order)	cumulative %
mawego	2300		45					
kachieng	3450		98					
Kodero	1235		49					
Kadem	3427		120					
Keroka	1256		35					
Karungu	5600		167					
Kochogo	3257		79					
Ringa	1938		67					
Kabondo	2190		34					
Kadongo	5434		146					
Ober	3248		78					
suna	980		45					
Kisegi	4560		124					

Reaching Every Pregnant Woman in Kenya With High Quality MNCH and PMTCT Services

REACHING EVERY DISTRICT (RED) APPROACH

Health Facility Micro-plan

_____
District

_____
County

_____
Period Covered

_____
Date updated

1A: DEMOGRAPHIC DATA

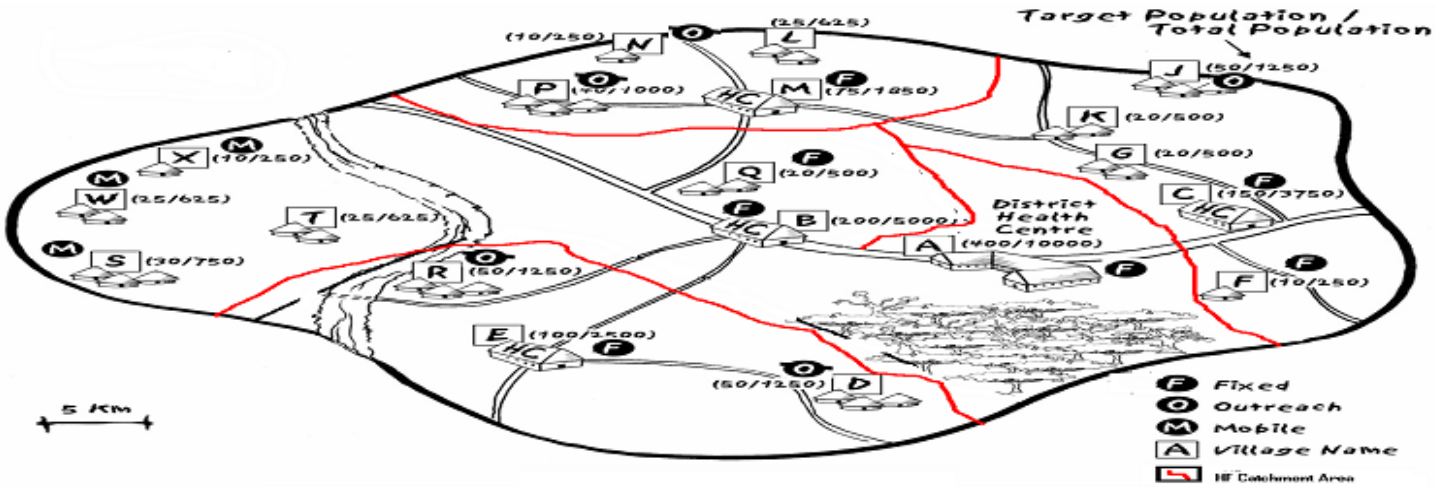
Province: _____District: _____ Health Facility: _____

	Proportion	Target Population
Total Population		
0 – 11 months		
6-11 Months		
12 – 59Months		
24-59 Months		
0 – 14 years		
WCBA 15 – 49 years		
Expected pregnancies(Same as 0-11Months)		

Tool 1B: Socio Demographics and Transport Requirements to Reach Target Population

Catchment Area Name (Village, Estate / Settlement)	Target Population			Distance nearest H/F <5km = Fixed >5km = Outreach/ Mobile	Priority *	No of Teams	No. of Outreach /Immunization Sessions	Transport means	Distance Total (km/month)	Transport Cost
	0-11months	12 – 59 months	Pregnant women							
A	B		C	D	E	F	G	H	I = G x D	J

(Show compass, villages, roads, streams/forests, population of villages and distances to HF)



Tool 1D: Problem Identification & Priority Setting (Childhood Vaccination)

Province: _____ **District:** _____ **Health facility**: _____

Catchment Area	**Compile data on population, ANC 1,ANC 4 & skilled delivery** **Calculate ANC/Skilled delivery coverage in the previous 12 months**	**Analyse problem**	**Prioritise** ***

Name (Settlement, Village and ,Estate,)	Target Pop.	ANC Visit			ANC coverage/Skilled delivery (%)			Missed ANC 4/ Missed Skilled Delivery (No.)		Dropout rate (%)		Identify problems*		Categorise problems **	
	Pregnant women	ANC 1	ANC 4	Skilled delivery	ANC 1	ANC 4	Skilled Delivery	ANC 4	Skilled delivery	ANC1-ANC 4	ANC 1 – Skilled delivery	Access	Utilisation	Category 1,2,3,4	Prioritise 1,2,3,4
A	B	C	D	E	F (C/B) x100	G (D/B) x100	H (E/B) x100	I (B-D)	J (B-E)	K [(C-D)/C] x100	L [(C-E)/C] x100	M	N	O	P

Key:

F = (C/B)x100; G = (D/B)x100; H = (E/B) x100; I = B-D; J = B-E ; K = [(C-D)/C] x100; L = [(C-E)/C] x100

M = Poor or Good. N = Poor or Good.

Categories

(1) No problem: low drop-out, coverage high

(2) Utilization problem: High drop-out, High coverage rate

(3) Access problem: Low drop-out, Low coverage

(4) Utilization and Access problem: High drop-out, Low coverage

P = (1) Very High, (2) High, (3) Medium, (4) Low, based on the number of Non attendance of ANC 4/Skilled delivery and Category of problem

ACCESS: ANC1>80%=Good. ANC1<80%=Poor; UTILIZATION: ANC1-ANC4 >10%=poor. ANC1-ANC4<10%=Good

Tool 2B: Resource requirements for MCH/maternity Services - Manpower, Transport, and Material

Province: _____ District: _____ Health Facility: _____

			Indicate number	Problems identified	Remarks
Human Resource	Qualified staff	Needed			
		Available			
	Other Staff	Needed			
		Available			
Transport	Vehicle	Needed			
		Available			
	Motor cycles	Needed			
		Available			
	Bicycle	Needed			
		Available			
	Fuel	Needed			
		Available			
	Other	Needed			
		Available			
Monthly summary sheets	Posters	Needed			
		Available			
	Fact sheets	Needed			
		Available			
	EPI Register	Needed			
		Available			
	Mother child booklet	Needed			
		Available			
	TT card for mothers	Needed			
		Available			
	Tally sheets	Needed			
		Available			
	Report forms	Needed			
		Available			
	Vaccine order forms	Needed			
		Available			
		Available			

	AEFI form	Needed			
		Available			
	Temperature record	Needed			
		Available			
	Vaccine Stock ledger	Needed			
		Available			
	Brochures	Needed			
		Available			
	Wall charts	Needed			
		Available			
	Banners	Needed			
		Available			
Cold Chain Equipment	Cold Box	Needed			
		Available			
	Vaccine Carrier	Needed			
		Available			
	Ice Packs	Needed			
		Available			
	Refrigerator	Needed			
		Available			
	Gas cylinder	Needed			
		Available			
	Dial thermometers	Needed			
		Available			
	Specimen kits for measles	Needed			
		Available			
	Specimen kits for AFP	Needed			
		Available			
	Specimen carrier	Needed			
		Available			

Tool 2C: Causes of problems and Solutions Analysis

Province: _____District: _____Health facility: _____

System components	Problem Identified	Activities to be conducted at Health Facility Level	Support required from District
A. Planning and Management of Resources			
B. Reaching the Target Population			
C Supportive Supervision			
D. Linking Services with communities			
E. Monitoring and use of data for action			

Tool 3: Mapping: Stakeholder Analysis.

Province: _____ District: _____ Health facility: _____

Catchment Area Name (Village, Estate and Settlement)	Community/Influential leaders		School			Religious Institutions (sect)/ Traditional Practitioner			NGOs / CBOs/ Extension Workers, Farmers & Business Name Others		
	Name / Title	Contact /Tel	Name of School	Focal person	Contact /Tel	Name	Focal person	Contact/ Tel	Name	Focal person	Contact /Tel

Current strengths of key partners:

Opportunities and challenges;

NB: Need to add columns for the contacts of the Community influential leaders and Institutions Focal persons:
-Need also column for the area of possible support.

Tool 4: RED APPROACH ACTIVITY SCHEDULE

Province: _____ District: _____Health facility: _____ Quarter; 1[ ] 2[ ] 3[ ] 4[ ]

	Activity/Component	Where? (Location)	Who Is Responsible?	Months in the Quarter			Remarks
A	**Planning and Management of Resources**						
B	**Reaching the target population**						
C	**Supportive Supervision**						
D	**Linking services with communities**						
E	**Monitoring and use of data for action**						

Tool 5: Budget Summary Activity for Reaching Every Pregnant Women

Province: _____ **District:** _____ **Health facility**: _____

	Activities	**Details/ inputs**	**Total Cost (USD)**	**Person Responsible**	**Remarks**
A	Planning and managing resources				
B	Reaching the target population				
C	**Linking services with communities**				
D	Supportive supervision				
E	Monitoring and use of data for action				
Grand Total					