

**Management Sciences for Health /Health Commodities and Services Management
Program (MSH/HCSM) Annual Report: 1st April 2011- 30th September 2012**

October 2012



MSH/Health Commodities and Services Management

Health Commodities and Services
Management Program

Center for Pharmaceutical Management

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This document is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID), under the terms of associate award cooperative agreement number AID-623-LA-11-00008. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.

About MSH/HCSM

The MSH/HCSM Program strives to build capacity within Kenya to effectively manage all aspects of health commodity management systems, pharmaceutical and laboratory services. MSH/HCSM focuses on improving governance in the pharmaceutical and laboratory sector, strengthening pharmaceutical management systems and financing mechanisms, containing antimicrobial resistance, and enhancing access to and appropriate use of medicines and related supplies.

Recommended Citation

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2012. Management Sciences for Health/ Health Commodities and Services Management Program, Kenya, Annual Report: [1st April 2011- 30th September 2012]. Submitted to the U.S. Agency for International Development/Kenya by the MSH/HCSM Program. Nairobi, Kenya

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ACRONYMS AND ABBREVIATIONS

ADR	Adverse Drug Reaction
ADT	ART Dispensing Tool
AL	Artemether-lumefantrine
AMU	Appropriate Medicine Use
APHIA	AIDS Population and Health Integrated Assistance (project)
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
CHAI	Clinton Health Access Initiative
CHS	Center for Health Solutions
CME	Continuous Medical Education
CPD	Continuous professional development
DANIDA	Danish International Development Agency
DASCO	District AIDS and STI Coordinator
DDPC	Department of Disease Prevention and Control
DHMT	District Health Management Team
DHIS	District Health Information System
DLTLD	Division of Leprosy, Tuberculosis and Lung Diseases
DOMC	Division of Malaria Control
DOP	Department of Pharmacy
DOD	Department of Defense
DRH	Division of Reproductive Health
DRHC	District Reproductive Health Coordinator
DTLC	District TB & Leprosy Coordinator
EMMS	Essential Medicines and Medical Supplies
FBO	Faith Based Organization
FP	Family planning
F&Q	Forecasting and Quantification
HCSM	Health Commodities and Services Management (program)
HSCC	Health Sector Coordinating Committee
ICAP	International Centre for AIDS Care and Treatment Programs
ICC	Inter Agency Coordinating Committee
ITT	Inventory Tracking Tool
KEML	Kenya Essential Medicines List
KEMSA	Kenya Medical Supplies Agency
KMTC	Kenya Medical Training College
KNPP	Kenya National Pharmaceutical Policy
LCM	Laboratory Commodity Management

LMIS	Logistics Management Information System
LMU	Logistics Management Unit
MOH	Ministries of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSH	Management Sciences for Health
MTC	Medicines and Therapeutics Committee
MTM	Medication Therapy Management
M&E	Monitoring and Evaluation
NAL	North Arid Land
NASCOP	National AIDS & STI Control Program
NEP	North Eastern province
NMTC	National Medicines and Therapeutics Committee
NPHLS	National Public Health Laboratory Services
PHMT	Provincial Health Management Team
PHC	Primary Health Care
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PPB	Pharmacy and Poisons Board
PSC-ICC	Procurement and Supply Chain Interagency Coordinating Committee
PV	Pharmacovigilance
RH	Reproductive Health
RDT	Rapid Diagnostic Test
RTK	Rapid Test Kit
SDP	Service Delivery Point
SOP	Standard Operating Procedure
SPHLS	Strengthening Public Health Laboratory Systems (Program)
SPS	Strengthening Pharmaceutical Systems (program)
STG	Standard Treatment Guidelines
SWAp	Sector wide approach
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group
USAID	U.S Agency for International Development

EXECUTIVE SUMMARY

Availability of health commodities of good quality and their safe and appropriate use is an important prerequisite for the provision of quality health services. Therefore in addition to ensuring access, it is important to also address issues relating to quality assurance of these products and implement programs that will support health care workers and consumers to use these commodities rationally, minimizing adverse and unwanted effects while at the same time deriving the required therapeutic outcomes. This requires a holistic approach in addressing commodity management systems that also include selection, procurement, distribution and use. These processes must be supported by an enabling policy and legal framework and proper management support including adequate financing, appropriate human resources and functional information management systems for evidence-based decision making.

Health Commodities and Services Management (HCSM) is a 5 year (1st April 2011 to 31st March 2016) USAID Kenya program, implemented by Management Sciences for Health (MSH). The goal of the program is to improve health outcomes and impact through sustainable country-led programs and partnerships. Specifically, this is a systems strengthening program supporting systems that deliver essential health commodities and services for the country's health sector with a focus on key public health priorities- HIV/AIDS, Malaria, TB and reproductive health. Anchored on the USAID Kenya objective of strengthening health systems for sustainable delivery of quality services, the program has three outcome areas - strengthened MoH commodity management, strengthened pharmaceutical services and strengthened laboratory services.

The program was officially launched by Prof. Peter A. Nyong'o, Minister for Medical Services, on 10th June 2011 at a ceremony attended by senior officials from Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS), USAID Kenya and other key stakeholders. During the set up period, the program developed an 18-month work plan (1st April 2011 - 30th September 2012) in collaboration with the Ministries of health (MoH), national and regional level counterparts and stakeholders. Additionally, a national baseline conducted during the initial months of the program informed activity design and prioritization as well as the development of the M&E framework for the program.

Overall, the program has adopted a systems strengthening approach based on an implementation model that seeks to improve local capacity to lead and manage service delivery and health commodity management. In doing this, the program seeks to adapt and implement proven pharmaceutical and laboratory management approaches and tools and bring them to scale as well as integrating them across all public health programs. The program is also cognizant of the need to build on existing and new collaborations and linkages with stakeholders, donors and implementing partners to scale up interventions and to develop strategic partnerships that promote harmonization of technical strategies and coordination of donor inputs.

In the implementation of work plan I, HCSM worked collaboratively with both MOMS and MOPHS, and other stakeholders to ensure that their priorities are addressed and that implementation is done according to approved health sector plans. To achieve this, the program

adapted a two-pronged approach that involved working with MoH at the central (national) level and the peripheral (regional) level in implementing activities.

At the central level, MSH/HCSM worked closely with the ministries of health to strengthen structures and systems for commodity security, appropriate use and medicine safety and supported initiatives to review and develop an appropriate policy and legal framework to facilitate and guide commodity management and service delivery at all levels of the health system.

Specifically, the program has provided technical leadership to national level commodity Interagency Coordinating Committees (ICCs) and Technical Working Groups (TWGs) for improved commodity security. A key activity has been the support for forecasting & quantification exercises across all programs to inform commodity procurement and supply planning. In addition, HCSM has supported compilation of national monthly stock status reports for the priority health programs which have informed national level decision-making.

Still at the national level, HCSM has supported the MoH in the development, finalization, dissemination and implementation of policy guidelines such as the Kenya National Pharmaceutical Policy (KNPP) and clinical governance tools including the National Clinical Management and Referral Guidelines and program-specific treatment guidelines. In addition the program contributed to the health sector policy reviews to support the implementation of the 2010 constitution of Kenya. The program also contributed to the finalization of the National Health Policy Framework 2012-2030 and the Kenya Health Sector Strategic Plan (KHSSP) July 2012-June 2017 that provides medium term direction for health services in the country.

Moreover, the program has supported the Pharmacy and Poisons Board (PPB) to promote patient safety through improved documentation and reporting of poor quality medicinal products, adverse drug reactions and utilization of pharmacovigilance data for decision-making. Specific decisions have included drug withdrawals, recalls, label changes and closure of drug manufacturing companies. Recognizing that provision of quality and appropriate health care requires a functional laboratory service, the program also worked with the Ministries of Health, the National Public Health Laboratory Service (NPHLS) and other stakeholders to strengthen laboratory systems at both the central and peripheral levels. The focus has been to ensure an uninterrupted flow of laboratory commodities and their appropriate management and use. This has included development and implementation of laboratory commodity management curricula to improve inventory management and commodity usage reporting.

At the peripheral level, the program focused on providing technical support to regional health management teams and facilities in setting up oversight structures for commodity management and use. These oversight structures include - provincial and district health commodity security committees, and strengthening Medicines and Therapeutics Committees (MTCs) at hospitals. Eight provincial and over 50 district commodity security committees have been operationalized with the mandate to improve commodity management, accountability and usage reporting. Working with these committees, HCSM has implemented a package of targeted interventions including: orientation on commodity management for district managers and facility staff; on job

training (OJT) and mentorship on the use of various commodity management tools and approaches; and support supervision in the program's priority districts.

This period has been marked by an enhanced roll-out of the ARV dispensing tool (ADT) - an electronic dispensing tool for ARVs - helping facilities to better manage these medicines, report usage and follow-up patients. Medicines and Therapeutics Committees have either been formed or reactivated in over 50 level 4-5 hospitals with the program supporting capacity building for these committees and implementation of activities and interventions to improve medicine use, quality of service delivery and ultimately health outcomes.

Overall and to ensure sustainability, HCSM has been deliberate in the design and implementation of activities to ensure skills transfer, integration and mainstreaming of approaches and tools. To this end, the program has worked to develop skills in commodity management and pharmaceutical care at both pre and in-service levels. Working with middle level colleges such as the Kenya Medical Training College (KMTC) and the University of Nairobi (UoN), the program has been instrumental in curricula reforms and restructuring and the introduction of courses that address specific health sector needs. For instance the program supported the development of a master's level course in Pharmacoepidemiology and Pharmacovigilance currently being implemented at the UoN, and the incorporation of commodity management in courses offered at KMTC. At in-service level, the program continues to work with the MoH and professional associations in developing and implementing targeted workplace and continuous professional development (CPD) based courses to address specific needs and identified gaps.

In implementing work plan I, a number of challenges were experienced by the program such as competing priorities among MoH counterparts, and additional needs beyond the scope of the program at the peripheral level e.g. weak commodity storage infrastructure and staffing issues.

During the implementation of work plan I, the program learned a number of key lessons which include the importance of leveraging with other partners, need for tailored region specific interventions and increased MoH engagement for enhanced sustainability of interventions.

These lessons learned from implementation of work plan I have played a critical role in the development of the program's new work plan II (October 2012-September 2013) through a participatory process led by MoH involving all stakeholders in line with the program's approach of promoting country-led and country owned initiatives.

INTRODUCTION

The MSH/HCSM program goal is to build capacity within the Kenya health system for **effective management of health commodities, delivery of quality pharmaceutical and laboratory services at all levels**. Awarded in April 2011 and running through to March 2016, the program is designed to contribute to strengthening health systems for sustainable quality services component of the USAID Kenya implementation framework for the health sector. Overall, the program has adopted a systems strengthening model that seeks to improve local capacity to lead and manage service delivery and health commodity management. This is augmented by a systematic approach to capacity building in the design and implementation of interventions for enhanced sustainability. The program has three focus areas, these are:

- Commodity Management Support for Ministry of Medical Services (MOMS)/Ministry of Public Health and Sanitation (MOPHS) and Health Facilities
- Support to Pharmaceutical Policy and Service Delivery
- Support to Laboratory Governance, Commodity Security, and Service Delivery (implemented in collaboration with CDC-funded Strengthening Public health Laboratory Systems (SPHSL) program implemented through MSH.

Figure I below illustrate the three focus areas

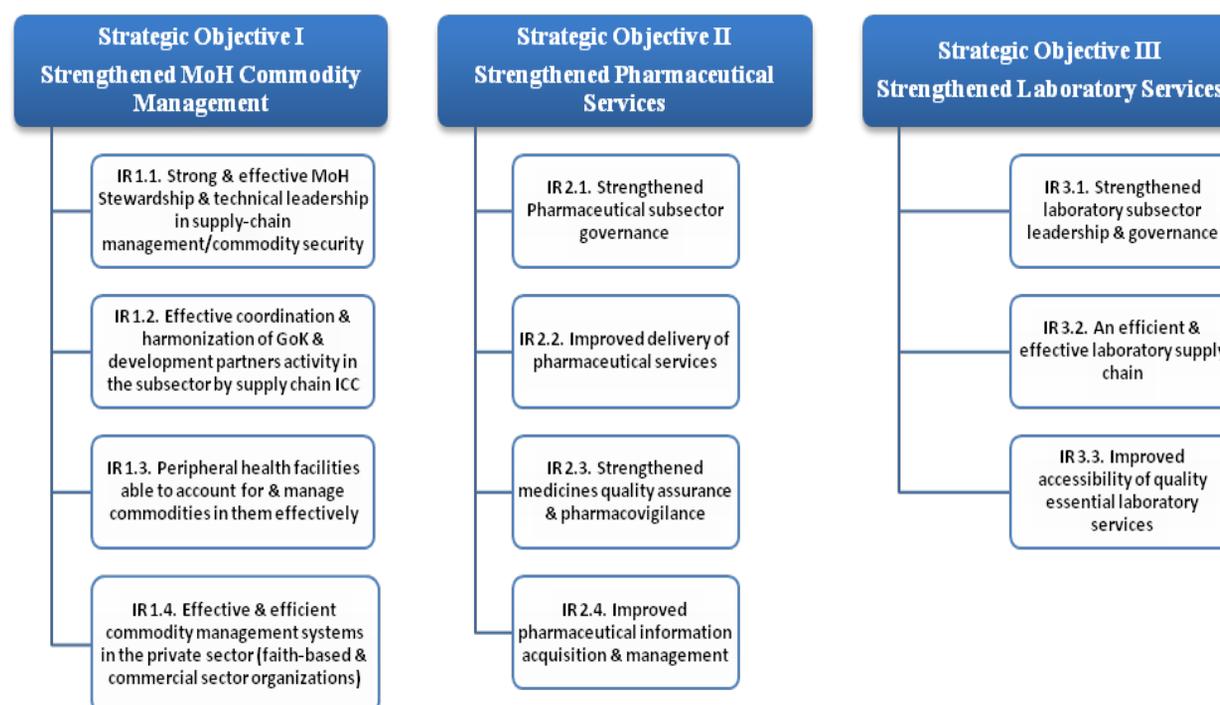


Figure 1 HCSM results framework

In implementing work plan I, the program sought to build on and strengthen existing systems using the following core principles and approaches:

- Promoting country led and country owned initiatives.
- Use of innovative approaches and building local capacity for improved management of health commodities.
- Adapting and implementing proven pharmaceutical and laboratory management approaches and tools and bringing them to scale.
- Promoting integration of approaches and tools for pharmaceutical and laboratory sub-sectors across public health programs.
- Engaging the private sector and professional bodies to strengthen both pharmaceutical and laboratory management systems in support of public health goals.
- Promoting new concepts in pharmaceutical management and services (such as pharmaceutical care and pharmacovigilance) and laboratory management and services (e.g. integrated laboratory networking and local QA) to complement commodity security and supply chain strengthening activities.
- Facilitating the adoption of new health technologies and innovative strategies to support scale up and expansion of treatment services.
- Building on existing and new collaboration and linkages with stakeholders, donors, and implementing partners to scale up interventions; develop strategic partnerships that promote harmonization of technical strategies and coordination of donor inputs.
- Health sector wide systems strengthening for commodity management and services to include both FBO and private sector.

SECTION I: COMMODITY MANAGEMENT AND SECURITY

During this period, HCSM implemented various interventions with the aim of ensuring uninterrupted access to health commodities at health facility level. The program focused on improving management and accountability at the peripheral level as well as improving oversight and planning at central level.

Central level commodity management and Security

HCSM supported the MOH to play a bigger and effective leadership role in supply chain management and commodity security. In activity implementation, HCSM adopted a mix of approaches including providing technical assistance and active participation in high-level stakeholder meetings, technical working groups, targeted training workshops, as well as through active support to specific initiatives. These interventions ensured that the stock-outs of health commodities for priority health programs-HIV/AIDS, Malaria, TB and Reproductive health were largely avoided at the national level. Major collaborators in these activities included both ministries of health, priority health program (NASCO, DOMC, DRH, DLTL), KEMSA, USG partners (e.g., Kenya Pharma, SCMS, KEMSA's technical assistance partner), other donor agencies (DANIDA, GIZ, Clinton Foundation).

Other key national level activities and achievements on commodity security over the period include the following:

Capacity building and skills transfer for F&Q and Pipeline monitoring

Using a systematic capacity building approach, that addresses all levels of capacity development, the program engaged in strengthening the capacity of MOMS/MOPHS and priority health program for commodity management and security. Besides supporting active participation of senior MOMS/MOPHS and priority program staff in commodity security related activities, HCSM conducted quantification and pipeline monitoring training courses during which a total of 25 key officer were trained. Those trained include 23 MoH officers drawn its various divisions and programs and 2 staff from the Mission for Essential Drugs and Supplies (MEDS). Additionally, six senior DRH staff were trained in quantification and pipeline monitoring including use of various tools (Reality Check, Pipeline®). These officers have continued to apply the skills learnt during the trainings to provide stewardship in national quantification activities.

Moreover, three staff from NASCO and DOMC successfully supported the review of the Global Fund Round 10 procurement plans on behalf of the country in Geneva in 2011. Their work contributed to ensuring that Kenya received a \$345 million grant for HIV and AIDS; and \$136.9 million for Malaria from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Supply chain audits

Supply chain audits are important in assessing the efficiency and effectiveness of supply chain systems. Undertaking supply chain audits on a regular basis can help identify potential areas of weakness and hence provide opportunities for targeted interventions.

To build systems and capacity for health commodity supply chain audits, the program initiated and supported various initiatives for achieving this goal. This included supporting the MoH to develop an integrated tracer list of health commodities - a key tool for these audits. The list comprises of pharmaceuticals, laboratory commodities and non-pharmaceuticals (medical supplies, dental, X-Ray and rehabilitative care products).

The program also supported the review of the supply chain audit checklist to cater for HIV laboratory commodities and in collaboration with NPHLS, conducted a supply chain audit in 4 sites in Nyanza province (New Nyanza Provincial General Hospital, Kisii level 5 Hospital, Siaya District Hospital and Bondo District Hospital). Measures to address the gaps identified within the 4 sites in Nyanza are being implemented with support from the Provincial Health Management Team (PHMT) and Hospital Management Teams (HMTs). As a result of the audit at New Nyanza PGH, the supply of HIV rapid test kits to the hospital, which had been suspended due to concerns on accountability, was re-established. The program intends to continue supporting MoH to scale up implementation of similar supply chain audits within the health system.

Pipeline monitoring of national health commodity stocks

The program supported the generation of national monthly stock status reports for priority health commodities which have been used to provide strategic information to MoH and programs, donors and partners supporting the public health sector. The information contained in these strategic information reports has continued to be used by all key stakeholders to understand the national stock status as well as make supply chain decisions such procurement planning and forestall potential stock out.

Key features of the national stock status reports

The national stock status reports are produced on a monthly basis.

They summarize the national commodity stock status in simple charts, showing how long the in-country stocks and pending stocks on order from suppliers will last.

Comments summarizing the key highlights for the month as well as the stock situation and key action points are included.

They have proven to be a popular and user-friendly as it provides a quick snapshot on the commodity security for the key program commodities.

They provide strategic information to support MoH decision-making thereby facilitating management of commodity availability, allocation of resources, and better coordination of the various donors and partners involved in the commodity supply chains.

National quantifications

Quantification informs planning and resource mobilizations for timely commodity procurement. When done properly, it minimizes the need for emergency procurements and ensures uninterrupted availability of commodities within the pipeline. During the last work plan period, HCSM provided technical support to MoH in the national quantification of commodities for HIV/AIDS, antimalarials, TB and family planning as well as essential medicines (EMMS). The national quantification process was led by key MoH departments and incorporated inputs from all key stakeholders including supply chain agencies (KEMSA, Kenya Pharma, and SCMS) and donor agencies among other stakeholders.

Quantification reports produced include; FP F&Q report for FY 2011/2012 – 2013/2014; F&Q and procurement plan for FY2011/2012 for malaria program; F&Q for FY 2011/12 for TB program; FY 2011/12 and 2012/13 F&Q for HIV commodities and FY 2012/13 F&Q for EMMS commodities. The above reports have informed development of commodity procurement plans for the various programs, supported commodity management and guided procurement. The outputs of the quantification process were used to lobby for financial commitment from the Government and development partners. For example;

- The, 2012/13 F&Q for HIV and supply planning report was used to in the preparation of GF Round 10 Year 2 work plan as well as GoK commodity procurements;
- The FP quantification for FY 2011/2012 – 2013/2014 informed donor commitments of over USD 18 million for procurement of family planning commodities.
- As a result of the malaria quantification, timely call down of pending procurement of Artemether-Lumenfantrine under GF as well as the second procurement of GF AMFm subsidy was initiated.
- Quantification for malaria Rapid Diagnostic Tests (RDTs) for FY 2012/2013 and FY 2014/2015 informed additional support for purchase of 4.2 million extra doses of AL occasioned by reduced GF funding for procurement.

Quality of care survey

The 2009-2017 National Malaria Strategy (NMS) in Kenya recommends that malaria case-management should be based on confirmed parasitological diagnosis and artemisinin-based combination therapy (ACT). The NMS sets targets to ensure universal availability of ACTs and diagnostics; universal coverage of health facilities and health workers with health systems support activities; and universal health worker's adherence to malaria case-management guidelines.

HCSM has provided technical support to DOMC on case and drug management at the central and peripheral level in implementation of the NMS. To monitor progress of these activities, HCSM in collaboration with DOMC has undertaken biannual national health facility surveys. Two surveys - round 3 (July-August 2011) and round 4 (March-April 2012) were conducted during

the reporting period. Key findings showed improvements in the availability of malaria diagnostic services with an increase from 55% to 65%, mainly due to increase in the availability of RDTs (7.5% Vs 16.9%) among other positive findings.

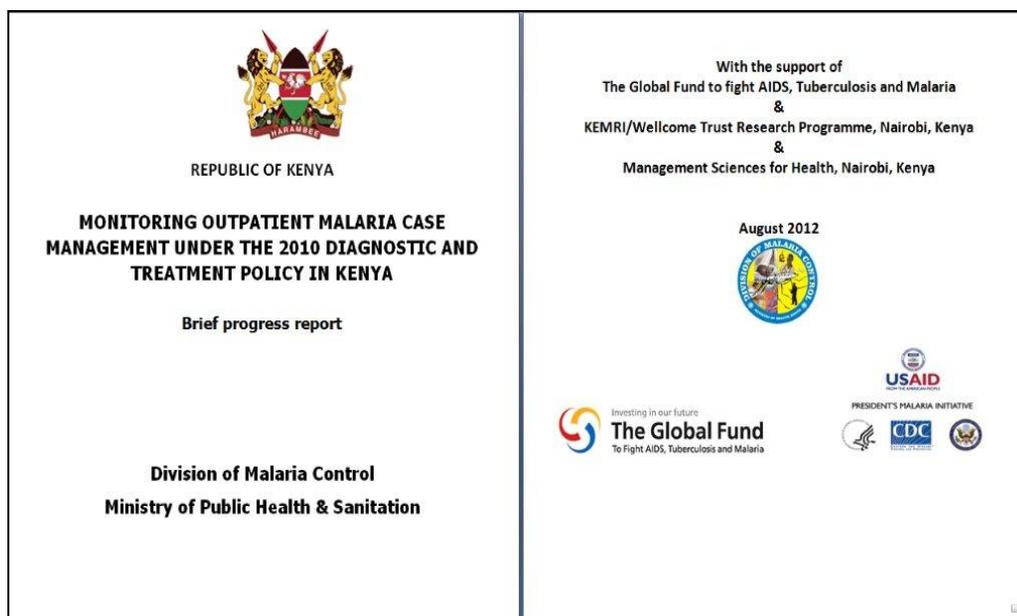


Figure 2 Malaria Quality of Care Survey Round 4

Participation in national policy reform activities for commodity security

The promulgation of the new constitution in 2011 has necessitated the need to review all health laws and ensure that they are consistent with the new structures established. Commodity security being an important element of service delivery has to be articulated in a clear manner in the revised policy documents and strategic plans being developed by the MoH. As such, HCSM has continued to participate actively in these initiatives including the formulation of the Kenya Health Sector Strategic Plan III. The program has continued to actively participate in these initiatives, specifically under the health technologies thematic group which is one of the pillars of Health Systems Strengthening (HSS) approach adopted by MoH. This is still an ongoing process in preparation for the merging of MOMS and MOPHS & devolution after elections in March 2013. The Health sector's coordinating mechanism under the SWAp secretariat is being re-structured to be aligned to the Comprehensive Health Sector Framework 2012 – 2030. Finalization of this process will spell out and harmonize the roles and responsibilities of the State and the non state actors.

HCSM has also supported MoH priority programs to review and develop policies and guidelines to promote commodity security and assist health care workers at all levels effectively manage the commodities placed in their custody. For example, DRH was able to review their National Reproductive Health Commodity Security Strategy for 2012-2017, as well as develop a booklet for Standard Operating Procedures and Job Aids for Reproductive Health Commodity Management.

Peripheral level Commodity management and security

During work plan I, MSH/HCSM worked to initiate and establish its decentralized regional (peripheral) level activities with a presence in all the 5 USAID Kenya defined health zones. To support the roll out of regional level work, the program deployed staff to each of the regions to work alongside MoH provincial, district and hospital management teams, regional level implementing partners such as APHIA Plus teams. The strategy for the program at this level has been to support the establishment of provincial and district health commodity security committees to provide oversight for commodity management and security and the implementation of targeted intervention packages for various levels. Using a systematic, phased scale-up approach, the program targeted roll out of district level interventions to cover 50 districts during the first phase in the initial 18 months. This standardized package on interventions has entailed the following:

Commodity Security

HCSM worked towards strengthening the capacity of provincial and district health management teams (P/DHMTs) to plan, manage, and supervise health commodities and services for improved service delivery. This was achieved through support for formation and operation of provincial and district level health commodity security committees. Eight provincial and 52 district commodity security committees have been formed and are operational. Members comprise of provincial and district health management team members as well as representatives of key stakeholders such as KEMSA, Kenya Pharma and APHIA Plus. In addition and in recognition of the need for broad-based multi-sectoral representation in health commodity management and coordination forums, especially at the provincial level, the program advocated for inclusion of FBOs e.g. Christian Health Association of Kenya (CHAK) and the Kenya Episcopal Conference (KEC) in these committees. The committees were oriented in commodity management, appropriate medicine use and pharmacovigilance and supported to develop their terms of reference and action plans. HCSM has subsequently been supporting these committees in the development and implementation of these action plans with an aim of strengthening their capacity to plan, manage, and supervise health commodities and pharmaceutical and laboratory services for improved service delivery.

Commodity management and reporting

This was implemented through strengthening the capacity of facility staff to manage commodities appropriately through capacity building, mentorship and OJT utilizing TOTs and champions to improve quantification, inventory management and use of Logistics Management Information Systems (LMIS) tools and reporting. A total of 603 DHMT members drawn from 59 districts were oriented on commodity management, additionally 412 out of these 603 DHMT members underwent a two- day intensive training on inventory management, PV and AMU to better position them as champions for commodity management in their respective districts. The program has worked with other stakeholders and actively engaged in the distribution of LMIS tools and provision of OJT to health facility staff on how to use them appropriately since

availability and use of tools has been singled out as one of the main contributory factors to low commodity usage reporting rates.

In addition, the roll out of electronic LMIS tools- The ART Dispensing Tool (ADT) and the Inventory Tracking Tool (ITT) is one of the key areas of support by the program to facilities to improve commodity management and reporting. The program supported review of the ADT to incorporate new regimens as per the revised NASCOP guidelines and feedback from users. The revised version was approved by NASCOP and regional orientations on the tool conducted. A total of 394 regional TOTs were trained in the upgraded ADT. As a result, there has been increased use of ADT in managing data of patients



Figure 3 ADT Tool

on ART. A total of 306 out of targeted 350 sites are using the tool and approximately 83% of patients on ART in the country are being managed using this tool. In addition 36 of the targeted district level hospital and district stores are using the ITT.

Supportive supervision

Strengthening the technical and operational capacity of PHMTs and DHMTs for supportive supervision including provision of integrated tools and support for quarterly missions was one of the strategies the program employed to improve commodity management in the priority districts. Specifically, the program utilized champions from the P/DMTs to conduct these visits. Jointly with MoH counterparts, the program has been employing a continuous quality improvement process which entailed gap analysis; problem identification and prioritization; root cause analysis; and intervention design and implementation at site level using a standardized tool. Subsequently supported facilities have developed action plans to guide activity implementation, monitoring and evaluation. Overall, the achievements realized at the peripheral level using this approach during work plan I are summarize in the table below:

Indicators	Target	Achievement	% Achievement
No. of DHMT teams oriented on commodity management and commodity security committees established	50	64	128%
Total No. of DHMT members oriented on commodity management	-	603	-
No. of District Champions Oriented on commodity management	-	412	-
No. of districts with commodity management champions	50	59	118%
No. of health workers trained on commodity management	-	2521	-
No. of districts supported to undertake support supervision	50	50	100%
No. of facilities reached under support supervision	500	1060	212%

Figure 4 Cumulative achievements in the priority districts

SECTION II: STRENGTHENED PHARMACEUTICAL POLICY AND SERVICE DELIVERY

The focus of the program in this area is to strengthen health systems to deliver quality pharmaceutical services in all sectors, Public, Private and FBO, and all levels-national and peripheral. The overall objectives include strengthening pharmaceutical sector governance; improving pharmaceutical services and pharmaceutical care; strengthening medicines quality assurance and pharmacovigilance (PV); and improving pharmaceutical information acquisition and management for decision making.

During the last 18 months, HCSM continued to use a health systems strengthening approach to strengthen pharmaceutical policy implementation and service delivery at the national/central and peripheral levels. At the national level, the focus was on development of governance related policies and guidelines whereas at the peripheral level focus was on dissemination and support of implementation of policies to improve both pharmaceutical service delivery and appropriate use of medicines (AMU). In addition the program continued to support the implementation of the national pharmacovigilance system to promote medicine quality and safety thus enhancing patient safety.

Strengthening pharmaceutical policy and services delivery at Central level

Support to policy and legislative reform

A functional policy and legal framework is key to the proper regulation and provision of pharmaceutical services. The program worked with the MoH and other stakeholders in the health sector policy reviews in support of the implementation of the constitution of Kenya; particularly in development of the MoH position paper on implementation of the new constitution. The program also supported the development of the health bill, National Health Policy Framework 2011-2030 and the associated first 5-year medium term implementation plan (KHSSP III July 2012- June 2017).

To improve governance, HCSM provided technical assistance to MoH in the development, finalization, dissemination and implementation of policy guidelines such as the Kenya National Pharmaceutical Policy (KNPP). In addition the program played a key role in supporting the development of clinical governance tools including the National Clinical Management and Referral Guidelines and program-specific treatment guidelines. In collaboration with other pharmaceutical sector stakeholders, HCSM supported the MoH- specifically the Department of Pharmacy (DOP) and the Pharmacy Poisons Board (PPB) in the on-going review of pharmacy laws to govern the regulation of medicines (health products and technologies) and pharmacy practice in the country.

Support to improved medicine Quality assurance and pharmacovigilance

HCSM supported the PPB to implement an integrated national pharmacovigilance system in collaboration with MoH, priority health programs and other stakeholders. The goal has been to

promote patient safety through improved documentation and reporting of adverse drug reactions, poor quality medicinal products, and utilization of pharmacovigilance data for decision-making.

At the national level, HCSM supported the development of guidelines, training materials job aids and bi-annual medicine information and pharmacovigilance (MIPV) newsletters. HCSM provided

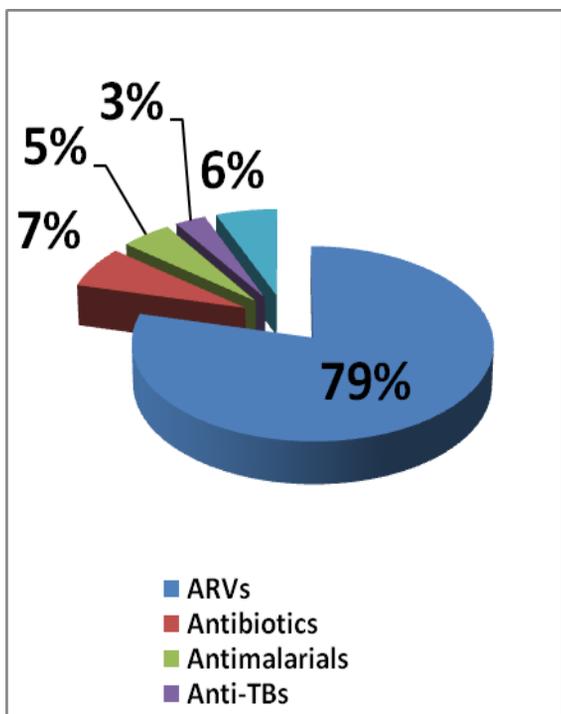


Figure 5 No. of ADR reports by class of medicines, end of September 2011

technical and operational support for pharmacovigilance data acquisition and transmission to the PPB. This support coupled with the trainings and sensitizations of health care workers on pharmacovigilance has resulted in improved reporting of adverse drug reactions (ADR) and poor quality medicinal products by health facilities to PPB.

Cumulatively the number of ADR reports received at PPB has increased from 1459 (in Sept 2011) to over 5000 (by Sept 2012), similarly the number of poor quality medicinal products reports received has increased from 175 (in June 2011) to over 250 (by Sept 2012) representing increases of over 240% and 42% respectively in one year. To boost reporting and increase the reach of the PV system, HCSM is currently supporting PPB in the development of an electronic reporting system on multiple platforms including the web, mobile

technology and desktop applications. This initiative is expected to make reporting easier and faster and to facilitate data collation and analysis at PPB.

To augment the above spontaneous reporting of poor quality medicinal products, PPB with support from HCSM and other stakeholders has been proactively monitoring the quality of medicines in the Kenyan Market through post-marketing surveillance activities. During the year the program provided PPB with technical and operational support for analysis, documentation and dissemination of post-marketing surveillance (PMS) survey reports for antiretroviral, TB and malaria medicines. This was done in collaboration with the World Health Organization (WHO), Centres for Disease Control and Prevention (CDC) and United States Pharmacopoeia (USP). These PMS reports were disseminated to central, regional and facility level MoH staff, Priority health program staff, health care workers in all sectors and other stakeholders in various meetings, events and fora.

Pharmacovigilance data analysis and PMS survey findings have led to several regulatory actions including drug withdrawals, recalls, label changes and closure of drug manufacturing companies. Examples include:

- Development and implementation of a KMTC-led accredited international course on effective management and appropriate use of medicines and medical supplies. This course is being administered by KMTC staff and participants are expected to pay a nominal fee to promote uptake while still ensuring sustainability in its implementation.
- Development and implementation of a Masters level degree course in Pharmacoepidemiology and Pharmacovigilance course by the University of Nairobi (UoN) in response to the increasing demands for skilled professionals in this area. The first intake of over 20 post graduate students have already enrolled for this course and classes are ongoing.

The focus of the program at the in-service level has been to build the skills of health care workers across all cadres for effective management of health commodities, and their appropriate use to promote better treatment outcomes. Specifically HCSM supported the following:

- Development of an integrated course on Effective Management of Health Commodities that incorporates essential medicines and supplies plus program-related health commodities.
- Development of a curriculum on implementation of Medicines and Therapeutic Committees to promote appropriate medicine use at facility level

Continuous Professional Development

The program supported implementation of needs- based Continuous Professional Development (CPD) programs and scale-up of trainings in partnership with professional associations such as the Pharmaceutical Society of Kenya (PSK) and the Kenya Pharmaceutical Association (KPA). To inform review of guidelines and implementation of CPD programs for pharmaceutical cadres, the program supported a countrywide survey to determine the status, needs, constraints and enablers for CPD programs. The survey findings were disseminated to 325 and over 500 participants during the June 2012 PSK symposium and the Kenya Pharmaceutical Association (KPA) conference held in July 2012 respectively. Collaboratively with PSK, HCSM identified priority CPD topics, developed a CPD log book for documenting participation in CPD activities and supported implementation of CPD sessions countrywide. To date a total of 7 PSK regional CPD sessions have been held reaching 244 health care providers. In addition, the CPD log book has been disseminated to 320 pharmacists.

Strengthening pharmaceutical policy and services delivery at Central level

Medicine and Therapeutic Committees and Appropriate Medicine Use

Medicines and therapeutic committees (MTCs) are institutional committee responsible for promoting appropriate use of medicines and delivery of quality pharmaceutical and related services. However, these committees are non-existent, moribund or non-functional in many facilities in the country. This has often been attributed to the lack of knowledge and skills to conduct MTC activities by health care workers. To support MTCs at facility level, the program in collaboration with the DoP, developed and implemented a set of interventions over the last 18 months. This included;

- Developing an MTC assessment tool for use in assessing status and identifying areas for capacity building and support. The tool was used in assessing over 30 level 4-6 facilities in the country
- Developing MTC training curricula and implementing training and related capacity building activities in over 40 level 4-6 facilities. Over 180 health care workers have been capacitated.
- Supporting facilities to develop and implement MTC action plans addressing gaps in rational medicine use and pharmaceutical service delivery.

For instance, HCSM worked with the Kenyatta National Hospital to revitalize its MTC which subsequently implemented a number of initiatives in the hospital to improve patient care. This included setting up systems for ADR monitoring and reporting, medication error reporting and prevention, and embarking on the review of the institutional formulary list and manual.

Medicine quality assurance and pharmacovigilance

In collaboration with the PPB and regional partners, HCSM program supported implementation of pharmacovigilance at the peripheral level through capacity building of health care workers and dissemination of guidelines, tools, job aids and newsletters. The program supported the dissemination of 6000 PV job aids and over 10,000 copies of the Medicines Information and Pharmacovigilance (MIPV) newsletter to health care workers in the public, private & FBO sectors. These materials are aimed at promoting medication safety through strengthening advocacy for PV and updating HCWs on activities and regulatory actions taken by PPB. Additionally the program provided technical and operational support in sensitizing health care workers in all sectors on pharmacovigilance using the revised national training curricula, job aids and manuals. The training curriculum has been used to train over 300 healthcare workers, additionally over 600 DHMT members and 2500 facility staff have been sensitized in pharmacovigilance.

In collaboration with PPB and NASCOP, HCSM also supported mini-post market surveillance (mini-PMS) for ARVs and OI medicines that was undertaken in 32 facilities in Nyanza and Nairobi Provinces in response to reports of counterfeit ARVs circulating within the country. As a result of this exercise a number of regulatory actions were taken including the following:

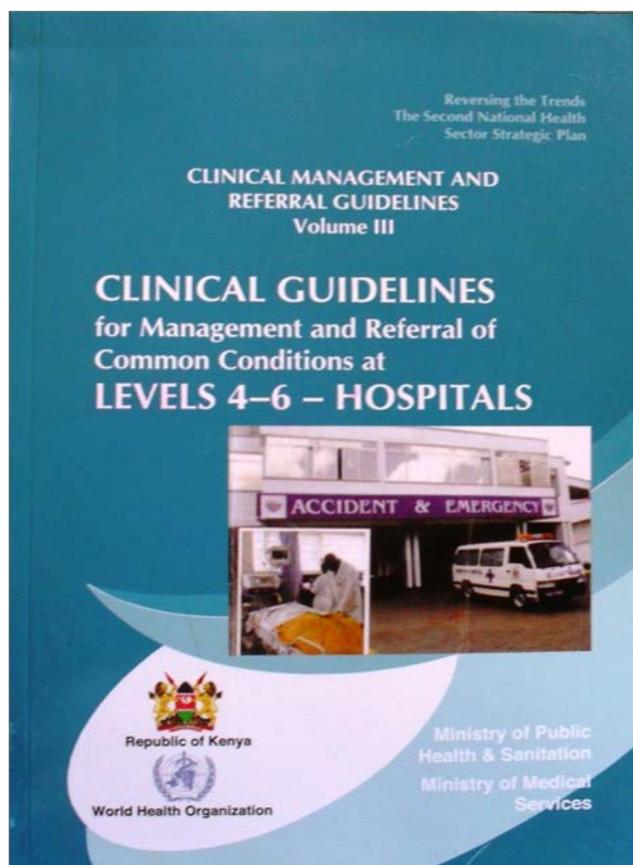
- Counterfeit Zidolam N batch EI00766 and A9366 was withdrawn, retrieved from the market and quarantined
- The program assisted NASCOP in developing recommendations that would mitigate recurrence of the same problem. These included expedited merging of the existing multiple procurement and supply chains for the public sector for ARVs and limiting these functions to KEMSA and Kenya Pharma.

Overall, pharmacovigilance related activities at the peripheral level have contributed to increase reporting of ADRs and poor quality medicines and these reports have been used for decision making resulting in several regulatory decisions including product recalls and withdrawals by the PPB as stated above.

Policy dissemination and Implementation

In collaboration with the MoH, regional and facility level health management teams and other stakeholders, the program worked to support the dissemination and implementation of pharmaceutical and related policies to strengthen service delivery at the peripheral level. Following the approval of the revised KNPP by the Cabinet, HCSM supported the DoP to review the policy and identify implementation requirements that need legislative, regulatory and

administrative changes. Further, the program is supporting the development of a pharmaceutical services governance framework aligned to the stipulated devolved system under the new constitution and in line with the policy directions of the KNPP.



For improved pharmaceutical service delivery and care, besides strengthening to MTCs, the program supported dissemination of clinical governance tools including the National Clinical Management and Referral Guidelines, the Kenya Essential Medicines List (KEML) and appropriate Medicine Use (AMU) guidelines nationwide. Beyond the distribution of these guidelines and policy documents, the program conducted regional dissemination workshops in several provinces including Nairobi, Nyanza and North Eastern Province (NEP) to sensitive health care workers and promote their use.

SECTION III: SUPPORT TO LABORATORY GOVERNANCE, COMMODITY SECURITY AND SERVICES

Laboratory diagnosis and monitoring is an integral component of quality health service delivery. The provision of quality laboratory services is dependent on an uninterrupted supply of laboratory commodities. For the program, laboratory commodity management and security have been key focus areas over the last work plan period. Implementation of other areas such as governance and quality of laboratory services have been led by CDC funded Strengthening Public Health Laboratory Services (SPHLS) project implemented by MSH.

Interventions to address laboratory commodity security have been targeted at both the central level as well as the peripheral levels. At the national level, the major stakeholders in implementing the activities included the various departments at the MoH (NPHLS, DDFS, National HIV Reference Laboratory, and National Blood Transfusion Services), donor agencies (e.g. USG, JICA), supply chain agencies (KEMSA, SCMS), other implementing partners and facility staff. These stakeholders have also been engaged during implementation at the peripheral level, with a focus on resource leveraging, and collaboration to maximize the impact of the desired interventions. The following are the achievements made in improving laboratory commodity security:

National quantification for laboratory commodities

The program supported the MoH of over the last work plan period to determine the national laboratory commodity requirements with a focus on the priority programs (HIV/AIDS, TB and malaria). Quantification of these laboratory commodities was incorporated into the overall commodity quantifications undertaken by NASCOP, DLTLD and DOMC for their commodity requirements.

Pipeline monitoring of national stock status

HCSM has continued to support key priority programs to monitor their commodity pipelines. On a monthly basis, the program has supported NASCOP to generate the national stock status report for HIV laboratory commodities. This information has been used to inform procurement planning and delivery of required laboratory commodities from suppliers among other supply chain decisions. This routine monitoring has also ensured that national stock-outs of key HIV laboratory commodities are avoided. Moreover, the stock status reports have been useful tools for sharing strategic commodity information with key stakeholders to inform decision making on commodity security. This approach has also been applied with other priority programs for tracking of key laboratory commodities on a regular basis e.g. malaria RDTs.

Coordination and oversight for laboratory commodity management and security

Effective coordination and oversight for laboratory commodity management is an important prerequisite for ensuring commodity security. In previous years, there has been a very fragmented approach in rolling out interventions addressing laboratory commodity management both at national and peripheral levels. As such, issues of laboratory commodity management have not been effectively tackled compared to other aspects of health service delivery.

At the national level, HCSM has worked to strengthen national level planning and oversight of laboratory commodity management activities. This has been done through technical support to commodity security technical working groups in the priority divisions at NASCOP, DLTLTD and DOMC to provide stewardship and oversight for commodity management interventions that address the laboratory commodity challenges. Additionally the program has been supporting interventions aimed at addressing lab commodity management gaps and usage reporting. For example, recognizing the importance of the availability of reagents in ensuring patient care, the program in collaboration with NASCOP and NPHLS convened a consultative meeting in August 2012 to chart the way forward in addressing the supply chain issues affecting CD4 reagents. During the meeting it was agreed that reporting of lab ART commodities would be a key performance indicator for laboratories. The stakeholders also agreed that issues of service, placement, and maintenance of equipment would be handled from the national level unlike before where individual facilities were dealing directly with suppliers.



Figure 7 Participants drawn from labs that perform CD4 testing at a national consultative meeting

At the peripheral level, weak coordinating structures has been highlighted as one of the issues to be addressed in order to improve laboratory commodity security. In view of this, the program embarked on an initiative to support the provincial and district laboratory managers to take lead in addressing laboratory commodity related issues. By September 2012, all the provinces had their provincial laboratory managers as crucial members of the provincial commodity security teams. In addition, the program also supported regional review meetings that brought together PMLTs, PMLSOs, DMLTs and laboratory in-charges. During these meetings, teams identified gaps and challenges in laboratory commodity management, developed action and set targets. The program is supporting the implementation of these action plans and in tracking achievements on the set targets.

Capacity building for laboratory commodity management

Strengthening of the laboratory commodity management system has required a variety of approaches due to the complexity of the challenges. The program adopted a comprehensive approach that targets to build both the human and institutional capacity to manage laboratory commodities.

To address the knowledge gaps in commodity management, the program developed a laboratory commodity management curriculum in collaboration with NPHLS, DDFS, NBTS and other stakeholders. This has been piloted and used to train 46 laboratory TOTs staff. The curriculum has been finalized in readiness for countrywide rollout. HCSM has also developed commodity management job aids that have been disseminated to sites. These address key aspects of commodity management such as quantification and inventory management of laboratory commodities.

Figure 9 below shows the various tools that have been printed and disseminated by HCSM to service delivery points.

Description
• Job aids (Quantification, storage practices, inventory management)
• Laboratory stock cards
• Commodity top up forms
• Instruction forms
• Daily Activity register (MOH 642)
• Facility Consumption request and reporting forms (MOH 643)
• Expiry Tracking charts
• Temperature Monitoring Charts

Figure 8 List of tools and other materials disseminated by HCSM to service delivery points

The above job aids and commodity management tools have been distributed to sites across the country, with specific focus on the priority districts targeted by HCSM under the first year work plan. For example 4,402 job aids, 9,462 stock cards, 11,084 lab top-up forms, 4,303 instruction forms, 4,420 DAR (MOH 642), 4,325 F-CDRR (MOH 643), 4,396 expiry tracking charts and 4,388 temperature monitoring charts were distributed between April 2012 and June 2012

Other approaches used by the program to address commodity management include supporting one day orientation sessions on the use of laboratory inventory and LMIS tools; provision of On-Job-Training (OJT) on good inventory management; support supervision on data quality and Continuing Medical Education (CME) sessions on laboratory commodity management. These strategies have improved the management of laboratory commodities, for example, Malaria Quality of Care (QOC) round 4 survey findings indicated that there has been improvement in availability of laboratory stock cards from 52% (HCSM baseline survey) to 79% (Malaria QoC round 4 survey) in the sampled facilities.

Support to rollout of the malaria RDTs

HCSM worked closely with the DOMC to develop a national system to scale up the use of malaria rapid diagnostic tests. Under work plan I, the program supported the piloting of malaria RDTs in five districts-Msambweni, Manga, Machakos, Ijara and Vihiga. The program's support entailed development of training materials on use of malaria RDTs, implementing training sessions and support supervision in the pilot districts. To date, a total of 491 front line workers from the five pilot districts and 33 epidemic preparedness and response districts have been oriented. The lessons learnt from the pilot will be used to rollout the use of malaria RDTs nationally in work plan II which is a priority for the DOMC, the President's Malaria Initiative and the Global Fund.

HOW TO DO THE RAPID TEST FOR MALARIA

REQUIREMENTS FOR TEST PERFORMANCE

<p>New unopened test kit*</p> <p><small>*These are not to be used beyond their expiry date.</small></p>	<p>Gloves</p>	<p>Timer</p>	<p>Sharps box</p>	<p>Sterile gauze/ cotton wool</p>
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PROCEDURE	TEST RESULTS
<p>1 Open & label the test cassette.</p>	<p>POSITIVE</p> <p>A line near letter "C" and a line near letter "T" means the patient is POSITIVE for malaria in single species detecting tests.</p>
<p>2 Open the alcohol swab. Clean the left finger on the patient's left hand with the alcohol swab. Allow the finger to dry before pricking. Open the lancet. Prick patient's finger to get a drop of blood.</p>	<p>POSITIVE</p> <p>The test is positive even if the line near "T" is faint.</p>
<p>3 Transfer the collected blood into the sample well marked "S".</p>	<p>NEGATIVE</p> <p>A line near letter "C" and NO LINE near letter "T" means the patient DOES NOT have malaria.</p>
<p>4 Add the required buffer solution into the buffer well marked "B".</p>	<p>INVALID</p> <p>NO LINE near letter "C" and one or no line near letter "T" means the test is INVALID.</p>
<p>5 Time the test as per manufacturer's instruction after adding the buffer. Read test results.</p> <p><small>(NOTE: Do not read the test cassette later than the recommended time after adding the buffer. You may get false results.)</small></p>	<p>RECORD</p> <p>Record the test results on your register.</p> <p><small>NOTE: Each test can be used ONLY ONE TIME. Do not try to use the test more than once.</small></p>

WASTE DISPOSAL	RECORD
<p>Dispose the used lancet, pipette, blood collecting device in the Sharps Box immediately after use.</p>	<p>Dispose the gloves, alcohol swab, cassette and packaging in a non-sharps waste container immediately after use.</p>

Figure 9 Malaria RDT Kit job aide

Increasing Universal access to Malaria Diagnosis in Kenya

Mbale Provincial Rural Health Training Centre in Western Kenya receives about 120 outpatient cases per day and 41% of those are usually treated for Malaria. The Centre provides various medical services at a subsidized rate; however Malaria treatment is free. According to Dr. Jacob Odipo, who is in charge of the facility, all children below five years receive free mosquito nets but there is still a high rate of infection of Malaria in children. He attributes this to Mosquito bites received before children go to bed.

At 11am, mothers start streaming into the hospital most carrying children. Mama Victor is one of the mothers visiting the hospital today. Victor is one year old and Mama Victor (Victor's mother) has brought him to the hospital for routine immunization but she is also concerned about his lack of appetite and high fever. The nurses recommend that Victor gets a Malaria test. In half an hour's time, Victor has received his test results and is receiving first line treatment for Malaria.

Three months ago, Victor's mother would have had to wait for three to four hours to receive treatment. Thanks to Malaria RDTs, Victor received treatment faster.



Figure 10 Mama Victor administering Malaria first line treatment to Victor in Mbale, Vihiga

. "Previously we used to rely on microscopy for Malaria test and with the limited number of Lab technicians, patients would have to wait for three to four hours for their results. Some left before receiving test results because of the long distances they have to travel back home. We suspect an unknown number were self medicating for Malaria to avoid the long lines," explains Dr. Odipo.

The hospital only has one lab technician performing an average of 200 lab tests per day thus the long lines.

" Malaria RDT's kits have helped ease congestion in the labs and helped patients receive treatment faster with only those who test positive for Malaria receiving medication," Dr. Odipo adds.

RDTs are a much needed intervention that represents benefits across all areas of the healthcare delivery system. Correct diagnosis saves the government or the patient 4USD in unnecessary treatment costs for a malaria negative case. The kit costs 1 USD while the unsubsidized retail cost for Artemisinin/ Lumefantrine (AL) 24s used for Malaria treatment is approximately 5 USD.

The management of malaria has previously been based on the clinical symptoms of a patient under five in malaria endemic zones. However the Kenyan government recently adopted a universal diagnostic policy to successfully provide universal malaria treatment. This led to the procurement of approximately eighty million RDTs for distribution and use in 2012 through the help of development partners.

USAID Kenya funded [Health Commodities and Services Management](#) (MSH/HCSM) program in collaboration with DOMC has been providing technical assistance through quantification, developing and rolling out the RDT implementation plan and supervision to ensure that the procured RDTs and other malaria commodities are managed appropriately at the facility level. The program is currently involved in orientating about 3,200 frontline health workers on the use of RDTs in lower level facilities countrywide. This hospital was a pilot site on the use of RDTs in improving service delivery to patients like Victor.

SECTION IV: NEXT STEPS

The program has since developed work plan II (Oct 2012-Sept 2013) that builds on the achievements of the previous work plan and drawing on lessons learnt in its implementation. The program will continue implementing interventions at both the central and peripheral level. At the central level, the program will continue supporting MOPHS/MOPHS, priority health programs and government agencies to strengthen health systems for commodity management and security. In addition, the program will also support the on-going initiatives to review the policy and legal frameworks for the health and pharmaceutical sectors. In providing TA at this level, HCSM will leverage with the MoH, donor organization, implementing partners and other stakeholders in the prioritization and implementation of interventions. The program will also take into account the evolving priorities, restructuring and reorganization occasioned by the implementation of the new constitution and devolution and the new national health policy framework.

HCSM is also providing guidance to the Ministry of Health (MoMS/MoPHS) on a conceptual framework for the implementation of a national Logistics Management Information System (LMIS). This LMIS is intended to institutionalize a framework for the optimal management of health commodities at all levels and provide critical information to improve the health commodities supply chain in Kenya.

At the peripheral level, HCSM will continue collaborating with regional stakeholders and implementing partners to scale up implementation of interventions initiated in the first cohort of priority districts. The program will build on the already established relationships with these regional stakeholders to fast-track and sustain activity implementation. The focus of activities at this level will be to improve management, use and accountability for health commodities through establishment and support for appropriate oversight mechanisms and capacity building of facility-level staff. The program will continue to use mentorship, on-the-job training and the Monitoring-Training-Planning (MTP) quality improvement approaches for institutional and individual capacity building and skills transfer.

SECTION V: INDICATOR PERFORMANCE TABLE

Indicator	Baseline	Target (Sep 2012)	Achievement as at sep 2012	Deviation from the target	Data source	Comment
Result Area 1: Strengthened MoH commodity management						
Expected Outcome 1a: Peripheral Healthcare Facilities Able to Account for and Manage Commodities Within Them Effectively						
Indicator 1: Proportion of health facilities submitting commodity usage reports to the central level for priority program commodities [ART, Malaria, TB, FP]	ART: 84% [ordering points] Malaria: 62% [SDPs] TB: 49% [ordering points] FP: 51% [stores]	ART: 90% [ordering points] Malaria: 70% [SDPs] TB: 70% [ordering points] FP: 70% [stores]	ART: 91% [ordering points] Malaria: 43% [SDPs] TB: 73% [ordering points] FP: 58% [stores] As at July 2012	ART: +1% [ordering points] Malaria: -27% [SDPs] TB: +3% [ordering points] FP: -12% [stores] As at July 2012	LMU Work books	Reporting rates have been fluctuating and in the last three months they have averaged as follows; ART: 92% [ordering points] Malaria: 48% [SDPs] TB: 56% [ordering points] FP: 52% [stores] This fluctuation has been influenced by diverse determinants such as availability of tools, capacity gaps in use of LMIS tools, challenges with data transmission systems to LMU. The program has been addressing these challenges in LMIS and has prioritized it in the work plan II
Indicator 2: Total number of health workers trained in commodity management. (desegregated by cadre and ownership (FBO or Public))	-	Capacitate regional and facility staff in commodity management in 50 districts	Over 2500 health care workers were trained from 59 districts	+9.	HCSM progress reports.	Training of the health care staff in commodity management was a part of intensive roll out of HCSM Commodity and Services Management Package at the peripheral level.
Indicator 3: Proportion of facilities reporting stock-out for a set of tracer health commodities on the day of the assessment.	AZT/3TC/NVP 300/150/200 tab (ART): 4.8% DMPA : 26.4% TB patient pack: 22.9% AL all sizes (Malaria): 25%	- DMPA: 20% TB patient pack: 15% AL all sizes (Malaria): 15%	- DMPA: 18% TB patient pack: 42% AL all sizes (Malaria): 7%	- DMPA: +2% TB patient pack: -27% AL all sizes (Malaria): +8%	Malaria QoC survey round 4.	The program leverage on the QoC survey to collect data on this indicator. At the time of the assessment the country was experiencing a shortage in TB patient pack occasioned by procurement delays by World Bank.

Indicator	Baseline	Target (Sep 2012)	Achievement as at sep 2012	Deviation from the target	Data source	Comment
Indicator 6: Proportion of health facilities having expiries of at least one commodity from the tracer commodities list	36%	<20	14.0% for one expired AL pack	+6	Malaria QoC survey round 4.	Expired antimalarial drugs were uncommon, though an increase trend in the availability of at least one expired AL pack was observed (2.9% at baseline to 14.0% at the last survey). This is a proxy indicator for existence of expiries in the facility pending for a comprehensive facility assessment scheduled for work plan II.
Indicator 7: Proportion of health facilities receiving integrated supportive supervision visits in the last 3 months	78% reported, but no supporting documentation [Actual estimated to be <40%]	No target for 2012 but at least 50% by 2013	60.5%	+10.5 for 2013 target	Malaria QoC survey round 4.	There was a significant increase from 41.5% of health workers receiving at least one supervisory visit in 3 months prior to the baseline to 60.5% prior to the last follow-up survey. This is a proxy indicator for facilities receiving integrated supportive supervision visits pending for a comprehensive facility assessment scheduled for work plan II however 50 districts were supported to conduct integrated supportive supervision visits during work plan I.
Indicator 8: Number of functional regional commodity security committees established (disaggregated by administration units)	Non-existent	Functional (8 Provincial and 50 district level) commodity security committees set up in all the regions with TORS and minutes of quarterly meetings;	8 Provincial health commodity committees formed 52 District health commodity committees formed	- +2	HCSM progress reports.	The program supported formation of provincial and district level health commodity management committees. The committees are chaired by MoH staff and members comprises of provincial and district health management teams (P/DHMTs) and representative of key stakeholders e.g. KEMSA, Kenya Pharma, APHIAplus, CDC partners etc.
IR 2: Strong and Effective MOMS/MOPHS Stewardship and Technical Leadership in Supply Chain Management/Commodity Security						
Indicator 1: Functional MOMS/ MOPHS supply chain oversight committee (SCOC) at national level	SCOC non functional	TORS reviewed and adopted Work plan developed Supply chain audit toolkit reviewed Two Level-4 hospital audits conducted	Draft TOR developed by not adapted Not done Supply chain audit toolkit reviewed Supply chain audits conducted in 4 sites in Nyanza province (New Nyanza PGH, Kisii level		HCSM progress reports.	The Health sector's coordinating mechanism under the SWAp secretariat is being re-structured to be aligned to the Comprehensive Health Sector Framework 2012 – 2030. Finalization of this process guide formation of this committee.

Indicator	Baseline	Target (Sep 2012)	Achievement as at sep 2012	Deviation from the target	Data source	Comment
			5 DH, Siaya DH and Bondo DH).			
Indicator 2: Proportion of priority programs and key MoH departments [including NASCOP, DLTLD, DOMC, DRH, NPHLS] able to independently generate monthly commodity stock status reports	None	DOMC, DRH, DLTLD and NPHLS able to generate monthly commodity stock status reports	Monthly stock status reports were routinely generated for all priority program			Staffs from priority program have been actively involved in generation of monthly stock status report.
Indicator 3: Proportion of priority programs [including NASCOP, DLTLD, DOMC, DRH, NPHLS] and key MoH departments mentored by HCSM that are able to independently undertake commodity quantification	NASCOP's ART program (1 staff), and DRH/FP (1 staff) able to independently undertake commodity quantification	Key officers from DOMC (2), DRH (2), DLTLD (1), NASCOP ART (1) and NPHLS (1)	23 key officers from DoP, NPHLS and priority MoH programs, as well as 2 MEDS officers were trained in quantification 6 senior DRH staffs were trained in quantification and pipeline monitoring concepts and tools (Reality-FP, Pipeline®).		HCSM progress reports	Staffs from priority program have been actively involved in developing and review of the quantification reports and as a result FY 2012/13 quantification reports have been developed for all priority programs and EMMS, including supply plans.
Effective Coordination and Harmonization of GOK and Development Partners' Activity in the Subsector by the Procurement and Supply Chain ICC						
Indicator 1: Functional and expanded Procurement and Supply Chain Inter-agency Coordinating Committee (PSC-ICC)	PSC-ICC partially functional. Non-existent harmonized (a) Procurement planning and F&Q guidelines, (b) Procurement Plan	TORs reviewed and adopted	None		HCSM progress reports	The Health sector's coordinating mechanism under the SWAp secretariat is being re-structured to be aligned to the Comprehensive Health Sector Framework 2012 – 2030. Finalization of this process guide formation of this committee.
Improved Delivery of Pharmaceutical Services						
Indicator 2: Percentage of health facilities with the most current edition of Kenya National STGs and Essential Medicines List	47.1% 5.7% new malaria guidelines	70% for all guidelines	Volume I 8646 copies and 10784 copies of Vol II National Clinical Management Guidelines and 2914 copies of KEML disseminated 45.3% new malaria	-	HCSM progress reports Malaria QoC survey round	The program has supported dissemination of National Clinical Management Guidelines and the Kenya Essential Medicine List (KEML) to all level 2 & 3 facilities countrywide This is a proxy indicator on trends in availability of key treatment guidelines. Health facility survey has been

Indicator	Baseline	Target (Sep 2012)	Achievement as at sep 2012	Deviation from the target	Data source	Comment
			guidelines		4.	scheduled to be undertaken in wok plan II.
Indicator 3: Percentage of tracer conditions treated according to treatment guidelines at health facilities	Diarrhoea 6.9% Malaria 22%	Diarrhoea 15% Malaria 40%	- Malaria 44%	+6	Malaria QoC survey round 4.	The performance of the composite malaria case-management indicator improved from 28.1% at the baseline to 44.3% during the last follow-up survey. <ul style="list-style-type: none"> – Testing rates increased from 42.5% to 57.8%. – In children below 5 years of age the composite performance improved from 19.3% to 37.9% while testing rates increased from 33.3% to 50.6%. – In patients 5 years and older the composite performance improved from 36.1% to 49.3% while testing rates increased from 50.8% to 63.6%.
IR 2: Strengthened Medicines Quality Assurance and Pharmacovigilance						
Indicator 1: Availability of pharmacovigilance guidelines at facilities	28.8%	40%	46%	+6	HCSM progress reports	The program has supported dissemination of pharmacovigilance guidelines to health facilities.
Indicator 2: Availability of suspected ADR and Poor quality medicinal products reporting forms at facilities	ADR forms: 57.6% Poor Quality Medicine Forms: 53.4%	70% for both	ADR forms: 47% Poor Quality Medicine Forms: 46%	ADR forms: -23% Poor Quality Medicine Forms: -23%	HCSM progress reports	
Indicator 3: Number of ADR reports received at central level	1400 (Sept 2011)	3500	Over 5000 reports received at PPB at Sept 2012	>+1500	PPB	The program provided on-going support in pharmacovigilance data acquisition from health facilities through national courier services for submission of reports to PPB.
Indicator 4: Number of poor quality medicinal products reports received at central level.	175 (Sept 2011)	200	Over 250 reports received at PPB at Sept 2012	>+50	PPB	
Indicator 5: Number of regulatory actions taken during the reporting period consequent on pharmacovigilance activities	No data available	1	20	+19	PPB, NASCOP	Key decisions made <ul style="list-style-type: none"> – counterfeit zidolam N batch number E100766 and A9366 quarantined – supply chain for ARVs merged into only two: KEMSA and Kenya PHARMA – Market authorization of a pharmaceutical company withdrawn due to poor quality products including

Indicator	Baseline	Target (Sep 2012)	Achievement as at sep 2012	Deviation from the target	Data source	Comment
						<p>brands of Azithromycin, Paracetamol, Itraconazole and Cefixime.</p> <p>– More than 10 products withdrawn and 8 products recalled from the market. This included counterfeit Quinine sulphate and Enzoy®, claimed to be a vitality drink</p>
Strengthened Pharmaceutical Subsector Governance						
Indicator 1: Updated National Pharmaceutical Policy approved by the government including corresponding implementation and M&E plans	Draft revised KNPP available and awaiting cabinet approval	Draft KNPP Implementation plan (KNPP IP) and M&E plan	<p>KNPP was adapted by the cabinet</p> <p>Draft KNPP Implementation plan has been developed.</p>		HCSM Progress report	The program has been providing technical and operational support to KNPP development process and its implementation.
Indicator 2: Updated strategic plans for KPA and PSK	<p>KPA: 2009-2012 strategic plan</p> <p>PSK: Strategic plan exists (2009-2014); No implementation plans</p>	<p>KPA Strategic plan revised and implementation plan developed</p> <p>PSK implementation plan developed</p>	<p>KPA Strategic plan revised and implementation plan developed</p> <p>Development of PSK implementation plan is ongoing</p>	-	KPA PSK	
An Efficient and Effective Laboratory Supply Chain						
Indicator 5: Proportion of health facilities submitting monthly commodity usage reports to the central level for priority programs [HIV, Malaria)	<p>HIV Test Kits 50%</p> <p>CD4-</p>	<p>HIV Test Kits 70%</p> <p>CD4:70</p>	<p>HIV Test Kits 57%</p> <p>CD4: 58% As at July 2012</p>	<p>HIV Test Kits: -13%</p> <p>CD4: -12%</p>	LMU Work book	<p>Reporting rates have been fluctuating and in the last three months they have averaged as follows;</p> <p>RTKs: 56% [sdps]</p> <p>CD4: 58% [SDPs]</p>
Indicator 6: Number of functional regional commodity security committees established (disaggregated by administration units)	Non-existent	Functional (8 Provincial and 50 district level) commodity security committees set up in all the regions with TORS and minutes of quarterly meetings;	<p>8 Provincial health commodity committees formed</p> <p>52 District health commodity committees formed</p>	- +2	HCSM progress reports.	<p>The program supported formation of provincial and district level health commodity management committees. The committees are chaired by MoH staff and members comprises of provincial and district health management teams (P/DHMTs) and representative of key stakeholders e.g. KEMSA, Kenya Pharma, APHIAplus, CDC partners etc.</p> <p>Lab commodity issues form part of the key agenda at the provincial and district commodity security committee meetings</p>

SECTION VI: ENVIRONMENTAL MITIGATION AND MONITORING REPORT

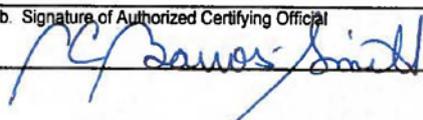
In compliance with USAID’s environmental procedures – 22 CFR 216 (“Reg 216”), HCSM completed and submitted an Environmental Mitigation and Monitoring Report (EMMR) to USAID/Kenya Mission.

The program activities as captured in the report were considered to be low risk to the environment as summarized in the table below:

Program Activities	Screening Result		
	Very low risk	High Risk	Moderate or unknown risk
1. Strengthen MOMS/MOPHS stewardship and technical leadership in supply chain management/commodity security.	✓		
2. Support effective coordination and harmonization of government and development partners’ activity in the subsector	✓		
3. Strengthen peripheral healthcare facilities to able to account for and manage commodities effectively.	✓		
4. Support effective and efficient commodity management systems in the private sector (faith-based and commercial sector organizations).	✓		
5. Strengthen pharmaceutical sector governance	✓		
6. Improve delivery of pharmaceutical services	✓		
7. Strengthen medicines quality assurance and pharmacovigilance	✓		
8. Improve pharmaceutical information acquisition and management	✓		
9. Strengthen laboratory sector leadership and governance	✓		
10. Support an efficient and effective laboratory supply chain	✓		
11. Improve accessibility of quality essential lab services	✓		

SECTION VII: SUMMARY OF FINANCE REPORT

FEDERAL FINANCIAL REPORT
(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted USAID/OFM		2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) AID-623-LA-11-000008		Page 1	of pages		
3. Recipient Organization (Name and complete address including Zip code) Management Sciences for Health, Inc. 784 Memorial Drive, Cambridge, MA 02139							
4a. DUNS Number 071713085	4b. EIN 04-2482188	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment) FRLC 72 00 1329		6. Report Type <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual		
8. Project/Grant Period From: (Month, Day, Year) 04/01/2011		To: (Month, Day, Year) 03/31/2016		9. Reporting Period End Date (Month, Day, Year) 09/30/2012			
10. Transactions <i>(Use lines a-c for single or multiple grant reporting)</i>					Cumulative		
Federal Cash (To report multiple grants, also use FFR Attachment):							
a. Cash Receipts					\$6,396,250.00		
b. Cash Disbursements					\$6,896,148.96		
c. Cash on Hand (line a minus b)					(\$499,898.96)		
<i>(Use lines d-o for single grant reporting)</i>							
Federal Expenditures and Unobligated Balance:							
d. Total Federal funds authorized					\$10,111,574.00		
e. Federal share of expenditures					\$6,896,148.96		
f. Federal share of unliquidated obligations					\$0.00		
g. Total Federal share (sum of lines e and f)					\$6,896,148.96		
h. Unobligated balance of Federal funds (line d minus g)					\$3,215,425.04		
Recipient Share:							
i. Total recipient share required					\$1,249,845.00		
j. Recipient share of expenditures					\$41,775.23		
k. Remaining recipient share to be provided (line i minus j)					\$1,208,069.77		
Program Income:							
l. Total Federal program income earned							
m. Program income expended in accordance with the deduction alternative							
n. Program income expended in accordance with the addition alternative							
o. Unexpended program income (line l minus line m or line n)							
11a. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
	Salaries	81%	07/01/2012	09/30/2012	50,594.39	40,981.46	100%
	Local Proff	40%	07/01/2012	09/30/2012	414,283.66	165,713.46	100%
	Consultants	40%	07/01/2012	09/30/2012	9,200.43	3,680.17	100%
					g. Totals: \$	684,453.57	
12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:							
13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)							
a. Typed or Printed Name and Title of Authorized Certifying Official Patricia Barros-Smith, Manager Corporate Accounting			c. Telephone (Area code, number and extension) 617-250-9214				
			d. Email address pbarrossmith@msh.org				
b. Signature of Authorized Certifying Official 			e. Date Report Submitted (Month, Day, Year) 10/22/2012				
14. Agency use only:							

Standard Form 425
OMB Approval Number: 0348-0081
Expiration Date: 10/31/2011

Paperwork Burden Statement
According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0081. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the