PLAN INTERNATIONAL USA, INC d/b/a CHILDREACH

3RD ANNUAL REPORT

Kenya Child Survival XV Project

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IMPLEMENTING AGENCY

PLAN International Kenya
In partnership with
Ministry of Health Kenya
Agakhan Health Services, Kenya

LOCATION

Kubo and Kinango Divisions
Kwale District, Coast Province, Kenya

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Abbreviations and Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
AKHS	-	Aga Khan Health Services
ANC	-	Antenatal Care
CACC	-	Constituency AIDS Control Committee
CBFs	-	Community Based Facilitators
CHW	-	Community Health Workers
CIMCI	-	Community Integrated Management of Childhood Illness
CO	-	Country Office
CORPS	-	Community Own Resource Persons
CRS	-	Catholic Relief Services
DACC	-	District AIDS Control Committee
DIP	-	Detailed Implementation Plan
DHC	-	Dispensary Health Committee
FMS	-	Financial Management System
GOK	-	Government of Kenya
HAD	-	Health Action Day
HIS	-	Health Information System
HIV	-	Human Immunodeficiency Virus
HMIS	-	Health Information Management System
HW	-	Health Worker
ICRH	-	International Center for Reproductive Health
IEC	-	Information Education and Communication
ITN	-	Insecticide Treated Net
IMCI	-	Integrated Management of Childhood Illness
KHF	-	Kwale Health Forum
KPC	-	Knowledge Practice and Coverage
MED	-	Micro Enterprise Development
MNT	-	Maternal Neonatal Tetanus
MOH	-	Ministry of Health
MOE	-	Ministry of Education
NID	-	National Immunisation Day
NGO	-	Non-Governmental Organisation
PLWA	-	People Living with AIDS
PHC	-	Primary Health Care
PHT	-	Public Health Technician
PO	-	Project Outline
PSM	-	Program Support Manager
PPM	-	Program Planning Modules
PSI	-	Population Services International
PVO	-	Private Voluntary Organisation
TBA	-	Traditional Birth Attendant
TOF	-	Trainer of Facilitators
TOT	-	Trainer of Trainers
TT2	-	Tetanus Toxoid (2nd dose)
TOR	-	Terms of Reference
VHC	-	Village Health Committee
VCT	-	Voluntary Counseling and Testing
WCBA	-	Women of Child Bearing Age

EXECUTIVE SUMMARY

Background Information

Plan Kenya has been implementing a Child Survival Project in two rural Divisions of Kubo and Kinango, in Kwale District of Coast Province. The major partners are Ministry of Health, Aga Khan Health Services and the community. The Project serves 196 villages in the Divisions.

The goal of the Child Survival project is to sustainably reduce child mortality through increased access to, and community demand for, quality health care. The overall program strategy aims at:

- Increasing access to health services within the rural communities in the project areas
- Developing a community based health system with strong links to Ministry of Health (MOH) service providers in first level facilities, Village Health Committees and Dispensary Health Committees
- Designing and implementing the Community Integrated Management of Childhood Illnesses (C-IMCI) approach at the village level
- Providing advocacy and support to MOH providers to be trained in and to apply Integrated Management of Childhood Illness (IMCI) approaches at the facility level.

The project interventions address four key Child Survival issues, which are related to high infant mortality rates and fall within the IMCI model. The interventions are as follows: Malaria, Pneumonia Case Management, HIV/AIDS Control, and Improved Immunization Coverage.

This report covers the period from October 2001 to September 2002, which represents the third year of implementation. The following is a summary of the salient features documented in the report:

Immunization

Broadly, a key objective of the Child Survival Program is to increase the full immunization of children aged 12-23 months as well as pregnant women. Interventions that have been undertaken to achieve this objective include the following:

- Monthly immunization outreaches for hard to reach areas

- Increased community mobilization for health services
- Strengthening the MOH in cold chain management and maintenance
- Accelerated immunization campaigns
- The introduction of IMCI (both community and facility)

Pneumonia

The objective of the Pneumonia Case Management intervention is to increase the proportion of mothers able to recognize rapid and difficult breathing as a sign of pneumonia in children aged 0-23 months and seek health care services. To achieve this objective:

- The project adapted the IMCI strategy that has included Community Health Workers as well as facility based health workers.
- A documentary on pneumonia identification and treatment has been developed and its utilization is ongoing.

Malaria

The malaria objectives are to increase the proportion of mothers who can recognize fever as a danger sign for malaria in children less than 2 years, seek treatment from health care providers and increase the proportion of mothers who report the use of Insecticide Treated Net (ITNs) and malaria prophylaxis during pregnancy.

To achieve this objective:

- The training of CORPS and Community Health Workers (CHWs) in IMCI has been conducted to increase awareness on the danger signs.
- Tailors have been trained to make and sell ITNs at community level.
- Although ITN social marketing has been undertaken, the use of ITNs has not been quite successful. Anecdotal evidence suggests that this could be attributed to poverty, low-income levels, as well as low capacity for risk assessment in order to spur behaviour change. We plan to conduct a research to determine the factors that influence ITN use.

HIV/AIDS

The objective of the HIV/AIDS intervention is to increase the proportion of mothers able to identify the modes of HIV transmission, identify means of protection and increase condom use and utilization of VCT services. Another

objective is to increase the number of functional VCT services with trained counselors.

Efforts towards achieving these objectives include:

- Training of community counselors, puppeteers and health workers. The community counselors create awareness during home visits and Health Action Days. Puppeteers provide public education on HIV/AIDS during organized health activities and advocate for voluntary counseling and testing. However, their access is rather limited in view of the fact that the areas of coverage are vast and there is need for transport. Health workers provide Voluntary Counseling and Testing (VCT) services at Kinango, Kwale and Msambweni hospitals.

Mid-Term Evaluation

Priority MTE recommendations have been implemented. For example, a partnership agreement with Aga Khan Health Services (AKHS) was signed and implemented to improve data collection and utilization at all levels for program management. The agreement also covers areas of Dispensary Health Committee (DHC) financial management and strengthening of DHC capacities. The training of first level health workers has immensely contributed to linking community IMCI to trained health facility service providers. Staff has been increased within the Child Survival Program to provide adequate support to communities. Eight Community Based Facilitators have been recruited and are providing useful links among the community, the project and CORPS.

Collaboration and Partnership

The project relies heavily on collaboration and partnerships. Key partners include the MOH, AKHS, CBOs, Kwale Health Forum (KHF) and the community.

INTRODUCTION AND BACKGROUND

Plan Kenya has been implementing a four year Child Survival Project in two rural divisions of Kubo and Kinango, situated in Kwale District of Coast Province. The project area which covers 196 villages, has some of the highest official rates of infant and child mortality in rural Kenya, with the main causes of death in Kwale being Malaria (28%) and Pneumonia (21%).

The goal of the project is to sustainably reduce child mortality through increased access to, and community demand for, quality health care.

The major partners are Ministry of Health, Aga Khan Health Services Community Health Department (AKHS-CHD), and Non-Governmental Organisation (NGO) specialised in community development and capacity building in Financial Management Systems (FMS) and Health Management Information System.
This is Plan Kenya's first CS project that has resulted in significant organizational learning, especially as its focus and implementation represents a departure from child sponsorship that is the largest part of the Country Office's effort.

The overall program strategy aims at:

- Increasing access to health services within the rural communities in the project area
- Developing a community-based health system with strong links between MOH service providers in first level facilities, Village Health Committees and Dispensary Health Committees
- Designing and implementing the Community Integrated Management of Childhood Illnesses (C-IMCI) approach at the village level, as well as to providing advocacy and support to MOH providers to be trained in and apply IMCI approach at the facility level.

The project interventions address four key Child Survival issues, which are related to high infant mortality rates in the project area that fall within the IMCI model and which is of priority concern to the MOH, namely:

- Malaria (30% effort)
- Pneumonia Case Management (25% effort)
- HIV/AIDS Control (20% effort)
- Improved Immunization coverage (25% effort)

A. Overall Estimation On Project Objectives

During this reporting period, significant efforts have been made towards achieving project objectives as summarized in the following matrix. Parts A and B of the guidelines are captured in the matrix:

Objectives for Immunization

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
1.1	Increase from 72% to 82% children age 12-23 months fully immunized by 12 months of age	Y	Activities being undertaken to help increase immunization coverage among children below 2 years include: • Monthly outreaches in hard to reach areas have been conducted. Ninety-three Health Action Days have so far been conducted during this reporting period • During Health Action Days, health education is provided to mothers on the importance of completing the immunization schedule. This is to help minimise drop out rates. • The project has provided Health Information Management System (HMIS) support for proper data keeping to avoid vaccine stock-outs and provide better tracking of children. • MOH has established programs to address immunization, i.e., National

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
			Immunisation Days (NIDs) and accelerated immunisation programs) • MOH has introduced incentives/trophies to facilities with highest number of children immunized and the incentives contribute towards controlling against stock outs of vaccines • There is improved maintenance of the cold chain • Eight Community Based Facilitators (CBFs) are now on board to support immunization activities at the community level
1.2	Increase from 16% to 60% number of mothers with Tetanus Toxoid 2nd dose(TT2) coverage before birth of last child	Y	Activities to increase TT2 coverage ongoing • Fifty Health Action Days as well as Maternal Neonatal Tetanus (MNT) campaigns have been done • Traditional Birth Attendant (TBAs) assisted in mobilizing mothers for immunisation • Health Education sessions are conducted by Health Facilitators • Joint Health Action days with other partners under the auspices of KHF are conducted
1.3	Increase From 23% to 50% number of mothers with	Y	• Vitamin A is administered alongside measles vaccination • Vitamin A is being administered during Health Action Day (HAD) and

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
	children age 6-23 months who received Vitamin A		NIDs • Introduction of IMCI has improved the administration of Vitamin A to sick children by trained IMCI Health workers
1.4	Increase from 12 to 16 sites with cold chain facilities in the project area	Y	• Fridges have been purchased and sent to four health facilities in the project area • 15 of 16 sites have operational cold chain facilities

2. Objectives for Pneumonia Case Management

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
2.1	Increase from 30% to 70% mothers able to recognise rapid and difficult breathing as a sign for Pneumonia	Y	54% as per Knowledge Practice and Coverage (KPC) 2002 have sought treatment implying recognition of signs for Pneumonia • Community IMCI has been introduced to CHWs • 1st level Health workers have been trained in IMCI and pass on information to mothers • Project has produced a documentary on Pneumonia identification and treatment • Role Plays by CORPS on specific cases during graduation ceremonies
2.2	Increase from 37% to 70% cases of rapid and difficult breathing in children age 0-23 months who received care from provider trained in IMCI	Y	• 26 Professional Health workers and CHWs have been trained in IMCI. The CHWs are linked to households, make initial diagnosis and advise mothers on when to take the children to health facilities. The facility based health workers provide first level treatment. Both cadres of health workers provide information on danger signs of pneumonia.

3. Objectives for Malaria Control

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
3.1	Increase from 17% to 70% mothers who can state at least one danger sign of Malaria using IMCI protocols for which they took their children to a trained provider	Y	51% according to KPC 2002 could state at least 1 danger sign of Malaria. This was achieved by: • Training of CORPs and 1st level Health workers on IMCI protocol and introduction of community IMCI. CORPS now provide information on danger signs of malaria through home visits as well as community Information Education and Communication (IEC) activities. • Increased awareness of DHCs/VHCs and community through Health Education sessions
3.2	Increase from 38% to 70% cases of fever in children under 2 years who visited a health provider trained in IMCI	Y	
3.3	Increase from 14% to 34% mothers who report the use of ITN during their last pregnancy	Y	According to KPC 2002, 36% of mothers reported the use of ITNs. This has been achieved through • Community Health Education and Awareness creation on ITNs • Trained tailors involvement in the making and selling of ITNs • UNICEF through MOH offered ITNs to expectant mothers in April 2001 • The presence of Population Services International (PSI) on ITN social marketing has boosted the use of

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
			nets in the Project area • Supply of sewing machines and net rolls • Although there is latent potential for higher ITN use, low income, poverty and poor risk assessment hinder this potential. However, DHCs have come up with different strategies of community net acquisition i.e. through loaning and "merry go rounds" (fundraising methods in which people contribute an equivalent amount of money in a group at regular intervals and group members take turns to borrow the whole amount and buy something they would otherwise not afford with their limited individual funds, e.g., the ITNs).
3.4	Increase from 19% to 29% children who slept under a bednet last night	Y	33% (98 out of 300 mothers) according to KPC 2002 stated that they had bednets. Of these, 84 (86%) stated that their children slept under a bednet the night prior to the interview. Further analysis shows that 28% of all mothers interviewed stated that the children slept under a bednet the previous night.
3.5	Increase from 76% to 86% mothers who report receiving	N	DHC/CORPS are providing health education on the need for supplementation to address anaemia during ANC. (However, mothers have a

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
	iron/folic acid supplementation when attending Antenatal Care (ANC)		poor risk assessment of anaemia during pregnancy and do not perceive the immediate/ long-term benefits.) The MOH policy on medical services is being revised and this may see the resumption of complimentary iron and folic acid supplementation.
3.6	Increase from 40% to 80% number of mothers who report receiving Malaria Prophylaxis (P) when attending ANC	N	DHC/CORPS are being trained to include malaria prophylaxis during pregnancy in the health education package. Though mothers have a poor risk assessment of malaria during pregnancy as well, efforts are being made by the MOH to include malaria prophylaxis in the antenatal care package.

4. Objectives for HIV/AIDS Prevention

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
4.1	Increase from 13% to 70% number of mothers able to correctly identify three HIV transmission modes over total number of Women of Child Bearing Age (WCBA)	Y	According to the KPC 2002, mothers' knowledge on HIV/AIDS is high, partly due to the projects intervention. • The project has been creating awareness and Community Health Education during Health Action Days through puppetry, peer education, video shows and distribution of T-shirts with messages on HIV/AIDS produced by Plan sponsorship.
4.2	Increase from 12% to 70% mothers able to name at least 2 ways to protect themselves from HIV	Y	81% of mothers could mention at least two ways of protecting themselves from HIV according to KPC 2002. The project has trained: • 20 community counselors in HIV/AIDS. They provide basic counseling during home visits and are involved in creating awareness among mothers on modes of transmission and prevention. • 30 puppeteers who are involved in education/discussion activities during health outreach services to villages. The puppeteers use puppetry shows as an entry point to discuss abstinence, fidelity and VCT. • 9 Health Workers trained in

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
			counseling skills are attached to VCT centers of Kinango, Kwale and Msambweni hospitals. • There has been improved awareness creation on HIV/AIDS by Government of Kenya (GOK) through District AIDS Control Committee (DACC) and Constituency AIDS Control Committee (CACC) • Public campaigns through radio, drama, IEC • The component of HIV/AIDS has been included in the DHC/VHC/TBA training curriculum

4.3	Increase from 0 to 2 functioning VCTs with trained counselors	Y	The Project area currently has 2 VCT Centers at Kinango and Kwale, which were established by GOK. Plan trained 9 MOH Staff in counseling skills. Data from the situational analysis study show the VCT centers require strengthening in terms of confidentiality, quality of care, adherence to the MOH guidelines and increase of personnel trained in counseling. The project will address these issues in the final year of implementation.
4.4	Increase from 2% to 12% mothers reporting use of condom during	Y	This is a relatively new intervention and social marketing for condoms is just beginning • The CBFs are now on board and are

	last sexual encounter		expected to provide services • The Situational Analysis survey report will facilitate the identification of the areas of intervention to have greater impact

Objectives for Capacity Building and Sustainability

5. Dispensary Health Committee (DHC)

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
5.1	80% of DHCs held at least 8 meetings in the past 12 months	Y	14 out of 15 DHCs held monthly meetings in the last 12 months (93.3%). A total of 168 meetings were held. One DHC does not hold regular meetings due to: • Lack of drive • Meeting dependant on one person/convenor (secretary) This is being addressed by: • On site trainings to revisit the roles and responsibilities of DHC members • Joint program supervision with partners (AKHS & MOH)
5.2	80% of DHCs have supplemental drugs purchased from cost sharing during the past year	Y	100% of DHCs are purchasing supplemental drugs.
5.3	80% of DHCs analyse health data and make decision	Y	Although there is progress, not all DHCs have internalised data collection and analysis on tools for decision-making. Flow of Health Information System (HIS) from the villages to the dispensary through CORPs (VHCs) has

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
			not been smooth. The initial DHC training did not prepare them for data collection and analysis. Also there was inadequate grassroots supervision. This was noted during the MTE and is being addressed: • The project entered into a partnership agreement with AKHS who are specialists in HMIS to build DHC capacities. • The CBFs currently on board provide follow up support.
5.4	80% of DHCs implement a Bi-monthly outreach and supervision of Village Health Committee (VHCs)	Y	DHCs are conducting outreach and supervision of VHCs. However, not all DHCs are able to conduct bi-monthly supervision of VHC, which has proved to be too ambitious given the number of villages to be covered. • Discussions are in progress on how best to supervise the VHCs as well as conduct the outreaches • Eight community facilitators have been recruited to provide supportive follow-up.
5.5	80% of DHCs show financial records with deposits, savings and expenditures for dispensary and outreach	Y	Almost all DHCs are now keeping proper financial records. Although the system of good governance, accountability and transparency in financial management has been a new concept to DHCs, a lot of progress has been made.

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
	services and % of patients paying		• The joint partnership with AKHS involves training DHCs on good governance, conflict resolution and financial management • CORPs who drop out are being replaced • Joint follow up supervision with AKHS and MOH has contributed to good administration • Trained Trainer of Facilitators (TOFs) in FMS assist in record keeping

6. Village Health Committees (VHC)

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
6.1	80% of DHCs have representatives from VHCs in catchment area	Y	DHC members are representatives elected from all village committees within the catchment areas. 100% of DHCs have met this objective.
6.2	70% of VHCs conduct at least 2 Health Promotion or education activities per year	N	Some, but not the majority of VHCs are conducting regular education activities. This is due to lack of adequate project staff on the ground to interact with the trained CORPs. The problem is being addressed with hire of Community Based Facilitators (CBFs) to help bridge the gap between the community and the project. • Discussion with the VHC are ongoing to review the strategy on health promotion and education in villages
6.3	70% of CHWs/TBAs/Tailors actually remunerated	Y	• 74% of DHC have formal written compensation agreements and give remuneration to CORPs, though it has been difficult to reinforce them due to lack of adequate resources at the DHCs.
6.4	50% of outreaches (HADs) actually held	Y	100% accomplishment 93 Health Action Days have been conducted as per implementation plan

7. Ministry Of Health (MOH)

	OBJECTIVE	Is the progress towards achieving the objective on target (Y/N)	Comments
7.1	To increase by 10% cost sharing revenue used for Primary Health Care (PHC) activities	Y	Ministry of Health is currently utilising 25% of its cost sharing revenue on PHC activities.

C. Technical Assistance

The Project requires technical assistance in the following areas:

- IEC materials development. The development of materials was delayed since the project was awaiting HIV/AIDS situational analysis, which was completed in September 02. The results of this analysis will form the basis for IEC strategy development.
- ITN Social Marketing strategy: A PVO (PSI) with social marketing skills has started operations in the Project area. Their nets are competitively priced. They have comparative advantage in social marketing of ITNs and their strategies include radio and TV advertisement, and a mobile public address system, as well as established outreach outlets. The project is exploring ways of collaboration with PSI to ensure the ITNs reach the child and the pregnant mothers.

D. Changes from Program Description and Detailed Implementation Plan (DIP)

Although no substantial changes from the Program Description and DIP were made, there were a few changes from the program description. Microscopes were to be purchased for all dispensaries but only two were bought. This change was necessitated by the fact that the IMCI strategy does not require a microscope for diagnosing Malaria. Besides, the dispensaries did not have qualified personnel to provide laboratory services. The two microscopes were taken to Kwale Hospital and Shimbahills as these are referral centers.
8 New staff hired as per MTE priority recommendation to provide supportive follow up and on job training to Community Own Resource Persons.
An objective on Malaria control (3.4) added during MTE "Increase from 19% to 29% children who slept under a bed net last night."

E. Mid-Term Evaluation Recommendations

A participatory Mid-Term Evaluation was conducted in August 2001 and 12 priority recommendations were made. A number of activities in preparation for the implementation of the recommendations has been accomplished and others are on going. The following are the recommendations and action taken:

1. Train CHW to improve communication skills in data collection.

Partnership agreement between Plan and AKHS was drawn to:

(i) Review input, pre-test all project HIS Tools, review and input HMIS Software to reinforce link to MOH/HMIS, and train project/MOH staff on this software
(ii) Develop a user-friendly operating manual for project HMIS and financial management system in the community (manual for use by project staff, MOH and the DHC's and CORPs).

(iii) Train 60 DHC members in financial management by use of case studies and establish capacities at DHC and community level for sound community management of project activities

(iv) Train 45 DHC members in HIS Management and decision making through use of analytical questions and case studies

(v) Make follow-up of the trainees (TOT/DHC) in the field for support visits

(see annex – AKHS Agreement)

2. Set up a supervision system of HIS Data collection, analysis, interpretation, utilization at all levels

- To date the AKHS has reviewed the tools and trained all CHWs, DHC members, MOH and project staff in Financial and Health Information Management Systems. Follow-up has begun of the trained members and is ongoing. Community-Based Facilitators have been recruited to complement follow-up of the trained CORPs.
- The project trained two staff members (MOH & Plan) on Project Planning and Data Management – a ten-day training organised by AKHS. The trainees were involved in the development of a system for data collection, analysis, interpretation and utilization.
- The development of an HIS operational manual is part of the agreement between AKHS and Plan. The drafting is in progress and the final manual will be ready by December

3. Training of 1st Level Health Workers on IMCI Strategy

- To date 20 first level health workers in all facilities of the project area except Shimbahills have been trained in IMCI case management and have since been followed-up.

- Kwale District is now an IMCI Resource with 26 Health Workers trained in IMCI Case Management, 4 trained as facilitators and 2 trained as Course Directors.

- The introduction of IMCI in Kwale through the CS Project has led the MOH headquarters to introduce IMCI in the Province ahead of the planned schedule.

4. ***Improve Financial Management at the facility level to have DHC financially sound and be able to hire qualified health personnel to ease staff shortage***

A training needs assessment on DHC Financial Management was done by AKHS /MOH/Plan. Areas of weaknesses were identified and the major ones were:

- Lack of trained personnel (clerk)
- Lack of proper records and books of accounts
- Poor handling and storage of financial documents (receipts, cash books, daily collection, daily expenditure)
- The Nurse-in-charge is the only one involved in all activities in the Dispensary

Activities undertaken to address the gaps are identified as the following:

- All DHCs that at the time of MTE had not opened bank accounts were facilitated to open bank accounts. Currently funds collected from all dispensaries are banked at Financial Services Association weekly (at least monthly in areas where banks are far).
- All DHCs have now employed clerks, collect revenue and assist in financial management. This has led to the improved financial situation of the DHCs and most have been able to employ qualified personnel on a part-time basis (e.g. the Laboratory Technician at Mkongani and Kibuyuni Dispensaries). Lukore and Mwapala have employed CHWs on a part-time basis. Due to better financial management, most DHCs are able to pay for operational allowances of their members, including meeting their transport cost for training.

- Since the MTE, the CS Project and AKHS personnel have made six (6) supervisory visits to the DHCs. During these visits, the team has audited the accounts and provided support to the DHCs in financial management. Training of DHCs on FMS has been completed as scheduled in the partnership agreement.

5. ***Health Action Days to be conducted in hard to reach areas once a month***

Health Action Days have contributed to improving immunization coverage within the project area. Apart from the project Health Action Day calendar, the MOH has also contributed through NIDs and the accelerated immunization program.

The paper developed by AKHS and MOH on Health Action Days requirements was reviewed and adopted. The major issues incorporated in the HADs in the project are planning, role of facilities staff, drug requirements and mobilization approaches. Currently HAD mobilization is being undertaken by DHCs, VHCs, local administration, schools, and CORPs.
A bi-annual HAD implementation schedule that covered April - September 2002 was developed.

6. ***Project to enter into annual partnership contract with AKHS (CHD) for ongoing Activities***

The partnership agreement between Plan and AKHS was finalized and a contract signed (refer to recommendation 1 above and annex "VI"-the contract agreement). Since the signing of the contract, AKHS has undertaken the following activities:

- Training of DHCs, VHCs, and CORPS on HIS
- Development of the HIS manual to be used by DHC's/VHC's, CORPS, Project staff and MOH.
- Financial Management training
- Follow-up of trained DHCs.

7. ***Conduct an in-depth survey on HIV/AIDS to provide Project with Baseline information (MTE Findings be used in*** Terms of Reference ***(TOR)***

Two studies (KPC on HIV/AIDS and situational analysis survey) were conducted. Internal resources were used to conduct the KPC while a consultant (Steadman Research Services) was contracted for the situational analysis survey after a review of the TOR.

Major finding of this survey includes:

- Majority of mothers with children <24 months are aware of HIV/AIDS
- Most of the mothers are at risk of getting HIV/AIDS because of multiple partners of their spouses and lack of condom use.
- There exists a gap between community-based systems of taking care of People Living with AIDS (PLWA) and AIDS orphans.
- There are very strong traditional and cultural beliefs that lead to stigmatization and denial.

8. ***Develop IEC Materials on HIV/AIDS, Targeting the Youth and Peer Groups to Strengthen Health Education***

This component has not been finalized because of the delay in finalization of KPC and situational analysis survey. The findings of these surveys will be used to develop IEC material on HIV/AIDs as from October 2002 as the final KPC and Situation analysis have been released in September 2002. Several educational/awareness-raising activities are being conducted:

- Training of 30 volunteers in puppetry who have since gone back to their respective community/village and formed puppetry groups. The groups use puppetry to pass health messages especially on HIV/AIDS, Immunisation, growth monitoring and family planning.

- The project has developed an audiovisual tape on the project interventions and has key messages on danger signs of a sick child, malaria control and HIV/AIDS. Since majority of mothers are illiterate, IEC materials in pictorial form are being developed. They have been pre-tested and are in the final stage of pre-production.

- Complimentary message on HIV/AIDS, Nutrition have been printed on T-shirts through Sponsorship funded projects.

- Child-to-Child activities in ten schools. Children are passing health messages among themselves and to their parents.

- Participatory development of the Digo/Duruma calendar, which has messages on Malaria control, Pneumonia, Immunisation and HIV/AIDS.

9. ***Materials and Supplies***

(a) ***Provision of bicycles to CHWs in hard to reach areas***

Due to financial constraints no more bicycles were purchased for the project to be distributed to the hard to reach areas. However, there is an on-going re-distribution process at the DHCs for hard to reach areas.

(b) ***Existing bicycles should have guidelines on utilization/maintenance***

Guidelines on utilization of bicycles and maintenance have been developed by the respective DHCs and modalities on distribution of other materials put in place

10. ***Ensure community resource persons receive working tools and materials immediately after training***

Drugs, TBA kits, Netting rolls and sewing machines have been re-distributed to all project areas. CHWs and TBAs are being provided with timers and delivery kits, respectively, during follow-up training.

11. ***Increase staff within Plan CS Project in order to ensure adequate support for activities***

Most project activities, especially mobilization and follow up after trainings were difficult to implement due to inadequate staff. After the MTE request for extra staff was made to the CO, eight Community Based Facilitators were hired. These have since received orientation and continue to carry out their duties in the field.

12. ***Enter into an agreement with DHCs that spells out both community and Plan Responsibilities***

The agreement between Plan, DHC and MOH was developed and shared with the other

partners. The agreement has since been translated into the local language (Kiswahili) and

signed by the DHCs (see annex)

F. DIP Phase out Plan

As part of the phase-out strategy, the project has been implemented in 3 phases with phase one covering the first year of the project and the 2nd and 3rd phase in the second year. To date the entire project area has reached the 2nd level (partial involvement) and 3rd level (sustainability).

Those in the 2nd level include Kibandaongo, Ndavaya, Shimba Hills, Mwapala, Mkongani, Mwaluvanga, Mwaluphamba and Kinango CBOs. Although these DHCs do not hold regular meetings, they have a mechanism for cost recovery and use information system for decision-making. They are yet to achieve a sustainable DHC outreach and supervision of VHCs.

Those in the 3rd level include: Kibuyuni, Lukore, Mtaa, Bofu, Vigurungani and Lutsangani. These DHCs are currently able to sustain their own operations financially, though still dependent on project staff and MOH supervision. We are working on strengthening the DHCs' capacity to supervise and mentor the VHCs and CORPs to ensure continuity after project phase out.

G. Impacted factors on project management

(i) Financial Management:

Positive aspects:
There are existing standard procedures by Plan on financial management, which the project uses.

Two major audits were done by:
(a) External auditor – Price Waterhouse
(b) Internal auditor from Plan International headquarters

Both audit reports confirmed compliance

- Extra money was provided by Plan to purchase an additional vehicle
- Core funds from sponsorship have been used to compliment CS Project activities in immunization and curative services during Health Action Days, and for training of the CORPs and TBAs.

Negative aspects:

- Delay in having funds released at the beginning of the financial year because a new Project Outline (PO) has to be in place i.e. be written and approved before expenditures are incurred
- Additional funds requested from USNO (Plan match) to address MTE priority recommendation have not yet been released to the Project. The money was needed for long-term partnership agreement with AKHS, HIV/AIDS situational analysis survey and recruitment of additional staff among other things. Although these tasks have been done, actual payments to partners and consultant are yet to be made.

(ii) Human Resources

Positive aspects

- Hire of 2 Community Health Trainers and 8 Community-Based Facilitators was done. These were not initially included in the DIP.
- Staff development through capacity building training in:

IMCI - Project Coordinator, Field Supervisor and 2 CHTs
HMIS - Administrative Secretary
Log Frame - Project Coordinator
Malaria Workshop - 1 Field Supervisor and 2 CHTs
Exchange visit to International Center for Reproductive Health (ICRH) Mombasa All Project staff
Rights of the Child - All Project staff
Micro Enterprise Development (MED) - All Project staff

Exposure Visit to other Child Survival Projects grant

Senegal - Project Coordinator
Siaya (Kenya) - Project Coordinator and 2 Field Supervisors

Staff has been involved in mentoring students and Interns from Moi University.

Negative aspect:

- Retrenchment of the Public Health Technicians (PHTs) by the MOH left the trained CORPS without a link person to the dispensary. This necessitated the hiring of CBFs by the project
- Concerns on project staff benefits that needed clarity not well communicated.
-

(iii) Communication

Positive aspects:

Communication and flow of information between the project, Country Office and among partners has been good.

- A Steering Committee meeting was held in May.
- Four quarterly Coordination Committee meetings were held in the past year. Participants included the Plan Coastal Health Advisor, CS Project staff, Kwale DHMT, AKHS, Kwale Health Forum, and CBO representatives.
- All stakeholders participated in the MTE and collaboratively made and prioritised recommendations.
- Eleven meetings were held with the various CBOs to provide feedback on MTE findings.
- Reporting has been regular and has contributed to the HIS to allow for proper monitoring and management decision-making.
- The CS staff in Kwale communicate regularly through telephone and e-mail with the Coastal Office in Mombasa and with the Country Office in Nairobi.

Negative aspect:

- The unreliable telephone system in Kwale (which also affects e-mail) causes some delay in communication. However, staff is able to

overcome these problems through the use of hard copies and hand deliveries from the Kwale Office to the Mombasa Office, which has reliable technical communication and is only one-hour drive from Kwale.

(iv) Local Partner Relationships

Positive aspects:

MOH

Ministry of Health is a key partner in all interventions. This is demonstrated in training, evaluation, supervision and facilitation of IMCI implementation. This partnership has extended to developing the MOH District Health Plan.

AKHS

Aga Khan Health Services entered into a long-term partnership agreement in which Plan buys AKHS staff time. AKHS is able to build the capacity of Plan staff, the MOH, DHCs, VHCs, and CHWs in HIS and FMS and conduct follow-up and supervision of the same.

KHF

The Kwale Health Forum is a networking forum of NGOs and the MOH. Together they are able to share resources and experiences and carry out quarterly joint Health Action Days in which community is able to access integrated health services.

Challenges:

Joint supervision remains a challenge because the key partner, the MOH, is not always available. Efforts are being made to have the Divisional Public Health Officers assist in the supervision in the absence of the DHMT. Their capacity to undertake the activity is being strengthened through training

(v) Private Voluntary Organisation (PVO) Coordination/Collaboration

- Bi-annual meetings of the Steering Committee bring together all the partners: MOH from the District to Provincial level, AKHS, selected CBOs/DHCs who come on rotational basis, Provincial administration, Ministry of Education (MOE), Ministry of Culture and Social Services, Kwale Health Forum, Plan backstoppers from Regional and Country office. Partners discuss the project's progress, achievements, challenges and the way forward.
- Sharing of ideas and materials with AMKENI on IMCI training
- Visits by other PVOs who have been awarded Child Survival Grants, e.g., World Vision (TESO), Catholic Relief Services (CRS) Mbeere.
- Participation in the weekly action point meeting where there is sharing on project and sponsorship activities. The Project Coordinator attends the PAMT meetings in which the project's progress/strengths/weaknesses, and best practices are shared.
- Other collaboration activities include:
  - Program Support Manager (PSM) Malawi visit
  - PSM Senegal visit
  -CS Project Coordinator/World Vision (TESO) visit

(v) Other Relevant Management Systems

- Utilize the Program Planning Modules (PPM) Ndugu to make project outlines. The system will assist in monitoring and evaluation of the project activities.
- Project Health Information System is in place and is at par with the MOH. The same is shared with the DHCs where the chalkboard is in place.
- The chalkboard has information on the utilization of health services in the dispensary catchment areas. This is posted monthly for everybody

to see and it is (supposed to be) used by DHCs for planning, monitoring and evaluation.

H. Scaling Up

- IMCI Advocacy

From the beginning, the design of the project was meant to implement IMCI protocols. This is a new approach in Kenya and few people are familiar with it. To fully implement IMCI in the project area was, therefore, not an easy task. The project team visited CARE CS Project in Siaya and used the experience to introduce C-IMCI in the project area by training CHWs.
This did not augur well with the MOH, especially the first level health workers. As a result, there was no link between the CHWs and the health worker. On realizing this major setback, the project started advocating IMCI case management training for MOH staff.
The MOH headquarters that had placed Kwale district in the 27th position to be reached in IMCI protocol training, agreed to reverse this and place Kwale in the 4th position in the country. Plan Kwale CS Project facilitated the introduction of IMCI in Coast Province. As a result, the district has 26 health workers trained in IMCI case management and follow up.
400 CHWs trained in IMCI assess children and advise mothers when to refer them. Mothers have improved in early care seeking behaviour with 52.5% of mothers seeking care for fever compared to 37.9 (KPC 99), while 74% sought care for ARI compared to 52.5% (KPC 99). There is an established link between CHWs and Professional Health workers that was initially lacking.

- Kwale Health Forum:

The formation of Kwale Health Forum has brought a change in the way health activities are run in the district. Coordinating health activities is important to avoid duplication and optimize the use of resources. The KHF has brought all stakeholders together to offer health services under one umbrella, thus helping the CS Project to reach a wider area.

Immunization coverage has increased, as many children are attended to at once.

- Puppetry

Given the fact that this media is both entertaining and educative, the puppetry shows have reached a big audience. The puppeteers were trained to provide STI/HIV/AIDS, Immunization and other intervention messages. The shows are performed by CORPs in their respective areas of coverage. Although coverage is limited by the small number of trained puppeteers, many of them have been trained as trainers and are teaching/recruiting others in their communities to participate.

- Dispensary Health Committees:

1. The Dispensary Health Committee was one of the strategies of the project to strengthen Health Services at the facility level. Existing dispensaries were not representing all the catchment villages leading to a lack of committed ownership.
2. The project facilitated community mobilization to elect VHCs. Each village then nominates a member who represents them at the DHC.
3. DHCs are increasing women's involvement and leadership in health, 30% of all members are female.
4. DHC members have been trained as Trainer of Trainers (TOTs) in Management, Conflict Resolution, HMIS and FMS
5. DHCs have constitutions, are registered as CBOs, and have operational bank accounts.

- Achievements:

1. DHCs are able to give stipend/honorarium to the CORPs as motivation as they implement PHC/CBHC
2. DHCs plan for outreach and support health activities
3. DHCs purchase gas and drugs for EPI
4. DHCs pay wages for cashier/clerk at the dispensary
5. DHCs have persons who provide financial follow up and this has helped in strengthening their management of resources

This structure can provide sustainability when the project phases out.

I. All topics in these guidelines are applicable in the program
J. All relevant aspects of the program are covered in these guidelines.

Annex I
Project Implementation Table

PROJECT IMPLEMENTATION TABLE
ACTIVITIES FOR YEAR 3

		1st Quarter			*2nd Quarter*			*3rd Quarter*			*4th Quarter*			*Total*		
1	**Mobilising activities**	**P**	**A**	**%**	**P**	**A**	**%**	**P**	**A**	**%**	**P**	**A**	**%**	**P**	**A**	**%**
1.1	Sharing MTE results	-	-	-	15	11	*73*	-	-	-	-	-	-	15	11	*73*
2	**Personnel hire**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2.1	Community based facilitators	-	-	-	-	-	-	8	-	-	-	-	-	8	8	*100*
3	**Assessments**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.1	KPC survey(HIV/AIDS)	-	-	-	-	-	-	1	-	-	-	-	-	1	1	*100*
4	**Financial and procurement**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.1	Procurement of vehicle	-	-	-	1	1	*100*	-	-	-	-	-	-	1	1	*100*
4.2	Procurement of office supplies	1	-	-	-	1	*100*	-	-	-	-	-	-	1	1	*100*
4.3	Procurement of IMCI training materials	1	-	-	-	1	*100*	-	-	-	-	-	-	1	1	*100*
4.4	Procurement of bicycles	-	-	-	-	-	-	56	-	-	-	-	-	56	-	-
4.5	Procurement of sewing machines	-	-	-	-	-	-	47	-	-	-	-	-	20	-	-
4.6	Procurement of netting rolls	-	-	-	-	-	-	930	-	-	-	-	-	930	-	-
4.7	Procurement of insecticide	-	-	-	-	-	-	18600	-	-	-	-	-	18600	-	-
4.8	Procurement of Medical supplies	-	-	-	-	-	-	1	-	-	-	-		1	-	-
4.9	Procurement of canvas bags	-	-	-	-	-	-	600	-	-	-	-	-	600	-	-
4.10	Procurement of TBA kits							2000						2000	2000	*100*
4.11	Procurement of timers	-	-	-	-	-	-	400	-	-	-	-	-	400	400	*100*
5	**Contractual services**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5.1	HIV Baseline survey	-	-	-	-	-	-	1	-	-	-	-	-	1	1	*100*
5.2	ITN Social marketing campaign design	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-
6	**Progress reports**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6.1	Quarterly report	-	-	-	1	1	*100*	-	-		-	-	-	1	1	*100*
6.2	Mid term Evaluation	1	-	-	-	1	*100*	-	-	-	-	-	-	1	1	*100*
6.3	Third annual report	-	-	-	-	-	-	-	-	-	1	-	-	1	1	*100*
7	**Training activities**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	--
7.1	**#** TOF trained	30	38	127	-	-	-	-	-	-	-	-	-	30	38	*127*
7.2	# IMCI Case management	-	-	-	34	37	*109*	-	-	-	34	-	-	68	37	*54*

NB: Items not purchases were dependent on additional funds from USNO (Plan Match). Redistribution of the materials, eg. on sewing machines, netting rolls and bicycles are on going.

PROJECT IMPLEMENTATION TABLE
ACTIVITIES FOR YEAR 3 CSP KWALE, KENYA

		1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Total		
		P	A	%	P	A	%	P	A	%	P	A	%	P	A	%
7.3	**# Project data design and management**	-	-	-	1	1	*100*	-	-	-	-	-	-	1	1	*100*
8	Coordination activities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8.1	Quarterly stakeholder meetings	1	2	200	1	1	*100*	1	1	*100*	1	1	100	4	5	*125*
8.2	Bi-annual steering meetings	-	-	-	-	-	-	1	1	-	-	-	-	1	1	*100*
9	**Supervisory activities**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.1	# CHWs supervised	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.2	# TBAs supervised	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.3	# VHCs supervised	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.4	# DHCs supervised	14	14	100	14	14	*100*	14	14	*100*	14	14	14	14	14	*100*
9.5	# ECNs/PHTs supervised	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.6	# Tailors supervised	-	-	-	-	-	-	-	-	-	-	-	-	75	44	*59*
10	**Implementation**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10.1	# DHC exchange visits held	1	1	100	1	-	-	1	-	-	1	-	-	4	1	*25*
10.2	# Community graduations held	15	-	-	-	15	*100*	-	-	-	-	-	-	15	15	*100*
10.3	# Community outreach sessions held (HADs)	12	12	100	16	13	*81*	34	34	*100*	34	34	100	96	93	*97*
10.4	Nets															
10.4.1	# of nets sold (cumulative)	-	-	-	-	717	-	-	950	-	-	1103	-	-	1103	-
10.5	IMCI strategy implementation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10.5.1	# of children with malaria treated at community	-	-	-	-	519	-	-	740	-	-	496	-	-	1755	-
10.5.2	# of children with pneumonia treated at community	-	-	-	-	67	-	-	100	-	-	84	-	-	251	-
10.5.3	**#** referrals to dispensary/hospital from community	-	-	-	-	121	-	-	142	-	-	98	-	-	361	-
10.6	EPI	-	-	-	-	-	-	-	-		-	-	-	-	-	-
10.6.1	# Dispensaries without cold chain	-	-	-	-	1	-	-	-	-	-	-	-	-	1	-
10.6.2	# Beneficiaries reached through HADs	-	-	-	-	2875	-	-	2090	-	-	1700	-	-	6665	-

Annex II
CS PROJECT – WORKPLAN FOR FY003

Annex II

CS PROJECT – WORKPLAN FOR FY003

	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
Hire of Staff (Community Based Facilitators) Staff Orientation	X														
Office Supplies			X												
Times			X												
Basins/KO-Tabs/Thread/Scissors			X												
TBA Kits assembly			X												
Puppet materials			X												
Rapid Test Kits			X												
Printing of IEC/HIS															
AKHS Contract	X														
HIV/AIDS Contract				X											
ITNS – PSI Contract			X	X											
Operational Research Purchasing Power					X										
Final Evaluation															
HIS TOT (2)	X														
FINANCIAL TOT (3)	X														
IMCI Training		X													
IMCI Follow Up			X												
CHW			X												
TBA			X												

DHC Training			X												
Tailors			X												
HIV/AIDS Workshop						X									
Exchange visits					X										
HADs/AV/PA	X	X	X	X	X	X	X	X	X	X	X				X
Facility Supervision					X			X							X
Net Re-treatment				X		X				X		X			
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
Community Education				X	X	X	X	X	X	X	X	X	X		
Community IMCI				X	X	X	X	X	X	X	X	X	X		
Community HIS				X	X	X	X	X	X	X	X	X	X		
IEC Development	X	X													
KHF/Partner meetings	X		X		X		X		X		X		X		X
Community Supervision		X	X	X	X	X	X	X	X	X	X	X	X		
Community Contact Updates (shopkeepers, Teachers)				X		X									
Re-distribution of assets	X	X													
Quarterly reports	X			X			X			X			X		
LQAS															
DHC Community meeting							X	X	X	X	X	X	X		
DHC Meeting (chalkboard)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
VHC Meeting	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
DHC Re-constitution			X		X				X						

Annex III
MEMORUNDUM OF UNDERSTANDING

MEMORUNDUM OF UNDERSTANDING BETWEEN PLAN INTERNATIONAL KENYA COASTAL/TAITA TAVETA CHILD SURVIVAL PROJECT, MINISTRY OF HEALTH, KWALE DISTRICT AND THE COMMUNITY OF KWALE DISTRICT

1. GENERAL

This Memorandum of Understanding is made between PLAN International Kenya Coastal/Taita Taveta of P. O. Box 985, Mombasa (Herein after called "The Sponsor" or PLAN which expression shall where the context so admit include its succession and assigns) of the first part, Ministry of Health, Kwale District on the Second part (hereinafter called "the Collaborator" or MINISTRY which expression shall where the contents admit means and includes its successors and assigns) and the Community on the 3rd part which participation of the Sponsor are outlined and agreed between the parties to the Project which is enumerated in the schedule annexed to the Memorundum which shall further include the agreed contributions, obligations and other aspects of participation for other parties to the Project hereunder known as the "CHILD SURVIVAL PROJECT or "PROJECT".

This document (MOU) is a collaborative document in the implementation of Health related activities by the Child Survival Project i.e Training of CHWs, DHCs, VHCs, Teachers, Outreach Camp Services, Health Facility Support and Staff Training in Kinango and Kubo Divisions of Kwale District.

2. PROJECT OVERVIEW AND BACKGROUND

PLAN is an International Humanitarian Child focused development organisation without religion, political or governmental affiliation. Child Sponsorship is basic foundation of the organisation. PLAN's vision is of a world in which all children realise their full potential in societies that respect people's rights and dignity.

PLAN strives to achieve lasting improvements in the quality of life of deprived children in developing countries through a process that unites people across cultures and adds meaning and value to their lives.

3. OBLIGATIONS AND RESPONSIBILITIES OF MINISTRY OF HEALTH, KWALE DISTRICT

The Ministry of Health, Kwale, through the DHMT has the overall responsibility for the provision and promotion of Health services/activities for the benefit of communities in Kwale District.

Although desirous to achieve the above goals has limited resources and may take a long time to address the expressed need of the above communities.

The MINISTRY is willing to commit staff time to carry out all the necessary activities that lead to full implementation of a sustainable Health Services delivery programme that will benefit the Communities for the said locations. The expected output is improved access to quality services delivered to communities especially for children and mothers. The implementation of the activities will be done during the life of Project with the agreed time frame jointly developed between "PLAN" ,the MINISTRY", and the "COMMUNITY".

The Officers will work concurrently in supporting the above activities in the said locations. Once the implementation of activities is complete, PLAN, MINISTRY and the COMMUNITY will evaluate the effectiveness and impact (with outside input where necessary) before a final Project document is prepared and presented by the MINISTRY & the COMMUNITY to PLAN.

The MINISTRY will offer the necessary technical support in mobilization, organisation, implementation and follow up of community initiatives to ensure quality and timely provision of Health services to communities. Staff assigned to implement the said activities shall produce activity periodic/weekly progress and final reports, which will be forwarded to PLAN and copies to the MINISTRY.

(b) THE COMMUNITY

The communities (beneficiary) are willing to avail time to attend and contribute during Project Implementation and avail any necessary unskilled labour, training facilities (i.e venues) and locally available materials as needed.

The Communities will use and disseminate acquired supplies, services, knowledge and skills and ensure successful and sustainable community health services delivery.

The community will oversee the implementation of activities, identification of beneficiaries (including the facilities) and Management of the Community Based Health Services delivery processes.

The Community shall administer allowances for Community Own Resource Person (CORP) (DHC, CHW, TBA) and Facility Staff from Community financing.

The Community shall endeavor to achieve Self Reliance

4. OBLIGATION AND RESPONSIBILITIES OF PLAN INTERNATIONAL KENYA, COASTAL/TAITA TAVETA

(a) Specific Obligations

PLAN is to ensure availability of and provide funds and any other needed support in form of Material resource to ensure successful implementation of the said activities. The specific resources include:

1. Netting\Skirting materials 2 per village

2. Insecticides 162 units @ 1 per village
4. Bicycles 200 Units @1 per village
5. Sewing machines 75 units 5 per DHC
6. Drugs 1 kit per CHW
7. Trainings for Teachers, DHC,VHC,CHW,Tailors, Health Workers
8. Healthy Facility Equipment
   - 10 Community Chalkboards
   - 2 Microscopes
   - 4 Vaccine Fridges

9. CHW working materials:

-Torches
- Water proof bags
- Stop clocks
- Stationery

PLAN shall mobilize the beneficiaries (communities) of the Project and seek local community cooperation, participation and contribution to ensure sustainability of the Project.

Where applicable PLAN will consider at their own discretion to refund minimal travel costs. This will only be done in exceptional cases.
Where applicable PLAN will seek and meet costs for Partnership with professional bodies like AKHS, FPAK, AMREF or any other organisation in order to impart appropriate skills to MINISTRY personnel and communities.

PLAN shall have the right to object and require any party to the Project removed forthwith who in the opinion of PLAN misconduct himself/herself or is incompetent or negligent in the proper performance of his/her duties whose presence on site is undesirable. In all respects, PLAN shall be seen and act as the SPONSOR and NOT the EMPLOYER for the Project

(b) Funds:

PLAN shall make all decisions as to the disbursement of all funds for the Implementation of the Project.

(5) CONTINUITY OF THE PROJECT

PLAN shall not be responsible for the maintenance of the Project upon completion in any way, and it shall be the role duty and obligation of the Community and MINISTRY to keep the Project sustained and to provide all the necessary maintenance to all aspects of the Project as shall be required from time to time.

(6) TERMINATION

(i) If the MINISTRY or the Community fails and or refuses to comply with basic conditions and agreements set out in the Memorandum of Understanding (MOU) and or any such requirement as shall be reasonably necessary for the success of the Project or mismanagement or embezzlement or fraud or default of any legal or contractual obligation or violation of law by the Community or its appointed representative occurring any way then at its sole discretion PLAN may summarily withdraw from its obligation and participation under this MOU wholly or in Part as it shall in its sole discretion decide.

(ii) Upon occurring of the event under clause (I) PLAN shall be entitled to take immediate possession of all materials provided for the implementation of the Project at its sole discretion and thereafter be entitled to dispose off or deal with such material in any way to recoup to itself and or recover any utilised funds where possible and in any way possible and/or practicable.

7. LIABILITY RELEASE CLAUSE

This Memorandum of Understanding does not create any obligation, legal, Contractual, Financial or otherwise on the Part of "PLAN"- Child Survival Project, to any person claiming entitlement to compensation or other remedies relating to personal injuries, economic harm or otherwise including but not limited to the staff of any of the parties to the Project or the Community or Collaborator and/or other users before, during and after the completion of the Project. In the event of any claim being asserted against PLAN, the MINISTRY and/or the Community shall take over any litigation to defend PLAN.

8. PROPERTY

The Property, Equipment and Material supplied to or for the purpose of the Project shall be except in the case of the applicability of clause 6(ii) be vested in the GOK attached staff and Dispensary Health Committees subject to the MINISTRY sole and exclusive decision and who are responsible for maintenance of the same.

This agreement shall hold for one year upon signature by all parties and to be renewed if all are in agreement.

Parties hereto have set their hand and cause their respective rubber stamps to be affixed hereto this day of…….day of……2000

PLAN INTERNATIONAL KENYA COASTAL/TAITA TAVETA

Sign: _____ _____

Beatriz Fernandez
Country Director

David Kiondo
Programme Area Director

THE COMMUNITY

_____

Sign: Nathan Hiribae
District Commissioner/Kwale

MINISTRY OF HEALTH

Sign: _____

Dr. Phillip Muthoka
District Medical Officer of Health/Kwale

Annex IV
HIV/AIDS KPC REPORT 2002

Knowledge, Practice and Coverage

(KPC)

Survey

KWALE CHILD SURVIVAL PROJECR XV - KUBO AND KINANGO DIVISIONS,
KWALE DISTRICT, COAST PROVINCE

Prepared by

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Plan Kenya, Coastal Program Area

and

Laban Tsuma MBchB
Project Coordinator
Child survival Project, Kwale

April 2002

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EXECUTIVE SUMMARY

1.0 INTRODUCTION

1.1 Plan International has been implementing a Child Survival (CS) XV Project in 196 villages of Kwale District in Kenya. The Project, that is supported by United States Agency for International Development (USAID), aims at increasing access by rural communities to health services, improving quality of dispensary and community health services and establishing sustainable systems via the Village Health Committees (VHC) and Dispensary Health Committees (DHC). Besides, CS Project is also assisting Kwale District Health Office in the implementation of an expanded program on immunisation (EPI), community governance and cost recovery processes in the dispensaries.

1.2 The 4 year project has four major interventions namely malaria control, pneumonia case management, control of immunisable diseases, and HIV/AIDS control. The HIV/AIDS intervention is the latest intervention to be undertaken as a project requirement, an HIV/AIDS baseline survey was required before activities on the program are started.

1.3 The purpose of the survey is to provide the project with information on HIV and other sexually transmitted infections (STIs) with regard to knowledge of HIV/AIDS risk factors and modes of transmission; sexually transmitted infections; HIV screening; stigma; sources of care and support; and identifying orphans and foster/adoptive children and risk and risk reduction. The survey also sought to compare the achievement of key findings at baseline KPC conducted in December 1999 with regard to management of Childhood Illness including identification of danger signs, care seeking, treatment, home care and coverage and drop out rates for childhood immunisation

1.4 The KPC survey adopted the 30 cluster sampling method in the selection of the respondents for the study. The study population consisted of 127,441 persons distributed in 196 villages of Kubo and Kinango Divisions of the project area in Kwale District. A total of 300 mothers with children aged below 24 months were interviewed. The interview questions focused on the mothers' knowledge and practise relating to HIV/AIDS and other critical information on life-saving household behaviours and care seeking patterns that affect the health and survival of children.

1.5 The KPC survey was conducted over five consecutive days from April 15-19, 2002. Filled KPC questionnaires were then coded and inputted into a computer by two data entry clerks using EPI Info Software. Immediately the inputting was completed, the data was cleaned for any inconsistencies/errors by running frequencies or listing all the data entered in the computer. Once this was accomplished, the data was analysed, using the EPI Info Software that was developed at the Centre for Disease Control (CDC) in Atlanta.

2.0 RESULTS

2.1 The mean age of mothers surveyed was 26.9 years while the modal age was 20 years.

2.2 Nine (9.0) percent of the mothers surveyed (27/300) were aged below 18 years while 29 percent were above 35 years of age.

2.3 Out of 300 households interviewed, 32 (10.7%) reported to have orphaned children. There were 82 orphans of which 44 were from within and 38 without the interviewed households.

2.4 Most mothers in the project area are assisted either by family members or by a traditional birth attendant (TBA) during birth. Out of the 300 mothers interviewed, 145 (48.3%) reported that their child's cord was cut and tied by a family member while 75 (25%) reported that a TBA did it. Only (34/300) had the cords of their children cut and tied by a professional health worker.

2.5 During delivery, most of the helpers use home/self prepared materials and this was reportedly true for (202/300) of the mothers.

2.6 Very few mothers (81/300) 27% indicated that pregnant mothers are vaccinated to protect mother and new born against tetanus.

2.7 When the mothers were asked about the number of injections that a pregnant woman needs to protect the new born infant from tetanus, (48/300) said one, (92/300) said two, (117/300) said three and (43/300) said four.

2.8 Majority of the mothers (86.7%) have cards where their children's vaccinations are recorded.

2.9 Full Immunization coverage for age group 12-23 months is 51%. Immunisation coverage for measles of this same age group is 70%. Drop out rate for the 12-23 month age group is 21%.

2.10 The common sign of illness that indicates to most mothers that the child needs treatment is high fever (85.0%) and when the child looks unwell and does not play normally (26.3%).

2.11 Two weeks prior to the survey, most of the children had experienced illnesses mostly fever (65.0%), blood in stool (42.7%), diarrhoea (40.7), cough (19.0%) and malaria (15.7%)

2.12 When children are sick, most of the mothers (46.7%) offer them less than usual quantities to drink and 5.8% give their children only breast milk.

2.13 Also, over half of the mothers give children less than the usual amount of food to eat when the children are sick.

2.14 Majority of the mothers (61/199) whose children had experienced fever and malaria in the last two weeks indicated that they took them to a health centre, (20/199) took the child to a hospital while 24/199 treated their children themselves.

2.15 Majority (166/300) of the mothers interviewed know that mosquitoes spread malaria. Only a few did not know the cause of malaria.

2.16 About a third of the mothers and members of their households were using mosquito nets to protect themselves against mosquito bites. Others (41/300) used household sprays and repellents, (11/300) eliminated stagnant water and (16/300) removed rubbish and bush.

2.17 Of the 300 mothers interviewed, 98 (32.7%) said that they have bed nets.

2.18 Most of the mothers who have bed nets used them the night before the interview. Only (10/98) reported that no body had used the net the night prior to the interview.

2.19 Very few mothers (9.9%) with bed nets soak or dip them in a liquid to repel mosquitoes.

2.20 Out of the 143 mothers who reported that their children had experienced some respiratory illnesses, 53.8% said they sought treatment for the child.

2.21 The treatment was sought mostly from hospital (28.6%), dispensary/health center (37.7%) and pharmacy/chemist/shopkeeper (19.5%)

2.22 Almost every mother interviewed during the survey said that she has heard of HIV/AIDS.

2.23 Majority (61%) of the mothers knew ways that a person can do to avoid getting AIDS or the virus that causes AIDS, only a few (23.7%) did not know.

2.24 Most mothers who know what a person can do to avoid getting AIDS, indicated that HIV/AIDS can be avoided by staying faithful to one partner (128/300), using condoms (69/300), and abstinence (46/300).

2.25 Mothers knows that the virus that causes AIDS can be transmitted from mother to child during pregnancy, delivery and breastfeeding.

2.26 Very few mothers (58/300) indicated that transmission of the AIDS virus from mother to child can be avoided.

2.27 Majority (90.3%) of the mothers interviewed indicated that AIDS cannot be cured.

2.28 216/300 of the respondents indicated that they would be willing to provide care and support to a relative who is infected with HIV/AIDS.

2.29 Most mothers (156/300) did not object to a teacher who has AIDS virus teaching their children.

2.30 Most mothers (66.0%) said they would not allow their children to play with a child who has the AIDS virus.

2.31 Few (32/300) mothers reported that they knew someone in their household who was very sick or bedridden for a period of more than 3 months.

2.32 In the 32 households, 11 persons were reported to have ailed and 26 died. Majority of those who were sick or died were in the 30-50 years age bracket.

2.33 Most households (21/32) with a sick person did not receive any help or care.

2.34 Relatives and friends are the main source of care and support for most households (10/32) with sick persons.

2.35 Money and counselling on how to deal with the illness and its effects are the main types of care and support provided to the sick and bedridden.

2.36 Majority of the household with orphans (28/32) did not receive any type of support. Only 4/32 (12.5%) households with orphans received help.

2.37 Households receive care and support for orphans mostly from relatives or friends 2/4 (50.0%).

2.38 The type of care and support received by the 4 households was counselling (50.0%), transportation (25.0%) and childcare (25.0%).

2.39 Most mothers (125/300) said a person could find out if he or she has HIV by going for a test. However 124/300 (41.3%) did not know.

2.40 Majority of the mothers (152/300) had not heard of a HIV/AIDS counselling and testing service.

2.41 Few mothers knew the reasons of (advantages) of going for HIV/AIDS test. The most cited reasons were protection of sexual partner (41/300) and help in planning for the future (29/300).

2.42 The most common reason cited for not going for an HIV test is the fear of knowing ones HIV status (104/300) and stigma (72/300). Majority (146/300) however did not know the disadvantageous of an HIV/AIDS test.

2.43 Majority (84.7%) of the mothers cited hospital as the place they would go for an HIV/AIDS test.

2.44 Most mothers (218/300) would inform their partners before having an HIV/AIDS test.

2.45 Also, 223/300 mothers would inform their partners of the results of their HIV/AIDS test.

2.46 A quarter of the mothers said that anyone at risk should go for an HIV/AIDS test, while 9.0% indicated that those who are sick should go for the test.

2.47 Very few mothers (55) have been tested for HIV/AIDS. Majority (94%) have not.

2.48 Only 9/15 of the mothers who underwent HIV/AIDS testing were counselled before the test.

2.49 All those who were tested (15/15) got the results of the test.

2.50 More than half of those who underwent HIV test were counselled after the results.

2.51 Apart form AIDS, 63 percent of the interviewees had heard about other STIs.

2.52 The most common signs and symptoms that would lead mothers to think that a man has STI are burning pain on urination (34.4%), genital discharge (22.2%), abdominal pain (13.8%), blood in urine (12.7%) and genital sores (7.4%).

2.53 In a woman, the most common signs and symptoms that would lead to thinking that she has STI are burning pain on urination (38.1%), genital discharge (24.3), abdominal pain (23.8%) blood in urine (15.9%) and foul smelling discharge (12.2%).

2.54 In the last 12 months before the interview only 3/300 mothers reported to have had STI.

2.55 Of the three mothers who had STI, 2 sought advice from a health worker in a clinic while the other sought help from a traditional healer.

2.56 141/300 mothers had had sexual intercourse days ago, 61/300 weeks ago, 82/300 months ago and only 14/300 years ago.

2.57 Almost all (295/300) the respondents did not use a condom the last time they had sexual intercourse.

2.58 The main reasons for using a condom for those few who had used are to prevent pregnancy (3/5) and to prevent STDs/HIV (1/5).

2.59 The last time they had sexual intercourse, majority (286/300) of the mothers had sex with either their husbands or boyfriends.

2.60 When asked how long they had a sexual relationship with the man they had sexual intercourse with last, majority (77.7%) of the respondents indicated that the relationship had lasted for years.

2.61 Four fifths of the respondents indicated that they lived with their partners.

2.62 A third (109/300) of the mothers think that their partners have other sexual partners.

2.63 A few (10/300) of the mothers reported to have had sex with someone else other than their regular partner in the last twelve months.

2.64 Of those that had sexual intercourse with somebody else, only 40.0% used a condom.

2.65 About half of mothers (51.0%) indicated that they know where to get condoms.

2.66 Majority indicated that they could get condoms from Government hospitals (44.4%), health centres (22.2%), Family Planning Clinics/Dispensaries (32.0%) and local retail shops (35.9%).

2.67 Almost half (153/300) of the mothers said that if they wanted to get condoms, they could.

3.0 DISCUSSIONS AND RECCOMMENDATIONS

3.1 The Child Survival Project needs to target women under 19 and over 35 years age groups and educate them on the risk of having pregnancy when one is below 19 or above 35 years of age. Since the survey results show that more women in these age brackets are giving birth now compared to the time of the last KPC (1999), to address the situation, there is a need for the project to support child spacing interventions in the project area.

3.2 Most of the deliveries in the CS Project area are conducted at home and attended to by a family member. Most mothers prefer to deliver at home because of the poor access to health facilities, inferior quality of care given at the health facility compared to that at home, prohibitive delivery expenses and fear of episiotomies. The project therefore has to continue with its efforts to improve service delivery in health facilities and be more user

friendly to mothers who are due. In addition, more TBAs need to be trained and equipped to enable them perform safe deliveries in their community.

3.3 Home/self prepared materials are often used for majority of deliveries conducted at home. If home deliveries are to be made safer, clean delivery kits will have to be used. Hence, the CS Project should find ways of promoting availability of clean delivery kits and sensitising communities on their use in the home.

3.4 Many mothers do not know the reason why pregnant women need to be vaccinated. To reduce maternal mortality rates, in the area, the level of mothers' knowledge on maternal immunisation should be addressed. The project should focus on intensifying its immunisation campaigns and outreaches and increase the frequency of health action days. Further, the project should also encourage and, where possible, assist the Ministry of Health to establish more immunisation centres/sites within the project area.

3.5 Although the survey results show that the maternal knowledge of child signs for treatment is high, mothers' knowledge on core danger signs of convulsions, lethargy, vomiting everything, refusing to feed and etc, home care of the sick child is limited. Professional Health Workers and Community Health Workers and care takers trained in IMCI in the project area need to intensify their efforts in counselling mothers on the various aspects of their children's illness and emphasize home care as defined in the IMCI protocol.

3.6 The use of TBAs, CHWs and other community based health workers is still low compared to self treatment of malaria. Since caregivers often seek help from friends or local healers, communities must be made knowledgeable about care seeking for malaria. This calls for further training of mothers and caregivers, TBA and CHWs on malaria treatment at home and in the community and when to make referrals.

3.7 Communities' knowledge on how malaria is spread is very critical as it enables the household to find ways of controlling malaria. Awareness campaigns on malaria should be emphasised in the project area with a focus on how malaria is spread, how it can be prevented and how it can be treated. Despite the CS project promoting ITNs in the project are, their use is still low. As part of its strategy to further promote the use of ITNs, the CS Project should endeavour to undertake an ITN social marketing campaign that would bring to the fore the importance of using ITNs and re-treatment.

3.8 Many mothers with children suffering from ARI are not following the recommended care seeking steps for a sick child with ARI. To address this, CS project should increase its efforts towards increasing mothers' knowledge on care seeking for pneumonia.

3.9 In the CS project area, almost all mothers (99%) have heard of HIV/AIDS and they are knowledgeable on how AIDS is transmitted and on what one needs to do to avoid getting the disease. Though levels of knowledge are high, the project still needs to enhance the level of awareness and knowledge through provision of correct information on the disease, so that the present gains are not lost.

3.10 Stigmatisation of people living with HIV/AIDS poses the greatest challenge towards combating HIV/AIDS. Behaviour change communication should be one of the strategies that the CS project should implement to address stigma and risk reduction issues. The developed BCC materials should however be appropriate to the local socio-cultural and religious environment. Focus should be on messages that would provide skills for negotiating risk reduction with sexual partners and increasing skills of program beneficiaries to use condoms and/or other forms of safer sex, abstinence and fidelity.

3.11 Culturally, communities in the CS project area have a well-knit social support system based on the extended family structure. The sick, the old and even orphans are traditionally taken care of and supported by family members and relatives in such times of need. For care and support of the sick and orphans to be sustainable in the CS project area, the project should endeavour to strengthen these existing support systems and structures. Home based care, should therefore be seen as the best alternative to hospital care, as it takes into consideration the existing support mechanisms and the involvement of other partners in a more sustainable way.

3.12 Despite high knowledge and awareness on HIV/AIDS, majority of the mothers have not heard of an HIV/AIDS counselling and testing service since VCTs as specialised HIV/AIDS testing centre, are yet to be promoted and popularised in the area. Also, information is scanty and knowledge low on the the advantages and disadvantages of being tested for HIV/AIDS. This is a challenge that the project needs to address. It is thus recommended that the number of VCTs be increased so that those who would want to know their HIV serostatus can access VCT services. Further, the CS project should design BCC materials, through puppetry and other forms of audiovisual

communication strategies that would provide culturally acceptable information on the benefits of HIV screening.

3.13 Although only 19.3% of the mothers knew that there was a away that transmission of HIV virus from mother-to-child can be avoided, the introduction of PMTCT holds promise in the project area given the high level of awareness of mother to child transmission. If nevirapine was on offer to pregnant mothers who test positive to HIV, the likelihood of agreeing to undergo VCT as part of ANC would be high.

3.14 Given the close association between STI and HIV/AIDS, services to detect and control STIs can be critically important for managing the HIV/AIDS epidemic. Thus, measures for controlling and preventing STI transmission should be incorporated in the HIV interventions of the CS project by incorporating STI screening and treatment in the antenatal and family planning services. The project should also promote and encourage care seeking for STI symptoms as part of its behaviour change communication initiative in the HIV/AIDS intervention.

3.15 More than a third of the mothers interviewed suspected that their partners, who are mostly their husbands, are having other sexual partners. The mothers are at very high risk of getting HIV/AIDS because the more partners your partner has the greater the risk that he/she will be infected and then infect you. Despite this situation, many mothers do not practice safe sex, particularly most do not use condoms. The actual reason for not using condoms need to be investigated before any HIV/AIDS control interventions are undertaken by the CS project. In promoting the use of condoms after identifying why they are currently not being used as discussed above, the CS project will need to look into how local retail shops can be best promoted as outlets for condoms, as they are the most accessible sources in the area.

1.0 INTRODUCTION

1.1 BACKGROUND

PLAN International, a PVO with its headquarter in London, has been implementing a Child Survival (CS) XV Project in 196 villages of Kwale District in Kenya. The Project is supported by United States Agency for International Development (USAID) for a period of four years starting from September 30, 1999.

The primary goal of this project, being conducted in partnership with the Ministry of Health and Aga Khan Health Services, Kenya, is sustained reductions in Infant and Child mortality through:

1. Increasing access by rural communities to health services
2. Improving quality of dispensary and community health services
3. Establishing sustainable systems via the Village Health Committees (VHC) and Dispensary Health Committees (DHC).

The total population of the Project area in 2002 is 131,686. The beneficiary population of the project is 56,625, which comprises 32,922 women of the reproductive age and 23,703 children under five years of age.

The communities in the project area are among the least served and highest need areas in Kenya. District Health Survey (DHS) 1998 revealed an infant mortality rate (IMR) of 741/1000 and CMR of 118/1000 live births. Also only 4% of women in Coast Province where the project falls used a condom during the last sexual intercourse with any partner whereas the national rate is 6%. In Kwale Malaria is the leading cause of infant mortality while Pneumonia is second. Immunisable diseases and HIV/AIDS account for many childhood deaths.

Knowledge Practice and Coverage (KPC) Survey conducted by the project in December 1999 found that:

- Less than 4% of mothers were exclusively breast-feeding their children
- 74% of mothers did not know why a pregnant mother should be vaccinated against tetanus
- 82% of mothers do not use any family planning method
- 79% of mothers did not have bed nets
- Of the mothers with nets, 91% stated that they did not soak or dip the nets to repel the mosquitoes or bugs
- 59% of mothers did not take any drug to prevent them from getting Malaria when they were pregnant

- Less than15% of mothers are knowledgeable that people can avoid being infected by HIV/AIDS through using condoms

With the objective of addressing the above health problems, CS XV project included the following interventions in its 4-year project period:

1. Malaria Control
2. Pneumonia Case Management
3. Control of Immunisable diseases
4. HIV/AIDS Control

Besides, CS Project is also assisting Kwale District Health Office on EPI, Community Governance and Cost recovery process in the dispensaries. Because the HIV/AIDS Control intervention is a late intervention in the CS XV Project, an HIV Baseline assessment as at 2002 was needed. USAID requires CS Project grantees to conduct a 30 cluster baseline/final survey by using standardised questionnaire initially developed by JHU and modified by CSTS and now known as KPC 2000+.

As part of this requirement CS XV project organised a 3 day rapid KPC training to survey supervisors and data collectors from April 10th to 12th 2001 for conducting HIV/AIDS baseline KPC. The KPC Survey training was coordinated by CS Project Coordinator Laban Tsuma, Plan Coastal Research and Evaluation Coordinator Issa Kipera and Plan Coastal Health Advisor Ruth Momanyi.

1.2 OBJECTIVES OF THE SURVEY

Provide Plan CS XV Project with information on:

1. HIV and other Sexually Transmitted Infections with regard to:
   - Knowledge of HIV/AIDS Risk factors and modes of transmission
   - Sexually transmitted infections
   - HIV Screening
   - Stigma
   - Sources of Care and Support
   - Identifying Orphans and Foster/Adoptive children
   - Risk and risk reduction

2. Comparative achievement of key findings at baseline KPC conducted in December 1999 with regard to:
   - Management of Childhood Illness including identification of danger signs, care seeking, treatment, home care

- Coverage and drop out rates for childhood immunisation

2.0 METHODOLOGY

The KPC survey adopted the 30 cluster sampling method in the selection of the respondents for the study. The study population consisted of 127,441 persons distributed in 196 villages of Kubo and Kinango Divisions of the project area in Kwale District. A total of 300 mothers with children aged below 24 months were interviewed. The interview questions focused on the mothers knowledge and practise relating to HIV/AIDS and other critical information on life-saving household behaviours and care seeking patterns that affect the health and survival of children.

2.1. THE QUESTIONNARE

The questionnaire, consisting 67 questions was designed to collect information from mother of children under 24 months of age. The questionnaire was adopted from the KPC 2000+ toolkit. Although the KPC was on HIV/AIDS, in addition to adopting the KPC 2000+ module on HIV/AIDS, the questionnaire also adopted the Rapid CATCH (Core Assessment Tool on Child Health) module and drew questions from other modules specifically from Immunisation and Malaria modules.

The questionnaire was developed from the standardised KPC survey instruments but customised to suit the local situation. The survey trainer and the CS Project Coordinator facilitated a participatory process, involving both interviewees and interviewers in the customisation of the KPC questionnaire. First, all the interviewers, were taken through the questionnaire to provide a common understanding for all the questions. At this stage, clarifications and minor amendments were made to make some questions clearer. Second, after the initial modifications, the questionnaire was pilot tested in 24 households in Mwapala Minazini, Skuli and Sagalato Villages[1]. Feedback received from the pilot exercise was used to finalise the customisation of the questionnaire.

Broadly, the questionnaire was divided into five sections. The first part was on general information that gave details of the interviewer, place of the interview, interviewee and the respondents' household composition, including identification of orphans. This section covered questions 1-3.

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[1] Mwapala Minazini, Skuli and Sagalato villages are three of the 196 villages under the project but were not among the 30 cluster sampled villages.

Questions 4 and 5 formed section two of the questionnaire that solicited for information on maternal and newborn care. Child immunization was covered in questions 6 – 9 of section three while Integrated Management of Childhood Illnesses (IMCI) formed section four of the questionnaire and that was covered under questions 10 – 13. Section five covered questions 14 – 21 that dealt with malaria prevention.

The last section was on HIV/AIDS. The section had the most of questions (22 – 67), as it was the focus of the KPC survey. The questions on HIV/AIDS focused on mothers' responses on mode of HIV/AIDS transmission, stigma, care and support, screening, others STIs and issues of risk reduction.

The questionnaire, which was originally designed in English, was translated into Kiswahili, the national language of Kenya that is widely spoken in the project area (annex 3). This translation was necessary for ease of administration in the field and to have a uniform and common understanding of certain terms and concepts.

2.2. DETERMINANTION OF SAMPLE SIZE

Sample sizes were calculated with the following formula:

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

Where; n = sample size
z = statistical certainty chosen
p = estimated prevalence/coverage rate/level to be investigated
$q = 1-p$ and
d = precision desired

The value of p was defined by the coverage rate that requires the largest sample size ($p = 0.5$). The value of d was dependant on the precision, or margin of error, desired (in this case $d = 0.1$). The statistical certainty was chosen to be 95% ($z=1.96$). Given the above values the following sample size (n) needed was determined by:

$$n = (1.96)^2(0.5x0.5)/0.1^2$$

$$n = (3.84)(0.25)/0.1$$

$n = 96$

It takes much time to randomly select an identified individual from the population and then perform this selection 96 times to identify a sample of $n = 96$. Adopting the method of 30-cluster sample survey in which several individuals within each cluster are selected to reach the required sample size can save time. However, in order to compensate for the bias which enters the survey from interviewing persons in a cluster, rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be given the values of p, d, and z above (Herderson et al, 1982). In general, when using a 30-cluster sample survey, the sample size should be approximately double the value of n, when $n = z^2(pq)/d^2$. In our case, a sample of 300 (10 per cluster) was selected to ensure that sub-samples would be large enough to obtain useful management type information.

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

95% confidence limit $= p \pm z \sqrt{(pq)n/2}$

Where:

- p = proportion in population found from the survey
- z = statistical certainty chosen (if 95% certainty is chosen, then $z = 1.96$)
- $q = 1-p$ and
- n = sample size

For example: if the proportion of mothers in the survey who in the last 12 months had STI is 5% and $n = 140$

95% confidence limit $= 0.057 \pm 1.96$(square root of {0.057X0.095)/140/2}

$$= 0.057 \pm 1.96 \sqrt{\frac{0.57 \times 0.095}{140/2}}$$

(z=1.96)

$= 0.057 \pm 2.9\%$ to 8.5%

This is to say that, we are 95% sure that the actual proportion of mothers in the survey area who had STI during the last 12 months is between 2.9 to 8.5%

2.3. SELECTION OF SAMPLE

A sample of 300 mothers with children aged below 24 months drawn from 30 of the 196 villages of the project area in Kinango and Kubo divisions were selected. The following steps were used in selecting the sample of 300 mothers.

Step 1: Section of Cluster Villages:
Out of a list of the 196 villages (annex 4), 30 cluster villages were selected. This was done by drawing a of all villages with their cumulative population and calculating a sample interval population figure that was used to determine the villages to be sampled based on their accumulated population. The village from which the sampling would begin was randomly[2] selected from the list of all the villages in the sampling frame.

Step 2: Selection of the respondents:
Once the survey team reached each of the 30 cluster village sites, the following procedure was followed.

1. Enquiring from the village elder/headman the boundaries and names of all the sub-villages in the village.
2. Using simple sampling method, choose one of the sub-villages
3. Move to the centre of the selected sub-village and choose ten households with a mother of a child aged less than 24 months for interview.
4. To identify household for interview, the team tossed a pen to get the direction of the line of household to follow. Each home that fell within the direction pointed by the pen was interviewed.
5. Repeat process until ten mothers with children aged less than 24 months are covered.

2.4. CONDUCT OF INTERVIEWS

2.4.1 Selection and Training of Supervisors and Interviewers.

The CS Project Coordinator in collaboration with the Ministry of Health pre-selected the KPC survey supervisors and interviewers (annex 2). All the selected

[2] A simple random sampling was used whereby a three-digit number was randomly picked from three lottery baskets each with number lots of 0-9. Number 349 (3 drawn from basket one, 4 from the second basket and 9 from the third) was picked and the village in the sample frame with an accumulative population of 349 was selected as the first sample village in the frame.

interviewers were female professional health workers from Kwale District. It was found necessary to select only female interviewers/data collectors as the survey questionnaire; particularly the section on HIV/AIDS solicited information that was very private and personal. Due to the nature of the questions and the cultural set-up of the survey area, women or even men would not provide honest responses to such questions if the interviewers were of the opposite sex.

Both the supervisors and the data collectors/interviewers were trained on the various issues of the KPC survey. The KPC trainer, CS Project Coordinator and CS project team conducted the training that lasted three days and covered the following issues:

a. An overview of the CS Project and the Purpose and objective of the survey
b. KPC methodology, selection of the sample size and interviewing techniques
c. Community protocols and taboos
d. Roles of supervisors and Interviewers
e. Questionnaire piloting, feedback and finalisation of Questionnaire Customisation

The training, which was done through both presentation and plenary discussions, also included practicals where each member of the team administered a questionnaire in 3 sub-villages of Mwapala Village, which is within the study area. After the pilot test, a debriefing was done where the field experiences and challenges were shared in a plenary session. The results of the pilot test were incorporated in the customisation of the final questionnaire.

2.4.2 Conduct of Interviews

The KPC survey was conducted over five consecutive days; April 15-19, 2002. The survey team using the technique explained in the section under methodology selected 10 mothers, with children aged less than 24 months, from each out of the 30 randomly selected villages.

The team was divided into six teams each with a supervisor and three data collectors (Annex 5). In each of the five days, each team was assigned one village where they were to interview ten mothers with children aged below 24 months. For each team the team supervisor was responsible for identifying the sub-village and determining the survey direction and the households to be interviewed.

In an effort to ensure that all questionnaires were correctly filled during the interview, the supervisor validated one questionnaire for each of the three data collectors. Also, each of the ten questionnaires daily filled by the team were checked for completeness and accuracy of the information before the team left the survey area.

2.5 DATA ANALYSIS

2.5.1. Data Inputting

The KPC questionnaire was coded and inputted into a computer by two data entry clerks using EPI Info Software. Immediately the inputting was completed, the data was cleaned for any inconsistencies/errors by running frequencies or listing all the data entered in the computer. Once this was accomplished, the data was analysed.

2.5.2. Data Analysis

Using the EPI Info Software that was developed at the Centre for Disease Control (CDC) in Atlanta, for the analysis of health surveys, the questionnaire was analysed. The analysis, mainly, involved the calculation of percentages and means of the observations. The data analysed was then presented either in descriptive form or as tables and graphs.

3.0 RESULTS

3.1 GENERAL INFORMATION

1. All the interview questionnaires were administered to the respondents between 15th and 19th April 2002.

2. The mean age of mothers surveyed was 26.9 years and the modal age was 20 years. Nine (9.0) percent of the mothers surveyed (27 out of 300) were aged 18 years and below and 29 percent were above 35 years of age. More than 90 percent (271 out of 300) of the households from which the respondents came from were headed by men.

3. Out of 300 households interviewed, 32 (10.7%) reported to have orphans. A total of 82 were identified which 44 were from within the household and 38 were from without the household.

3.2 MATERNAL AND NEWBORNE CARE

4. Most mothers in the project area are assisted either by family members or by a traditional birth attendant (TBA) during birth. Out of the 300 mothers interviewed, 145 (48.3%) reported that their child's cord was cut and tied by a family member and 75 (25%) reported that it was done by a TBA. Only 11.3% (34 out of 300) had the cords of their children cut and tied by a professional health worker, i.e a doctor (8 out of 300) or a nurse (26 out of 300). The family members who assist mothers during birth are mostly mother in laws (29.3%), mothers (27.9%), co-wives (14.1%) and sister-in-laws (7.1%)

5. During delivery, most of the helpers use home/self prepared materials. 67% (202 out of 300) of the mothers reported that the helper used a home or self-prepared material and 23.3% (70 out of 300) reported to have used other types of materials. Only 9.3% (28 out of 300) said that the helper used a clean home delivery kit.

3.3 CHILD IMMUNIZATION

6. Most mothers (181 out of 300) indicated that they do not know the reason why pregnant women need to be vaccinated. Only 81 (27%) out of the 300

mothers interviewed, indicated that pregnant mothers are vaccinated to protect mother and new born against tetanus. While 6% (18 out of 300) and 7% (21 out of 300) said that pregnant mothers are vaccinated to protect only the mother and only the child against tetanus respectively.

7. When the mothers were asked the number of injections that a pregnant woman needs to protect the new born infant from tetanus 16 % (48/300) of the mothers said one, 30.7% (92/300) said two, 39% (117/300) said three and 14.3% (43/300) said four.

8. However, majority of the mothers have cards where their children's vaccinations are recorded. Out of the 300 mothers, 260 (86.7%) had cards, 22 (7.3%) had the card misplaced, lost or not at home and only 17 (5.7%) never had a card.

9. Of those who had the cards of the children, 241 children had received BCG, 149 Polio 0, 237 Polio 1, 204 Polio 2 and 165 Polio 3. DPTI vaccinations was recorded to have been given in 239 of the children's card and DPT2 in 204 children's immunisation cards and DPTI3 in 166 cards. Measles and Vitamin A vaccinations had been recorded in 105 and 43 cards respectively.

   Full Immunization Coverage for age group 12-23 months is 51% (this represents children in this age group-54 out of 106- who became fully immunised when they were 9-12 months of age). Immunisation Coverage for Measles of this same age group is 70%. Drop out rate for the 12-23 month age group is 21% (100 of 106 received DPT1-79 of 106 received DPT3).

3.4 INTERGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

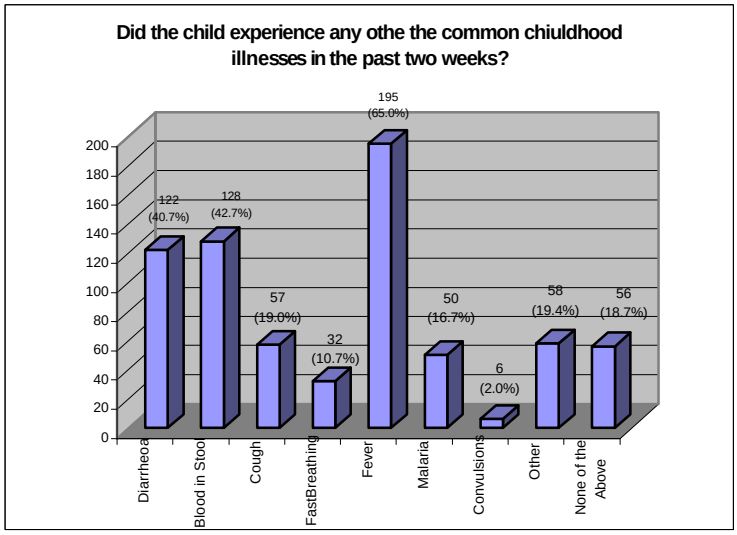
10. The most common sign of illness that indicates to most mothers that the child needs treatment is high fever and child looks unwell and does not play normally as shown in the table below.

Sign	No of mothers	Percentage
High fever	255	85.0
Looks unwell or not playing normally	79	26.3
Not Eating or drinking	59	19.7
Lethargic or difficult to wake-	27	9.0

up/unconscious		
Fast or difficult breathing	24	8.0
Convulsion	19	6.3
Vomits everything	15	5.0
Do not know	10	3.3

Only 10 (3.3%) out of the 300 mothers intervened did not know the signs that indicate that a child needs treatment.

11. When the mothers were asked as to whether their children had experienced certain common childhood illnesses over the last two weeks, more than 80% had, as detailed below.



12. When children are sick, most of the mothers offer them less than usual quantities to drink as shown below. 113 out of 242 mothers offer their children less than usual to drink when they are sick and 77 (31.8%) give same amount, while 34 (14%) give more than usual. 14 mothers reported that they give their children only breast milk when they are sick.

	Frequency	Percentage
Less than usual	113	46.7
Same amount	77	31.8
More than usual	34	14.0
Not given	4	1.7
Only breast milk	14	5.8
Total	242	100.0

13. Similarly, mothers give children less than usual amount of food to eat when the children are sick. Out of 242 mothers who answered this question, 143 (59.1%) reported that when the child was sick, it was offered less than usual to eat, 77 (31.8%) mothers offered the child same amount, 10 (4.1%) more than usual, 3 (1.2%) did not give the children food to eat and 27 (11.2%) only breast fed the child.

3.5 MALARIA

14. When the mothers whose children had experienced fever and Malaria in the last two weeks (Q.11) were asked as to what they did first when the child was sick, 20 (10.1%) out of 199 indicated that they took the child to a hospital. Majority of the mothers took the child to a health centre (61/199) and 24 (12.1%) treated the child her herself. Very few of the mothers took the child to a private clinic, a traditional healer, Trained TBA or sought advice from a friend or relative as shown in the table below. A reasonable number of mothers went to a pharmacy (7.15%), a community health volunteer - CHW (7.15%) or a quack/drug peddler (5.0%).

	Frequency	Percentage
Went to district hospital	20	10.1
Went to health centre	61	30.7
Went to private clinic	7	3.5
Went to pharmacy	15	7.15
Went to community health volunteer	15	7.15
Went to a trained TBA	2	1.0
Went to a traditional healer	6	3.0
Sought advice from friends and relatives	2	1.0
Treated him/her myself	24	12.1
Sponged him/her	7	3.5
Went to a quack/drug peddler	10	5.0
Others	30	15.1

15. Majority (166 out of 300) of the mothers interviewed said that malaria is spread by mosquitoes. Other causes for the spread of malaria were given as:

- The environment 8% (24/300)

- Eating mangoes 0.3% (1/300)
- Stagnant water 5.3% (16/300)
- Too much sum 1.3% (4/300)
- Don't Know 38.7% (116/300)
- Other 7.0% (21/300)

16. Although majority of the mothers and their household members are doing something to protect themselves from mosquito bites, 139 out of 300 are not doing anything. Among those who reported to be doing something, the majority, 36.3% (109/300) were using mosquito nets, 13.7% (41/300) were using household sprays and repellents, 3.7% (11/300) were eliminating stagnant water and 5.3% (16/300) they were removing rubbish and bush. A few used other means, mostly burning of traditional herbs e.g. Mwarobaini (neem tree).

17. Of the 300 mothers interviewed, 98 (32.7%) said that they have bed nets.

18. Of these 84 reported that the child had slept under it during the night before the interview, 79 (80.6%) mothers out of the 98 respondents with bed nets and 48 (49.0%) other individual had used them during the night before the interview. Ten (10.2%) mothers out of 98 however reported that, despite having a net, no body had used it the previous night, prior to the interview.

19. When the mothers were asked if the bed net was ever soaked or dipped in a liquid to repel mosquitoes or bugs, only 10 (9.9%) said yes.

3.6 RESPIRATORY ILLNESSES

20. Out of the 143 mothers who reported that their children had experienced some respiratory illnesses (Q11), 77 (53.8%) of the mothers said they sought treatment for the child.

21. The treatment was sought from the following sources:

Whom/Where did you seek treatment	Frequency	Percentage
Hospital	22	28.6
Dispensary/Health Centre	29	37.7
Private Clinic	6	7.8
Faith Healer	6	7.8
Pharmacy/Chemist/Shopkeeper	15	19.5
Other	4	5.2

3.7 HIV/AIDS

3.7.1 Risk factors and mode of transmission

22. Almost every mother interviewed during the survey said that she has heard of an illness called HIV/AIDS. Only 3 out of the 300 mothers said they have not heard of the disease.

23. When asked whether they knew about any way that a person can do to avoid getting AIDS or the virus that causes AIDS, 183 our of 300 (61%) said yes, while 46 (15.3%) said no and 71 (23.7%) did not know.

24. Out of the 183 mothers who know what a person can do to avoid getting AIDS, 128 (69.9%) indicated that HIV/AIDS can be avoided by staying faithful to one partners, 69 (37.7%) by use of condoms and 46 mothers (25.1%) cited abstinence. Other suggestions given for avoiding AIDS are as follows:

	Frequency	Percentage
Staying faithful to one partner	128	69.9
Use of Condoms	69	37.7
Abstinence	46	25.1
Avoid sex with persons who have many partners	23	12.6
Limit number of sexual partners	16	8.7
Avoid sex with prostitutes	16	8.7
Avoid sharing razor blades	15	8.2
Avoid injection	6	3.3

Avoid Blood Transfusion	5	2.7
Other	5	2.7
Avoid Kissing	1	0.5
Avoid sex with person who inject drugs intravenously	1	0.5

25. When asked if the virus that causes AIDS can be transmitted from a mother to child during pregnancy, delivery or breastfeeding, majority said that it can during all the three stages.

	During Pregnancy		During Delivery		During Breast feeding	
	Frequency	%	Frequency	%	Frequency	%
Yes	246	82.0	216	72.0	252	84.0
No	16	5.3	31	10.3	13	4.3
Don't Know	38	12.7	53	17.7	35	11.7

26. One hundred and forty five (145) out of 300 mothers indicated that if a mother is infected with AIDS virus, then there is no way to avoid transmission to the baby. Only 58 (19.3) of the respondents said that transmission to the baby could be avoided while 97 (32.3%) mothers said they did not know.

27. Majority 271 (90.3%) out of 300 mothers interviewed indicated that a person who has AIDS cannot be cured. A few (5.0%) said that AIDS could be cured while 14 (4.7%) did not know.

3.7.2 Stigma

28. Very few (78 out of 300) of the respondents indicated that they would not be willing to provide care and support in their home to a relative who is infected with HIV/AIDS. Majority of the mothers (216 out of 300) stated that they are willing to provide care and support while 6 (2.0%) could not tell.

29. One hundred and fifty six (156) of the mothers did not object to a teacher who has AIDS virus, but is not sick, from teaching. Only 114 out of 300 objected while the rest did not know.

30. When the mothers were asked if they would allow their children to play with a child who has the AIDS virus, majority, 198 out of 300 (66.0%) said no and only about a third (33.7%) said yes.

3.7.3 Sources of Care and Support for the Chronically ill

31. Over the last 12 months, only 32 mothers reported that somebody in their household was very sick or bedridden for a period of more than 3 months. The rest (268 out of 300) did not have a very sick or bedridden person.

32. Of the 32 mothers who reported a sick or bedridden person in their household, 11 persons were reported to have ailed while 26 persons were reported to have died. The average age of those that were sick is 27.7 years while the average age of those who died is 39.4 years. Majority of those who were sick and died were in the 30-50 years age bracket.

33. Most households, 65.6 percent (21 out of 32) that had a sick person did not receive any help or care from outside the household.

34. Of the 31.3 percent (10 out of 32) households that received care and support from outside the household, the major source of the care and support have been relatives and friends. The other sources are:

(i) Anyone from a hospital or clinic	2 out of 10 (20.0%)
(ii) A relative of friend	7 out of 10 (70.0%)
(iii) A religious worker organisation	3 out of 10 (30.0%)
(iv) Any other Community group or organisation	3 out of 10 (30.0%)

35. The care and support that the sick and bedridden received in the last 12 months was mainly money from friends, organisations or relatives. Fifty percent (5 out of 10) received money form friends, an organisation or relatives while 30% (3 out of 10) received support in terms of counselling on how to deal with the illness and its effects. Those that reported having received medicines were two and also two received assistance in terms of transport. Only one household was supported with food.

36. Majority of the household with orphans (28 out of 32) did not receive any type of support because of the presence of an orphan in the household. Only 4 out of 32 (12.5%) households with orphans reported to have received help.

37. Of the four households that had received help, 2 (50.0%) had received help and care from a relative or friend, while one had received care from a religious organisation. The other household had received care from a community group or organisation.

38. The type of care and support received by the 4 households was counselling (50.0%), transportation (25.0%) and childcare (25.0%).

3.7.4 HIV Screening

39. When the mothers were asked how a person could find out if he or she has HIV (the virus that causes AIDS) the majority of the mothers, 125 out of 300 (41.7%), said by going for a test, 6 said by going to a health facility and 53 (17.7%) by other methods. The rest, 124 (41.3%) did not know.

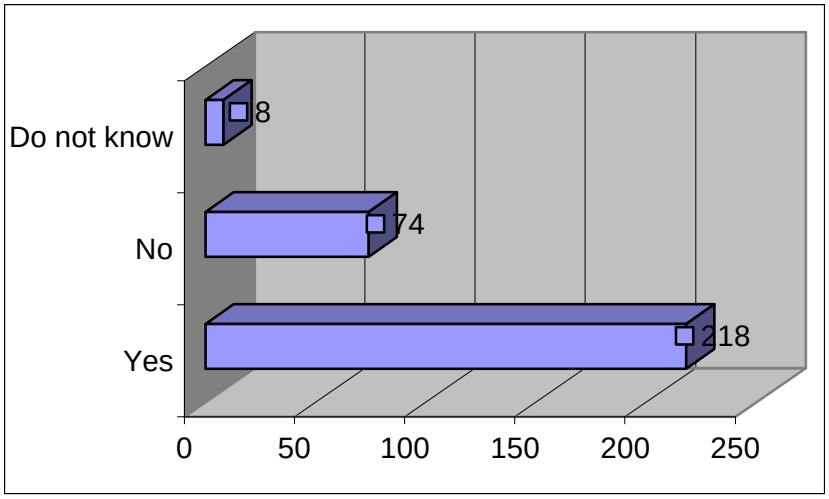
40. Many (152 out of the 300) mother have not heard of an HIV/AIDS counselling and testing service. Only 116 (38.7%) have heard and 32 (10.7%) did not know.

41. Although majority of mothers (144 out 300) did not know the reasons (advantages) of doing an HIV/AIDS test, of those who know, majority said it is advantageous in that it would protect sexual partner (41 out of 300). 29 out of 300 of the mothers said that the test would help in planning for the future, 13 (4.3%) gave marriage preparation and another 13 gave protection of child as a reason for taking an HIV/AIDS test.

42. The disadvantages of an HIV test were also varied. The most common reason for not getting an HIV test among mothers is the fear of knowing that one is HIV positive (104 out of 300). Stigma was another important reason (72 out of 300) while reason like losing a job, terminal benefits, and pension was cited by six mothers. Majority, 48.7 percent (146 out of 300) of the mothers however did not know the disadvantageous of an HIV/AIDS test.

43. Hospital was cited by majority (84.7%) of the respondents (254 out of 300) as the place they would go for an HIV/AIDS test and a health clinic was cited by 7 mothers (5.7%). Only one mother said that she could go to a VCT site for the test. However, 34 out of 300 did not know where to go for HIV/AIDS test.

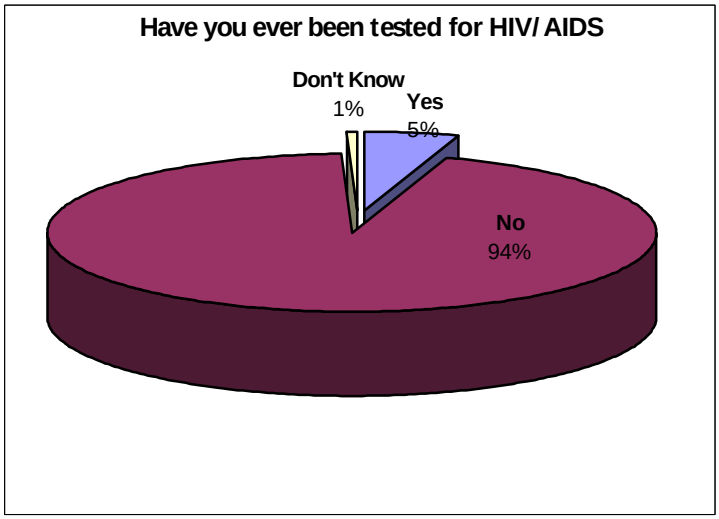
44. When the mothers were asked if they would tell their partners/spouses before having an HIV/AIDS test, the following answers were given:



45. Similarly, a majority of the mothers (223 out of 300) said that they would inform their partners/spouses the results of their HIV/AIDS test. 69 would not tell and 8 did not know.

46. Out of the 300 mothers, 75 (25.0%) indicated that anyone at risk should go for an HIV/AIDS test and 27 (9.0%) indicated that those who are sick are the ones who should go for the test. About a third of the respondents (32.7) cited other categories while 92 (30.7%) indicated that they did not know.

47. Very few mothers have been tested for HIV/AIDS as shown below:



48. For those you had undergone HIV/AIDS testing, when they were asked if they received counselling before being tested, 60 percent (9 out of 15) indicated that they were counselled before the test while the rest were not.

49. All those who were tested (15 out of 15) got the results of the test.

50. More than half (53.3%) of those tested were counselled after getting the results of the test.

3.7.5 Sexually Transmitted Infections (STIs)

51. Apart form AIDS, 63 percent of the interviewees had heard about other infections that can be transmitted through sexual intercourse. 13 out of the 300 respondents however, did not know of any.

52. The signs and symptoms that would lead the mothers interviewed to think that a man has STI are:

Sign/Symptoms	Frequency	Percentage
Burning pain on urination	65	34.4
Genital discharge	42	22.2
Abdominal pain	26	13.8
Blood in urine	24	12.7
Genital sores/ulcers	14	7.4
Foul smelling discharge	8	4.2
Redness/inflammation in the genital area	6	3.2
Genital warts	3	1.6
Loss of weight	3	1.6
Swelling in genital area	2	1.1
Impotence	1	0.5
Others	10	5.3
Do not know	79	41.8

53. In a woman, the signs and symptoms that would lead to thinking that she has STI are:

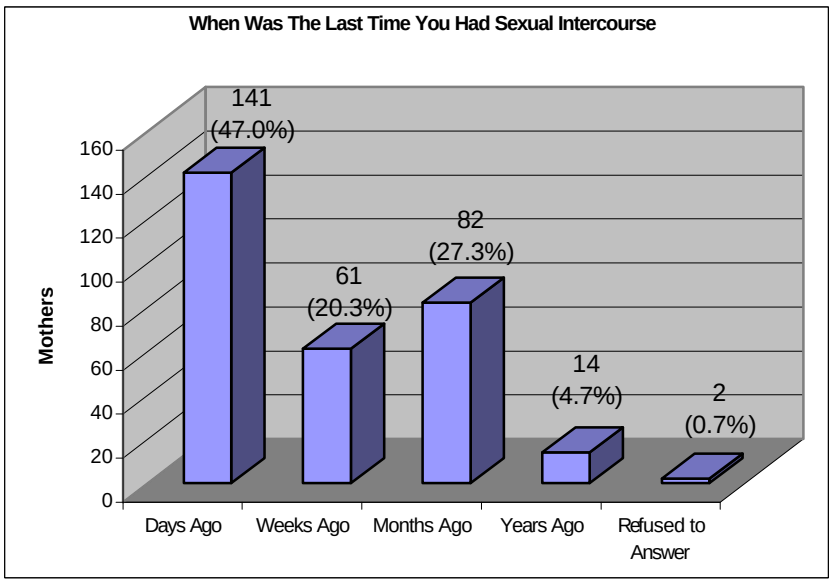
Sign/Symptoms	Frequency	Percentage
Burning pain on urination	72	38.1
Genital discharge	46	24.3
Abdominal pain	45	23.8
Blood in urine	30	15.9
Foul smelling discharge	23	12.2
Genital sores/ulcers	13	6.9
Loss of weight	5	2.6
Redness/inflammation in the genital area	4	1.6
Swelling in genital area	3	1.6
Genital warts	1	0.5
Impotence	1	0.5
No symptoms	1	0.5
Others	14	7.4
Do not know	79	41.8

54. During the last 12 months before the interview, 3 out of the 300 respondents (1.6%) reported to have had STI. 3 respondents did not know and one refused to answer.

55. The three who indicated that had STI during the last month when they were asked what they did, 2 (66.7%) said that they sought advice from a health worker in a clinic or hospital while another sought advice or medicine from a traditional healer. One of those who sought help from a clinic or hospital, also asked for advice from friend and/or relatives.

3.7.6 Risk and Risk Reduction

56. When the mothers were asked when they last had sexual intercourse, the following answers were given:

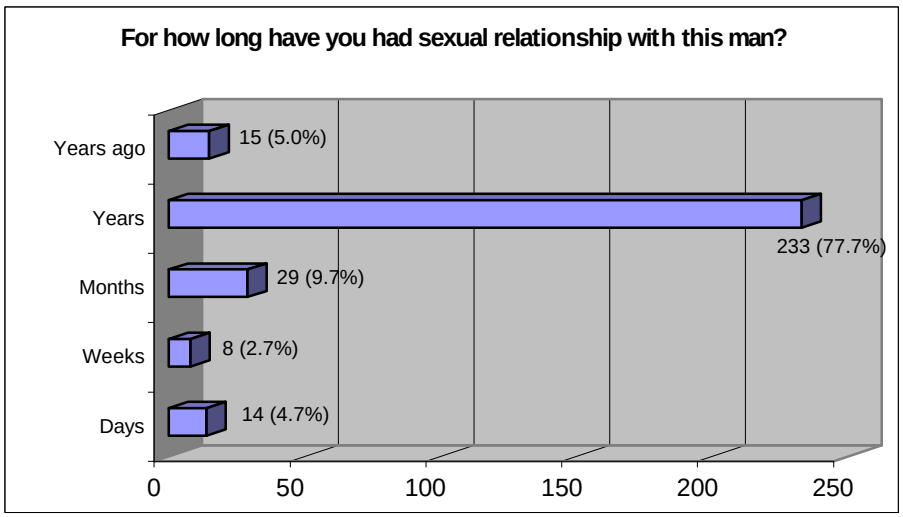


57. With the exception of 5 respondents (1.7%) almost all (295 out of 300) did not use a condom the last time they had sexual intercourse.

58. For the few who used a condom, the main reasons of using a condom was to prevent pregnancy (3 out of 5) and the other reason was to prevent STDs /HIV (1 out of 5) with one person refusing to answer.

59. Majority, 95.3 percent (286 out of 300) of the mothers last had sex with their husbands or boyfriends, 3.3 percent (10 out of 300) was with other friends and 0.7 percent (2 out of 300) was with casual acquaintances. The rest refused to answer. All those who reported to have used a condom (question 58 above), during the last sexual intercourse was with their husbands.

60. When asked how long they had a sexual relationship with the man they had sexual intercourse with last the following responses were given:



61. Majority of the respondents indicated that they live with their partners. About four fifths (243 out of 300) of the mothers interviewed said that they are living with their partners and only 19 percent (57) do not.

62. When the mothers were asked if they think whether their partners are having other sexual partners, more than a third (109 out of 300) said yes and 30.7 percent (92 out of 300) said no while a third (33.0%) did not know.

63. A few (10 out 300) of the mother indicated that in the last twelve months they had sex with someone else other than their regular partner.

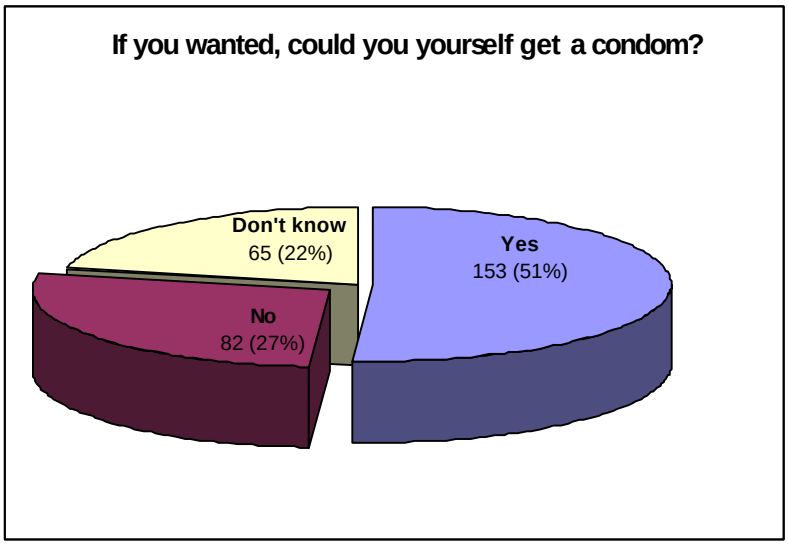
64. The last time these mothers had sexual intercourse with somebody else, only 4 (40.0%) out of 10 had used a condom. None of those who used a condom when they had sexual intercourse with somebody else in the last twelve months was among those who used a condom the last time they had sexual intercourse (question 58 above).

65. More than half of the respondents (51.0%) indicated that they know where to get condoms.

66. When asked where they can get the condoms majority indicated that they could get them from public sector institutions particularly Government hospitals (44.4%), Government health centres (22.2%) and Family Planning Clinics or Dispensaries (32.0%). Another major source of condoms is local retail shops (dukas), which was cited by 55 out of the 153 mothers (35.9%). Many mothers did not cite religious institutions, community

health/Field workers and private sector institutions as sources for condoms.

67. About half of the mothers (153 out of 300) stated that if they wanted to, they could get condoms by themselves.



4.0 DISCUSSION AND RECCOMMENDATIONS

4.1 GENERAL INFORMATION

The book Facts for Life published by UNICEF/WHO/UNESCO states that the risk of child bearing is greatest when the mothers are under 19 or above 35 years old. With 9.0 percent of the mothers surveyed below 19 years and 29 percent above 35 years of age, the Child Survival Project needs to target women in the under 19 and over 35 years age groups and educate them on the risk of having pregnancy at these two age groups.

Compared to the results of the 1999 KPC the situation now is worse as more women in this age bracket are giving birth. To address the situation, there is a need for the project to support child spacing interventions in the project area.

4.2 MATERNAL AND NEWBORN CARE

Most of the deliveries in the CS Project area are conducted at home and attended to by a family member (48.3%). Only 38.3 % are attended to by a TBA or a professional health worker. Although this situation has slightly improved when compared to the results of the 1999 KPC (68% of the births were attended to by a family member and only 24% were conducted by a TBA or professional health worker), the project still needs to increase its efforts in addressing the problem. According to results of a Health Facility Assessment (HFA) survey conducted in the project area in 2000 (HFA 2000), mothers prefer to deliver at home because of three reasons: poor accessibility of the health facility, inferior quality of care given at the health facility compared to that at home and prohibitive delivery expenses at the health facility. Apart from health services being far away, most mothers prefer delivering at home because of negligence at the hospital, fear of harassment from health workers at the health centres and fear of episiotomies. The project therefore has to continue with its efforts to improve service delivery in health facilities and be more user friendly to mothers who are due. In addition, more TBAs need to be trained and equipped to enable them perform safe deliveries in their community.

In Kwale, the major problem with deliveries conducted at home is that majority 67% (202 out of 300) of those who help others to deliver use home/self prepared materials. It was only in 9.3% (28 out of 300) of the deliveries that the helper used a clean home delivery kit. If home deliveries are to be made safe, clean

delivery kits will have to be used. The CS Project therefore has to find ways of promoting availability of clean delivery kits and sensitising communities on its use in the home.

4.3 CHILD IMMUNIZATION

The PVO Child Survival Technical Reference Materials refers to child immunisation as one of the most cost effective health interventions for reducing child morbidity and mortality. The WHO goal is to achieve coverage rates of 90% for all antigens. For children to be immunised and protected against several dangerous diseases as stated in Facts for Life, mothers and caretakers must have immunisation cards for each of their children and they themselves must know the importance of immunisation.

With majority of the mothers having cards where their children's vaccinations are recorded (94%), which is an increase of 2% from the previous KPC, the major challenge for the project is to sustain the high levels of immunisation that it has attained. Full immunization Coverage for age group 12-23 months is 51% (this represents children in this age group-54 out of 106- who became fully immunised when they were 9-12 months of age) though relatively high in the project area compared to other areas in the district, it is still low by national standards. Also although the immunization drop out rate of 21% in the project area is lower that the district average of 24.1% is still high as some divisions in Kwale e.g. Samburu have achieved lower rates of 9.2% (MoH Annual report 2001).

On mothers' immunisation, the survey results showed that despite the improvement of mothers' knowledge on importance of Tetanus immunisation from 13% to 27%, a high number of mothers do not know the reason why pregnant women need to be vaccinated. To reduce maternal mortality rates, in the area, the level of mothers' knowledge on maternal immunisation should be addressed. Knowledge that a pregnant mother needs at least two Tetanus immunisations during pregnancy increased from 63% (KPC 1999) to 84%. Efforts in child immunisation need to be increased. To increase immunisation rate and reduce dropout rates, the project need to intensify its immunisation campaigns and outreaches and increase the frequency of health action days. The project should also encourage and where possible assist Ministry of Health to establish more immunisation centre/sites within the project area.

4.4 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

The IMCI protocols provide a systematic approach to managing a sick child at home and at the health facility. In the case of caretakers the IMCI protocol requires that they know signs and symptoms of a child who requires treatment outside the home and home care for the child once treated.

Although the survey results show that the maternal knowledge of child signs for treatment is high, mothers' knowledge on core danger signs of convulsions, lethargy, vomiting everything, refusing to feed and etc, home care of the sick child is limited. While the Facts for Life stresses the importance of breastfeeding and giving extra food and fluids when a child is sick, the survey results show that most mothers do not provide sick children with more fluids and more food when sick as recommended.

Results of the HFA survey (HFA 2000) showed that most of the Health Workers in the CS Project area do not counsel mothers and caretakers on the importance of giving more food or continuing breastfeeding when a child is sick. Out of the 143 mothers and caretakers observed during the HFA survey only 34 (22.8%) were counselled on the importance of giving more food, fluids and continuing breastfeeding for a sick child at home. Professional Health Workers and Community Health Workers and care takers trained in IMCI in the project area need to intensify efforts in counselling mothers on the various aspects of their children illness and emphasize home care as defined in the IMCI protocol.

4.5 MALARIA

Fever is a common symptom of malaria, which is a major cause of illness and death among young children in many tropical countries. Malaria kills about 7,000 persons daily in Africa and about 5% of children below 5 years die of malaria related illnesses (WHO: 1998). In Kwale district Malaria is the leading cause of infant mortality. The survey results show that 199 out of 300 mothers surveyed reported that their children had fever (or malaria) in the last two weeks. This indicates that there is a high incidence of malaria in the area. The high incidence of malaria is partly attributed to the time the KPC survey was conducted (during the rainy season when mosquito breeding is highest).

If Malaria is not treated in time, it is likely to cause death as children die from Malaria within two days of developing symptoms. In the CS Project area, hospitals and health centres are still the main sources for treatment of fever and other malaria related symptoms. Although the Fact for life states that wherever Malaria

is common, a child who has fever should be taken to a health worker or trained provider, there are still a few mothers who treat their sick children at home or seek advice from a traditional healer, friend or relative. The use of TBAs and CHWs and other community based health workers is still low at 8% as opposed to self treatment which is at 12%. Since some of the people and indeed children with fever often seek help from friends or local healers, communities must be made knowledgeable about care seeking for malaria. This calls for further training of mothers and caregivers, TBA and CHWs on malaria treatment at home and in the community and when to refer if treatment is to be availed by a professional health worker.

Knowledge on how malaria is spread and can be controlled is critical in the fight against and control of malaria. In the CS project area however, knowledge on these two major aspects is still low. About 40% of the mothers did not cite the correct cause of malaria and about 46% reported to be doing nothing to protect themselves from mosquito bites. The knowledge on how malaria is spread is critical as it enables the household to find ways of controlling malaria. Awareness campaign on malaria should therefore be emphasised in the area with a focus on how malaria is spread, how it can be prevented and how it can be treated.

According to Charlwood J. D Edoh the mosquito that spreads malaria in the project area, anopheles gambiae S.L. starts biting at 8pm until dawn with the peak biting time being at 12-2am. For one to protect him/herself from the mosquito bites, the use of insecticide treated net (ITN) is thus recommended. In the project area however, despite the CS project promoting ITNs, their use is still low. The number of mothers who reported to have bed nets during the survey (98 out of 300) was more than those reported during the last KPC (63 out of 300), and also the number of mothers who reported that their children slept under the net were higher now (85.7%) than during the last KPC (75%). Bed net prevalence increased from 21.3% (KPC 1999) to 32.7%. While the importance of the child sleeping under the net may have been adequately campaigned for, the importance of treating the net has not as only 10% of nets had been treated. The implication here is that even the few who have nets are not well protected against mosquito bites since the nets are not treated. As part of its strategy to promote the use of ITNs, the CS Project should endeavour to undertake an ITN social marketing campaign that would bring to the fore the importance for using ITNs and retreatment.

4.6 RESPIRATORY ILLNESSES

Facts for Life ARI message, stresses the importance of taking the child for treatment to the nearest health facility when the child has ARI.The survey result show that only about 54% of mothers sought treatment when the child had ARI. While it is recommended that treatment for ARI be sought from a health facility, about 31% of the mothers who sought treatment were from sources other than a health facility or trained provider i.e. a faith healer, shop or a friend. While this represents an improvement of care seeking from 52.5% (KPC 1999) to 69% this shows that many mothers with children suffering from ARI are not following the recommended care seeking steps for a sick child with ARI. The CS project should increase its efforts geared at increasing mothers knowledge on care seeking for pneumonia.

4.7 HIV/AIDS

4.7.1 Risk factors and mode of transmission

The Facts for Life states that AIDS is an incurable disease that is caused by having a virus which can be passed on by sexual intercourse, by infected blood, and by infected mothers to their unborn children. In the CS project area, almost all mothers (99%) have heard of an illness called HIV/AIDS. This is 3% more in comparison to the results of the 1999 KPC and is comparable to the national average level of HIV awareness of 99% (MOH: 2001). General knowledge on several aspects of HIV/AIDS is very high among mothers interviewed. Majority (271/300) know that AIDS has no cure, many (183/300) are also knowledgeable on how AIDS is transmitted and on what one needs to do to avoid getting the diseases. Though levels of knowledge are high, in its interventions, the project needs to enhance the level of awareness and knowledge through provision of correct information on the disease, so that the present gains are not lost.

4.7.2 Stigma

Stigmatisation of people living with HIV/AIDS poses the greatest challenge in combating HIV/AIDS. A report by the Ministry of Health on AIDS in Kenya (MOH: 2001) observes that stigma associated with HIV causes great hardship for many living with HIV and hampers efforts to provide proper care and get people to learn their HIV status. Although the survey results show that many (216/300) of the mothers interviewed were willing to provide care and support to relatives infected with HIV/AIDS, stigma is relatively high in situations where the persons infected is not a relative. Many Mothers (66.0%) felt uncomfortable allowing their

children to play with a child who has the HIV virus, or even accepting a teacher who has AIDS virus, but not sick, from teaching (38%).

Due to stigma, person infected with HIV are usually discriminated and alienated. Stigma is strongest in situations where the fact about how HIV/AIDS does not spread is lacking. Since almost all mothers know how HIV/AIDS can be spread, the CS project needs to focus on creating awareness about how HIV/AIDS does not spread. The Facts for Life states that there is a dare need for people to know the facts about how HIV does not spread, particularly children. Children need to be reassured that they run no risk of getting the virus from ordinary social contact with HIV infected children or adults. Behaviour change communication should be one of the strategies that the CS project has to implement to address stigma and risk reduction issues. The developed BCC materials should however be appropriate to the local socio-cultural and religious environment. Focus should be on messages that would provide skills for negotiating risk reduction with sexual partners and increasing skills of program beneficiaries to use condoms and/or other forms of safer sex, abstinence and fidelity.

4.7.3 Sources of Care and Support for the Chronically ill

Culturally, communities in the CS project area have a well-knit social support system based on the extended family structure. The sick, the old and even orphans are traditionally taken care of and supported by family members and relatives in such times of need. The results of the study confirmed the existing care and support systems for orphans and the sick when it was found that care and support for the sick and bedridden in the last 12 months was received mainly from friends and relatives and 46.3% (38 out of 82) of the orphans were being cared outside their households. Majority, 65.6 percent (21 out of 32) of the household that reported to have had a sick person did, not receive any help or care from outside the household. It is however important to note that religious and community groups and health facilities also provide critical care and support services that the families can not provide. For example, care and support that family members and relatives provide are mainly in the form of money, while external groups and organisations provided counselling and treatment related care and support.

For care and support of the sick and orphans to be sustainable in the CS project area, the project should endeavour to strengthen existing support systems and structures. The MOH report on AIDS in Kenya (MOH: 2001) have observed that the increase in the number of persons living with HIV/AIDS calls for promotion of home based care which should be a partnership with the family members, health

care workers, local CBOs and NGOs in providing care and support to those infected and affected. Home based care, should therefore be seem as the best alternative to hospital care, as it takes into consideration the existing support mechanisms and the involvement of other partners in a more sustainable way.

4.7.4 HIV Screening

HIV/AIDS testing and counselling, particularly voluntary counselling and testing, plays an important role both in preventing HIV infection and, for people with the infection as an entry point for care. The knowledge on what somebody needs to do to know his/her HIV status is very high in the project area. Many of the mothers, 125 out of 300 (41.7%), knew that someone's HIV status could be known by going for a test. However, despite this knowledge, majority (152/300) of the mothers have not heard of an HIV/AIDS counselling and testing service, but surprisingly, majority (84.7%) of the respondents (254 out of 300) reported they would go to a hospital for an HIV/AIDS test. As at the time of the survey the VCT prevalence among mothers was only 5% (MOH Annual report 2001). These results show that VCTs as specialised HIV/AIDS testing centre are yet to be promoted and popularised. This is a challenge that the project needs to address, including efforts to increase the number of VCTs in the area, so that those who would want to know their HIV serostatus can access VCT services.

One area where information is scanty and knowledge low is the advantages and disadvantages of being tested for HIV/AIDS. Knowing what one stand to gain and to loose by having a HIV test done is the most important determinant and motivating factor in making decisions on whether to go for a test or not. From the survey it was found, that majority of the mothers are lacking correct information and facts on why HIV testing is advantageous and what are the disadvantages if one accepts to be tested. For example, if one knows that knowing his/her HIV status through testing is beneficial in that if infected you can benefit from early appropriate medical care and interventions to treat or prevent opportunistic infections, such a benefit becomes a major motivating factor for going for the test. Without the full knowledge of the pros and cons of taking the test, there will be no motivation for one to demand for VCT services. It is therefore recommended that the CS project design BCC materials, through puppetry and other forms of audiovisual communication strategies that would provide culturally acceptable information on the benefits of HIV screening.

In the project area, only two hospitals (Kinango and Kwale sub-district hospitals) are providing VCT services. This fact is well known to majority (84.7%) of the mothers. The limitation of HIV/AIDS counselling and testing services to these

two hospitals, despite the training of many community based HIV/AIDS counsellors, has inhibited many would be users of the facilities due to their inaccessibility. For the project to succeed, VCT should be made more accessible to the community. In addressing the issues of accessibility of VCTs, the CS project should consider supporting the establishment of more VCTs, particularly in the hard to reach areas of Ndavaya and Mkongani locations.

Since 77% of the mothers surveyed knew that the HIV virus could be transmitted from mother to child during pregnancy, delivery and breastfeeding, this provide for opportunity for interventions that can reduce mother to child transmission of HIV. Although only 19.3% of the mothers new that there was a away that transmission of HIV virus from mother to child can be avoided, the introduction of PMTCT holds promise in the project area given the high level of awareness of mother to child transmission. If nevirapine was on offer to pregnant mothers who test positive to HIV, the likelihood of agreeing to undergo VCT as part of ANC is high.

4.7.5 Sexually Transmitted Infections (STIs)

Apart from HIV/AIDS, the most mothers (63%) in the CS project area are aware of other STIs, such as gonorrhoea, syphilis and chancroid. Their knowledge on the disease is also quite high as many are able to recognize signs and symptoms for the disease in both men and women. Although the results indicated that STIs are not very common, as only 3 out of 300 (1.6%) respondents reported to have had STIs in the last twelve months, the mere acknowledgement of its existence should be worrying, particularly in cases where STI is not properly managed and prevented. The PVO Technical Reference Material of USAID points out that STIs are very important in the transmission of HIV. A study in Mwanza, Tanzania for example has found a reduction of 42% in the number of new HIV infections after an improved STI prevention and treatment program (MOH: 2001). Services to detect and control STIs can be critically important for managing the HIV/AIDS epidemic.

Given the close association between STI and HIV/AIDS, measures for controlling and preventing STI transmission should be incorporated in the HIV interventions of the CS project. Efforts should be made to incorporate STI screening and treatment in the antenatal and family planning services. The project should promote and encourage care seeking for STI symptoms as part of its behaviour change communication initiative in the HIV/AIDS intervention.

4.7.6 Risk and Risk Reduction

Fact for Life AIDS messages stress that people who are sure that both they and their partners are uninfected and have no other sex partner are not at risk from AIDS. However, people who know or suspect that this might not be the case should practise safe sex. Results of the survey however indicate that despite more than a third of the mothers interviewed suspecting that their partners, who are mostly their husbands, are having other sexual partners, only 1.7 percent of the mothers were practicing safe sex. Inasmuch as 95.3 percent (286 out of 300) of the mothers were sexually active and had sex with their husbands, the mothers are at very high risk of getting HIV/AIDS. This is because, as noted in the Fact for Life the more partners your partner has the greater the risk that he/she will be infected and then infect you.

Interestingly more than half of the mothers know where to get a condom and they are aware that use of condoms can protect one from getting HIV/AIDS. None use of condoms by majority of mothers despite suspecting their partners of infidelity may therefore largely be due to cultural or religious reasons. The actual reason for not using condoms need to be investigated before any HIV/AIDS interventions are undertaken by the CS project. The investigation must provide answers to the reasons why majority of the mothers are not using condoms while more than half indicated that that if they wanted to, they could get condoms by themselves, from Government hospitals (44.4%), Government health centres (22.2%), Family Planning Clinic or Dispensaries (32.0%) and even local retail shops (35.9%). In promoting the use of condoms after identifying why they are currently not being used as discussed above, the CS project will need to also to look into how local retail shops can be best promoted as outlets for condoms, as they are the most accessible sources in the area.

5. REFERENCES

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Partick Mungai (1999) Plan International Kenya Knowledge, Practice and Coverage (KPC) Baseline Survey for Kwale Child Survival Project XV Kubo and Kinango Divisions, Kwale District Coast Province.

Issa Kipera and Laban Tsuma (2001) Health Facility Assessment Survey for Kwale Child Survival Project XV Kubo and Kinango Divisions, Kwale District Coast Province.

MOH (2001) Ministry of Health Annual Report 2001.

SELECTED 3O VILLAGES

1. Mlafyeni A
2. Goyo
3. Timboni
4. Ziaradundo
5. Mwachinga
6. Tserezani
7. Chanyiro
8. Bumani
9. Mabesheni (Bofu)
10. Mwaluvuno
11. Burani B
12. Mkundi
13. Mazumalume
14. Kifyonzo
15. Yapha A
16. Bahakanda
17. Miembeni
18. Chonyi
19. Mwandimu
20. Kibandaongo
21. Mirihini
22. Amka
23. Mtsamviani
24. Takawa
25. Mlingo
26. Ndule
27. Mikanjuni (Lutsangani)
28. Dziweni
29. Msulwa
30. Miamba

Annex V
HIV/AIDS KWALE SITUATIONAL ANALYSIS REPORT (STEADMAN CONSULTANTS)

Annex VI
AKHS CONTRACT

AKHS Contract

This agreement sets out the collaboration between Plan Kenya, Coastal Program Area and Aga Khan Health Services (AKHS) in the implementation of the Child Survival (CS) Project in Kubo and Kinango Divisions of Kwale District

This agreement is made on this ---------- day of ---------- Two thousand and two between **Plan Kenya**, a duly registered Non Governmental Organisation (NGO) under the NGO Coordination Act of 1990, as represented by its Coastal Program Area, of PO Box 985 Mombasa, hereinafter referred to as "**Plan"** and **Aga Khan Health Services** of PO Box a duly registered NGO under the NGO Coordination Act of 1990 herein after referred to as "**AKHS**"

A. WHEREAS

1. Plan is an international humanitarian, child focused development organisation without religious, political and government affiliation. Child sponsorship is the basic foundation of the organisation.

2. Plan strives to achieve lasting improvement in the quality of life of deprived children in developing countries by enabling deprived children, their families and their communities to meet their basic needs and increase their ability to participate in and benefit from their societies and promoting the rights and interests of the world's children

3. Plan through the Child Survival Project is primarily committed to reducing infant and child mortality in a sustainable way and increasing access and improving the quality of health services by rural communities. Specifically, the project interventions are targeted at the main underlying causes of infant and child deaths viz malaria, pneumonia, immunizable diseases and HIV/AIDS.

4. Plan as part of its strategy to promote and implement its Child Survival interventions, favours to collaborate with existing institutions with similar visions, missions and objectives.

B. AND WHEREAS

AKHS is an international private non-profit health care agency that supports interventions that build institutional capacity of health care systems through strengthening and developing partnerships between stakeholders from the state to the community

C. AND WHEREAS

1. Communities in Kwale district have some of the highest official rates of infant and child mortality compared to other rural areas in Kenya. The main reported causes of child deaths in the district are malaria (28%), Pneumonia (21%) Diarrhoea/dehydration (17%), Anaemia (12%) and ARI (8%).
2. The CS Project will therefore address specific interventions that will target these underlying causes of infant and child deaths, including HIV/AIDS in the district. These interventions

include *inter alia* capacity building of dispensary Health Committees in the management of health facilities and collection and utilisation of Health Information and cost recovery mechanism.

D. NOW THIS AGREEMENT WITNESSETH AS FOLLOWS:

Plan and AKHS have agreed to jointly support strengthening of the capacities of Dispensary Health Committees, CBOs, Ministry of Health (MOH) and CS Project staff in Kwale district in the management of health information and financial systems. Cognizant of the fact that most health facilities in the Child Survival project area lack the capacity to collect and utilise available information for decision-making, and proper management of finances for the betterment of health services of the community, AKHS's practical experience in this field would be beneficial to the community, Plan and other stakeholders. To this end, AKHS will undertake a comprehensive capacity building program that would strength the capability of the CS project to meet its objectives. AKHS in partnership with Plan will customise the existing HIS tools and train community own resource persons on the HIS tools and financial management of rural-based health facilities. Specifically, Plan and AKHS agree to undertake the following:

(i) Review, input and pre-test HIS tools including community register for the children, expectant mothers, community stock/revenue monitoring, village and dispensary summaries (chalkboards), health action day monitoring form, project implementation table and other related tools required for the CS project objectives and reporting requirements.

(ii) Review and input HMIS software to reinforce link to MOH HMIS and train CS and MOH staff on the same.

(iii) Develop a user friendly operating manual for project HMIS and Financial management system in the community

(iv) Train 60 DHC members in Financial Management by use of case studies

(v) Train 45 DHC members in HIS management and decision making through use of analytical questions and case studies.

(vi) Undertake supportive follow-up visits in the field of trained CORP (DHCs and VHCs) .

E. OBLIGATIONS

1. JOINT OBLIGATIONS

(i) Plan and AKHS are responsible for ensuring that the capacity building of the various implementation partners in the CS project takes place

(ii) Plan and AKHS both share equally and collectively any output or credit that may be associated with the Health Information and Financial Management Systems in the CS project area.

(iii) Plan and AKHS can independently invite their partners or donors to visit the benefiting health facilities and communities without prior notice to the other party, except in situations where the other parties' presence shall be required. In such a case, the party involved shall notify the other party in good time.

(iv) During the term of this agreement, the parties shall hold bi-monthly meetings to:

a) review the progress of the activities for the preceding period
b) discuss any adjustments in the programming strategies, methodologies, objectives and outputs. However, any agreed adjustments arising from such discussions shall be in writing and shall be signed by both parties.

2. Plan OBLIGATIONS

Throughout the period of this agreement Plan shall participate in the implementation and development of the Health Information and financial management systems through:

(i) Availing of existing HIS tools for review
(ii) Assisting in the collection of information for pre-testing of the revised tools
(iii) Mobilisation and selection of CORPs for training on Health Information and financial Management systems
(iv) Provide finances for buying AKHS staff time in the implementation of the program as per attached annexure 1.

3. AKHS OBLIGATIONS

During the entire period of this agreement, AKHS agrees to:

(i) Provide technical expertise in the implementation of the Health Information and financial Management System as detailed in annexure 1
(ii) Provide support to Plan and MOH in the implementation of the Health Information and financial Management System in the respective rural health facilities and community.
(iii) Review and adapt the operational district HMIS

F. PROVIDED ALWAYS AND IT IS HEREBY AGREED AND DECLARED as follows:

1. That the finances provided by Plan shall be used solely for the purpose of achieving the objectives as provided in section D of this agreement and shall not be converted to any use.

2. That AKHS shall maintain a proper books of accounts based on Generally Accepted Accounting Principles (GAAP) accounting for all funds provided by Plan for the implementation of the program

3. That any fraud or misappropriation of any funds provided by Plan to AKHS shall, besides giving rise to criminal proceeding against the involved person(s) entitle Plan to bring a civil action against any or all such persons for recovery of any misappropriated funds.

4. Any information and documents supplied by Plan shall be kept confidential by AKHS and AKHS shall use them for the purpose of implementing the assignment. AKHS shall return promptly to Plan upon termination of this agreement, any such materials or information and all copies thereof. This clause similarly applies to Plan in relation to AKHS

5. Any notice to be served shall be in writing and shall be deemed to have been sufficiently served upon either party if forwarded to the party by registered post or left at the party's last known address in Kenya. A notice sent by post shall be deemed to be given seven days after the date of posting thereof.

6. Each party may cease or suspend its financial support to the program upon giving three (3) months written notice:
   (i) In the event that its funding decreases to such a degree as to make continued funding of the project financially impossible, or
   (ii) If it is not satisfied with the results achieved as described in the objectives of the program, neither party will have any further financial or other liability to the other after the expiry of the notice.

6. Duration of Agreement

This agreement shall remain in force for a period of one year effective from the date of signing of the agreement

7. Changes to Agreement

Any changes and or amendments to this agreement shall be approved by both parties and effected in writing and shall be appended to and form part of this agreement

8. Agency

Neither of the parties is an agent or partner of the other and neither of the parties shall have the right to commit the other party in any matter or transaction whatsoever, that is not explicitly stated or agreed in this agreement

9. Arbitration:

All differences or disputes whatsoever which shall at any time hereafter whether during the continuance in effect of this agreement or upon or after its discharge or determination arise between the parties hereto touching or concerning this agreement or its construction, effect as to the rights, duties or liabilities of the parties hereto under or by virtue of the agreement or otherwise or as to any matter in any way connected with or arising out of or in relation to the subject matter of this agreement shall be referred to a single arbitrator to be agreed upon by the parties hereto or in default of agreement to be nominated by the Chairman of the time being of the Law Society of Kenya in accordance with and subject to the provisions of the Arbitration Act 1996 or any statutory modification or re-enactment thereof for the time being in force. Upon every and such reference the arbitrator shall have power to take the opinion of such counsel as he may think fit upon any question of law that may rise and in his desecration to adopt any opinion so taken and obtain the assistance of such accountant, surveyor, valuer or other expert as he may think fit and act upon any statement of accounts, survey, valuation or expert assistance thus obtained. The decision of the arbitration shall be final and binding on both parties.

10. Liability Release Clause:

The present agreement does not create any obligation, legal, financial or otherwise on the part of Plan to any person claiming entitlement to compensation or other remedies relating to personal injuries, economic harm or otherwise, including but not limited to any contractor, sub-contractor or any employee of AKHS or any other party before, during and after the term of the agreement. In the event any claim is asserted against Plan, AKHS shall defend PLAN and indemnify Plan from all costs occasioned thereby, including any assessment of damages or imposition of legal obligations.

This Agreement shall be governed by and construed in accordance with the Laws of Kenya

G. IN WITNESS whereof the parties hereto have hereunto set their hands the day and the year above written.

SIGNED by the duly
Appointed representative of
Plan Kenya, Coastal Program Area

The Duly appointed representative of
Aga Khan Health Services

Witnessed by: