



**World Vision, Inc.**

**Fourth Annual Review Report  
Teso Child Survival Project  
Teso District, Kenya  
Grant # HFP-A-00-01-00045-00**

Beginning Date: October 1, 2001  
Ending Date: September 30, 2006

Submitted to:  
Susan Youll  
USAID/GH/HIDN/NUT/CSHGP  
Room 3.7-74  
Washington, DC 20523-3700

Prepared by:  
Joseph Ngugi, Project Manager  
Jonathan Magero, Training Coordinator  
Alice Shitambasi, HMIS Coordinator  
Peggy McLaughlin, Technical Health Specialist  
Nicole Barcikowski, HIV/AIDS Technical Specialist

Date of Submission: October 31, 2005

## TABLE OF CONTENTS

ABBREVIATIONS.....	3
EXECUTIVE SUMMARY.....	5
A. PROJECT ACTIVITIES: Main Accomplishments.....	6
B. FACTORS IMPEDING PROGRESS.....	12
C. TECHNICAL ASSISTANCE REQUIRED BY THE PROJECT.....	14
D. VARIATIONS FROM THE DIP.....	14
E. SUSTAINABILITY PLAN.....	14
F. DIP/MTE RECOMMENDATIONS.....	15
G. FAMILY PLANNING.....	18
H. PROGRAM MANAGEMENT SYSTEMS.....	18
I. MISSION COLLABORATION.....	20
J. ANNUAL WORK PLAN FY 06 (OCT 05 – SEP 06).....	20
K. KEY ISSUES.....	20
M. ADDITIONAL INFORMATION IN 2005 ANNUAL.....	20

## **ABBREVIATIONS**

AKHS-CHD	Aga Khan Health Services- Community Health Department
AIDS	Acquired Immune Deficiency Syndrome
ARK	Abstinence and Risk Avoidance for Youth
CHW	Community Health Worker
CORP	Community Own Resource Persons
CDD	Control of Diarrheal Diseases
DHMT	District Health Management Team
DHMB	District Health Management Board
Distr. Hosp	District Hospital
EPI	Expanded Program on Immunization
H/C	Health Center
HMIS	Health Management Information System
HFMC	Health Facility Management Committee
HH/C IMCI	Household /Community Integrated Management of Childhood Illness
HIV	Human Immuno-deficiency Virus
HPC	High Prevalence Countries
ITNs	Insecticide Treated Nets
IGAs	Income Generating Activities
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
KATSO	Kenya Aids Treatment and Support for OVC.
MOH	Ministry of Health

OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PCM	Pneumonia Case Management
PLA	Participatory Learning and Action
STI	Sexually Transmitted Infections
TOT	Training of Trainers
VHC	Village Health Committee
VCT	Voluntary Counseling and Testing
WRA	Women of Reproductive Age

## **Executive Summary**

USAID approved the implementation of the Teso Child Survival Project in Kenya in 2001. The project began in July 2001 and covers four rural sub-districts of Teso District in Western Kenya. The project targets 36,988 children under 5 (comprising 18.9% of the population of 181,481) and 39,572 women of reproductive age.

The goal of the Teso Child Survival Project is “To contribute to the Kenya Ministry of Health’s effort in Teso District to sustain a reduction of morbidity and mortality among children aged below five years and to improve maternal outcomes for Women of Reproductive Age.” Local partners include the District Health Management Team, government health centers, and various community-based organizations.

The main strategies, as defined in the Teso Child Survival Project Detailed Implementation Plan (DIP), are to 1) Strengthen the capacity of local partners at the District level for improved management of District Health Services; 2) Strengthen capacity of local partners to implement Household and Community IMCI; 3) Training, support, and follow-up for skills in: Participatory Learning & Action, Quality Assurance, HMIS, and Gender Awareness; 4) Integrate child survival activities into World Vision Kenya Area Development Programs’ activities and programs; 5) Enable communities to identify their own strengths and constraints in attaining better health and take action for health management through Participatory Learning and Action exercises; and 6) Partner with MOH and other NGOs for technical support in project implementation. To operationalize the above aims, the project has adopted the HH/C IMCI framework for the design and implementation of project activities. Using this framework, the Teso Child Survival Project focuses on five technical interventions: Malaria Prevention and Treatment, HIV/AIDS, Pneumonia Case Management, Control of Diarrheal Diseases, Immunization, and Vitamin A supplementation.

This Fourth Annual Review (FoAR) focuses on achievements and constraints since the Mid-term Evaluation and makes recommendations from an internal perspective for the last year of the project. The project team discussed the project achievements and constraints using the MTE report as a guideline, and the preliminary comments and various documents of the Teso Child Survival Project (TCSP) staff. The team conducted a three-day field visit to target groups, key participants and stakeholders of the TCSP in the project areas. Key findings of the FoAR include:

- The FY 2006 strategy and plan are consistent with the DIP, MTE and FoAR recommendations, and the TCSP staff and partners are all aware of the need to start transferring project activities to the MOH and communities.
- Pneumonia case management and appropriate knowledge and health seeking behavior for ARI still require attention to ensure that the related end-of-project objectives area achieved
- Teso Child Survival Project and WV Area Development Program staff should clarify the priority capacity building and sustainability objectives and strategies to ensure that CSP lessons are incorporated into programs as planned in the DIP Approaches for maximizing sustainability in this regard include:
  - Ensuring that community-based organizations and local authorities provide adequate support to community health volunteers
  - Ensuring that the ADP staff has the knowledge and skills to continue child survival activities.

- Teso Child Survival Project activities should be scaled-up and lessons disseminated widely. The CSP has implemented approaches that have the potential to be successfully sustained in the project areas and adopted in other areas by World Vision Kenya, the DHMT, and other partners. In FY05, TCSP will conduct a Lessons Learned workshop to share its experience with the Ministry of Health (MOH), other agencies involved in maternal and child health, and World Vision staff from the Africa region.

#### **A. Project Activities: Main Accomplishments**

The Teso Child Survival Project accomplished significant progress towards objectives in FY2005. A description of TCSP achievements is provided in Table 1 in the appendix: “Project Accomplishments”.

#### **Malaria Prevention and Treatment**

*ITN Social marketing Strategy* The CSP has been successful in working with local groups to advance an ITN social marketing strategy. Social marketing activities are coordinated with MOH efforts to increase ITN coverage: MOH provides subsidized ITNs at ANC clinics, and TCSP’s provision of ITNs is available for a wider community audience. A total of 51 ITN social marketing groups have been trained, up from 39 groups at the start of the year. Each group has received 100 ITNs. These groups have steady distribution channels in all 30 of Teso district’s administrative locations, which has enhanced ITN accessibility for community members.

ITN social marketing entails an elaborate marketing procedure that advances positive behavior change in the target audience. Community members have become familiar with the concept of appropriate use of ITNs, even if they don’t have nets at the household level. Reports from community members indicate that the ITN social marketing strategy is very effective. Several beneficiaries have appreciated that women take time to explain the importance of using ITNs, demonstrate their use and care, and advise them to re-treat on schedule.

Support supervision of groups continues, as community members assess with TCSP staff progress in social marketing and ITN sales in communities, and plan to deal with constraints. This supervision occurs on a quarterly basis and has been the key to successful social marketing.

In Teso, the high demand for nets has surpassed the supply of available nets. TCSP has not been able to replenish supplies quickly enough to meet this demand. TCSP has discussed with PSI options for increasing the supply of ITNs, and now groups are able to order supplemental ITNs from PSI. At the outset of the net distribution program, communities wanted nets to be given to beneficiaries for free. Through efforts to teach community members the value of nets and of sustainable marketing, the TCSP staff, partners and Community Own Resource Persons (CORPs) have created awareness about the need to charge money for ITNs.

The breakthrough in this area of malaria control (improved coverage for children under five and pregnant mothers, with the development of the ITN culture has occurred because ITN Social marketing groups reach a wide target audience through integration of activities with VHCs, CHWs, Health Facility Development Committees, and at community meetings.

Sales records indicate an increased demand for ITNs during the rainy season, when the mosquito menace intensifies. However, TCSP is concerned that the rate of re-treatment is low, as evidenced by the low demand of KO tablets in relation to the nets sold and existing nets in the community that were not treated. As part of the follow-up of ITN marketing, TCSP has set up criteria to be followed by staff to ensure that the aspects of utilization, care and re-treatment are addressed

In FY05, TCSP received money from the Global Fund for malaria control activities including ITN re-treatment and Malaria Field Days. Communities have responded enthusiastically to the Field Days, where they learn about malaria prevention and appropriate re-treatment. With the provision of additional re-treatment tablets during Field Days, ITN re-treatment has increased.

## **HIV/AIDS**

Teso Child Survival Project has continued to share HIV/AIDS prevention and care messages through VHCs and women's groups, which then share the information with the community. Participatory Learning and Action exercises with couples, families and households have enabled MOH, CORPs, and TCSP staff to address correct feeding techniques, exclusive breastfeeding options, and positive living. Stigma has reduced as evidenced by the increased number of people who declare their HIV status. The majority of those visiting VCT centers have established Post-test Clubs. Now, there are four such community support groups, one in each of the four supervision areas.

Private funding from WVUS for PMTCT activities has enhanced the HIV/AIDS component of the CSP. With the integration of that PMTCT project, TCSP now supports training more intensive training of community-based volunteer counselors (for psycho-social support), and training of Home-Based Care Providers.

Through the PMTCT project, 70 CORPs have been trained on HIV prevention, destigmatization, and care, and are advocating for better HIV/AIDS support in villages. These CORPs, some of whom were also trained on CS initiatives, are integrating maternal and child health promotion messages into their work with communities.

## **Strengthen Health Management Information Systems**

*Improved Management of District Health Services.* Supporting the district in HMIS strengthening is a major TCSP objective. The IMCI training provides health workers with knowledge to improve assessment and treatment skills, counseling, and follow-up for children and mothers as a component of improving health service delivery.

The 2002-2006 Strategic Plan for implementing IMCI in Teso District targets training of 100% of eligible health care workers on IMCI in all of the facilities. The MOH has embraced this strategy but has been unable to fully finance activities. TCSP has supported health worker training to the extent that training for DHMT staff has attained a level of 56.4%, near the 60% targeted per the Strategic Plan. Two trainings were conducted in FY05. The chart on the following page shows results by section:

## TESO DISTRICT IMCI TRAINING SUMMARY

Total number of clinical staff in Teso District	149
Total number of health facilities in Teso District	16
Total number of health facilities implementing IMCI	10
Total number of health facilities supervised in the last six months including observation of case management	10
Total number of Health workers in Teso District trained in IMCI Supervision and Facilitation skills	12

In years past, TCSP organized and followed IMCI training for local health workers. The year FY05 has seen a shift, with a concerted effort to enable the DHMT to sustain a complete IMCI implementation strategy by:

- Conducting facilitation and supervision skills training for 12 health workers in IMCI in order to establish core trainers for the district.
- Conducting Case Management Training for health workers in the district.

This training is intended to contribute to improved management of childhood illness in all facilities, thereby improving both health care accessibility and quality. Training also aims to reduce the number of children going to the District hospital directly by ensuring that clinicians in peripheral health facilities are knowledgeable and confident in their diagnostic and referral skills.

Another TCSP achievement in FY05 was the training of health workers and project staff on issues of Quality Assurance (QA). All together, 24 participants are expected to maintain QA in all their activities. Follow-up of the same will enhance the formation of QA committees and mentors at TCSP sites in FY06.

One other area of success in IMCI implementation in Teso District has been the support supervisory system. This was made possible after training 12 Health workers in IMCI supervision skills. This year, the District Public Health Nurse conducted two supervisory visits. Information from supervisory visits has been shared at 2 district stakeholder fora and will be used by the DHMT and TCSP for decision-making to improve the delivery of health services.

*Training CORPs on health data collection, flow and utilization.* As planned, 950 CHWs and 82 VHCs have undergone HH/CIMCI training on community health data collection to ensure that results are analyzed and used for strategic planning.

Through a process of “Data Flow”, household data is collected monthly by CHWs and is submitted to sub-location VHCs. At that point, the household data is summarized and given to the catchment health facility, where it is entered onto stationary data “chalkboards” by the Health Facility Development Committee members. The District HIS office is the ultimate recipient of the household data.

Of nine health facilities with chalkboards, only two are to a reasonable degree functional. In Aboloi health facility, CORPs are able to collect and analyze data consistently. As a result, CORPs in Aboloi consider data collection and analysis to be an integral part of TCSP, and are able to plan and make decisions on more effectively performing their duties. CORPs also assert that through regular data collection and analysis they have been able to monitor and evaluate their community health trends.

Improvement in indicators has been a source of motivation. Building on the success of the chalkboard approach at Aboloi, TCSP will promote exchange visits among health facility staff and VHCs to share lessons that may be applied at other health facilities.

TCSP has noted that households and the general community do not take part in data analysis and strategizing, despite progress made through the implementation of PLA for health education. In general, community members are not involved in analyzing their own data, mainly because it is not shared with them in a manner that can be understood by a largely illiterate population. Because data is analyzed not with household members, but in isolation by healthcare workers and CORPs, health decision-making and planning is not done with community members. In light of this finding about the level of data analysis, TCSP has been working with CORPs to revise and develop better data management tools. Data Flow is being revised through the revision of data collection registers, already used for household data collection and now being expanded to include relevant data analysis tools that can be implemented with community members.

*Health workers sensitization on data.* Ten of the district health workers have been trained on computer packages to enhance utilization of the computerized health information system at the district HIS office.

*Improving HH/CIMCI Practices.* Complementing the focus on technical interventions, the TCSP focuses on activities to address service delivery issues, through PLA and feedback sessions with households and communities. Activities during the past years focused on establishing community based structures for improved child health. Following mobilization that was carried out by TCSP in conjunction with district partners, a total of 82 VHCs established with 1,260 VHC members and 950 CHWs.

The CHW training component on HH/CIMCI has been inconsistent. In FY05, eight sessions were undertaken. In the training, 69.6%, or 661 of 950 CHW were trained. There are 289 CHWS yet to be trained. The reasons for incomplete training are several.

First, scheduling conflicts, or concurrent training sessions on other areas of community health, prevented CHW from attending scheduled IMCI training. Second, the low achievement rate was primarily due to the fact the District had so many training activities involving health workers that conducting another training lasting over one week would have significantly interfered with the delivery of services in the district. During the year, TCSP has worked and planned closely with the MOH in the training.

In FY05, planned activity in the area of VHC training involved incorporating the three executive officials of the VHCs in the CHW HH/CIMCI training sessions. Accordingly, for this year, the CSP adopted a system of planning activities per available funds. This has enabled the program to train 225VHC members

VHC training will continue, as those groups have been conducting health education sessions for caregivers and communities jointly with their CHW counterparts. Further training will enable them to articulate child survival health messages with more confidence. Although training has been initiated during support supervision, the sessions are too short to discuss issues at hand. All actors and sectors in the community should be seen to be involved, and not simply a small part of the community.

At the community level, TCSP staff, CORPs and Public Health Technicians have been working to improve knowledge, attitude and practices through PLA and health

education sessions on technical interventions. Specifically, health education addresses CDD (exclusive breastfeeding; hand-washing), PCM (identification of danger signs, prompt care-seeking), the importance of immunization and vitamin A supplementation, and immunization defaulter tracking as key preventive family practices.

*Improving health delivery systems.* The CSP is supporting the District in the strengthening HMIS and health facilities management.

The main accomplishment in the area of improving the health delivery system has been on health management. The dispensary model establishes functional implementing structures to strengthen management and enhance linkages between community and health facility-level health provision. This model is designed to strengthen the role of communities in the planning, delivery, supervision and monitoring of health services. Sustainability and ownership underpin the principles of the “dispensary model”. There are eleven such health facility development committees, and the 2 District Health Management Boards (DHMB) for the District Hospital and the Sub-District Hospital at Alupe.

Regular support supervision and follow up by project and MOH staff has been the pinnacle of activity in this area. DHMB training was accomplished for a class of 6 members of the District Hospital.

With this in place, DHMBs are expected to lead, together with DHMT and the CSP, in supervision and follow-up for lower level health committees. In this regard, the dispensary model approach offers communities the opportunity to get involved and own the delivery of health services at health facilities. Ownership refers to the community working in conjunction with health facility staff to deliver health services, thus promoting community support for decisions that affect health care. Community ownership is intended to raise both the demand for and supply of health services.

A learning visit for one HFMC was organized for one committee in Angurai Division. The program plans to adopt replicable issues that have made some committees a success.

Proven successful in some communities, support supervision and feedback for implementing structures will be the main activity focus in FY06. Through support supervision, issues not articulated in the trainings have been captured and addressed. The DIP stipulates that implementing structures should be supervised at least once every quarter, which has occurred to date.

TCSP is becoming more effective in performing supervision that integrates all implementing structures, including ITN social marketing groups, VHC members, CHWS, HFMC and other actors in a specific location. The exercise is conducted on-site for practicality and maximum attendance. During supervision visits, the turnout for the session has been lower because of dropout as a result of motivational factors, death, and employment opportunities elsewhere. As result, 1,080 VHC members and 520 CHWs were supervised at least four times over the year.

The VHC structure has become an indispensable component for the implementation of the program as they are entry points to the community, undertake the mobilization, collect, analyze, and interpret community health information, make decisions and action plans from the data, and organize for health education sessions for communities on child survival initiatives. These they do jointly with CHWs and other actors. The major issues shared during CORPs support supervision include

- Strengthening the health information system
- Development of a functional plan of action
- The 17 key family practices
- The TCSP's 5 technical interventions
- Income Generating Activities

As a result, 40% of VHCs have functional action plans developed on quarterly basis against the project target of at least 70%. TCSP will work with all VHCs to strengthen planning ability and to ensure that the majority have action plans.

The VHC membership are linked to all 11 health facilities through their representatives in the health facility development committees.

*Conducting PRA/PLA with Communities.* Participatory Learning and Action has been instrumental as an approach to influencing families to adapt key practices that not only improve care seeking and treatment compliance, but also motivate them to maintain good health. In the Mid-term Evaluation report, capacity building for staff on PLA approaches in community development was identified as an area warranting technical support. Now after training, TCSP staff and partners are able to engage communities in assessing their own health situations. TCSP is on target with “focused” PLA training, conducting at least 8 sessions every month across all of the divisions.

The PLA health education audience has been caregivers, including mothers and fathers, who have developed health action plans. This methodology has supplemented the health education talks.

*Behavior Change and Communication Strategy.* The main accomplishment in this intervention objective has been initiation of the process of training mothers, fathers and caregivers on child survival initiatives to impact positive health behavior change. This has been accomplished with the dissemination of knowledge on the 17 key family practices using clear and simple-to-understand tools. TCSP has developed and 40,000 brochures on the key family practices. (The brochures were written in Kiswahili, the national language. It is apparent that written the local Ateso language was more complex to read and understand by the majority of the populace than Kiswahili.)

Brochures are distributed by VHC members and CHWs, and are used by CORPs to enhance performance and motivation. The messages captured in projects IEC materials include among others; ITN use, exclusive breastfeeding, ANC, Immunization, complimentary feeding, World Vision's model of Transformational Development, hand washing, safe refuse disposal, growth monitoring, and HIV/AIDS/STI prevention.

Audio-visual tools are also used as a means of disseminating knowledge, and those used have been so effective that TCSP will intensify their use to attain greater impact.

*Other accomplishments in local partner capacity building.* An important lesson learned is the need for the availability of a well-trained cadre of core implementers between and across communities so that CS advocacy is seen not as a task assigned to one section of the community only. As a result, a wide spectrum of community sectors and members has been trained, encouraging fruitful partnerships for capacity building such as those described on the following page.

*PHAST training.* In line with this, 37 participants from a cross-section of the community (teachers, Community Development Assistants, healthcare workers and community members-at-large) were trained on Participatory, Health and Sanitation Transformation (PHAST) and are teaming up with other implementing structures at the community level to facilitate positive behavior change. In the Angurai supervision area, a Community Based Organization has been formed to oversee this initiative in the Division.

*Training of shopkeepers selling drugs.* The project in partnership with the MOH conducted eight sessions for shopkeepers selling antimalarial drugs to address issues related to safety, positive care seeking and compliance for treatment behavior among health care seekers in the community. In total 180 shopkeepers were trained, and will be supervised in FY06.

*Establishment of School Health Clubs.* TCSP is partnering informally with the Teso Ministry of Education, to advance CS initiatives to households and communities through reactivating school health clubs. A local ITN social marketing youth group has spearheaded this activity. As a result, primary school children are beginning to question their caregivers on the rational of some the negative health practices in their households and are impacting positive health practices by “doing”.

All in all there has been notable collaboration demonstrated between TCSP and other district stakeholders in training and learning initiatives. Collaboration has been enhanced by effective communication established with these partners who had previously not been so actively participating in health and other technical areas. These stakeholders include Public Health Technicians, Community Development Assistants, the Provincial Administration, District Education Officers, and Adult Literacy Officers.

The CSP has reactivated district cadres that have been trained as Community Educators and Animators (as their primary roles), but which have in the past remained under-utilized. As such, TCSP has made considerable efforts in establishing and strengthening linkages between “Community Based Providers” (i.e. VHCs, Health Center Committees, women’s groups) and health facility staff as well as other multi-sectoral workers, thus demonstrating the use of a “multi-sectoral platform approach” in implementing HH/C IMCI in Teso District.

## **B. Factors Impeding Progress**

Despite progress made, the TCSP team has met challenges that impede progress, including:

- **Lack of basic infrastructure.** The CSP approach was based on the premise that all community and government sectors will be functional. In Teso, this has not been the case. Teso District is relatively new (9 years) and lacks some basic services and infrastructure in comparison to other districts. That the sub-District Hospital is limited in both space and equipment restrains TCSP’s impact on maternal and child health status. Exacerbating inadequate health access are

conditions that keep peripheral health facilities chronically undersupplied and understaffed.

- **Poverty and Community Conception of Donor Support.** High levels of household poverty have been traditionally alleviated by a donor approach to development in Kenya that provides tangible goods such as health centers, equipment, and boreholes. Communities acknowledge TCSP's intangible benefits, but continue to ask for inputs that the project cannot deliver.
- **Staff and CORPs turnover.** Targets for IMCI training have been difficult to achieve because of staff movement to other districts and new staff recruitment. At the outset of TCSP, 100 eligible health workers served Teso District. Today, the denominator has changed to 149 thus reducing the percentage trained. The VHC members and their CHW counterparts initially perceived themselves as WV staff, and so they expected an incentive for their involvement in project activities. Sustaining this, VHCs are initiating income generating activities for their members, having been registered with the Ministry of Social Services. Their activities range from merry-go-rounds to horticulture, brick molding, and farming.
- **HH/CIMCI Curriculum.** One key challenge in making meaningful progress in improving HH/CIMCI has been the absence of a standard curriculum for training at the national level. However with concurrence from the Division Of Child Health, Ministry of Health Nairobi, and the CSP team and the Teso DHMT spent considerable time reviewing and analyzing the South Africa and the Ugandan Curricula for training CORPs on NN/CIMCI. Now, it is this HH/CIMCI package that constitutes the Third phase for VHC training.
- **Partner involvement** .The key implementing partner (MOH) has been slow in planning and agreeing to collaborate as TCSP has continued its work with communities. As a result, progress towards achieving objectives has been slow, and activity schedules have not always been followed as planned.
- **Other PVOs.** With the incoming of other development agencies in the District such as the Population Council (for safe motherhood) and Ampath (for PMCT), there has been a lull of activity due to competition for the same audience and implementing structures. However through consultations and partnerships, TCSP have been able to integrate activities in the same communities.
- **Absence of sustainability plan for implementing structures.** One challenge for ITN social marketing groups, HFMC, VHCs and CHWs has been absence of viable income generating activities for the groups. To address this, capacity building processes have been initiated through TCSP where capacity assessments are to be carried out to identify performance gaps and institute relevant interventions for all gaps identified. This is strengthened by intensive support supervision being undertaken for all groups at least once every quarter.

*Steps taken to overcome challenges.* In response, TCSP staff has made a concerted efforts to educate communities on the project's objectives. Community dialogues have also focused on the principles and process of "Transformational Development" as the approach for initiating and maintaining community responses for improved child health. There is continued development of staff capacity in improving their communication, negotiation and partnership skills. CSP staff use these skills on a continuous basis as they

strive to enhance partnership. Also, frequent communication and coordination meetings help to synergize efforts. In addition, TCSP staff use both formal and informal networking mechanisms to maintain partnerships.

This year, TCSP achieved a breakthrough with the DHMT where joint planning and activity implementation was undertaken with the MOH team. Currently the team is taking initiative and lead in implementing CSP activities and only requesting facilitation from the CSP. As a result, the process is gradually shifting to the MOH and other partners. Daily coordination with the DHMT has created a relationship built on trust, to the point that DHMT now offers its vehicle for field supervision.

### **C. Technical Support Required by the CSP**

The project requires technical assistance in the following areas:

*HMIS*- Communities are collecting data and do use it at their level to design operational plans. However not all of this information is then captured at the project /district level. The Teso CSP has spoken with the USAID M&E officer to ask for support and suggestions as to how the project can better synchronize the collection gathering. The specific areas for support are:

- Revision and harmonization of community data collection tools.
- Revision and development of the data collection process from the community (to be done in conjunction with the MOH and VHCs).
- Working with the MOH to develop monitoring indicators for HMIS strengthening through the formation of M&E working groups.
- Conducting quarterly follow up of facility-based health workers in data collection and use.
- Computerization of the district health information system

### **D. Variations from the DIP/ Changes since the MTE that require a modification**

There has been no significant change from activities that were presented during the DIP revision (FY 02) and outcomes of the Mid-term Evaluation. The only emphasis from the mid term evaluation is to re-focus on the nutrition aspect.

### **E. Sustainability Plan**

The sustainability plan is inherent in the DIP and has been integrated at each and every level of project implementation. The focus on sustainability is also through WV's strategy in the capacity building for transformational development that targets communities and implementing partners. From the baseline survey, DIP preparation and MTE, partners and communities have been involved to understand the project and processes. In addition to training local partners such as MOH staff, the project has built the capacity of VHCs and CHWs, ITN social marketing groups, and Health Facility Management Committees (HFMC).

*IMCI training and supervision-* Training core IMCI facilitators, supervisors and implementers for the district is also another approach for the sustainability of the project activities. The current trend is that the MOH is taking lead in activity implementation. The project staff role is now support and facilitation of the MOH. The district status is 56.4% IMCI-compliant, which is the national leading position for Kenya.

*CHW-* Through a community process, CHWs have been trained and supervised on the HH/CIMCI and on the 17 key family practices. They in turn train mothers, fathers and caregivers and have been provided with teaching aids. CHWs are expected, together with VHC members to develop an operational plan for their area of jurisdiction. Given that they are community members operating within their communities, sustainability is expected

*VHC-* The project has 82 village health committees planning and supervising health activities in the 82 administrative sub-locations in Teso district. The VHC members are drawn from among the villages in the district therefore they are very representative. The committees are trained on various aspects of planning and management so that they are informed and effective supervisors for all CORPs in their sub-locations. The VHC operate on a plan of action drawn on a quarterly basis. The project staff check and guide them on this during supervisory visits.

*HFMC-* There are 11 trained HFMC two DHMT board members in Teso District. The HFMC are drawn from the VHCs within the health facility catchments area. The chairman and treasurer are community members while the secretary to this committee is the health worker in-charge of the facility. This has helped to put a linkage between the community and the formal health system. Comprised of respected community members, the boards have been effectively trained to provide support for lower level community structures. The boards are made up of mostly retired community members and are less likely to leave the district and as such will continue teaching and supporting the community.

*ITN Social Marketing Groups-* The project has trained 51 groups on ITN social marketing and CS initiatives. These groups have been effective agents of change in the community. Their enthusiasm and desire to teach and work with others will hopefully continue when TCSP phases out.

These implementing structures, as they are community-based, constitute a critical mass of key HH/CIMCI implementers at the community and facility levels. The knowledge disseminated is expected to impact health attitudes and practices that will evolve into positive behavior change culture and generate sustainability.

## **F. MTE Recommendations follow-up**

The TCSP completed its midterm review in August 2005. This is also the last year of the project, therefore this section responds to two questions asked in the guidelines for annual reporting.

F.1. Firstly please find the information requested in the MTE.

## 1. Identification and Training of enumerators/KPC Survey Methodology

Conducted in the month of August 2004, the MOH in conjunction with the project team identified field assistants for the survey who included 4 supervisors, 36 enumerators, 8 FGD guides and a survey coordinator. The survey coordinator was the Ministry of Health Disease Surveillance officer while the supervisors were key District Health Management Team members. The 8 FGD guides were each paired with one WV Community Development Motivator and one Divisional Public Health officer. All of the enumerators were drawn from a pool of Village Health Committees that the CSP is already using for child survival initiatives and for the management of a Community Based Health Information system.

The MTE Team Leader, the WV-Kenya Health Coordinator, and the Teso CSP manager conducted a 2-day training. Topics included those enumerated on page 3 of the KPC qualitative Assessment report. Pages 4 and 5 of the same report state the methodology used, and the clustering. Page 16 to 20 of the main midterm evaluation report provides the survey evaluation process and methodology

## 2. MTE Data-decline in Indicators- Reasons for the decline in indicators

It is true that some indicators have declined since the TCSP inception; this is related to the context of the implementation process and the stage at which the project is now.

The TCSP aims to transform key health practices of the Teso community while improving the health status of mothers and children. This transformation largely depends on training health workers and local partners in the management of childhood illness. As such, the project is a process as opposed to a quick-fix situation that would improve indicators in Teso in a relatively short period. The process involves creating structures for a suitable implementation environment.

The TCSP has taken more time than anticipated to proceed systematically in establishing and strengthening linkages with partners, namely the MOH, and to ensure the participation of project stakeholders. Among the processes that TCSP builds on, community mobilization; selection of 82 VHCs; identification of trainers and facilitators; curriculum development; CHW training; and preparing women's groups for ITN social marketing have occurred alongside the accomplishment of a host of other unseen activities, all of which have taken time to manifest to provide a solid basis for the project.

Once the groundwork for partnership was laid, the CSP began training all of the aforementioned entities to be change agents for improved household health status in the community. A particular challenge was persuading an impoverished community to volunteer time and effort to take part in a capacity-building program where results are not immediately tangible or all-inclusive of other sectors. The process of engendering this transformational development has been slow, but capacity-building structures are now solid and are being enhanced by support supervision and refresher courses.

Indicators relating to malaria control (e.g., sleeping under ITNs) increased. This is because the women's groups trained in ITN social marketing are fully operational in villages. A mosquito net culture is now properly entrenched in Teso. Other indicators that improved were as a result of education provided by trained VHCs. Since these operate at the sub-local level, their scope is limited and that is why only modest successes were realized at midterm.

### 3. Plan to Check and Improve Deteriorating Indicators

The project is starting in earnest after setting organization, intensive training, and follow-up in motion, and expects to realize significant improvements in 2 years' time.

Key activities, ongoing and planned, include the following:

- Engage the already trained community health workers (542 in number) to their respective households to train and follow-up caregivers and mothers on the 16 key practices for the remaining 2 years of the project. This has just started.
- Train the balance of CHWs and engage them as above. A teaching aid has been developed in conjunction with the MOH and other partners, and each CHW has a copy. After their own training, mothers will be given a translated brochure on the 16 key practices for their own reference. The brochures have already been printed. This in turn will be followed by support supervision by project staff to ensure that CHWs are implementing their action plans as designed during their trainings. Completion of these activities will lead to project scale-up and further progress toward achieving results.
- Train the remaining eligible health workers on IMCI by the 3rd quarter of FY 05.
- Paint shop walls in market places and health facilities with key health messages by end of the second quarter of FY05. The process is underway.
- Undertake a training course for facilitators drawn from across the various sectors on Participatory Health And Sanitation Transformation. The trained group will then train a critical mass of trainers who will join the CHWs to transform communities towards better health.
- Further support and enhance the Community Based Health Information System to enable the MOH to undertake meaningful interventions as a result of information from the community.
- Further activate the public health officers and technicians to provide a more active role in the communities that they are supposed to serve. At the inception of TCSP, this cadre of staff had not been fully functioning according to their capacity, but are now very engaged in CSP activities. This enthusiasm portends continued engagement in promoting the positive impacts of the CSP beyond the life of the project.
- A nutritionist has been assigned to the DHMT. This nutritionist is working closely with the project to address issues of malnutrition. Two studies have already been undertaken, on infant feeding options and on factors contributing to malnutrition in Teso. An action plan has been discussed and will be implemented.

#### F.2. Secondly, please find the current expectations on progress phase-out.

The CSP has had a gradual pace in acceptance and ownership in the community and with local implementing partners. As discussed earlier, the MOH has project activities taken up project activities as their own, and are planning and executing initiatives with TCSP staff playing a minimal facilitative role. The early beginnings were beset with problems where MOH staff viewed the CSP activities as WV activities and not part of their overall District activities. The recognition of Teso District by the Child Health Division of the MOH has made the DHMT realize that the success is theirs and not that of the project alone. This ownership has clearly evolved over the life of the project. There was resistance at first, acceptance, participation, and now ownership.

In the community, enough structures have been created and strengthened to effectively take over project activities. These include HFMCs, VHCs; and women's groups trained on ITN social marketing and child survival initiatives. These community structures have evolved over time.

FY06 being the last year of the project will concentrate on support supervision to strengthen these structures in readiness for phase-out. The phase-out process has developed through sustained efforts to convince the communities that the project is theirs and for their benefit.

## **G. Family Planning**

N/A

## **H. Program Management Systems**

*Financial Management System-* The WV system of budgeting, financial disbursement and financial accounting is very well defined at project level, and is well understood by project staff. The project accountant relays financial data to the World Vision Kenya financial analysts who in turn submit a report to the WVUS finance officer. The CSP had a change in project accountants during the year, but this did not disrupt project activities or the financial management system. The current project accountant has also been trained on USAID financial rules and regulations. Furthermore, all staff participate in developing quarterly activity plans that are used in making funding requisitions so that activities are closely matched to funding levels. Technical assistance has been helpful and supportive in this area as it is well provided by both Nairobi and Washington, DC.

The only handicap in financial management arises when dealing with partners such as MOH, MSS, etc. who expect compensation such as payment for attending trainings or meetings. Financial incentives were not budgeted into the CSP. The CSP shared experiences with the other PVOs which implement USAID-funded CSPs in August 2005 in Mbeere, Embu. The outcome was to discuss this further with USAID to see if they could standardize a payment system. Again the CSP does not have the funding to provide financial incentives even if a standard system is established.

*Human Resources-* The CSP has been a major learning experience for staff. Going through an evolving process to promote the CSP has build staff capacity levels in all aspects in the wide spectrum of management and planning. Staff have been called to various seminars, workshops and government seminars by virtue of being in the project.

Although there has been movement and promotion of TCSP staff there has always remained a continuous flow in programming. The staff have either been promoted within the CSP, providing a continuum of care, or have been promoted within the WVK family. As a result the staff capacity is growing and the team works diligently knowing that a promotion is possible. For example, one of the Divisional Field Coordinators whose position expired under the project is now a project manager in a WV program, which is

among the 5 ADPs where the scale up is to be initiated. The CSP's former Training Coordinator also moved up to be the CSP manager when the incumbent left and joined the Center for Disease Control in Nairobi. Furthermore, a CSP Community Development Motivator is thriving in his new role as Training Coordinator.

*Communication System and Team Development-* Teso district borders Uganda and is over 700 kilometers from Nairobi. Initially there was no email facility and telephone communication was very unreliable. The systems have greatly improved. The CSP uses cellular phone to maintain communication with the WVKenya National and Zonal Offices. The postal services are slow, and the CSP relies on courier services to facilitate postage.

One outstanding feature of the CSP is the team spirit demonstrated by the CSP staff. This camaraderie has translated to cohesiveness, and even new staff identify with this team spirit. With the introduction of other USAID funded programs namely KATSO and ARK, the program has seen an upsurge for staff growth and collaboration.

*Local Partnership Relationships-* Initially the different interpretation and understanding (between the CSP and local partners) in Teso had resulted in misunderstanding between the DHMT Teso District and TCSP. However, every quarter the CSP has been able to conduct meetings with opinion leaders and departmental heads to share about the project's progress. It is through this forum that TCSP has been able to undo the previous thinking on project expectations and address issues of sustainability. The CSP has also been able to affect the district acceptance on the project and has received strong support from the Members of Kenya's Parliament, the District Commissioner, and the politicians who seek opportunities to propagate development for their communities. The CSP is looking forward to enhancing this collaboration in the final year. With the MOH team finally realizing that TCSP is supporting them in their jobs, they have progressively become responsive and enthusiastic partners. Lastly, partners are now beginning to understand that capacity building for transformational development is the best investment an NGO can give a community.

*PVO Coordination/Collaboration in the Country-* A positive trend for TCSP in FY05 was the initiation, together with Mbeere Child Survival Project under the auspices of Catholic Relief Services, of a forum for experience-sharing for all CS implementing PVOs funded by USAID. As a result, the first of such fora took place in between July and August, 2005 at Mbeere CSP, Embu. The 4 PVOs were World Vision Kenya, Catholic Relief Services, Plan Kenya, and AMREF. The USAID Mission in Kenya also supported the meeting. The PVOs advocated for the replication and dissemination of best practices and lessons learned amongst them but also to the USAID Mission in Kenya. Upon the conclusion of the proceedings, the CS group developed an action plan to address pertinent issues and enhance future partnership. Further meetings will be annual.

In Teso District, the CSP project operates within the established District Management System, thus activities are harmonized within the district plan. Like other district stakeholders or departmental heads, the CSP Project Manager is a member of the District

Development Committee under the chairmanship of the District Commissioner, and is subject to reporting systems and attending all meetings that relate to development issues in the district. Furthermore the program collaborates with the MOH especially the Division of Child Health. The division has been of great encouragement for the program especially in the area of IMCI training.

#### **I. Mission Collaboration**

The USAID/Kenya Mission's strategy includes improving health conditions, and providing education support for children of marginalized populations. TCSP's work is strengthening efforts to achieve those aims; with strides made in addressing both health behavior and health knowledge, TCSP looks forward to continuing to collaborate with the Mission.

#### **J. Annual Workplan FY06**

The annual work plan (Attachment 2) is the original plan. However, because of unaccomplished targets for the previous year, it is apparent that some trainings must be conducted in the first quarter of the year especially in the areas of HH/CIMCI for health workers and CORPs and the replication of CSP to other ADPs.

#### **K. Key Successes**

Still a leading killer in Teso District, malaria control is the technical intervention in which TCSP has made the largest strides.

Based on community expression of need, TCSP has been working with healthcare providers and community groups to establish a process of analyzing progress and following up on feedback with the malaria control activities. Aiming to initiate positive behavior change to reduce morbidity and mortality, TCSP and MOH have created a local cadre of trainers and change agents focused on integrating malaria control into activities of daily living. The process required training materials appropriate for the local context; intensive training; and evaluation through supervision. Key to the success of this process has been ongoing community involvement. Households determine attitudes and elements critical to behavior change, and these analyses with TCSP change agents have led to successful, contextualized malaria control in the TCSP area.

At the time of the Mid-term Evaluation in 2004, prevention efforts had raised malaria prophylaxis during pregnancy from 16.3% at baseline in 2002 to 61.3% . ITN use, too, has increased: in 2005, household ITN possession stands at 69.8%, up from 22.2%. The percent of children under five sleeping under ITNs rose from 6.9% to 40.9%.

#### **L. N/A**

#### **M. Additional Information In Annual Report- 2005 Memorandum**

##### *Contribution to scale/scaling up*

The Teso CSP manager continues to work with 5 other specified ADP's as a "multiplier effect" that will spread the investment of the Teso CSP in Kenya. The ADPs are Bunyala (which includes Teso District), Marich Pass, Kabarnet, Pokot and MPP. With the initial set of five, the Teso CSP will serve as a "model" for eventual incorporation into all existing WVK ADPs. World Vision is the largest international

NGO working in Kenya, reaching a population of over 1.2 million people. This strategic use of USAID support will go a long way toward WVK's capacity-building and scaling-up objectives. Furthermore, the long-term multi-sectional commitment of the ADP strategy enhances the sustainability of these efforts well beyond the life of the CSP.

A network of USAID funded CSP implementers in Kenya has also been established to borrow best practices by physical visits and meetings. Amref and Catholic Relief Services visited Teso CSP to learn about the program and in return Teso experiences have been replicated beyond the borders of the project. Teso CSP also participated in meetings when Amref was formulating its proposal for the project in Busia, Kenya. Additionally, the Teso CSP has borrowed heavily the implementation structures from Plan Kenya especially their project in Kwale, Kenya.

b) In FY 05, the CSP was joined by two other mission funded programs namely the KATSO and ARK programs. These 2 projects have blended well with the community structures created by the CSP and use the same administrative and management structures. KATSO and ARK are also in Bungoma District where the CSP does not operate, however all projects are able to share lessons learned and provide cross support to communities.

c) The Teso CSP has strengthened the weak district health system to a level that it now has the capacity to carry out proven interventions at scale:

1. Trained 5 key District Health Management Team members on sentinel surveillance for HIV/AIDS as part of a national strategy.
2. Trained 30 facilitators from different sectors of the district such as the public health officers/ technicians, adult education officers, community development assistants on the dispensary model and HH/ CIMCI. In the absence of a national curriculum to train CORPs, the CSP in partnership with the ministry of health blended a Ugandan and South African program to create one for Teso, which has been shared with other programs. The Child Health Division of the Ministry of Health has approved the curriculum.
3. Trained 12 health personnel as facilitators in the improved management of childhood illnesses. While TCSP used to seek facilitators from outside of the district, Teso now has the capacity of facilitators to train all eligible health staff in the district and beyond.
4. Trained 12 health workers as supervisors of IMCI to follow up clinicians trained on the same.
5. Trained CHWs and VHCs to transform Teso community for improved health that will reduce child morbidity/ mortality and improve maternal outcomes. With further support in identified areas such as nutrition the District health system has been strengthened by the CSP to a level where a health focus can now grow towards the Millennium Goal.

#### *Civil Society Development*

Institutions that TCSP has worked with in the District and whose capacity has been built include:

- The Ministry of Health and The District Health Management Team  
In conjunction with MOH headquarters, the district development officer and the project team were trained on their roles and functions including team building, management and work plan development. Though the process has been slow, the CSP can now witness the writing of plans, especially joint ones, with the project team. They hold regular management meetings and plan together as opposed to

the earlier method where a few officers made decisions. In fact while the CSP had difficulties in implementing training sessions because an officer was often busy with other duties, there now exists a training committee as a subcommittee of the wider DHMT. The medical officer of health is able to distribute functions to different officers unlike in the year 2002. The DHMT has evolved from a disjointed team in 2002 to a solid team in 2005 where the turning point has been the Teso CSP.

- Public health officers/ technicians have evolved from meat and hotel inspectors to community based health workers / trainers and facilitators in all aspects that relate to their respective areas.
- Nurses at the facility level have also moved out of the facilities to participate in community IMCI and Data Management.

Despite the many problems experienced by health staff, the rapid pace of project implementation has challenged them to become and join the already moving train

#### *Community structures*

- The village health committee is the greatest strength of the project. The established structures took root gradually and are now being used by all sectors and donors, including Katso and ARK projects. While the VHCs started as structures for implementing the CSP they have evolved as district community structures for developments occurring in their jurisdiction.
- Women groups for ITN marketing are becoming stronger by the day. Starting as groups selling nets after being trained on social marketing and income generation, the women now provide catering services to WV training sessions and other events. Some have gotten funding from the National Aids Council to undertake HIV/AIDS prevention activities such as home-based care. They have evolved from simple women groups that concentrated on contributing small money for loans to strong groups that are taking up other functions.

#### **Equity**

With extreme poverty in Teso, the project is working to reduce infant and child mortality and to improve maternal health for children under five and women of reproductive age. Given the Teso cultural situation, these are the most vulnerable groups.

The contribution of females in sustaining the Teso economy is enormous. Women provide almost all the farm labor. It is the women who mainly go to markets to trade in various wares to earn an income and it is the women who mainly organize themselves into groups to implement community programs and set up income generating activities. Despite their enormous contribution and their large number, women have not attained gender parity in decision making and control of resources commensurate with their contribution. Due to out migration of men and the HIV/AIDS pandemic, many households are female headed. The level of gender awareness is quite low as the traditional position of men and women in the society and at household level is largely maintained.

#### *Visibility and recognition of the project and PVO grantee*

World Vision has been acknowledged as the first major NGO to operate in Teso, operating in the entire district. There are smaller NGOs operating as satellites from neighboring districts because of the remoteness of the district and then in only small pockets. At DDC meetings, the CSP has been commended as the only NGO that transparently provided the project budget and regularly provides financial statements and progress reports to the district development committee. Members of parliament at different fora have commended the project for a job well done. At stakeholders meetings involving the provincial administration and opinion leaders, feedback on project activities have been very positive and encouraging.

In the financial year 2003, the project manager who was then the training coordinator presented a paper to the Public Health Association entitled 'The Role of Public Health Officers in a Changing Environment'. This paper discussed the possible new roles and opportunities for officers who are working in communities.

*Widespread development or adoption of innovative approaches*

The CSP is currently using stationary chalkboards posted on the walls at each health facility to communicate monthly progress in both technical and training activities. Village health committee members use household data that has been tabulated and list numbers and rates achieved for the relevant village. VHC member and health care providers are able to track and analyze the data on the chalkboards to further develop action plans for integrating CS initiatives into community health initiatives. As previously noted there are two challenges with the chalkboard communication of data. First, all of the information is written in English and is not translated into the local language. Second the chalkboards are stationary and remain at the health facility. TCSP is working with VHC's and health care providers to develop data presentations and analysis tools that will effectively translate information on the chalkboards at the household and general community level. For example, the health education coordinator intends to devise and pretest health education methods that will be presented to communities. In addition to the PLA which is already being conducted to enhance decision making skills, the revised data collection and flow tools will bring information from the facility level to the household level and help individuals understand and practice better health maintenance behaviors. This is an activity that is both dispersible and sustainable as it trickles down from the health facility to the community and will continue to be used in WV programs.





### Workplan

	OCT 05				NOV 05				DEC 05				JAN 06				FEB 06				MAR 06				APR 06				MAY 06				JUN 06				JUL 06				AUG 06				SEP 06			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4				
(ix) Support outreach activities																																																
(x) Conduct community feedback sessions.																																																
(xi) Assessing the level of partnership involvement (MOH)																																																
3. Implement Behavior Change and Communication Strategy for Child Survival Initiatives																																																
(i). Continue training caregivers, mothers & 40,000 Households on child survival initiatives through VHCs and CHWs.																																																
4. HIV/AIDS/STI Control																																																
(i) Strengthen Community Based Responses to HIV/AIDS through the WV (US) funded PMCT Project and the PEPFAR OVC program.																																																
(ii) Conduct jointly monthly monitoring and supervision for health facilities & CORPs																																																
(iii) Revise monitoring tools for HIV/AIDS prevention																																																



**Teso CSP Accomplishments**

<b>Project objective</b>	<b>Key Activities</b>	<b>Status</b>	<b>Success Factors</b>	<b>Plan for successful continuation in FY06</b>
<p><b>1.Support the District in HMIS Strengthening</b></p>	<p>(i) Supervision for health workers and CORPs involved in Data collection at the facility and community level. Data analysis for project monitoring and reporting.</p>	<p>82 VHCs and 668 CHWs supervised.</p> <p>Workshop conducted for MOH facility staff on data collection and management, in collaboration with the provincial health office.</p>	<p>The CDMs and PHTs team to conduct supervision, thus reinforcing data collection and analysis.</p> <p>MOH was very involved in workshop planning, together with the provincial team.</p> <p>CORPs collect data and use information for planning their personal activities at the village level. At the district level, data analysis is weak largely because</p>	<p>TCSP will focus on increasing the level of involvement at the household and community level to analyze data and develop health maintenance plans</p>

			this is a new concept and needs time to be integrated.	
	(ii) Revise data collection tools used by facilities and communities.	Data tools for data collection for CORPs at community level revised, developed and distributed to CORPs at Village levels 1000 Copies developed. The data collection tools for IMCI had not been developed by the MOH, since IMCI was slow to catch on as a concept in the District	Input from many various sources, like Amref and Busia District Hospital, provided tips for improving the data collection tool.  VHCs can now retain data for use. Data flow is clearer. The data registers become more durable and an organized document in triplicate.	Further revise, with CORPs, CHWs, and beneficiaries, the data collection tool to enhance sustainability.
	(iii) Train 950 Community Health Workers and 82 Village Health Committees in data collection and management	661 CHWs and 82 VHCs trained	Training on CS initiatives was conducted simultaneously. This approach both saved time and reinforced learning.	Training on-going during support supervision
	(iv) Continue	Monitoring of processes	CDMs are regular	Technical support

	monitoring the extent of system strengthening through already developed indicators.	taking place.	in reporting, and receive useful feedback from the TCSP staff at CDM biweekly meetings.	required in the area of Monitoring for impact indicators and the District HMIS
<b>2. Strengthen the capacity of local partners to implement HH/Community Integrated Management Of Childhood illnesses</b>	(i) Train 950 CHWs & 82 VHCs on Child Survival Initiatives.	661 CHWs trained.8 VHCs trained in third phase.	Trainers were trained on IMCI at district level. This amplified the IMCI training taking place at community levels.	Accomplish full coverage by training the remaining 289 CHWs and 74 VHCs CORPs in the first quarter of FY06
	(ii) Conduct Monitoring/ Support visits for Health Facility Management Committees, VHCs, and women's groups trained in ITN marketing.	Quarterly supervisory visits were conducted for all implementing structures.	Supervision is coordinated to coincide with other TCSP training.	This will be the main activity in FY06. Supervision will be executed at all levels of activity implementation and for all the implementing structures at least once every quarter Special effort will be made to share lessons learned in health systems management are

				shared as appropriate for each group..
	(iii) Train 12 women's groups in social marketing for ITNs.	12 women's groups trained for ITN social marketing, bringing the total number of women's groups trained to 51.	Women's groups are very receptive to and enthusiastic during, in particular as it relates to malaria control.	Groups actively engaged in ITN social marketing. Supervision will continue to ensure sustainability.
	(iv) With the DHMT, conduct supervision for IMCI implementation at the 13 facilities in the District.	2 IMCI supervision, each session covering all 13 health facilities were conducted in FY05.	With an increasing number of health facility supervisors have been trained, and this has generated interest by additional staff in health care training.	Training produced two reports for the improved health workers skills available. Results from these reports will be reviewed during quarterly supervision.
	(v) Conduct PRA/PLA with communities. A minimum of 8 sessions per month across the District	Staff trained on the project methodology, and on using Focused PLA.	Focused PLA is an efficient, practical tool for BCC in TCSP areas. The methodology is increasingly becoming popular among staff, partners and CORPs. The tools are becoming indispensable to	Continue to use PLA for caregiver BCC. Also incorporate analysis of HH data, and strategic planning for health maintenance, into PLA.

			the CSP.	
	(vi) Health facility training on IMCI	2 sessions for case management held in the year. The cumulative totals stand at 84. This translates to 56.4%.	<p>TCSP has supported the MoH in IMCI training to the extent that there are now many qualified IMCI trainers available to lead training sessions.</p> <p>IMCI practice is now popular in health facilities as the majority of the health workers are compliant.</p>	Conduct another IMCI training for the remaining 24 health workers who have not yet been trained to attain a target of 100 trained health workers.
	Health facility training on Quality Assurance.	24 health workers and project staff trained on QA.	Supervision in this area is key to actualization.	The establishment QA mentors to be put in place.
	(vii) Continue supporting the tracking of dropouts in the immunization schedule.	CORPs conduct talks on importance of immunization and vitamin A supplementation. Drop-outs captured in community data tools.	<p>WV provides transport for CORPs and MOH staff to make home visits and conduct meetings.</p> <p>CORPs and MOH also identify drop-outs and urge them to visit outreach post or health facility.</p>	At community levels, CORPs are doing a good job in terms of advocating for full immunization and coverage and defaulter tracking. CORPs will be encouraged to continue the good work, and to

				develop sustainable mechanisms for preventing/tracking dropouts
	(viii) Assist MOH to conduct continuous assessment of essential drugs	MOH continue to manage and maintain adequate drug stocks.	<p>Meds are procured by MoH from provincial depots; logistical support from WV enables MoH staff to deliver meds during health facility visits.</p> <p>Due to training and advocacy done by TCSP, IMCI kits now being availed regularly Government of Kenya..</p>	Continue to coordinate med distribution, and advocacy for appropriate procurement, with MoH
	(ix) Support Child Survival outreach activities such as immunization, VA supplementation, and malaria prevention and management.	CORPs trained by TCSP work to mobilize community members, and support MOH staff during follow up.	Selection and training of a large number of CORPs increases impact and outreach.	Because mobility hampers outreach sessions, TCSP will seek to improve ways to facilitate logistics for outreach sessions..
	(x) Conduct community	Key stakeholders discuss progress with TCSP and other	Support from community	Feed back sessions to continue, in

	feedback sessions.	community health activities in their areas during opinion leaders sensitization fora.	leaders and the District leaders (e.g., District Commissioner) creates more interest in and demand for feedback sessions.	collaboration with partners and DC.
	(xi) Assess the level of MoH partnership and involvement	Partner involvement has been dependant on motivational factors.	TCSP has initiated joint planning with MoH, as well as coordinated implementation, reviews and trainings. The level of partnership in terms of planning together has become closer.	Continue joint review, preparation, and activity implementation with MoH staff.
<b>3. Implement Behavior Change and Communication Strategy for Child Survival Initiatives</b>	(i). Initiate the process of training caregivers: 40,000 Households trained on child survival initiatives through VHCs and CHWs.	A committee with TCSP and MOH staff reviewed brochures adapted from the WV South Africa CSP on the 17 key family practices. 40,000 brochures were developed, printed and distributed to households.	Collective review and discussion between TCSP and MOH staff. Use of proven effective existing BCC materials as a starting point rather than developing brand new materials from scratch.	Share the brochures, and other BCC materials used successfully by TCSP, with Catholic Relief Services CSP and any other interested agencies.  Develop with

			More and more mothers are being reached by CORPS, who take time to explain to them the 17 key family practices.	communities and health workers a plan to continue using the most appropriate BCC materials in communities beyond the life of the TCSP.
<b>HIV/AIDS/STI Control</b>	(i) Strengthen Community Based Responses to HIV/AIDS through the WVUS-funded PMCT project. (ii) Collaborate with WV's PEPFAR projects (ARK and KATSO) operating in Teso.	Conduct BCC through PLA on HIV prevention and HIV/AIDS support	The MoH has integrated HIV/AIDS education into the work of Public Health Technicians, who incorporate education into CS activities. Lessons are being learned from other HIV/AIDS programming	Continue collaborating with programs implementing HIV/AIDS programming.
	(iii) Develop/revise monitoring tools for HIV/AIDS prevention and care	Tools from Siaya being revised and adopted for Teso.	Collaboration with the Ampath project (which assists in drug procurement) enhances TCSP's work on the community education	Continue collaborating with Ampath

			component of HIV/AIDS	
<b>5. Others</b>	(i) Support the MoH on other Ad hoc health activities budgeted under District Development Committee (DDC) activities.	TCSP has assisted DDC to provide transport and materials support in order to improve the condition of needy health facilities.	Health facilities are in need of small improvements and some transport, which the TCSP has been able to support.	This activity will no longer be conducted after FY05.
	(iii) PHMT activities, Consultations, Steering committees	TCSP takes part in District and Provincial-level health coordination meetings.	Participation promotes collaboration and learning.	Continue to attend health coordination meetings and actively participate.
<b>6. Monitoring and Evaluation</b>	i) Compile FY05 annual report and prepare FY 06 workplan.	This draft is part of this process.		