BUSIA CHILD SURVIVAL PROJECT

(Busia District, Kenya)

AMREF Kenya in partnership with BUSIA DHMT

ANNUAL REPORT, YEAR 1

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMKENI	Awakening the Spirit of Kenya's Communities through Collaboration and Empowerment
AMPATH	Academic Model for the Prevention and Treatment of HIV
AMREF	African Medical & Research Foundation
APHIA II	AIDS, Population and Health Integrated Assistance
BACT	Baseline Assessment Coordinating Team
BCC	Behaviour Change and Communication
BCSP	Busia Child Survival Project
CATCH	Core Assessment Tool for Child Health
CDQ	Community Defined Quality
CBHMIS	Community Based Health Management Information System
CIMCI	Community Integrated Management of Childhood Illnesses
CORP	Community Own Resource Person
CRS	Catholic Relief Services
CS	Child Survival
CSHGP	Child Survival Health Grant Program
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus
DHC	Dispensary Health Committee
DHEO	District Health Education Officer
DHMB	District Health Management Board
DHMT	District Health Management Team
DHRIO	District Health Records and Information Officer
DIMCI	District Integrated Management of Childhood Illnesses
DIP	Detailed Implementation Plan
DMO	District Medical Officer
DPHO	District Public Health Officer
EmOC	Emergency Obstetric care
EOC	Essential Obstetric Care
FANC	Focused Antenatal Care
FGDs	Focus Group Discussions
GPS	Geographical Positioning
HDQ	Health Worker Defined Quality
HEWs	Health Extension Workers

HIV	Human Immune Deficiency Virus
ICS	International Child Support
IHFA	Integrated Health Facility Assessment
KCO	Kenya Country Office
KPC	Knowledge, Practice, and Coverage
LQAS	Lot Quality Assurance Sampling
MAMAN	Minimum Activities for Mothers and Newborns
MDG	Millennium Development Goal
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSF	Medecins Sans Frontières
PDQ	Partnership Defined Quality
PHMT	Provincial Health Management Team
PIT	Project Implementation Team
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Service International
PVO	Private Voluntary Organization
QI	Quality Improvement
SMNA	Safe motherhood needs assessment
SPSS	Statistical package for social science
TA	Technical Advisor
TAG	Technical Advisory Group
TNA	Training Needs Assessment
TOR	Terms of reference
USA	United States of America
USAID	United States Agency for International Development
VHC	Village Health Committee
WV	World Vision

EXECUTIVE SUMMARY

This is the annual report covering the period between October 2005 and September 2006 for the Busia child survival project in Kenya. The goal of the project is a sustained reduction in child and maternal mortality in Funyula and Butula divisions, Busia District. The main activities implemented during the reporting period included hiring of staff, establishment of a field office in Busia, procurement of equipment, baseline assessment, development and presentation of a detailed implementation plan (DIP) at the USAID CSHGP mini-university, stakeholder consultative meetings, establishment of project management structures, identification of CORPs, and training. Key trainings include training of health staff on partnership defined quality (PDQ), BEHAVE, and training of facilitators (TOF). PDQ is one of the processes that AMREF and DHMT is rolling out in an effort to foster trust between health staff and community members, improve quality of care, and increase utilization of maternal and child health services.

Some of the challenges that the project has experienced and developed solutions to include: shortage of staff coupled with high turnover; biased CORPs identification process; and budget shortfalls. In order to foster a successful implementation of the project, technical assistance will be required for the following processes: implementation of MAMAN; project documentation; workload management; development of community emergency transportation system; monitoring of capacity building interventions; and mid-term evaluation and DIP refinement thereafter.

There have been a few changes from the submitted DIP. These include changes in: timing of annual LQAS; number of CORPs; structure for organization and supervision of community level structures (*community implementation framework*); number of villages in which to pilot the CBHMIS; and improvement of the BEHAVE framework. Most of the issues that arose during the DIP review process were addressed and responses included in the final DIP submission. Responses to issues that had not been addressed are included in this report; they include: organizational capacity assessment; sustainability assessment; integration of training into the district health plan; and monitoring of behavior change. Regarding sustainability, AMREF has developed outcome indicators under each of five elements of child survival sustainability assessment (CSSA) framework, and measured baseline values. The project is taking steps in each of the five elements to ensure that gains accruing from the project will be sustained after the project comes to an end. The BEHAVE framework has been updated with findings from barrier analysis and indicators for behaviors developed during the designing for Designing for Behavior change/BEHAVE workshop.

AMREF has developed a cordial relationship with the Busia DHMT, based on mutual respect and recognition that AMREF Kenya and DHMT are equal partners in BCSP. The project has developed strong linkages with the USAID mission and other child survival PVOs in Kenya, and is collaborating with the mission's APHIA II program. The USAID mission in Nairobi, Kenya, is playing the critical role of fostering collaboration between PVOs that have child survival projects in Kenya, by convening PVOs meetings during which experiences are shared. The last such meeting was held on December 8, 2005. AMREF and the DHMT are in the process of developing and rolling out a community implementation framework to ensure efficient implementation of project activities at the community level.

A. MAIN ACCOMPLISHMENTS

BACKGROUND

The AMREF Busia Child Survival Project (BCSP) is located in Busia District in Western Province of Kenya. Busia district has an estimated population of 450,000. Most of the people live on small-scale agriculture, business, and fishing. Approximately 300,000 people live in absolute poverty (<1US$ per day). Poor health status due to malaria, HIV/AIDS, maternal and childhood illness are the main contributing factors to high poverty level in the district. Poverty, gender inequality and cultural factors prevent women from adopting health practices that are essential for their survival and that of their children.

BCSP is a five-year project launched on October 2005 and expected to end in September 2010. The project beneficiaries include 49,858 women of reproductive age and 31,664 children under 5 years in Funyula and Butula divisions of the district. The project integrates maternal and newborn care, malaria prevention and treatment, and prevention of mother-to-child transmission of HIV. It is implemented by the African Medical and Research Foundation (AMREF) and Busia District Health Management Team (DHMT), the local department of the Kenyan Ministry of Health.

The project is aligned with the United Nations' Millennium Development Goals (MDGs) – and specifically MDG 4, which seeks to reduce child mortality, and MDG 5, which aims to improve maternal health. The project aims to reduce child and maternal morbidity and mortality in the two divisions within Busia by creating sustainable health structures so that the gains made can be sustained beyond the project's life.

In order to achieve its goal, the project is using three strategic approaches:

(i) Building capacity of the DHMT, health facility staff, and CORPs (community own resource persons, who are community volunteers trained by AMREF to educate their fellow community members), aimed at improving the scope of their skills and knowledge in providing health services in order to improve access to services;
(ii) Quality assurance and improved approaches in accessing quality care at health facilities and in the community;
(iii) Behavior change and communication strategies at the household and community level addressing cultural and societal barriers to disease prevention.

MAIN ACCOMPLISHMENTS

This report covers the period between October 2005 and September 2006. The main activities implemented during the reporting period included hiring of staff, establishment of a field office in Busia, procurement of equipment, baseline assessment, development and presentation of a detailed implementation plan at the USAID CSHG mini-university, stakeholder consultative meetings, establishment of project management structures, identification of CORPs, and training. Table 1 outlines achievements under each of the activities that had been planned for year one.

(i) Hiring of Project Staff

Between October 2005 and February 2006, AMREF hired eight members of the project staff, including a Project Manager, Training Officer, Monitoring and Evaluation Officer, Behavior Change and Communication Officer, Administrative Assistant, Assistant Accountant, Office

Assistant, and a Driver. The Project Manager developed job descriptions for project staff in consultation with the human resources and administration manager at AMREF Kenya.

In January 2006, the DHMT assigned seven MOH personnel to work with the project as lot supervisors during the baseline survey and later for project implementation and management purposes. These MOH personnel include one clinical officer, four public health personnel, and two nurses. The key DHMT counterparts are: District Medical Officer (DMO); District Public Health Nurse (DPHN); District Public Health Officer (DPHO); District Integrated Management of Childhood Illnesses (IMCI) coordinator; District Health Education Officer (DHEO); and District Health Records and Information Officer (DHRIO).

(ii) Establishing Project Office

In December and January, the Project Manager identified and equipped the project office space in Busia. The office has reliable internet and telephone communication, and power supply (power back-up system has been installed). This office is located one kilometer from the office of the Busia DHMT that is at the Busia district hospital. Initially, it was planned that the project office would be co-located with that of the DHMT, but lack of space in the district hospital restrictions on the use of grant money for construction prevented this. However, the project office is easily accessible. A vehicle was purchased for the project.

(iii) Inception Meetings

With DHMT and PVOs

The Project Manager contacted key stakeholders and secured their participation in the project startup activities. This was formalized during a one-day stakeholders meeting in Busia on December 14, 2005. The members of the DHMT, district health management board (DHMB), private and voluntary organizations (PVOs) working in the project area, and the provincial administration attended the meeting. During the meeting, participants deliberated on the child survival situation in Busia district and project staff briefed participants on: project duration, project beneficiaries, goal and objectives, planned strategic approaches, baseline survey, and DIP preparation. The district commissioner, district medical officer, and chairman of the DHMB called for partnership in support of child survival, and set the stage for joint planning.

With Community Leaders

On December 15 and 16, 2005, the project held two inception meetings with 150 community leaders in the project area. During these meetings, the project staff: communicated project information (donor, project duration, beneficiaries, goal and objectives; and deliberated on the roles of the community leaders during the project's baseline survey. This was done through group discussions, which generated a list of child health needs and gaps in their areas of jurisdiction and possible remedial actions. These inception meetings held at the start of the project laid the foundation for the trust that the project has gained from the community. Trust is critical, as the baseline assessment later indicated that one of the greatest weaknesses in the health system is lack of mutual trust between community members and health service providers. AMREF will be facilitating a process to redress this weakness, by helping the DHMT, health facility staff, and the community to develop joint goals for service quality, and working together to achieve the goals.

(iv) Establishment of Project Management Structures

Project management structures with representation from diverse stakeholders have been constituted, with detailed terms of reference (TORs). These structures include the project implementation team (PIT), technical advisory group (TAG), and a memorandum of understanding (MOU) with the Busia DHMT.

Project Implementation Team

The project implementation team has 10 members with representation of AMREF (2), Busia DHMT (3), PVOs (3), and the community (2). The PVOs represented are: Medecins Sans Frontiéres-Spain (MSF-Spain); World Vision; and the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH). The PIT plans to meet in Busia once every three months. The first PIT meeting was held in December 2005, and the second in July 2006. At its meetings, the PIT reviews quarterly project progress reports and planned project activities; promotes coordination of child survival interventions in the project area, to achieve synergy and avoid duplication; shares lessons learned and challenges, and reviews and approves best practices before wider dissemination.

Technical Advisory Group

The TAG has nine members with representation of AMREF (3), ministry of health (5) (represented by divisions of malaria control, reproductive health, child health, national AIDS and sexually transmitted infections control program, and Busia DHMT), and USAID mission (1). The TAG meets in Nairobi at the AMREF Kenya country office every s months. The inaugural TAG meeting was held in August 2006. TAG meetings aim to achieve the following: ensure coordination of key players to ensure synergy and non-duplication of processes; sharing of information, including provision of policy guidance to the project; and advocacy for policy adjustments based on best practices documented by the project. During the meeting in August 2006, the following issues arose and are helping the project address recognized challenges:

- ✓ ***Integration:*** BCSP will ensure that maternal and child health services are integrated, for example, that PMTCT is part of Focused Ante Natal Care (FANC). This will be addressed during curriculum review.
- ✓ ***Empowerment of women:*** BCSP will in its processes strive to empower women, to ensure sustainability of gains; the project will achieve this by targeting women during household visits by CORPs, to empower them with the information that they need to make critical decisions.
- ✓ ***Maintenance of equipment:*** equipment bought will need to be maintained, and this is the responsibility of DHMT, since there is a maintenance unit at the district hospital; the project will help strengthen the maintenance system so that health workers promptly send damaged equipment to the maintenance unit. The process of maintenance will include preventive aspects, such as ensuring that health workers are oriented on how to use any new equipment.
- ✓ ***Communication on breastfeeding:*** there is need to avoid confusing the community through different messages regarding exclusive breastfeeding. In the project documents we cite that we will promote breastfeeding for babies 0-5 months; the MOH promotes the practice for babies up to 6 months. Although this probably means the same thing, we will harmonize the message we pass on to the community.

- ✓ ***Referral system:*** it is necessary to ensure that referral from the centres of excellence to higher centres is smooth. The MOH will ensure that ambulance services are available in these centres. AMREF will work with the DHMT to strengthen the referral system ensuring there are clear referral protocols in all health facilities and that communication equipment are available.
- ✓ ***Adolescent health:*** youth-friendly services are very much needed. In BCSP we include adolescents in primary school during our communication initiatives. Additionally, during training of health workers we will incorporate aspects on how to make health services friendly to young mothers, considering that a quarter of mothers with children age 0-23 months are under 21 years.
- ✓ ***Training:*** the project relies on local capacity (at district and provincial level); the project will work with DHMT trainers, provincial health management team (PHMT) trainers. Only in cases where capacity at these two levels is inadequate will the project seek trainers from national level.
- ✓ ***Collaboration:*** it is important to coordinate with second phase of the AIDS, Population and Health Integrated Assistance (APHIA II) project, which is supported by USAID and aims to strengthen integrated HIV/AIDS, TB, RH/FP, and MCH services. The project will maintain collaborative linkages with APHIA II, and especially develop referral linkages especially for HIV positive mothers to receive comprehensive care for HIV/AIDS in health facilities supported by APHIA II.
- ✓ ***Policy clarity:*** there is need for policy clarification with regard to vacuum extraction as a component of emergency obstetric care (EmOC), because in Kenya, vacuum extraction has also been discouraged in the context of PMTCT. The department of reproductive health and the national AIDS control program promised to address this conflict.
- ✓ ***TBAs:*** it is unrealistic to expect that all mothers will deliver in health facilities as outlined in recent ministry of health policy change, so there is need for decision makers to also consider ways to ensure those who deliver outside health facilities are not discriminated against. The project will focus on adopting a rights based approach ensuring informed choice for women and working to optimize women's role in the decision-making process with regard to delivery care.

Memorandum of Understanding with Busia DHMT

In February and April 2006, AMREF and Busia DHMT developed an MOU outlining the details of the partnership. This document is important because it defines the roles and responsibilities of each partner, and includes risk mitigation approaches such as the clause in which DHMT pledged not to transfer staff trained by the project from the project area.

(iv) Collaboration with USAID Mission and Other Child Survival PVOs

The project is collaborating adequately with USAID mission based in Nairobi, Kenya, and other PVOs that have child survival projects in Kenya (see section M, mission collaboration).

(v) Baseline Assessment

KPC Survey

In January 2006, the project carried out trainings for the baseline knowledge, practice, and coverage (KPC) survey and completed KPC data collection. Members of the baseline assessment coordinating team (BACT), drawn from AMREF, Busia DHMT, and the district statistics office,

developed survey logistics plans, reviewed the KPC tools, agreed that the project's catchment area be divided into seven lots for ease of management, and identified field personnel for each lot. Members of BACT were trained on KPC survey methodology from January 9-13, 2006 by 3 facilitators drawn from AMREF and CARE Kenya. The training included review of the project objectives and indicators, translation and pre-testing of the KPC tool, selection of sampling methodology (Lot Quality Assurance Sampling ie LQAS was selected), sampling frame and sampling points, household selection protocol, anthropometry, data tabulation and analysis, survey logistics, and preparation for the training of field personnel.

On January 16 and 17, 2006, members of the BACT met with supervisors to orient them on the project and pre-test the KPC questionnaire. Survey enumerators joined the supervisors from January 18 to 21 for supervisor/enumerator training, with BACT members being the facilitators. The training covered roles of supervisors and enumerators, review of the KPC questionnaire, household and respondent selection protocols, interviewing techniques, informed consent, quality control, anthropometry, and field testing.

KPC data collection using LQAS was conducted from January 23 to 27. Data entry was carried out concurrently with data collection, and data cleaning and analysis commenced on January 28. The project's Technical Advisor (TA) at that time (Garth Osborn) together with the Head of Programmes (Dr Festus Ilako) arrived in Busia on January 24 and worked with project staff to develop the health facility assessment, safe motherhood, and antimalarial vendor survey tools. Garth offered technical support on data cleaning and analysis, development of a DHMT capacity assessment tool, drafting of the KPC survey report, and development of qualitative research questionnaires.

In early February 2006, the Monitoring and Evaluation Officer from AMREF Kenya facilitated a KPC post-survey analysis workshop. The workshop included members of the DHMT, project staff, and lot supervisors. The main achievements were increased capacity of DHMT and project and field staff to interpret KPC survey data, and setting of preliminary targets for the various project indicators based on performance indices outlined in the KPC 2000+ field manual.

Safe Motherhood Needs Assessment

The safe motherhood needs assessment (SMNA) was conducted in February 2006 using an adaptation of the WHO's SMNA tools. A team consisting of AMREF staff and provincial and district MOH staff collected data after a 3-day training/adaptation of the tool. This assessment measured 4 project indicators namely: No. of health facilities providing basic EmOC; # of HIV+ mothers who received ART for PMTCT within the previous 12 months; # of newborns who received ART for PMTCT within the previous 12 months; and # of trained facility based health workers providing PMTCT services.

Integrated Health Facility Assessment

The integrated health facility assessment (IHFA) was also conducted in February using an adaptation of the BASICS tool. Effort was made to ensure the tool was consistent with Kenya's integrated management of childhood illnesses (IMCI) protocols. A team consisting of provincial and district MOH staff and AMREF staff collected data after a three-day training/adaptation of the tool. The IHFA measured the project indicator: *percentage of HF staff who assess, classify and treat malaria/fever according to MOH protocols*.

Qualitative Research

In February 2006, the project collected qualitative information using focus groups and key informant interviews with the aim of explaining the findings of the KPC. The qualitative research provided useful information for the preparation of the project's detailed implementation plan (DIP).

Anti-Malarial Drug Vendor Survey

In February/March the project collected data on anti-malarial drug vendors. The assessment measured the project indicator: *percentage of shopkeepers correctly dispensing anti-malarial drugs according to MOH protocol.*

(vi) Development of the Project Detailed Implementation Plan

DIP Workshop

In March 2006, project staff reviewed the work plan for the DIP and held a three-day DIP workshop. Thirty-nine participants attended the workshop including representatives from the MOH, AMREF, the new project technical advisor, and PVO representatives that had child survival projects or activities in the project area or other areas of Kenya. The District Medical Officer of Health, the District Public Health Nurse, the District Public Health Officer, project lot supervisors, the Provincial Health Management Team, and the national level divisions of reproductive health and malaria control represented the MOH. PVOs included Catholic Relief Services (CRS), World Vision (WV), Population Services International (PSI), AMKENI, and International Child Support (ICS). Senior Technical staff from AMREF Kenya Country Office (KCO) and the CS project attended.

During the DIP workshop, organizations shared their experiences in maternal and child health; the baseline assessment results were disseminated and discussed; recommendations were developed with regard to strategies and activities that the project should implement; and an overview of sustainability, including the concepts of the "local system" and the "CSSA framework," was presented and discussed by the participants. Project staff and the technical advisor facilitated small group discussions followed by plenary sessions, in which participants developed recommendations for the DIP.

DIP Writeshop, Submission, and Approval

After the DIP workshop, the writing team, comprised of the TA; Director, Institutional Giving AMREF USA; project staff; and the DHMT; held a DIP debriefing workshop. |Team members reviewed the recommendations from the DIP workshop and agreed on the contents and outline of the DIP. The methods used included: brainstorming around recommendations and prioritization of the recommendations based on cost-effectiveness, feasibility, sustainability, and the potentiality of strategies to lead to benefits across all three project intervention areas. The team also reviewed the project indicators and made changes.

Between March 24 and April 7, 2006, the DIP writing team shared responsibility for developing, writing, and reviewing different sections of the DIP, held in-depth discussions regarding sustainability, using the CSSA Framework, and agreed on some of the sustainability indicators with the DHMT. The team also reviewed and revised the training plan and budget. Completed draft sections were reviewed by peers, the TA, DHMT, and AMREF KCO. The project workplan

was the last to be written and entailed identification and scheduling of all activities described in the intervention-specific approaches and the monitoring and evaluation plan.

In June 2006, Dr Festus Ilako (AMREF Kenya Head of Programmes), Roseline Oboya (Busia District Public Health Nurse), and the AMREF Project Manager traveled to the mini-university in Baltimore and successfully presented the DIP. Upon returning, the team responded to comments from the reviewers and incorporated the same into the DIP. One of the components that had not been included in the initial DIP submission was data on Rapid CATCH indicators. Data on Rapid CATCH indicators were collected and added into the DIP. Final submission of the DIP to CSHGP was made on July 10, 2006, and approval received shortly thereafter.

The DIP development process and the outcomes were important for this project because the process was participatory and led to ownership of key project processes by key stakeholders, especially the DHMT. The DIP will serve as the roadmap for the project – it is a working document to guide project staff on the day-to-day implementation of activities. CSHGP will also use the DIP to monitor progress in program implementation.

(vii) Identification of CORPs

In June 2006, AMREF held meetings with DHMT and community leaders and developed criteria for selection of CORPs and their roles in the project. Village elders, assistant chiefs, chiefs, divisional officers, and health extension workers (HEWs) attended the meetings. Thereafter, the project identified 810 CORPs. CORPs will be responsible to village health committees (VHCs), HEWs, and health facility staff. The HEWs and health facility staff will provide technical support to CORPs and community structures and conduct facilitative supervision. The CORPs will be community mobilizers. They will provide health promotion and education, basic home-based care. They will collect village maternal and child health data and implement the behavior change and communication strategy at the village level. The project is in the process of organizing the CORPs into a sustainable supervision structure with insights from: the Kenyan government's strategic plan for community level service provision, the Care Group model developed by World Relief, and experiences of other child survival projects in Kenya.

(viii) Development of Behavior Change and Communication Strategy

Barrier Analysis

In July and August 2006, AMREF conducted a barrier analysis for priority behaviors (see section G, Assessment Reports not included at time of DIP). The following priority behaviors were identified:

(i) pregnant women utilize focused antenatal care services;

(ii) women are attended to by a skilled birth attendant during delivery;

(iii) mothers utilize post-natal care services within two days after delivery;

(iv) children with fever are taken to a health facility within the first twenty four hours of developing the fever;

(v) mothers exclusively breastfeed their babies up to age six months.

Thereafter, health extension workers conducted focus group discussions with doers and non-doers of these behaviors, and identified factors that prevent women from adopting the behaviors and factors that support adoption of the behaviors. Findings from this process indicate that key determinants of child health behavior include perceptions regarding susceptibility to health problems, severity of expected health problems, benefits that people expect to get if they adopt recommended behaviors, barriers that obstruct them from adopting the behaviors, and social acceptability of the behaviors.

BEHAVE Workshop

Thirteen health staff were trained in Designing for Behavior Change/BEHAVE during a 4 day workshop, and using findings from the barrier analysis, AMREF and Busia DHMT refined the project's behavior change strategy (see section H, Social and behavior change strategy) to be rolled out in October 2006. The project's BCC Officer and the TA jointly planned, coordinated, and co-facilitated the workshop.

(ix) Cross Visits

In May and July 2006, project staff made cross-visits to other projects to garner lessons vital for establishing sustainable structures in BCSP. In May, two project staff visited Teso child survival project, managed by World Vision, and gained vital lessons on sustainable structures for organizing CORPs. In July 2006, project staff visited AMREF Kenya's Makueni project, and gained vital lessons on the development of a Community Based Health Management Information System (CBHMIS). The project is currently using lessons learned from these cross-visits to design a model for organizing CORPs and the project's CBHMIS.

(x) Mapping Community Resources

In June and July 2006, a geographic information system (GIS) data base for the project was developed through a process of physically mapping key community resources, including schools, health facilities, administrative centres, and religious organizations. This data base is useful to the project in the following ways: 1) ensuring easy communication in the way of a detailed project map; 2) providing points of reference for studying the impact of quality improvement interventions on the health seeking patterns of women with a view to accumulating evidence for best practices; and 3) assessing the impact of the project on geographic health service equity with a view to ensuring that all project beneficiaries have a fair chance of benefiting from the project.

(xi) Capacity Building

Qualitative Research

During the first week of December 2005, the Project Manager undertook a qualitative research methods (QRM) course offered by CORE/CSTS+ at AMREF Headquarters in Nairobi; he was sponsored by AMREF Kenya. This considerably improved the capacity of BCSP staff to conduct qualitative research, and the team used the skills gained through the course during the qualitative component of the baseline assessment in February 2006.

Operations Research

The project's Monitoring and Evaluation (M&E) Officer attended an operations research proposal development workshop in Rockville, Maryland in May 2006. He gained skills and knowledge in operations research proposal development. The training resulted in the

development of a draft operations research proposal for the BCSP, aimed at testing the impact of PDQ on improving utilization of maternal and newborn care services in the project area. The project M&E Officer has oriented project staff and DHMT members on operations research to pave the way for joint understanding and support for the project's operations research processes.

Community Integrated Management Of Childhood Illnesses

In April 2006, the project supported training of the AMREF behavior change and communication officer and a counterpart from the Busia DHMT on community integrated management of childhood illnesses (C-IMCI). CRS organized the training, in collaboration with the MOH's Department of Child Health. This ensured that the project's behavior change and communication messages would be in line with the C-IMCI guidelines. One of the facilitators during this training was BCSP's Training Officer, who is experienced in C-IMCI.

Training of Facilitators

From September 18 to 29, 2006, two DHMT members, seven lot supervisors, and four AMREF staff undertook a Training of Facilitators (TOF) course offered by the AMREF training centre in Nairobi. This course equipped the staff with skills needed to facilitate community development processes and adult learning sessions. It is important for this project because the lot supervisors, with the support and supervision of project staff, will play a leading role in rolling out Partnership Defined Quality (PDQ), the organization of CORPs, and BCC.

Partner-Defined Quality

Twenty three health staff were oriented on PDQ with the aim of having PDQ rollout in October (after MOH staffs have undertaken a TOF course at the AMREF training centre to equip them with skills to facilitate participatory community development). The aim of PDQ is to improve quality of care offered at health facilities. The project's Training Officer, M & E Officer, and the TA jointly planned, coordinated and facilitated the PDQ workshop.

(xii) Centres of Excellence

As part of the quality improvement strategy, AMREF and Busia DHMT identified four centers of excellence for maternal and newborn care in September 2006. The four health facilities include: Khunyangu sub-district hospital, Bumala-B health centre, Nangina dispensary, and Sioport health centre. The selection criteria were: equity of access to essential obstetric care (EOC) services, presence of a maternity unit, and size of catchment population. These centres of excellence will provide quality antenatal, delivery, and post-partum care and emergency obstetric care. They will serve as demonstration sites to help build the capacity of staff in other health facilities. Transformation into centres of excellence will include: renovations, procurement of equipment; and training of staff. Through on-site consultation with staff from the four centres, an equipment procurement and renovation list has been developed. Procurement and renovation will commence in October.

(xiii) Operations Research

Partnership Defined Quality

Operations research protocol to test the impact of PDQ on utilization of maternal and newborn health services has been developed, and data collection will begin in November 2006.

Newborn Health/MAMAN

AMREF and DHMT are working with the Kenya Pediatric Association to conduct a baseline assessment for newborn care practices at the facility and community levels, and incorporating newborn life-saving interventions during training of facility-based health workers and CORPs. The newborn life-saving interventions have been conceptualized in line with the minimum activities for mothers and newborns (MAMAN) initiative developed by CSTS+/CSHGP. In August, a CSTS+ child survival consultant, Michel Pacqué, visited the project to share and discuss the MAMAN concept with AMREF and MOH at national level and in Busia. The project plans to gather data regarding the effectiveness, sustainability, and cost of implementing the MAMAN initiative.

(xiv) Training Needs Assessment

The project Training Officer conducted a training needs assessment in 16 health facilities in August 2006 using self-administered questionnaires. Data was collected from 55 technical health staff in 16 health facilities. BCSP will use the results (see section G, assessment reports not completed at time of DIP) during joint curriculum review with partners in October 2006.

(xv) Design of Community Implementation Framework and CBHMIS

Project staff members, in consultation with the DHMT, have developed a draft community implementation framework, outlining how CORPs will be organized and supervised (see section L, Project's Management System). Similarly, the initial draft of the CBHMIS design has been developed and will form the basis of further consultation with stakeholders.

Table 1: Key Project Activities

Note: all the activities carried out in the 1st year are cross cutting for all the project objectives

Project Objective	Key activities (as outlined in the DIP	Status of activities	Comment
1. Increased proportion of pregnant women who attend antenatal clinic at least four times during pregnancy and postnatal clinic at least once. 2. Increased proportion of women attended by a skilled health professional during delivery. 3. Increased proportion of women who deliver at a health facility 4. Improved quality of and access to basic EmOC at health facilities.	Recruit project staff/DHMT assigns its staff to project	8 project staff recruited as planned 7 lot supervisors assigned to the project	1 lot supervisor left the project for further studies, but has already been replaced
	Present approved proposal to Busia District Development committee	Done	
	Hold one inception workshop with DHMT and relevant government departments	Inception meeting held	
	Identify and furnish project office in Busia town	Office fully furnished	
	Negotiate and sign MOU between AMREF and DHMT	MOU developed and signed	
	Procure commodities (ITNs/LLINS, testing kits, etc. and equipment	Procurement process initiated	

Project Objective	Key activities (as outlined in the DIP	Status of activities	Comment
5. Improved knowledge and practice of malaria prevention and treatment at household and community level. 6. Increased proportion of pregnant women and CU5 who sleep under insecticide-treated nets 7. Improved case management of malaria among CU5 at health facilities. 8. Increased proportion of pregnant women who receive at least two doses of SP for Intermittent Preventive Therapy (IPT). 9. Increased access to HIV counseling and testing among pregnant women at ANC. 10. Increased knowledge of PMTCT and ART among women of reproductive age	Procure vehicles, motorbike and bicycles	1 vehicle and 1 motorbike procured; procurement of 2nd vehicle and bicycles initiated	Procurement of second vehicle delayed because of non-availability of desired model
	Hold inception workshop with division, location and village administrators	2 inception workshops held (1 in Butula and 1 in Funyula divisions	
	DHMT and AMREF training on LQAS	7 DHMT and 4 AMREF staff trained on LQAS	
	Baseline KPC survey	Baseline KPC survey completed and findings disseminated	
	Baseline Health Facility Assessment	Baseline Health Facility Assessment completed and findings disseminated	
	DIP Workshop	DIP workshop held	
	Submit DIP	DIP submitted	
	Hold mobilization workshop with local administration, DHMT, and HEWs to develop CORPs selection criteria	2 mobilization workshops held- 1 for each division	
	HEWs, Village Elders and Provincial Administration assists communities to select CORPs using approved criteria	810 CORPs identified	
	Exchange visits to Child survival and other AMREF projects	2 exchange visits made	
	Training needs assessment (LRNA's will be conducted prior to each training)	LRNA for staff in the 16 facilities and DHMT members completed	
	Further review curricula and prepare training materials	Curriculum review meeting not held	To be done in the next quarter
	Conduct joint capacity assessment & Capacity Building action planning for DHMT & AMREF	Consultant recruited; capacity assessment not completed	To be completed in the next quarter
	Design prioritized OR protocols	1 OR protocol developed	
	Identify 4 Centers of excellence (COE)	4 COE identified	
	Training of Facilitators (DHMT/HF, CS Staff – 6 people will be trained during a 10 day session)	13 staff from DHMT, BCSP and lot supervisors trained on TOF	

Project Objective	Key activities (as outlined in the DIP	Status of activities	Comment
11. Increased number of HIV+ pregnant women and newborns who receive PMTCT 12. Improved feeding practices among caretakers of infants 0-5 months of age.	AMREF, DHMT and HEWs oriented on the new Malaria Strategy	DHMT oriented MOH staff on new malaria strategy	
	Conduct barrier analysis to identify key factors that influence priority health behaviors	Barrier analysis done	
	Conduct BEHAVE training for BCC strategy refinement (based on results from Barrier Analysis) (Selected DHMT, AMREF staff, HEWs, HF staff and CORPs) (3.5 day training for 12 people)	15 staff from DHMT BCSP and lot supervisors participated in a 4 day BEHAVE training	
	PDQ Orientation for HEWs (2 day orientation as a follow-on to the BCC strategy workshop)	29 staff from DHMT, BCSP, facility in-charges and lot supervisors trained on PDQ	
	PDQ sessions implemented by HEWs, CORPs & HF staff	Implementation not done	PDQ to be rolled out in first quarter of year 2
	Advocacy to influence practice and policy within AMREF and at district, province and national forums		
	Further explore gaps and opportunities within the existing community health information system	Information gap analysis not done	To be conducted in first quarter of year 2
	Work with Kenya Pediatric Association (KPA) and CSHGP to design minimum activities for mothers and newborns (MAMAN)	Partners oriented on MAMAN	MAMAN baseline survey scheduled for November; MAMAN components incorporated in curriculum review criteria
	Identify domiciliary midwives	Not identified	HEWs to identify domiciliary midwives in 1st Qrt, year 2, as they roll out PDQ and Community implementation framework
	Hold annual project review with partners	Not done	Rescheduled 2nd Qrt to include review of annual LQAS data

Project Objective	Key activities (as outlined in the DIP	Status of activities	Comment
	Project Implementation Committee (PIC) meetings	Inaugural PIC meeting held	
	Technical Advisory Group (TAG) meetings	Inaugural TAG meeting held	
	Facilitative supervisory visits	Not done	Supervisory system to be improved in Qrt 1, year 2
	AMREF regularly update District development committee (DDC)	Briefings given in 2 DDC meetings	

B. CHALLENGES AND CONSTRAINTS

(i) Shortage of MOH Staff

In Kenya, the ministry of health is experiencing staff shortage in most of the health facilities, largely attributable to an embargo on employment that has now lasted several years. A foreseen challenge is lack of enough health staff at the health facilities when utilization of services increases due to demand creation caused by the project. The project will not increase the number of staff. However, the project will explore methods that can help those staff members who are available to utilize time in the health facility more efficiently. Workload management is one of the processes the project has planned to include during thematic trainings and facilitative supervision.

(ii) Turnover of MOH Staff

AMREF does not have direct control of MOH staff in the project area whose capacity it is strengthening. Because the project is to a great extent relying on MOH staff to implement project activities, it is a challenge when these staff must leave the project area to pursue further studies. Indeed, one of the lot supervisors has already left the project area to pursue further studies. In order to mitigate risks posed by this challenge, the project has taken the following steps.

Memorandum of Understanding with DHMT

AMREF and DHMT have agreed, through a clause in the MOU, that health staff trained by the project will be retained in the project area for as long as will be reasonably possible. The DHMT is fulfilling this promise, since none of the staff trained by the project have been transferred into another division.

Distribution of Technical and Managerial Capacity

Managerial/leadership capacity: because some health staff will inevitably leave the project in due course, AMREF and DHMT have agreed to have deputies for each of the seven lot supervisors. The plan is that the lot supervisors will involve their deputies in all project processes, mentoring them in the process. Through this arrangement, it is hoped that departure of a lot supervisor will not lead to disruption of project activities because the deputy will immediately take over. Related to this, the community implementation framework that the

project is rolling out fosters shared leadership, where lot supervisors build the capacity of CORP's leaders from the community, so that they have a deep understanding of the project's processes, and are able to sustain the processes even during times of transition from one technical supervisor to another.

Technical capacity: another approach that the project is using to distribute technical capacity is ensuring that at least two people are trained from each health facility, so that departure of one of them does not bring project activities to a halt.

(iii) Biased CORPs Identification Process

The implementation of project activities entails working together with CORPs. According to the MOH protocol, CORPs are supposed to be selected by the community members, through their leaders (chief, assistant chiefs, and village elders). This process is prone to nepotism, and leaders may pick their relatives, who may not be accepted by the community. AMREF project staff and DHMT members are consulting on how to alter the CORPs selection and replacement process, so that those chosen as CORPs are those whom the community respects, values, and is willing to listen to. Two of the suggested options are: (1) dialogue with community and their leaders for endorsement of CORPs who have been selected; and (2) encourage households to play a major role in deciding who serves as "their CORP."

(iv) Budget Shortfalls

Community implementation framework: During the DIP development process, the BCSP perceived that to implement project activities at the community level using the CORPs, the project needed to have at least 240 CORPs. During planning and consultation with the MOH, we have realized that the project actually needs to recruit many more CORPs to meet the recommendations of the recently released national health sector strategic plan, which recommends one CORP for every 15-20 households. Achieving this ratio in the project area would require between 1500 and 2000 CORPs. A community implementation framework with a higher number of volunteers will cost more than budgeted. AMREF is in the process of estimating the cost of such a framework, with a view to local and international fund raising in order to bridge the gap. Such a large increase also raises issues of sustainability, which are discussed in section L, Project Management System, sub-section on Community Implementation Framework.

Field allowances for MOH staff: while the project does not pay salaries to MOH staff members who are supervising community processes, funds are needed to support them with lunch and transport when they travel to areas beyond their places of work. AMREF is in the process of estimating the cost, feasibility, and sustainability of providing field allowances.

C. TECHNICAL ASSISTANCE REQUIREMENTS

The project will require technical assistance in the following areas:

Area needing support	Tentative scope of work for Technical Advisor/ Consultant	When support is likely to be needed
MAMAN initiative/newborn care interventions	Sampling; cost analysis; operationalization of proven newborn saving technologies	Year 2; Year 3

Project documentation: to link inputs (budget; staff time); outputs (activities); and outcomes (indicators).	Software development in MS access; orientation of staff on how to use software	1st Qrt, Year 2
Workload management at health facilities in the face of staff shortages	Work with project staff and DHMT to develop innovative approaches to help health facility staff use time more efficiently	2nd Qrt, Year 2
Community emergency transport system	Help with participatory development of sustainable community transport system; testing cost effective models of community based transport systems	3rd Qrt, Year 2
Monitoring of capacity building exercises	Help with development of strategies to enhance the effectiveness of training sessions; refine training indicators	2nd Qrt, Year 2
Mid-term evaluation		2nd Quarter, 3rd Year
DIP refinement based on findings from MTE	Develop strategies to help project meet its objectives	1st Qrt, Year 4
Final Evaluation		4th Qrt, Year 5

D. SUBSTANTIAL CHANGES FROM THE DIP

Annual LQAS

The annual LQAS has been re-scheduled to Quarter 4 of each project year for the following reasons: (i) the project does not expect major changes in Quarter 2 of Year 2 when the annual LQAS had been planned in the DIP; (ii) this timing of annual LQAS coincides with the end of the AMREF and USAID financial years; (iii) the timing coincides with timing of mid-term evaluation and end of project evaluation.

Number of CORPs

The project had planned to identify and train 240 CORPS to implement community level project activities. However, considering that there are about 37,000 households in the project area, this would imply that a CORP would serve more than 150 households. This would rapidly lead to burnout and high attrition. In order to ensure that a CORP works just a few hours in a week, the project has identified 810 CORPs. As these CORPs roll out community activities, extra CORPs will be identified to reduce the burden for CORPs serving more than 20 households.

Community Implementation Framework

At the time of DIP submission, the project had not outlined how CORPs will be organized and supervised, and how they will be linked with village health committees and the formal health system. The project has now developed a strategy called *the community implementation framework*, which will be rolled out this calendar year (see section L, project's management system).

CBHMIS

The community health management information system was earmarked for piloting in two villages in the DIP. However, this has been revised upward to five villages in each of the two divisions in the project area in line with the community implementation structure, in which a community unit comprises five villages (see Section L, Project Management System)

BCC Strategy

The BEHAVE framework has been retained but with the inclusions from the BEHAVE workshop. The workshop generated communication strategies, key factors, behavioral indicators and the tools for data collection (see section H, social and behavior change strategy)

E. SUSTAINABILITY PLAN

(i) Measuring Sustainability

BCSP will plan, implement, monitor and evaluate sustainability based on the Child Survival Sustainability Assessment (CSSA) framework as outlined in the DIP. The CSSA framework has six dimensions, namely: health status; health services capacity; local organizational capacity; local organizational viability; community capacity; and enabling environment.

AMREF has developed outcome indicators under each of 5 elements of sustainability, and measured the baseline values (Table 2). Although the project will not specifically measure and track indicators under the component of enabling environment, we will report on significant changes that occur in this dimension, such as: health policy environment; political stability and governance issues; and economic growth.

Table 2: Sustainability objectives, indicators, baseline values, and indices

Component	Sustainability objective	Indicators	Source of data	Baseline value	Mean baseline value*	Index (scale: 0-10)
Health status	Increased proportion of women attended by a skilled health professional during delivery	% of children 0 – 23 months whose delivery was attended by a skilled health professional	Annual LQAS	26%	19%	1.9
	Improved feeding practices among caretakers of infants 0-5 months of age	% of children 0 – 5 months who were exclusively breastfed within the last 24 hours		11%		
Health services capacity	Improved capacity of DHMT staff to monitor and evaluate health programs	No. of DHMT staff with adequate knowledge and skills to perform M & E	Self-admin-istered question-naire		0%	0.0
	Improved facilitative supervision system	% of facilities visited (using facilitative supervision checklists) at least 4 times a year	DHMT reports on supervision visits Health facility assessment	0%		

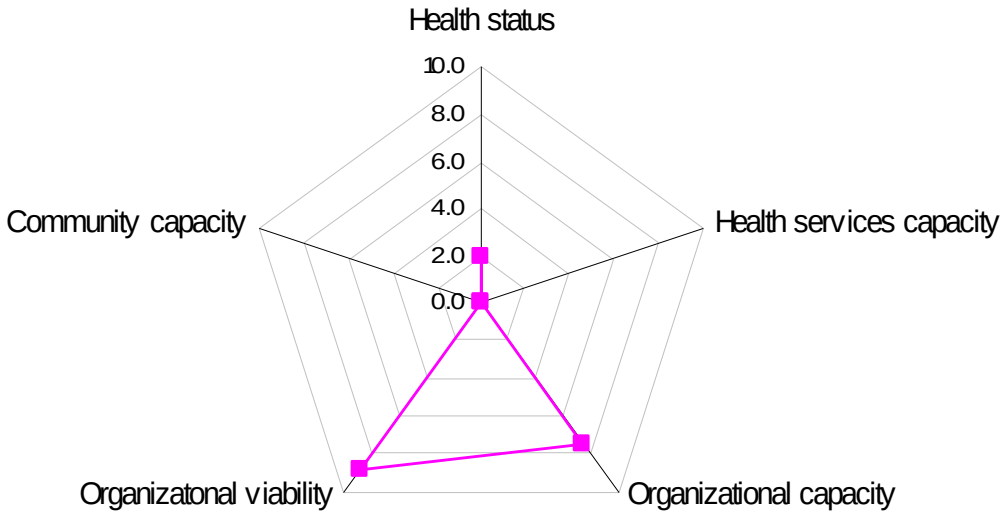
Component	Sustainability objective	Indicators	Source of data	Baseline value	Mean baseline value*	Index (scale: 0-10)
Local organizational capacity	Improve financial management practices that lead to accurate financial planning	% of project personnel (DHMT, BCSP staff & backstop staff) who at least agree that BCSP's financial management practices lead to accurate financial planning	Organizational capacity assessment	56%	75%	7.5
	Strengthen management systems and practices of the project	% of project personnel (DHMT, BCSP staff & backstop staff) who at least agree that the project staff participate in project planning and management		94%		
Local organizational viability	Increased use of empirical evidence to make program decisions	% of project personnel (DHMT, BCSP staff & backstop staff) who at least agree that project implementation practices are modified based on findings generated through data collection and analysis	Organizational capacity assessment	94%	88%	**8.8**
	Improve networking and external relations	% of project personnel (DHMT, BCSP staff & backstop staff) who agree that AMREF engages stakeholders in designing community projects		81%		
Community capacity	Improved capacity of community to plan for and improve their health status	% VHCs who are active	VHC's reports	0%	0.0%	0.0
	Improved linkage between communities and health facilities	% of VHCs submitting data to the health facilities on a monthly basis	Health facility reports	0%		

** mean baseline value is the average of the baseline values of corresponding two indicators*

The project has constructed the sustainability dashboard (Figure 1, next page) in which this array of indicators is converted into indices on a scale of 0-10. The dashboard eases communication regarding progress towards sustainability to stakeholders. Progress on sustainability will be reviewed during the midterm evaluation and at end of the project.

To ensure that BCSP is abreast with the best practices with regard to CS sustainability, we will constantly share our experiences with other child survival projects that use the CSSA framework. To do this, we have liaised with CSTS+ and joined the Sustained Health Outcomes (SHOUT) child survival email group.

Figure 1: BCSP's sustainability dashboard



(ii) Steps Taken and to be Taken to Achieve Sustainability

Health Status

The project is implementing interventions whose effectiveness has been proven, as exemplified by delivery by skilled attendant, and exclusive breastfeeding. We believe that this will contribute to sustainability because the gains made from the interventions will motivate stakeholders including the community to sustain the processes that this project will put in place. The community will understand the impact of the interventions through the CBHMIS and participatory monitoring and evaluation.

Health Services Capacity

To improve the quality of health services in health facilities, the project has trained DHMT members and lot supervisors on facilitation skills and behavior change strategy development, and has begun to implement PDQ and to equip and renovate COEs. The project will also:

1. review the facilitative supervisory guides and transform them into a checklist to assure high quality supervision by the DHMT;
2. build the capacity of health staff to provide quality ANC, EOC, PMTCT, and IMCI;
3. build the capacity of health staff to monitor and evaluate health programs; and
4. improve the referral system at both community and health facility levels.

Importantly, improvements in supervision, referral, M&E (including the CBHMIS), and maintenance of equipment in the COEs will be institutionalized by the DHMT so that gains will be sustained after the project comes to an end. To ease the process of institutionalization,

AMREF has ensured that all interventions are in line with existing MOH policies, including the second National Health Sector Strategic Plan (NHSSP II).

Local Organizational Capacity

This section will be completed after a one day action planning workshop to be conducted in November 2006.

Local Organizational Viability

This section will be completed after a one day action planning workshop to be conducted in November 2006.

Community Capacity

BCSP will work with village level community structures and CORPs. We will help the communities to set up village health committees, and build their capacity to collect community level child and maternal health data and use the same to develop action plans aimed at improving the health of people living in their jurisdiction. This will be done in the context of the CBHMIS that the project is piloting. Additionally, we will build the capacity of CORPs to help alter health related behaviors in the community (see section G, social and behavior change strategy).

F. RESPONSES TO ISSUES FROM DIP CONSULTATION

Most of the issues that arose during the DIP review process were addressed and responses included in the final DIP submission. Issues that had not been addressed by the time of DIP submission are discussed below:

Capacity Assessment: Joint capacity assessment for DHMT and AMREF has been undertaken (see section G, assessment reports not completed by time of DIP). Joint action planning will be conducted in November 2006.

Sustainability Assessment: The project is using the Child Survival Sustainability Assessment (CSSA) framework to monitor sustainability and has identified and measured sustainability indicators, and set targets (see section E, sustainability plan).

Integration of Training into District Health Plan: Most of the trainings to be implemented by the project are captured in the current district health plan (DHP- FY 2006/2007). This was achieved through a meeting of stakeholders convened by the Busia DHMT in March 2006. During this meeting, health organizations in Busia district shared responsibilities outlined in the DHP. In order to ensure continued integration in the coming years, project staff will participate in the annual DHP development process

Monitoring Behavior Change: Indicators for behavior change have been defined and will be monitored as outlined in section G, behavior change strategy.

G. ASSESSMENT REPORTS NOT COMPLETED BY TIME OF DIP

(I) BARRIER ANALYSIS

(i) Introduction

A workshop for AMREF Busia Child Survival Project staff, the DHMT and lot supervisors on Barrier Analysis was conducted in Busia District at Farmview Hotel from July 17th to July 21st 2006. The BCSP staff in collaboration with the DHMT facilitated the workshop. The 14 participants included two from AMREF Busia, seven lot supervisors, two FGD moderators from the MOH, and three DHMT representatives. The facilitators used the Barrier Analysis Facilitators Guide from Food for the Hungry International.

The goal of the workshop was to equip participants with skills to be able to collect data on health related behaviors through an in-depth understanding/study of the community from within. The objective of the training was to equip the DHMT members, lot supervisors, and FGD moderators to identify key behavioral determinants in the project area, so that they could help design effective communication strategies and supporting activities. They used insights gained during the barrier analysis to refine the project's behavior change strategy during the Designing for Behavior Change/BEHAVE workshop.

(ii) Barrier Analysis Process

Five key behaviors were prioritized: ANC attendance; delivery in health facilities; PNC attendance; exclusive breastfeeding; and health facility referral. The behaviors were prioritized based on expected impact on maternal and child health and survival. The trained participants identified doers and the non-doers of the above behaviors in the project area. The team was then divided into two groups, each consisting of one moderator, one note-taker, and three observers to facilitate focus group discussions. The identified groups (doers and non-doers) participated in the focus group discussions. Four FGDs were conducted per prioritized behaviour. One team conducted the FGDs in Butula and the other in Funyula. Each team facilitated one doer and one non-doer FGD per behaviour in each division.

(iii) Experiences/Lessons Learnt

- √ Whereas most of the FGD participants realized that health problems associated with failure to practice desired behaviors are severe and that they and their children are susceptible to the problems, almost all of them are hindered by: social acceptability-(for example mothers-in-law do not approve their daughters-in-law attending the ANC at least four times or delivering in the health facilities; lack of the ability to affect the behaviors (self-efficacy); and the negative attributes associated with some of the practices (see annex 2, barrier analysis results matrix).
- √ It is difficult to identify the doers of most of the priority behaviors. At first it appeared to be easy to identify those who delivered in health facilities, but it turned that all those who came for the FGDs had had delivery complications, and that is why they decided to deliver in the facilities.
- √ An organization needs adequate time to conduct barrier analysis. It is appropriate to conduct barrier analysis for both the doers and the non-doers. However, where it is difficult to identify the doers, it is still appropriate to conduct the FGDs with the non-doers.

- √ One needs a large enough team to analyze content from the FGDs in a short time. In the case of the BA data analysis, it was easily completed in four days. Every team member who took part in the FGDs was involved in the analysis. The team analyzed all the notes taken by the note takers and the observers and reached consensus.
- √ Behaviour change interventions should also focus on the doers, for they are likely to retrogress to the non-doers category given the fact that they are surrounded by non-doers.

(II) ORGANIZATIONAL CAPACITY ASSESSMENT

(i) Objectives and Methods

The organizational capacity assessment for BCSP was conducted by Impact Centre, an NGO support organization registered under the NGO Act in Kenya. The assessment had the following objectives: (a) to assess the technical and managerial capacity of AMREF and DHMT to steer the project towards achievement of its goal; (b) based on the findings, to facilitate action planning for capacity building.

The capacity assessment focused on AMREF and the Busia DHMT as implementing partners of the BCSP. The assessment sought to establish AMREF's and DHMT's capacity in seven areas: management practices and governance; administrative infrastructure and procedures; financial resources management; human resource management; technical knowledge and skills; programme management, monitoring, evaluation and reporting; and organizational learning.

An external consultant collected data from staff in AMREF Kenya Country office, project staff in Busia, Busia DHMT staff, members of the PIT, and staff at health facilities. Methods used included: self administered structured questionnaire (n=17); individual interviews; group discussions; and document review. Qualitative data was grouped into themes and analyzed manually. Quantitative data was analyzed using the statistical package for social science (SPSS).

(ii) Key Findings

The BCSP design is consistent with current Kenya governmental health policy, and is relevant and appropriate because its design meets the priority needs of the target group. The first year of the project (October 2005- September 2006) was largely preparatory. All the necessary infrastructure has been put in place in terms of physical facilities, office equipment, baseline assessments, formation of management teams and structures, and development of the project's DIP. The project staff has a solid working relationship with DHMT. The activities that were identified in the DIP to be undertaken in the first year have all been undertaken.

Overall, AMREF and the Busia DHMT registered an organizational capacity score of 70%. This shows that AMREF and the DHMT have the necessary capacity to implement the BCSP successfully. The organizational strength scores for each of the assessment areas was as follows: management practices and governance (68.8%); administrative infrastructure and procedures (60.4%); financial resources management (50%); human resource management (61.3%); technical knowledge and skills (83.7%); programme management, monitoring, evaluation and reporting (79%); organizational learning (87.5%)

In spite of the high organizational capacity, the assessment established gaps in certain critical areas of organizational capacity (table 3):

Table 3: Capacity gaps for BCSP

Assessment Area	Weakness
Management Practices and Governance	Role of backstop staff at KCO and their input in project implementation not well understood by PIT and DHMT
	Maternal Health and HIV/AIDs project component PIAs team leaders in AMREF Kenya are not reflected in the project Organization structure. In addition to their role not being understood by others, as a result, this may indirectly tend to diminish their engagement and participation in the project
	AMREF project implementation protocols and procedures not well understood by PIT and DHMT
	Lack of awareness on key project information on the part of PIT/DHMT
Administrative Infrastructure and Procedures	While communication systems at BCSP are adequate (including optional channels for internet/email connectivity), the same cannot be said of the DHMT. Sometimes, BCSP staff have to make personal visits to the DHMT when an email, fax or telephone call would have served the purpose
	Procurement Delays from KCO
	Lack of awareness on organizational administrative procedures by non-AMREF persons engaged in BCSP
Financial Resources Management	The PIT and DHMT members are not aware of the financial policies and practices under which the project is being implemented. A general level of knowledge is necessary.
	Slow process of obtaining project cash reimbursement slowing down activities and causing distress to staff
	Lack of guidance manual at the project office- a guidance manual is a crucial source of information and guide for action to project staff
Human Resources Management	Project requirements and general HR practices not known to PIT and DHMT
Technical Knowledge and Skills	Role of technical staff at KCO are not fully understood by PIT and DHMT
Programme Management, Monitoring, Evaluation and Reporting	A significant number of BCSP, PIT and DHMT not fully aware of what each party has done or achieved.
	A significant number of PIT and DHMT not fully aware of project reporting mechanisms
	Multiple activities taking place at the same time or back to back may compromise quality and lead to staff burn out
Organizational Learning	Staff meetings are not formally included in the quarterly work plan. This puts them at the risk of being forgotten or sidelined.
	Minutes are not being circulated on time for any necessary action to be taken before the next meeting.
Partnership with the Ministry of Health (DHMT)	Frequent staff changes at DHMT and health facilities
	Inadequate Staff at the health facilities
	Lack of adequate equipment in the health facilities

Assessment Area	Weakness
	Office of the district public health officer unable to effectively play the role of secretariat to the PIT due to lack of facilities
	Risk of pull back effect as a result of all of the above
Sustainability and Exit Strategy	The project's DIP is silent on the issue of exit strategy

(iii) Way Forward

In November 2006, Impact Centre will facilitate a one-day action planning workshop with AMREF Kenya KCO staff, project staff, DHMT staff, and PIT. During this workshop, participants will explore methods of addressing identified capacity gaps and develop plans to redress the gaps, with indicators for monitoring progress.

III. TRAINING NEEDS ASSESSMENT

BSCP carried out a training needs assessment in the project area using a self administered questionnaire. We assessed needs in the following areas: PMTCT; FANC; IMCI; and monitoring and evaluation. The assessment enabled project staff to identify learners' needs and training gaps, to be used during curriculum review.

Summary of Findings

Perceived benefits of training: health workers felt that hospital deliveries had increased due to implementation of FANC, and that there is greater integration of services at health facilities. Some felt that their skills to detect and manage maternal health problems had been enhanced through previous training, and that this has led to reduction in maternal complications. Another perceived benefit relates to the acquisition of counseling skills that would enable health workers to equip women with knowledge and skills to identify health problems early. Importantly, health staff reported that there could be a reduced workload since clients would only come for 4 visits unlike before when they were expected to make more frequent visits.

Challenges and constraints that hamper translation of skills to practice: health staff felt that prior trainings had failed to address several issues, and that constraints at work hamper their effectiveness. Key constraints cited include drug shortages and lack of resources to fuel the ambulance for referral of women with complications. They also felt that male involvement deserves greater emphasis during trainings and practice, since men play a critical decision making role in the community. Staff felt that some policies are not coherent enough to provide clear direction on reproductive health - for example, there are conflicting guidelines on the use of vacuum extraction during delivery, with one advocating for it, while the other discourages it in the context of PMTCT. AMREF is addressing such conflicts by negotiating with the relevant MOH departments through fora such as the TAG and the child health inter-agency coordinating committee in which AMREF is adequately represented.

Recommendations on how to improve trainings: health staff felt that more time should be allocated to the EOC course to avoid facilitators rushing over contents. They also felt that there should be a curriculum to train CORPs in order for them to support FANC, PMTCT, IMCI and monitoring activities. Most health workers interviewed felt that there was need to include real

life experience during trainings to enable them to relate what they learn with their experiences at work. The staff felt that it was important to include topics aimed at equipping them with skills to help women understand their rights.

Several methodologies were suggested for inclusion during trainings: observation and demonstrations, use of visual aids (video in FANC) to ensure adequate skills transfer, increase in group discussion during trainings to foster greater sharing of individual views, and exchange visits during training to enhance skills transfer.

H. SOCIAL AND BEHAVIOR CHANGE STRATEGY

(I) Broad Behavior Change Goal and Specific Objectives

Broad Behavioral Objective

The broad objective for the Busia Child Survival Project's social and behavior change (SBC) strategy is to address individual, family, household and societal cultural practices aimed at changing their behaviors towards adoption of the desired best health practices for the purpose of improved maternal and newborn health care.

Specific Behavioral Objectives

i) To address the behavioral practices aimed at motivating mothers to attend ANC at least four times during pregnancy and postnatal clinic at least once.
ii) To ensure women deliver under the care of a skilled attendant in or outside health facilities.
iii) To help health workers improve on their client-provider relationships in order to improve quality of and access to basic EmOC.
iv) To identify the best practices for mothers to manage and treat malaria at household and community level.
v) To change the behaviors of fathers so that they can allow and support mothers and children under two to sleep under ITNs every night.
vi) To enhance behaviors that aim at helping women of reproductive age and their spouses to utilize and know the importance of attending PMTCT and VCT services.
vii) To help mothers and caretakers adopt the best feeding practices of infants 0-5 months of age.

(ii) Summary of the Strategy

The strategy has been informed by individual, household, community and healthy facility staff behaviors, some of which were identified during the baseline assessment and barrier analysis to be undesirable for improved maternal and newborn health outcomes.

AMREF and the DHMT used the existing information from the district information system, KPC survey and qualitative research results to develop the BCC strategy. Key behaviors were prioritized during the barrier analysis workshop. Prohibitive factors were identified during the barrier analysis process that followed. During the BEHAVE workshop, the team identified the priority groups, key behaviors, key factors, activities, and the indicators that will be used to monitor behaviors.

The project will improve the maternal and newborn health practices by improving on the practices of women of reproductive age, their spouses, and other support groups like mothers-in-law, co-wives and neighbors. This will, for example, enhance mothers to attend ANC at least four times during pregnancy, deliver in health facilities, sleep under ITNs, refer children to the health facilities within 24 hours after onset of fever/malaria, attend PMTCT clinics, and exclusively breastfeed infants aged 0-5 months. These will be achieved by addressing various determinants of behavior, namely: perceived susceptibility; perceived severity; perceived social acceptability; perceived action efficacy; perceived self efficacy; perceived divine intervention; and positive and negative attributes.

The following key factors will also be addressed through the project's behavior change strategy:

Maternal and Newborn Care

1. Mothers believe that breast milk alone does not satisfy the baby.
2. Mothers believe that exclusive breastfeeding will mean that one is HIV positive.
3. Mothers believe that they do not have adequate nutrition, and therefore do not have adequate milk for the infant.
4. Neighbors think that one is proud when she goes to the health facility for delivery.
5. The health workers have poor attitude towards clients (poor relations).
6. Community members have poor attitudes towards the health workers.
7. The presence of TBAs in the villages discourages women from going for ANC at least four times since TBAs also perform palpation.
8. Opposition from support groups like husbands and the mothers-in-law discourages mothers from attending ANC and from delivering in health facilities.
9. TBAs fear to lose their source of income.
10. Health workers' attitude towards the TBAs is poor.
11. TBAs fear to loose recognition in the community.

Malaria

1. The belief that ITNs are only used by people with beds.
2. The belief that nets have got chemicals which are harmful and can cause poisoning and suffocation.
3. The belief that nets are very hot in the night.
4. People find it difficult to tie the nets.
5. The belief that the net will separate the mother from the father.
6. The belief that there are no mosquitoes during certain periods of the year.
7. People believe the net causes suffocation.
8. Shopkeepers lack knowledge about the MOH drugs and how to correctly dispense them.

HIV/AIDS

1. Women have limited decision making powers.
2. Women fear marital conflicts if they go for PMTCT services.
3. Women fear that they will be stigmatized by other community members when they test positive.
4. Fear of knowing one's HIV status.

5. Lack of understanding by the mothers that ART can minimize mother to child transmission of HIV.
6. Negative attitude by the health workers towards mothers.
7. Lack of confidentiality on the part of the health workers, including lack of adequate space in health facilities for counseling.

Community Health Workers

1. Lack of skills on record keeping
2. Lack of recognition by the community as a source of information

The project will use different communication channels, like 5x5x5, child-to-child, child-to-parent, local *barazas*[1], mothers support clubs, mother-to-mother communication, father-to-father communication, social mobilization, community special events, and local frequency modulation radio stations. The health facility staff members are expected to change their attitudes after the training on inter-personal communication and counseling regarding best maternal and newborn practices. The project will also use non-communication processes to help alter behavior. These include: the PDQ process to help increase utilization of health care; facilitative supervision of health workers to help sustain appropriate case management practices; and cross visits for health staff to centers of excellence to help them learn how to operationalize best practices.

(iii) Channels of Communication

***5x5x5*:** the project will design five different messages per each intervention areas in phases, which will then be rolled out for dissemination by the lot supervisors through the CORPs. For instance a lot supervisor will orient one CORP on five messages; the CORP will then orient five different community members on the messages, who are then expected to pass on the messages to five other different community members in order to create a continuous information flow about the best maternal and newborn practices. The project will start with the malaria messages, followed by MNC and then HIV.

***Child-to-child*:** the project will use school health clubs to communicate health messages to school-going children, who in turn are expected to pass the same information to their parents through the **child-to- parent** channels. The schoolchildren will also be involved in competitions in order to come up with rallying statements that are easy to remember for message dissemination about child survival.

***Parent-to-parent*:** mothers and fathers will be exposed to desired behavioral attributes through debates in their normal settings, in which they will be encouraged to communicate to other parents about the behaviors. Just as in the child-to-child or 5x5x5, the messages will be in phases and intervention-specific so that both the disseminators and receivers can easily easy understand them.

[1] Baraza: meeting convened by the local leader (chief or assistant chief) to communicate important messages to the community

Local barazas: these are local provincial administration gatherings in which the administrators communicate government policies to the community members. The project intends to use CORPs and even the local leaders themselves to pass health messages pertaining to child survival to the community members at such gatherings.

Father-to-father**:** men have been known to listen to fellow men before taking any action. The project will use this approach by identifying men who practice desired behaviors, who will then communicate to other men in the community on a one-to-one basis in order to influence their behaviors positively.

Community special events**:** these are sporting or cultural activities that bring people together. Such forums will be used to reach wider audiences. The members of the father-to-father clubs will be used to communicate health messages to community members and will be rewarded for their efforts in order to motivate others in the gatherings to copy their positive behaviors.

Positive deviants**:** positive deviants will be identified through informal discussions such as the FGDs. The project will depend upon such individuals to help spread the messages about the desired behavioral changes among other community members.

Radio messages**: t**hese will be delivered by the local vernacular radio stations like Mulembe FM and West FM, which broadcast in the widely spoken local Luhya dialects.

Designing and testing the messages**:** messages will be designed based on locally available IEC materials. These will be screened by a team comprising the DHMT, AMREF, and four community representatives (two men and two women). This team will help in conducting surveys on the memory retention of the messages and their applicability to child survival. The messages that can be easily memorized and retained by the recipient will be rolled out through all the above communication channels. CORPs, under the supervision of the lot supervisors, will conduct pre- and post-message rollout surveys to determine the impact.

Interpersonal communication: lot supervisors will be oriented on the IPC skills they are expected to pass to CORPs. The CORPs will use the skills to offer quality IPC to mothers and fathers at home, and during organized meetings of men and women.

Community drama**:** BCSP will use this approach for some behaviors like PNC attendance. For example, almost all the people who participated in the FGDs during the baseline assessment do not understand that one is supposed to attend PNC services. The project will therefore use drama to raise awareness among community members on the need for mothers to seek PNC services. We have identified a theatre for development (TfD) expert, who will produce and direct community drama skits. The project has identified one drama group (*Tusonge Mbele*) in Butula Division that has been in existence for the last six years, and is identifying another group for Funyula Division. The TFD will also guide school clubs to form short skits that they will present to their parents and teachers during the parent-teacher meetings. We will conduct both pre- and post rollout tests with the audiences to assess the effectiveness of the skits and the methods used.

(iv) Non-Communication Approaches

Facilitative supervision for CORPs: facilitative supervision of the CORPS will help them improve their skills, such as one-on-one counseling and record keeping. It will also foster sustainability because the CORPs will continue to practice the skills after the project ends.

Identifying, interpreting, and distributing relevant maternal and newborn health policies: sometimes the relevant health policies do not reach health workers. The BCSP will network with DHMT and provincial and national MOH departments to ensure that relevant policies and guidelines reach the health providers in the project area.

Partnership defined quality: the project staff will roll out the PDQ process, in which community members will define the kind of quality health services they desire, so that health workers understand and work towards achieving that quality in health facilities.

Cross/exchange visits: the strategy will include exchange visits by health workers from one health facility to another, with the aim of sharing experiences on how to overcome some of the challenges, such as management of heavy workloads.

(v) BEHAVE Framework

For behave framework, see annex 1.

I. PROGRESS TOWARDS PHASE OUT (N/A FOR BCSP)

J. INDICATORS REPORTING TABLE (FAMILY PLANNING - N/A FOR BCSP)

K. MONITORING INDICATORS (TB PROGRAMS - N/A FOR BCSP)

L. PROJECT'S MANAGEMENT SYSTEM

(i) Financial Management System

AMREF uses a float system[2] in disbursement/reimbursement of finances to the field and financial returns are made based on the Sun System[3] adopted by AMREF Kenya. In this system, budget line items are coded according to donor reporting codes. This system has a number of advantages, described below.

[2] Float system is a cash management policy where a sum of money is released for utilization by the project based on the average level of activities; once the project incurs expenditure and makes returns, it is reimbursed the exact amount spent.

[3] Sun System is accounting software used by AMREF Kenya to record the organization's accounts and accounting transactions.

Financial Reporting

Accountability financial management system: this is a procedure AMREF Kenya has put in place to ensure that the process and record of financial events are effectively and efficiently monitored. This system provides complete, timely, reliable and consistent information for managers and project staffs.

Standardized information and electronic data exchange: this helps in deterring fraud, waste and abuse of financial resources, and facilitates efficient and effective delivery of programs through relating financial cost to program performance

Common transaction processing: common processes are used for processing similar transactions throughout the system, to enable these transactions be reported in a consistent manner.

Sun System ledgers: provides for tracking of specific program expenditures, and covers financial and financially related information. This structure helps to minimize data redundancy, and ensures that consistent information is collected for similar transactions throughout. It encourages consistent formats for entering data directly into financial management systems and ensures that information is readily available and provided to internal managers at all levels within the organization.

Financial Controls

Internal control systems: this checks strengths and weaknesses of financial processes. Internal control over data entry, transaction processing and reporting is consistent throughout the system to ensure validity of information and protection of resources

Activity-based cash disbursement: ensures that money is used in the right activity

Reconciliation: bank and cash reconciliation is done after every surrender to the AMREF Kenya Country Office (KCO). Surrenders are given with supportive documents such as receipts attached for openness and accountability.

Cash Controls: To deter fraud in the field, amounts ranging from Ksh 10,000 to 100,000 are paid using checks approved by the project manager. Transactions amounting to or exceeding Ksh 100,000 are submitted to the tendering committee at AMREF KCO for approval.

Measurement of Financial Performance

Performance Measures: financial management system captures and produces financial information required to measure program performance, financial performance and financial management performance.

(ii) Human Resources

Staff Skills

Recruitment of technical and support staff has been undertaken (see section A, main accomplishments). Most skills areas relevant for the project are covered. If skills gaps exist, the project has outlined areas in which technical support is needed (see section C, technical

assistance requirements), in addition to targeted staff development (see below). Technical support is availed either by AMREF USA or through local contracting.

Staff Development

Staff members are continuously undergoing training to build skills (see section A, main accomplishments). Staff development is linked to periodic performance appraisal, which has the following objectives: to improve organizational effectiveness; to motivate employees by communicating how well they are doing their job; to identify performance weaknesses and formulate training and development needs; and to set objectives for staff. To ensure there is funding for staff development, AMREF Kenya remits 2% of the gross pay package of each staff to a training cost-centre.

Organizational Diversity

The Busia Child Survival Project has brought together staff with diverse experience, ethnicity, age, and gender. In the project implementation team, project staff and DHMT ensured that the two community representatives are women, in order to foster empowerment of women during the project's processes.

(iii) Communication Systems and Team Development

The project staff meets once every month to discuss issues ranging from approaches to improve management of project's resources such as transport, to issues that help with fulfilling needs of staff, such as staff welfare. The project technical staff also meets every Monday to review activities carried out during the previous week and those that need to be carried within that week. To further foster intra-office consultation and sharing of information, BCSP has adopted an open office space and open door policy. This is further complemented by an effective office network that allows efficient sharing of electronic information.

(iv) Local Partner Relationships

AMREF enjoys a cordial relationship with the Busia DHMT, based on mutual respect and recognition that AMREF Kenya and DHMT are equal partners in BCSP. Formal and informal coordination mechanisms include the PIT (see section A, main achievements), and informal mechanisms include day-to-day consultation between project staff and DHMT members.

(v) PVO Coordination/Collaboration in Country

Role of USAID Mission

The USAID mission in Nairobi, Kenya, is playing the critical role of fostering collaboration between PVOs that have child survival projects in Kenya. In December 2005, AMREF Kenya's Malaria Program Manager and the BCSP Project Manager attended a child survival partners meeting in Nairobi convened by the USAID Nairobi Mission. The meeting aimed to foster greater collaboration between child survival grantees in Kenya. Child survival grantees in Kenya and representatives from the ministry of health attended. The PVOs gave an overview of their projects, and thereafter the mission representatives facilitated a discussion on ways to improve performance within child survival projects. Of the four child survival grantees[4] in Kenya then,

[4] In 2005, there were 4 child survival grantees in Kenya, namely AMREF, CRS, PLAN, and World Vision.

AMREF Kenya had the youngest project. The meeting gave us an opportunity to meet with and establish lasting contacts with other PVOs; this has fostered sharing of key lessons learnt, including information on effectiveness of different approaches. For example, this project will implement an approach called "mother support groups" to help mothers exclusively breastfeed their 0-5 months infants; we learned that the strategy is effective from the Mbeere child survival project, managed by CRS.

Role of PVOs

The PVO child survival grantees in Kenya hold an annual meeting to foster collaboration. From September 4 to 8, 2006, BCSP staff attended the annual PVOs meeting, hosted by PLAN Kenya in Mombasa. The objective of the meeting was to provide PVOs implementing child survival activities with a forum to share experiences. PVOs shared their experiences regarding project implementation, lessons learnt, constraints and challenges, and possible solutions for the challenges. In addition, PVOs shared their monitoring and evaluation frameworks, including baseline results, midterm or end of project evaluations. On the third day all PVOs visited the PLAN Kenya project area in Kilifi and met with community members, who shared their experiences. As a project, AMREF gained insights on the community implementation structures involving CORPs and CBHMIS. All PVOs agreed to share their annual work plans, create a central information hub (to be coordinated by AMREF Kenya), where PVOs can quickly access information from the others, and create a child survival network. The ministry of health also agreed to involve PVOs at relevant policy level meetings.

(vi) Community Implementation Framework

AMREF and the DHMT are in the process of developing and rolling out a community implementation framework. This framework will ensure efficient implementation of project activities at the community level. The project has borrowed from the Care Group model developed by World Relief, the draft community implementation framework released by the MOH, and the experiences of PLAN Kenya and World Vision in their child survival projects.

Each household in the project area will have a health contact person selected by household members. The health contact person will be responsible for giving relevant health information on the family to the CORP in charge of their area, and also delivering child health messages generated by the project. One CORP will be in charge of about 20 households in the project area. The CORP will deliver health messages to the health contact person, conduct home visits, and collect relevant household health information to feed into the CBHMIS. CORPs will be supervised by a CORP's group leader, who will be a CORP selected by a group of about 15 CORPs. The CORP's leader will be responsible for households under her or him, and will supervise about 15 CORPs, who will each represent four to five villages. The CORP's leader will represent the CORPs under her or him at the village health committees (VHC), and give them information on health matters and decisions made at the VHC level. The CORP's leader will also represent the VHC at the health facility committee. The health facility committee reports to the DHMT. With the support of the DHMT and AMREF, the lot supervisors and health facility in charges will supervise the CORPs.

To foster sustainability of the community implementation framework, AMREF will build the capacity of local MOH structures to supervise and support the community implementation structure, so that the system will thrive after the end of the project. Related to this, AMREF and

DHMT have ensured that the framework is in line with the recommendations of the ministry of health regarding ratios of CORPs to households, and relationship with VHCs as the governance structures at the community level. We will roll out the system gradually over a period of about one year, ensuring that establishment of each VHC is based on community's ideals, and the local MOH personnel have time to learn, internalize, and operationalize their facilitative supervision roles over the VHCs and CORPs. We believe that the system with a larger number of CORPs will ensure that a CORP will spend just a few hours per week conducting home visits; this will in turn prevent burnout and reduce attrition rates. To ensure that training for the large number of CORPs remains affordable, the project has adopted the cascade method of training, where COPRs leaders will be equipped with facilitation skills by the lot supervisors through a mentoring process, and consequently train other CORPs.

(vii) Response to Findings from Organizational Capacity Assessment

(See section G, assessment reports not completed by time of DIP)

M. MISSION COLLABORATION

(i) Role that BCSP Plays in Contributing to the Mission's Objectives

BCSP fits well within strategic objective 615-003 of the USAID/Kenya Strategic Plan FY 2006-2011: *reduce transmission and impact of HIV/AIDS* and *improved reproductive, maternal and child health*. BCSP is specifically contributing to the mission's intermediate results:

- increased use of proven and effective interventions to prevent HIV transmission,
- treat those infected, and provide care and support to those affected by HIV/AIDS; and
- increased customer use of family planning, reproductive health, and child health services.

The HIV/AIDS intervention of the project addresses the first intermediate result, while all of the project's interventions foster achievement of the second result.

(ii) Collaboration with Mission's Bilateral Programs

AMREF has pledged to collaborate with the USAID mission's APHIA II program. To this end, the BCSP Project Manager has contacted the manager of the regional bridging program, with a view to a formal discussion on areas of collaboration between BCSP and the upcoming APHIA II program. One area of collaboration is referral – AMREF hopes to refer some of the HIV positive mothers in the project area to health facilities supported by APHIA II for long-term comprehensive care, including ART.

(iii) Frequency and Nature of Interactions with Mission Personnel

Interaction with USAID mission personnel occurs on an ad hoc basis and during planned meetings. Ad hoc interaction involves telephone and e-mail communication, usually aimed at seeking clarification and soliciting necessary documentation. Planned meetings include:

- ✓ Annual PVOs meeting convened by the PVOs (last one held from September 4 to 8, 2006). These meetings provide a forum where the USAID representative communicates information aimed at fostering synergy between different PVOs, and collaboration with the mission (see section L, project's management system)

- ✓ TAG meeting held once every six months, but more frequently during the second project year (last one held on August 8, 2006). These meetings are aimed at helping BCSP remain within MOH and USAID policy frameworks, and is also an avenue to disseminate best practices generated by the project (see section A, main accomplishments)

- ✓ PVOs meeting convened by the mission (last one held on December 8, 2005). During these meetings, PVOs share with the mission and other PVOs their experiences, and the mission communicates information aimed at improving program effectiveness, synergy, and visibility of USAID(see section L, project's management system)

- ✓ Meeting between USAID mission and AMREF. The mission has convened one such meeting aimed at debriefing on the DIP. During this meeting, the mission representatives sought and were provided with a deeper understanding of the DIP. At the same time, USAID representatives requested AMREF to collaborate with the APHIA II program, in line with the mission's principle of synergy, non-duplication, and coordination of effort.

N. TIMELINE OF ACTIVITIES FOR COMING YEAR

Busia CS Project Work Plan	2007 Project Year 2				Responsible person
Procure commodities (ITNs/LLINS, testing kits…) and EmOC equipment	X		X		PM
Training needs assessment (TNA)	X	X	X		TO
Further review curricula and prepare training materials	X				TO
Conduct joint capacity assessment & Capacity Building action planning for DHMT & AMREF	X				PM
Implement Operations Research	X	X	X	X	MEO, PM
Distribute targeted subsidized ITNs/LLINs	X	X	X	X	BCCO
Renovate and equip 4 COE	X	X			PM
Roll out community implementation framework in 360 villages	X	X	X	X	
M&E/HIS Training for HF, DHMT, and HEWs (two sessions of 5 days each for a total of 34 people)	X				MEO
PDQ sessions implemented by HEWs, CORPs, HF staff, and health facility committees	X	X			TO, MEO
Quality of Care/IPCC Workshop (one session of 2 days for 22 DHMT/HF staff) (content will follow-on to PDQ sessions)		X			TO
Advocacy to influence practice and policy within AMREF and at district, province and national forums	X	X	X	X	PM, BCCO
Review and develop/adapt BCC materials	X				BCCO
Orientation to the Child to Child, Child-to-Parent, Parent to Parent, & 5x5x5, Positive Deviance Approaches, (2 sessions of 1 day each for 7 HEWs & 13 PHTs); 2nd session is follow-up refresher training)	X				BCCO
Make contacts & begin initial planning with existing school clubs in 33 schools in project area	X				BCCO
Organize project slogan/rallying call contest & launch of child-to-child approach		X			BCCO

Busia CS Project Work Plan	2007 Project Year 2				Responsible person
Continue child-to-child activities in schools; monitor activities with teachers & students		X	X	X	BCCO
Conduct/participate in/support health days (child health days, malaria field days, Africa Malaria day, Day of the African Child, World AIDS day) –	X	X	X	X	BCCO
Orientation to the Parent-to-Parent Approach (mothers and fathers support groups) for 40 CORPs (20 different CORPs will be oriented during each of two 1-day sessions)	X				BCCO
HEWs orient CORPs on the PD approach and peer clubs (1 day) and develop action plans		X			
CORPs formulate/ identify father-to-father clubs & mother-to-mother clubs and identify positive deviants		X			
Orientation to the 5X5X5 approach (20 different CORPs will be oriented during each of two 1-day sessions) and develop integrated action plans (MNC, Malaria & HIV/AIDS)	X				
Explore the use of local radio stations to broadcast health messages	X				BCCO
Implement communication of health messages via radio		X		X	BCCO
CORPs to implement 5X5X5 approach in phases on key household behaviors	X	X	X	X	BCCO
Revise existing supervision guides to checklist	X				TO
Follow-up Training on facilitative supervision (HF, LS – one session of 2 days for 24 people)	X				TO
Further explore gaps and opportunities within the existing community health information system	X				MEO
Develop/adopt community health information system	X				MEO
Procure materials for CBHMIS	X				MEO
Training of CORPs in CBHMIS by HEWs during 2 day until all 1870 have been trained	X			X	MEO
Pilot CBHMIS data collection	X	X	X		MEO
Roll out Community health information system data collection				X	MEO
TOT in anti- malarial treatment (two sessions of 2 days each for 7 HEWs and 13 PHT)			X		TO
Focused ANC training (DHMT, HF, LS & CS project staff – 2 sessions of 5 days each for a total of 35 people)	X	X			TO
PMTCT Training (AMREF, HF – two session of 10 days each for a total of 31 people)		X			TO
Train 40 CORPs in supporting PMTCT (2 sessions of 3 days each for 20 CORPs)		X			TO
Cascade training of CORPs on supporting PMTCT		X	X		TO
Quality assurance workshop for AMREF, DHMT & HF staff for 21 people			X		TO
Work with Kenya Pediatric Association (KPA) and CSHGP to design minimum activities for mothers and newborns (MAMAN)	X				TO
Implement MAMAN		X	X	X	
Identify domiciliary mid wives	X				TO

Busia CS Project Work Plan	2007 Project Year 2				Responsible person
Essential Obstetric Care (DHMT, HF, LS, AMREF & domiciliary midwives – two sessions of 5days each for 38 people)		X			TO
Training of CORPs in EOC (120 CORPs will be trained during 2 sessions of 2 days each)		X	X		TO
Cross-visits between health facilities			X		
Training of 250 shopkeepers (during 2 sessions of 1 day each, the RDVs will be trained) in Malaria prevention, home treatment & appropriate drug use			X		TO
Provide refresher to shopkeepers				X	TO
IMCI Training of Trainers (DHMT, HF – one 5-day session for 10 people)			X		TO
IMCI Case Management Training (HF – 2 sessions with 10 people each for 14 days for a total of 20 people)			X		TO
IMCI Follow-up training (DHMT, HF – one session of 2 days for 10 people)			X		TO
Training of 40 CORPs in malaria prevention, home treatment, appropriate drug use and ITN treatment and retreatment (20 CORPs will be trained in 2 sessions of 2 days each)			X		TO
CIMCI Training of Trainers on dialogue approach (one session of 5 days for 13 people)				X	TO
CIMCI Follow-up training on dialogue approach (one 1-day session for 13 people)				X	TO
CIMCI Training on dialogue approach for 240 CORPs (2 day sessions will be held for 20 CORPs simultaneously by each HEW in each of 7 lots)				X	TO
Prepare annual progress reports				X	All
Hold annual project review with partners				X	
Submit Annual Reports to CSHGP	X				
KPC surveys (LQAS), health facility assessment & Qualitative Research				X	
HFs staff and Health Committee meetings			X	X	
Project Implementation Committee (PIC) meetings	X	X	X	X	
Technical Advisory Group (TAG) meetings	X	X		X	
Facilitative supervisory visits	X	X	X	X	
Monitoring and evaluation	X	X	X	X	
AMREF regularly update DDC	X	X	X	X	
Documentation and dissemination of lessons learned and better practices	X				

Substantial Changes from the Original Workplan

- Piloting of the CBHMIS data collection was originally to start in the 2nd quarter but it has been scheduled to start in the 1st quarter of year two.

- Formative Research on Community Emergency Transport and Communication System (CETCS) was postponed to 3rd year and it will depend on the 2nd year results of the annual survey. Additionally, it is critical that the community trust that care offered in health facilities is high quality, so that women are really willing to seek care (demand is high), but are constrained by transportation. This will foster community participation in development of a transportation system. In year two, we will therefore concentrate on improving quality of care offered at health facilities.
- Community Implementation Framework: we had initially planned to work with 240 CORPs but we recognize that this will be too burdensome for the volunteers (one volunteer would cover more than 150 households). We are therefore rolling out a community implementation framework in which one volunteer will cover a maximum of 20 households (see section L, project's management system).
- Annual LQAS: the annual LQAS has been re-scheduled to Quarter 4 of each project year (see section D, substantial changes from the DIP)
- Annual project review meeting: initially planned in first quarter; not conducted because the project has not conducted annual LQAS to provide outcome data to form the basis of review.

O. RESULTS HIGHLIGHT

(i) Partnership Defined Quality

Introduction

PDQ provides for the enhancement of a quality improvement (QI) process by looking for answers that may be outside the health system. PDQ's many advantages include:

1. it focuses on health issues that mostly affect the community;
2. it engages both clients and non-clients;
3. it empowers the community to make decisions on health matters affecting them;
4. it leads to commitment of community resources by the community;
5. it ensures equitable use of services provided to the community;
6. it helps eliminate social and cultural barriers to better health;
7. it provides a forum for the vulnerable members of the community to be heard;
8. it strengthens the community's capacity to improve health;
9. it creates mechanism for rapid mobilization around health priorities; and
10. it levels the playing field for discussions of matters affecting both the community and health service providers in service provision and consumption.

The intermediate results of the approach include: increased sense of ownership of health facility by the community members; improved provider's job satisfaction; opportunities created for shared rights and responsibilities for better health outcomes among both health providers and community members; better health; improved client satisfaction; increased community capacity

for social change; improved decision-making mechanisms among community members – the community has the power to decide what is good for them, hence commits resources required to achieve their goals (selections of best options). The PDQ process involves building support to develop the support necessary to implement the process from the health system and the communities involved.

The next step is to explore the perceptions of quality from both the providers and consumers of services. Exploring quality has two components. In the first, Community Defined Quality (CDQ), the catchment population of BCSP is defined using the health facility as the point of reference. In exploring quality, the focus is on types of care the community has a right to receive and how it is consumed In the second, Health Worker Defined Quality (HDQ), the health worker needs to know why quality improvement is important, and in particular what benefits they will realize while partnering with the community to reduce the burden of disease. During the exploring quality stage, the two groups are separate. This allows open and honest discussions.

In the Bridging the Gap stage, the two groups come together to share their perspectives. Through this process they develop a shared vision of quality and eventually establish a Quality Improvement Team. The quality improvement team's main responsibility is to find solutions and actions to bridge the identified gaps in quality.

The Problem

The project is using PDQ to address the problem of low utilization of maternal and newborn care services at the health facilities. The baseline survey established that the proportion of women who attend antenatal clinic at least four times is 32%, and only 23% of them attend postnatal clinic within two days at least once. The results also showed that the proportion of women who deliver in health facilities is 20%.

The baseline also revealed that most pregnant women (80%) deliver at home and are usually attended to by Traditional Birth Attendants (TBA). The TBAs also attend to them during their antenatal period. Focus group discussion and key informant interviews established that most of the women preferred TBAs to their health worker counterparts because of the accessibility and the care and support offered by the former.

The project will use the PDQ model to improve quality of care (technical and non-technical) provided by health workers in the project area. Its end result will the creation of demand for maternal and newborn care services provided at the health facilities. We believe that increased use of services will lead to: reduced complications during pregnancy, delivery and postnatal period; improved neonatal health; enhancement of management of malaria at health facilities; and increased utilization of PMTCT services during pregnancy.

The Project's Input

The project conducted a two-day training on PDQ, during which 30 participants from the MOH and AMREF acquired skills to implement and monitor PDQ. Among the MOH staff trained, seven were lot supervisors, 16 health facility in-charges, and three DHMT members. A technical advisor with experience in PDQ methodology facilitated the training. The main objective of orientating the lot supervisors was to equip them with knowledge and skills in PDQ, so that they will subsequently orient the CORPs on the PDQ approach and facilitate the process.

To effectively monitor and evaluate the approach, the project has planned to initially train 34 people (DHMT, lot supervisors, facility in-charges) on monitoring and evaluation, health information systems (HIS) and community-based health management and information system (CBHMIS) in the first quarter of the second year. To prepare them to effectively facilitate these trainings, 13 people (2 DHMT, 4 project staff and 7 lot supervisors) attended a two-week Training of Facilitators (TOF) course from 18th – 29th September at AMREF Training Center in Nairobi.

The Magnitude of the Intervention

The project targets two of the six divisions within Busia District. Together, Butula and Funyula have an estimated population of 215,384 (2000). The percentage of the population directly benefiting from the CSHGP initiative is 37.8%. The direct beneficiaries of the project include 31,664 children 0-59 months and 49,858 women of reproductive age.

It is worth mentioning that BCSP has been in the planning stage in the first year, including building capacity of implementers to facilitate community development processes, and most activities will be rolled out in the second year. The project intends to undertake operations research to assess the effectiveness of the PDQ approach in improving quality of care and increasing utilization and access to maternal and newborn care services. Some of the expected outcomes are as follows: increased proportion of women who attend antenatal clinic at least four times from 32% to 50%; increased proportion of women who attend postnatal clinic at least once from 23% to 40%; increased proportion of women who deliver under supervision of a skilled health professional from 26% to 40%; increased proportion of women who deliver in a health facility from 20% to 35%; increased number of health facilities providing EmOC services from 0 to 6; increased proportion of children 0-23 months taken to HF or community health worker within 24 hours after onset of fever from 7% to 60%; increase proportion of Health Facility staff who assess, classify, and treat malaria/fever according to MOH protocols from 0% to 40%.

Plans for PDQ Rollout

In October 2006, project staff will conduct a one-day PDQ planning meeting with DHMT and lot supervisors. During this meeting, lot supervisors will develop action plans detailing how and when they will roll out PDQ in each of the health facility catchment populations in their management unit. To gradually improve the process of PDQ, lot supervisors will initially participate in the PDQ processes of two health facility catchment populations, during which key lesson will be documented and utilized in PDQ rollout in the remaining catchment populations. Through out the process of PDQ rollout, project and DHMT staff will provide facilitative supervision aimed at mentoring the lot supervisors, facility in-charges, and CORP's leaders.

(ii) Increased Governance Capacity in Local Institutions

Busia DHMT

The project has strengthened the capacity of Busia DHMT in the following ways:

- ✓ Training in LQAS survey methodology and health facility assessments followed by involvement in the baseline assessments. The DHMT and lot supervisors are well versed with LQAS as a management tool to help identify regions performing below expectation, in order to target resources to ensure geographical equity in health promotion and access.

- ✓ Training of DHMT members and health extension workers on how to facilitate community health development processes during the recent TOF course at AMREF training centre in Nairobi.

Community Institutions

The project intends to strengthen the governance structures established by the Ministry of Health at the community, health facility, and district levels. The existing health structures have been reviewed and areas needing strengthening identified have already been identified. The project has categorized community level governance structures as follows:

(a) Household: each household will have a health contact person chosen by the family, whose roles will include data collection, promotion of desired health behaviors and disseminating key health messages to the household members. The project in partnership with the DHMT through the lot supervisors and CORPs' leaders will train the health contact persons on data collection and tracking of household members who need health care.

(b) CORPs: each CORP supervises a maximum of 20 households. They are responsible for managing simple illnesses, referring cases to health facilities; dissemination of health messages and promoting desired health behaviors in the community. The project together with DHMT, will train the CORPs in CBHMIS, how to support PMTCT, EOC, data collection and collation.

(c) CORPs' leaders: the senior CORP is in-charge of 4-5 villages. Their main responsibility is to supervise the activities of the CORPs, and they also represent the CORPs at the village health committee (VHC) level.

(d) Village Health Committee: each committee will be formed out of 4-5 villages. Their responsibilities will be to plan and supervise implementation of health activities in the community. The project staff and lot supervisors will provide technical assistance in terms of trainings, monitoring and resource planning and management.

(e) Health facility committee (HHC): its responsibility is to plan, manage health facilities and provide a linkage between the facilities and the communities through the VHCs. The project has planned to facilitate quarterly HFs staff and DHC meetings to plan and review progress.