



THE BUSIA CHILD SURVIVAL PROJECT
Busia District, Kenya

**AMREF Kenya in Partnership with
the Busia District Health Management Team**

ANNUAL REPORT, YEAR TWO

Submitted on:
October 30, 2007

Submitted to:
U.S. Agency for International Development
Bureau for Global Health
Office of Health, Infectious Disease, and Nutrition
Child Survival and Health Grants Program
Washington, DC

Cooperative Agreement Number GHS-A-00-05-00009-00

Project Start Date: October 1, 2005
Project End Date: September 30, 2010

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical & Research Foundation
APHIA II	AIDS, Population and Health Integrated Assistance
BCC	Behaviour Change Communication
BCSP	Busia Child Survival Project
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMIS	Community Health Management Information System
CHW	Community Health Worker
CIMCI	Community Integrated Management of Childhood Illnesses
QoC	Quality of Care
COE	Centre of Excellence
CORP	Community Own Resource Person
CSHGP	Child Survival Health Grant Program
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus
C-to-C	Child to Child
C-to-P	Child to Parent
DEO	District Education Officer
DHMIS	District Health Management Information System
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
EmONC	Emergency Obstetric and Newborn care
EOC	Essential Obstetric Care
FANC	Focused Antenatal Care
FGD	Focus Group Discussions
GLUK	Great Lakes University of Kisumu
HIV	Human Immunodeficiency Virus
HF	Health Facility

IMCI	Integrated Management of Childhood Illnesses
KPA	Kenya Paediatric Association
LLINs	Long Lasting Insecticidal Nets
LQAS	Lot Quality Assurance Sampling
MAMAN	Minimum Activities for Mothers and Newborns
MNC	Maternal and Newborn Care
MOH	Ministry of Health
OR	Operations Research
PDQ	Partnership Defined Quality
PHMT	Provincial Health Management Team
PHT	Public Health Technician
PMTCT	Prevention of Mother to Child Transmission
PVO	Private Voluntary Organization
QI	Quality Improvement
TAG	Technical Advisory Group
TOT	Trainer of Trainer
USA	United States of America
USAID	United States Agency for International Development
VHC	Village Health Committee

EXECUTIVE SUMMARY

This second annual report for Busia Child Survival Project in Kenya covers the period from October 2006 to September 2007. The goal of the project is sustained reduction in child and maternal mortality in Funyula and Butula Divisions of Busia District. Integrated project interventions include maternal and newborn care, malaria prevention and treatment, and prevention of mother-to-child transmission of HIV. Key activities carried out during year two have set the project in motion toward reaching the goal.

During the reporting period, AMREF and the District Health Management Team (DHMT) conducted the following activities: trained 77 health facility staff and nearly 700 community health workers; strengthened facilitative supervision at health facilities, renovated and equipped centres of excellence, implemented the initial phases of partnership defined quality (PDQ); began implementing the behaviour change communication (BCC) strategy, distributed 3,290 long lasting insecticidal nets (LLIN); developed community health management information system (C-HMIS) prototype; conducted various assessments; and initiated research on QI.

Inadequate health workforce, parallel/vertical project processes, and emerging needs for additional funding, are the main factors that pose challenges and for which solutions include: improved workload management; joint planning with DHMT; integration of related project processes; fundraising to bridge funding gaps; and focus on other specific factors that led to underperformance for some objectives. The project will require technical assistance in addressing these challenges as well as in the following areas: measurement of newborn care as it relates to research; strengthening capacity of community governance structures; establishing community-level supportive supervision; workload management at health facilities; assessment of effectiveness of BCC approaches; community emergency transport system development; mid-term evaluation planning and subsequent revisions to the Detailed Implementation Plan (DIP); and final evaluation planning.

There have been enhancements and changes to the project since DIP development, including integration of the C-HMIS rollout process with CHW training, expansion of the project's research agenda and partnerships, and changes to original activity schedules. AMREF continues to address sustainability based on the elements of the Child Survival Sustainability Assessment Framework outlined in the first annual report, and will develop a phase-out plan in year three.

AMREF has maintained a strong partnership with the Busia DHMT, strong linkages with the USAID Kenya Mission and other CSHGP grantees in Kenya, and is substantively involved with the Mission's AIDS, Population and Health Integrated Assistance (APHIA) II Program in Western Kenya.

Key year-two result highlights include development and rollout of five promising practices to bridge the gap between the community and formal health system: 1) community strategy, 2) C-HMIS, 3) PDQ, and 4) mobile clinics used to distribute LLINs to hard-to-reach populations, and 5) formalized PVO collaboration.

A. MAIN ACCOMPLISHMENTS

Background

The 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 the 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.

The 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 (WRA) and 31,664 children under-five (CU5) in Funyula and Butula Divisions of the district. The project integrates maternal and newborn care (MNC), malaria prevention and treatment, and prevention of mother-to-child transmission (PMTCT) of HIV. The project 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 (MOH).

The project is aligned with the fourth and fifth Millennium Development Goals, which seeks to reduce child mortality, and improve maternal health, respectively. The project aims to reduce child and maternal morbidity and mortality in the two divisions within Busia by supporting and establishing health structures that can sustain the gains made beyond the project's life.

In order to achieve its goal, the project uses three mutually-reinforcing strategic approaches:

- (i) Capacity strengthening of the DHMT, health facility staff, and community health workers (CHWs) to increase the scope of their skills and knowledge in delivering health services, and to improve access to these services;
- (ii) Quality improvement (QI) to improve quality of care/services at health facilities and in the community and, thus, increase demand for target services; and
- (iii) Behavior change communication (BCC) at the household and community level to address cultural and societal barriers to disease prevention.

Main Accomplishments

This report covers the period between October 2006 and September 2007. The main activities accomplished, as per the three aforementioned approaches, during the period include: training of facility based staff and community health workers (CHWs), including curriculum adaptation; facilitative supervision, establishing centres of excellence (COE), and partnership defined quality (PDQ) implementation (as part of QI); communication for behaviour change using a cascade approach and distribution of long lasting insecticidal nets (LLINs); development of a community health management information system (C-HMIS) prototype; and various research studies and assessments. Table 1 outlines year-two activity status.

(i) Capacity Building

Training of Facility Based Staff

AMREF and DHMT have, together, trained 16 health facility (HF) staff on focused antenatal care (FANC) over five days, 16 HF staff on essential obstetric and newborn care (EONC) over ten days, 23 HF staff on prevention of mother-to-child transmission of HIV (PMTCT) over 10 days, and 22 HF staff on monitoring and evaluation (M&E) over five days. We used Ministry of Health (MOH) curricula that had been improved through a curriculum review process involving the Provincial Health Management Team (PHMT), AMREF and DHMT. Availability of and commitment from MOH trainers at the district and provincial levels are factors of these successful capacity building processes.

Trainings of Community Health Workers

AMREF and DHMT have trained 14 community health extension workers (CHEWS), 16 HF in-charges, and 40 CHWs as trainers of CHWs (TOTs) during five days, also using MOH curriculum that had been updated and improved by the team beforehand. These TOTs have subsequently trained more than 680 CHWs on *primary health care, the community strategy, and BCC*. The *community strategy* is an initiative of Kenya's ministry of health, and in line with the National Health Sector Strategic Plan (NHSSP, 2005-2010) it aims to make the health system more effective and accessible by focusing on the needs of individuals and groups of people, rather than on diseases. The use of the cascade training approach has made it possible to train a large number of CHWs in a short time. Additionally, the community strategy, itself, part of the MOH health policy, embraces working with CHWs.

AMREF staff has held discussions with a team from Kenya's Division of Child Health and discussed potential roles of the BCSP in the development of community newborn care training materials for Kenya. As a result, AMREF (together with UNICEF, WHO, and other stakeholders) has been requested to support and participate in the adaptation of a national community newborn care training curriculum and to pilot the curriculum within the BCSP. This curriculum adaptation process is the result of interest in newborn care and survival among health stakeholders in Kenya, and has greatly benefited from the recent work of UNICEF's Regional Office for Eastern and Southern Africa (ESARO), SEARCH foundation in Asia, and USAID's Minimum Activities for Mothers and Newborns (MAMAN) package (<http://www.childsurvival.com/documents/usaaid.cfm>). AMREF's role in the adaptation process is strengthened and informed because of its membership in Kenya's Child Health Interagency Coordinating Committee (ICC), as well as other national health fora.

(ii) Quality Improvement

Facilitative Supervision

As part of the project's QI approach, AMREF has supported the DHMT to improve facilitative supervision at health facilities. Together, the two partners have revised the facilitative

supervision materials and developed a checklist that is focused on performance improvement and allows tracking of performance. After having piloted the checklist, DHMT has adopted it, trained all HF staff on its use, and started applying it in September 2007.

AMREF recognizes that facilitative supervision is also critical at the community level and, together with DHMT, is developing a facilitative supervision system for application by CHEWs, CHW Team Leaders, and other community structures.

Centres of Excellence

AMREF has renovated and equipped four health facilities as partial fulfillment of the MNC centre of excellence accreditation requirements. AMREF is currently assisting the DHMT and PHMT to provide facilitative supervision of professional health staff to help enable facilities to meet accreditation criteria and be launched by the MOH.

Partnership-Defined Quality

AMREF and DHMT have implemented the early phases of PDQ in an effort to improve care, particularly client-provider interaction at 13 health facilities. PDQ is a QI method, first developed and applied by Save the Children a few years ago. It is a process for improving quality of health services that comprises five steps: 1) *Planning and Design*, 2) *Building Support*; 3) *Exploring Quality*, 4) *Bridging the Gap*, and 5) *Working in Partnership*. So far, AMREF and DHMT have reviewed and adapted the PDQ manual, constituted a PDQ implementation team with membership from the community, completed the first two steps in the 13 health facilities, and initiated step three in 10 of these facilities (*see section O, Results Highlights*). The PDQ process has been accepted by the community and health facilities because of rigorous support-building activities, and recognition that (currently) poor quality of health services is a major impediment to service utilization.

(iii) Behaviour Change Communication

AMREF, DHMT, and CHEWs have designed malaria and MNC messages, prioritized BCC methods, and implemented the child- and peer-based activities described below:

Child-to-Child (C-to-C), Child-to-Parent (C-to-P)

AMREF and DHMT have implemented C-to-C and C-to-P communication processes in which school-going children are involved in community sensitization and act as agents of change by delivering key messages to their peers, parents and neighbors.

In early 2007, project staff held a consultation meeting with the District Education Officer (DEO) about implementing C-to-C and child-to-parent C-to-P communication processes in primary schools in the project area. Thereafter, project staff worked with CHEWs, head teachers and teachers in-charge of health clubs to launch C-to-C and C-to-P communication processes in 48 primary schools. In each of the schools, CHEWs oriented 64 school club members on facts of malaria.

Slogan Contest

In September 2007, school pupils entered a competition in designing an MCH slogan against a given set of criteria (i.e., one message, no more than five words, captivating, motivating, etc). The project will adopt the winning slogan(s) for use at various sensitization fora to help rally communities to support child health initiatives. Forty eight school health clubs participated and submitted their entries, from which winners were selected and will be announced and rewarded in November 2006.

5*5*5

This BCC method is used by communities and organizations to spread messages (i.e., health, development, security) in a short time span. It provides an opportunity for community members to be directly involved in improving the health of their neighbors and community. As per its title, five messages are selected and given to five different households or people in the village who then pass on the same five messages to five other households or people in the neighborhood. The second round of recipients, in turn, passes these messages to another five households until the community or other geographical area is covered. In March and April 2007, project staff and CHEWs oriented more than 228 CHWs on the 5*5*5 communication approach on key household behaviors. The CHWs thereafter disseminated malaria messages using the approach.

Mass Media

Between March and May 2007, CHEWs conducted a rapid assessment to identify the most widely listened-to FM radio stations in the project area. From the findings, *citizen FM* and *Mulembe FM* were identified, and will be contacted in FY3 as part of the project's media advocacy plan.

(iv) Distribution of Subsidized Long-Lasting Insecticidal Nets

Early in the year, AMREF received a donation of 3,500 LLINs from World Swim for Malaria Foundation, of which 3,290 were distributed to pregnant women and children under-five during mobile outreach clinics targeting hard-to-reach populations (*see section O, Results Highlights*).

(v) Community Health Management Information System

AMREF, DHMT, and other district health stakeholders have developed a model of C-HMIS based on a participatory process that included an information needs and gap analysis (*see section O, Results Highlights*).

(vi) Health Systems Research and Assessments

Health Systems Research

BCSP research agenda and partnerships: In line with AMREF's new strategic Plan (2007 – 2017), through which AMREF will focus on a broad-based culture of health promotion, prevention and care in Africa, the BCSP has re-aligned its research efforts toward developing

and testing models that help make the Busia health system more responsive to communities. Therefore, BCSP staff has revised the research issues that are relevant, and hope to pursue some or all of them during the project life (*see appendix 4*). Considering the multiplicity and scope of the identified research questions, coupled with responsibilities and workload among the project staff, AMREF is negotiating research partnerships with the Great Lakes University of Kisumu (GLUK) in Kenya, and the Kenya Paediatric Association (KPA).

Quality Improvement Research: AMREF is undertaking the research study entitled, “*The Role of a Joint Community/Health Facility Quality Improvement Approach in Improving the Quality of Maternal and Newborn Care Services and Newborn Outcomes in Health Facilities: The Case of Busia District, Kenya*”. Collection and analysis of pre-intervention observation data have been completed (*see appendix 7 for findings*), and is currently used to tailor the PDQ approach (*see section O, Results Highlights*).

MAMAN Baseline Assessment and Research: In November 2006, AMREF and DHMT conducted the MAMAN baseline survey in 133 villages during seven days using lot quality assurance sampling (LQAS) methodology (*see appendix 2 for a summary of findings*). AMREF, in consultation with KPA, has developed a draft research protocol entitled, “*Effectiveness and Cost of an Essential Maternal and Newborn Care Intervention in Busia, Kenya*”. The protocol is being revised based on review comments from AMREF USA staff and the Child Survival Technical Support Plus (CSTS+) group, and should be ready to implement in the early part of the new year.

Assessments

FANC follow-up: In April 2007, DHMT and AMREF monitored performance of health workers trained in FANC based on key skills transferred during the training. Overall, AMREF and DHMT found good performance, but with gaps especially on birth preparedness, male involvement, and linkage with the community. The project has since been addressing these gaps, for example, during the follow-up exercise and subsequent supervision visits.

PMTCT follow-up: In June 2007, DHMT and AMREF monitored implementation of PMTCT in 16 health facilities in the project area, and have used the findings to improve PMTCT services. Key gaps being addressed include: HF staff, previously trained on elements of PMTCT (before BCSP), were not trained on testing; shortage of commodities, especially testing kits and anti-retroviral (ARV) drugs; heavy workloads; shortage of clinic furniture; weak linkages with the community; low male involvement; and weak referral linkages.

BCC Assessment: In July 2007, the project conducted a rapid assessment to assess the effectiveness of the various BCC approaches that the project has so far applied. Recommendations from the assessment include the following: CHEWs to reinforce and correct any misconceptions about health messages during health club follow-up meetings; CHEWs and CHWs to sensitize community members regarding the communication role that school-going pupils are playing; AMREF to seek synergy with other organizations that are supporting school health clubs; the C-to-C and C-to-P communication approach should be sustained; activities being undertaken by the pupils could be reinforced by health club sports tournaments.

Annual LQAS: In late September 2007, the project conducted the annual LQAS, and analyzed the data (*see appendix 5, Findings of the Annual LQAS*). The project is on course with regard to the effecting the following performance and behavioral objectives: (i) Increased utilization of ANC services; (ii) Timely care-seeking among mothers of sick children; (iii) Increased utilization of LLINs by children; (iv) Increased uptake of intermittent presumptive treatment (IPT) for malaria among pregnant women; and (v) Increased uptake of counseling and testing services for HIV by pregnant women.

Notably, year two targets were not met for the following objectives: (i) Increased utilization of LLINs by mothers of children 0-23 months; (ii) Increased deliveries by a skilled attendant; (iii) Increased knowledge on PMTCT; (iv) Increased utilization of ART for PMTCT among HIV + mothers and newborns of HIV + mothers. Reasons for the shortfall and action planned to fast-track progress on these indicators are outlined in section B, Challenges and Constraints.

Table 1: Key Project Activities

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
Technical Objectives³ 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	Procure commodities (i.e. LLINS, test kits) and EmOC equipment	– 3,500 LLINs procured – HIV and antenatal profile test-kits ordered – EmOC equipment procured	Ongoing/On-schedule	X	X	X	
	Training needs assessment (TNA)	– TNA done in FY2 adequate	Ongoing/On-schedule	X	X	X	
	Review curricula and prepare training materials	– 4 curricula reviewed (FANC, EOC, M & E, CHW Manual) – Key sessions revised	Completed	X	X	X	
	Conduct joint capacity assessment & capacity building action planning for DHMT & AMREF	– Capacity building action plan developed and implementation initiated	Ongoing	X	X	X	X
	Implement Operations Research	– 2 OR protocols developed – 1 OR implemented – Research agenda updated	Ongoing/On-schedule	X	X	X	
	Distribute subsidized LLINs	– 3,290 LLINs distributed pregnant women and CU5 in hard-to-reach areas	Ongoing/On-schedule		X		
	Renovate and equip four COE	– 4 COEs renovated and equipped	Completed	X			
Roll-out community strategy in 360 villages	– CHW component rolled-out – Other components to be rolled-out in FY3	On going/behind schedule –	X	X	X	X	

¹Activities are described as outlined in *section N, timeline of activities for coming year*, of the first annual report since substantial changes to project's activities timeline were outlined and described/justified in that report.

² Although sustainability is not outlined as an intervention in the DIP, we have included it in this table so that we can highlight activities that are contributing to it

³ Most activities carried out in year two cut across a handful of technical objectives, and therefore, activities have not been matched with objectives in this table

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
4. Improved quality of and access to basic EmOC at health facilities.	M&E/HIS Training for health facility staff including CHEWs and DHMT (two sessions at 5 days each for a total of 34 people)	– 22 persons trained (2 DHMT staff, 7 CHEWs, 13 HF staff)	On going/Behind-schedule: actual costs exceeded budget and therefore we could not train the planned 34 staff	X	X	X	X
5. Improved knowledge and practice of malaria prevention and treatment at household and community level.	PDQ sessions implemented by CHEWs, CHWs, HF staff, and health facility committees	- Completed Steps 1-3: planning, building support, and exploring quality	On going/behind schedule; process will be completed in year 3	X	X	X	X
6. Increased proportion of pregnant women and CU5 who sleep under insecticide-treated nets	Quality of Care Workshop (one session of 2 days for 22 DHMT/HF staff) (content will follow-on to PDQ sessions)	Not done	– Will be conducted after PDQ process for optimal effect – Kenya does not have a quality of care curriculum (or customer care) ...AMREF plans to develop one in consultation with MoH and stakeholders	X	X	X	
7. Improved case management of malaria among CU5 at health facilities.	Advocacy to influence practice and policy within AMREF and at district, province and national forums	Accomplished through various fora in which AMREF is a member; key issues addressed: – Community newborn care – TBAs: need for research on potential roles – Vacuum extraction: need for skills development at peripheral health facilities Need for customer care curriculum for use in health care settings	Ongoing	X	X	X	
8. Increased proportion of pregnant women	Review and develop/adapt BCC materials	Malaria and MNC messages and IEC materials reviewed, designed	Ongoing/on schedule	X	X	X	

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
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	Orientation of CHEWs, CHWs on the C-to-C, Child-to-Parent, Parent to Parent, & 5x5x5, Positive Deviance Approaches	<ul style="list-style-type: none"> - 7 CHEWs oriented on C-to-C, C-to-P communication, and 5*5*5 - 48 school clubs oriented on C-to-C and C-to-P, and participated in slogan competition - BCC assessment conducted, and generated key recommendations for improving BCC strategy - 228 CHWs oriented on 5*5*5 and implemented in 2 lots on a pilot basis 	<ul style="list-style-type: none"> - Parent to parent approach (positive deviance) will be done in year 3- mapping results will be used to identify positive - Initial orientations done on a pilot basis; 5*5*5 guidelines have been updated and will be used to further orient 40 CHW -TOTs in FY 3; the CHW-TOTs will then cascade train all the other CHW 	X	X	X	
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.				Explore the use of local radio stations to broadcast health messages	2 Priority radio stations identified	Completed	X
13. Improved capacity of DHMT staff to monitor and evaluate health programs	Implement communication of health messages via radio	Radio survey data collection delayed	<ul style="list-style-type: none"> - Behind Schedule; Radio stations will be contacted in FY 3, in the context of a well defined media advocacy plan - Radio communication delayed because we do not consider it as high impact 	X	X	X	
Sustainability Objectives	Revise existing supervision guides to checklist	Supervision checklist developed	Completed	X	X	X	X
	Follow-up Training on facilitative supervision (HF, LS – one session of 2 days for 24 people)	40 health staff oriented	Completed	X	X	X	X
	Further explore gaps and opportunities within the existing community health information system	Information needs and gaps analysis done	Completed	X	X	X	X
	Develop/adopt community health information system	C-HMIS model developed	Completed	X	X	X	X

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
14. Improved facilitative supervision system	Training of CHWs in C-HMIS by CHEWs during 2 day until all 810 have been trained, and roll out Community health information system data collection	Not done	To be trained in FY 3; delayed because of need to harmonize with the rest of the CHW trainings	X	X	X	X
15. Improve financial management practices that lead to accurate financial planning	TOT in anti- malarial treatment (two sessions of 2 days each for 7 CHEWs and 13 PHT)	Not Done	Kenya's policy on community malaria case management is in transition and it is advisable to wait for clarity		X		
16. Strengthen management systems and practices of the project	Focused ANC training (DHMT, HF, LS & CS project staff – 2 sessions of 5 days each for a total of 35 people)	16 health staff trained	Behind schedule: funds available in budget not enough to train 35 people.	X	X	X	
	PMTCT Training (AMREF, HF – two session of 10 days each for a total of 31 people)	23 health staff trained	Behind schedule: funds available in budget not enough to train 31 people.			X	
17. Increased use of empirical evidence to make program decisions	Train 40 CHWs in supporting PMTCT (2 sessions of 3 days each for 20 CHWs); Cascade training of CHWs on supporting PMTCT	Not done	Will be done I n Qrt 1, year 3 as Phase II; this is because AMREF decided to first train CHWs on Phase 1, described in the text			X	
18. Improve networking and external relations	Work with Kenya Pediatric Association (KPA) and CSHGP to design minimum activities for mothers and newborns (MAMAN); Implement MAMAN	<ul style="list-style-type: none"> – OR protocol developed – Developed research partnership agreement with KPA – MAMAN being implemented in the context of FANC, EOC, PMTCT, and CHW based processes 	<ul style="list-style-type: none"> – Agreement undergoing review – MAMAN implementation Ongoing/ but behind schedule 	X			
19. Improved capacity of community to plan for and improve their health status	Essential Obstetric Care (DHMT, HF, LS, AMREF & domiciliary midwives – two sessions of 5days each for 38 people)	<ul style="list-style-type: none"> – 16 health staff trained – 13 community midwives identified 	Behind schedule: funds available in budget not enough to train 31 people.	X			
20. Improved linkage between communities and health facilities	Training of CHWs in EOC (120 CHWs will be trained during 2 sessions of 2 days each)	Not done	Will be done I n Qrt 1, year 3 as Phase II	X			
	Cross-visits between health facilities	Not done	Centres of excellence not yet accredited; will be done in FY 3	X	X	X	

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
	Training of 250 shopkeepers (during 2 sessions of 1 day each, the <u>Retail Drug Vendors</u> will be trained) in Malaria prevention, home treatment & appropriate drug use ; Provide refresher to shopkeepers	Not done	Kenya's policy on community malaria case management is in transition and we prefer to wait		X		
	IMCI Training of Trainers (DHMT, HF – one 5-day session for 10 people); IMCI Case Management Training (HF – 2 sessions with 10 people each for 14 days for a total of 20 people); IMCI Follow-up training (DHMT, HF – one session of 2 days for 10 people);	Not done	To be done in Qrt 1, FY 3		X		
	Training of 40 CHWs in malaria prevention, home treatment, appropriate drug use and ITN treatment and re-treatment (20 CHWs will be trained in 2 sessions of 2 days each)	Not done	To be done Qrt 2, FY 3 as Phase 3, and as part of C-IMCI		X		
	CIMCI Training of Trainers on dialogue approach (one session of 5 days for 13 people); CIMCI Follow-up training on dialogue approach (one 1-day session for 13 people); CIMCI Training on dialogue approach for 240 CHWs (2 day sessions will be held for 20 CHWs simultaneously by each CHEW in each of 7 lots)	Not done	To be done Qrt 2, FY 3 as Phase 3, and as part of C-IMCI	X	X	X	
	Hold annual project review with partners	Completed	–	X	X	X	
	KPC surveys (LQAS), health facility assessment & Qualitative Research	Completed		X	X	X	
	Project Implementation Team (PIT) meetings	4 PIT meetings held	–	X	X	X	

Project Objective	Key Activities ¹ (as outlined in First Annual Report)	Status of Activities	Comments	Interventions that activity contributes to			
				MNC	Malaria	PMTCT	Sustainability ²
	Technical Advisory Group (TAG) meetings	3 TAG meeting held	–	X	X	X	
	Facilitative supervisory visits	DHMT started visiting facilities in the project area to conduct supervision with revised tool	Ongoing	X	X	X	X
	Monitoring and evaluation	BCC assessment, post-training assessments conducted, health facility data, community data	Ongoing	X	X	X	
	AMREF regularly update DDC	Project staff attended 2 DDC meetings	–	X	X	X	
	Documentation and dissemination of lessons learned and better practices	Research in progress to generate lessons	Ongoing	X	X	X	

B. CHALLENGES AND CONSTRAINTS

Factors that have challenged or impeded project progress over the past year are described below along with the project's responses.

(i) Inadequate Health Workforce

Shortage of MOH Health Workers: The MOH currently employs relatively few health workers each year, well below numbers needed to fill existing gaps. As a result, most of the health facilities are understaffed leading to work overload and often low morale. Although the project will not increase the number of health workers, AMREF and DHMT have developed a facilitative supervision tool and are using it to support health workers during facilitative supervision visits conducted once every quarter to each of the health facilities. In year three, AMREF and DHMT will also explore with health workers ways to improve workload management in order to increase efficiency.

Competing Tasks of the DHMT: DHMT staff has many responsibilities and, as a result, they often have to choose between supporting project activities and other tasks. This constraint has often led to delays in implementation of project activities. AMREF and DHMT are addressing this constraint through joint planning processes such as during quarterly work planning.

Attrition of LQAS Survey Enumerators: The project has experienced high attrition rates of personnel trained in LQAS survey methodology, largely because they are offered other opportunities and move out of the project area. To address this constraint, AMREF and DHMT have identified and trained CHWs in LQAS methodology.

(ii) Parallel vs. Integrated Project Processes

During the first half of the second year, project staff was managing project activities as parallel or vertical processes, which sometimes led to duplication of efforts, missed opportunities, and delay in implementation of some activities. Having recognized this poor management practice, project staff now integrates selected project activities that are conceptually or inherently related. For example, the PDQ and COE processes are being integrated, since both aim at quality improvement, whereby, COE accreditation criteria define selected technical elements of care that HF QI teams should continually address. Similarly, we have decided to integrate the rollout of CB-HMIS with Phase II training of CHWs because the two processes are related.

(iii) Emerging Needs for Additional Funding

As the project has progressed, realities in the field and changing economic environment has increased the estimated cost of conducting planned project activities. This has contributed to failure to train the required number of health staff in M&E, FANC, PMTCT, and EOC. We now estimate that it will cost an additional USD 238,227 to carry-out the project to completion, a variation of +13%. **This entire fund gap has been met by AMREF in Netherlands, and will be mostly utilized in FYs 3 and 4 to address existing training gaps.** Insights from other child survival projects suggest that the new level of funding is within acceptable limits. For this

project, the average cost per direct beneficiary is now \$5 per year (*total budget/direct beneficiaries/years of project; e.g., \$2,040,829/82,000 direct beneficiaries/5 years*). The project design has not changed. Three overarching factors have contributed to this cost variation:

- **Economic environment:** when the initial project budget was finalized in 2004, the dollar was worth Ksh 75. Today, the dollar is worth Ksh 66, a difference of 12%. This variation is likely to be sustained or increased during the remaining project period. This partly explains the rising costs of the project. For example, facility level training activities that were initially budgeted at a unit cost of USD 40, now actually cost USD 50.
- **Change in the community strategy:** initially, we planned to work with 300 CHWs. This would have meant an average CHW/household (HH) ratio of 1:130, which would result in rapid burnout and attrition of CHWs and jeopardize success and sustainability of the project. To mitigate this situation, we enrolled an additional 500 CHWs, bringing down the mean ratio to 1:50. Although we are applying a very cost effective cascade training approach for CHWs, additional CHW and procurement of incentives has substantially increased the community component budget. It is worthwhile to note that, while the current CHW/HH ratio is much lower than before, it is still above the MOH-recommended ratio of 1:20. At the same time, there is currently no evidence regarding the optimum ratio/s for different settings. Based on selected parameters of comparison (soon to be discussed by project partners), the BCSP may be able to contribute to such an investigation since, in some project areas, the CHW/HH ratio is above or below the mean ratio (i.e., 1 CHW:25 HH to 1CHW:75 HH)
- **Change in training plans:** The EOC training program was initially planned to take five days, but after the training needs assessment and curriculum review, we recognized that the ten days, recommended by the Division of Reproductive Health is needed. In addition, the initial budget did not include training of community health committees (CHCs), although it has since been added as a necessary component.

(iv) Underperformance of Some Objectives

Delivery by skilled attendants: the QI (PDQ, COE, facilitative supervision), capacity building (EOC training), and BCC (i.e., support groups and home visiting of pregnant women to support with birth planning) processes likely to lead to higher number of deliveries by skilled attendants, were initiated late or had not been initiated during the second project year. Based on this finding, AMREF and DHMT have planned for more realistic scheduling of activities (*see section N, Timeline of Activities or FY3*).

Knowledge about PMTCT: similarly, coverage with knowledge on PMTCT failed to increase as expected because PMTCT messages were not released in FY2 and CHWs were not trained on MNC. In response, we have decided to integrate messages in MNC, malaria and PMTCT.

Uptake of ARV for PMTCT: although more women are getting counseled and tested, fewer than expected are benefiting from ART for PMTCT, likely due to preference of unskilled delivery attendants who are not trained to deliver ART for PMTCT in Kenya. In order to respond to this anomaly, AMREF and DHMT will be: increasing delivery by skilled attendants (see above); and increasing the likelihood that HIV+ women who deliver outside health facilities get ART for

PMTCT by dispensing the ART during pregnancy, and encouraging them to go for a postpartum visit within 72 hours after delivery. We will also work with traditional birth attendants (TBAs) and community midwives to promote safe motherhood, and have already identified 205 TBAs and 13 community midwives.

Utilization of LLINs by mothers of children 0-23 months: the shortfall of this objective is most likely due to the fact that malaria BCC messages are about pregnant women and CU5 sleeping under LLINs, and not necessarily mothers. Now knowing this, CHEWs and CHWs will emphasize in their work that, while pregnant women and CU5 are very vulnerable to malaria, it is important that everybody in the family sleeps under a net in order to prevent malaria.

C. TECHNICAL ASSISTANCE REQUIREMENTS

The type, scope and timing of TA required by the project are outlined in table 3 below.

Table 2: Technical Assistance Requirements

Area needing support	Tentative scope of work for Technical Advisor/ Consultant	When support is likely to be needed
MAMAN (newborn care) operations research	Finalization of OR protocol including development of research tools; development of newborn care training materials, and quality assurance during training; sampling; data management; cost analysis; publication	Year 3, 4, 5
Other Operations Research	Review various OR protocols	Year 3, 4
Strengthening capacity of governance structures	Work with project staff to finalize framework for strengthening capacity of community health committees	Year 3, 4
BCC Assessment	Work with project staff to develop methods of assessing effectiveness of various BCC approaches	Year 3, 4
Community level supervision	Work with project staff to refine tools / approaches for supervising CHWs, CHEWs, and community health committees	Year 3
Workload management	Work with project staff and DHMT to develop innovative approaches to help health facility staff cope with increased workload, and incorporate the approaches into the facilitative supervision process	Year 3
Community emergency transport system	Help with participatory development of sustainable community emergency transport system	Year 3, 4
Mid-term evaluation	Together with BCSP staff and DHMT staff, lead the MTE process	4 th Qrt, Year 3
DIP refinement based on findings from MTE	Refine project strategies to help meet project objectives	1 st Qrt, Year 4
Final Evaluation	Lead the EOP evaluation process	4 th Qrt, Year 5

D. SUBSTANTIAL CHANGES FROM THE DIP

Important project changes are described below.

(i) C-HMIS

According to the last annual report, the C-HMIS was to be piloted in five villages in each of the two divisions in the project area. This plan has been cancelled, due to ongoing cascade training of the CHWs, which already integrates the C-HMIS. We have decided to integrate the rollout of CB-HMIS with Phase II - CHW training, because the two processes are inherently related.

(ii) Change of Terminologies

In order to be in line with Kenya's the NHSSP II and its associated changes, the project has changed terminologies as shown in table 3:

Table 3: Altered Terminologies

Previous terminology	New terminology
CHEW	Community health extension worker
Domiciliary midwife	Community midwife
Community own resource person	Community health worker
Village health committee	Community health committee

(iii) Research

AMREF and DHMT have expanded the project's research agenda to include issues that we now recognize to be relevant (*see appendix 4, Research Questions*).

(iv) Partnerships

In order to address evolving needs of the project, AMREF and DHMT are exploring new partnerships not outlined in the DIP. Key among these partners is The Great Lakes University of Kisumu (GLUK), which will help to support the project in health systems research.

(v) Number of CHWs

In the last annual report, we indicated that extra CHWs would be identified to reduce the burden on those serving more than 20 households. However, having re-evaluated the situation, project staff feels that a CHW-to-household ratio of 1:50 is manageable for both project staff and CHWs, which translates to 810 CHWs with whom the project is working with.

E. SUSTAINABILITY PLAN

(i) Measuring Sustainability

As outlined in the DIP and the first annual report, the BCSP is utilizing the Child Survival Sustainability Assessment (CSSA) Framework as a tool for sustainability planning and implementing, monitoring and evaluating planned action. The CSSA Framework has six dimensions: *health status*; *health services capacity*; *local organizational capacity*; *local organizational viability*; *community capacity*; and *enabling environment*. As described in the first annual report, AMREF has developed outcome indicators under each of the first five of these dimensions, and has obtained baseline measurements. Progress on sustainability will be assessed during mid-term and end of project evaluations.

(ii) Actions Undertaken to Achieve Sustainability

CAPACITIES AND COMPETENCIES

Dimension 1- Health Status: AMREF and DHMT have initiated QI, BCC, and other processes that will increase adoption of life-saving practices among women and children, and utilization of health services, leading to improved health status of women and children. These efforts have contributed to increased coverage with key maternal and child health indicators as outlined in section A, Main Accomplishments, and appendix 5, Findings of the Annual LQAS.

Dimension 2- Health Services Capacity: To improve the quality of health services in health facilities, AMREF and DHMT have: reviewed the facilitative supervisory guides and transformed them into a checklist to assure high quality supervision by the DHMT; trained health staff to provide quality ANC, EOC, and PMTCT; trained health staff to monitor and evaluate health programs; implemented the PDQ process; and equipped upcoming centres of excellence (*see section A, Main Accomplishments*)

Dimension 3- Local Organizational Capacity: AMREF and DHMT have addressed certain management practices that were found to be weak during the project's organizational capacity assessment. For example, in response to a gap in financial planning recognized during the baseline assessment the Project Manager has supported staff to manage line budgets better and avoid unjustifiable cost variations. The DHMT has also improved on communication by acquiring telecom wireless telephones for each DHMT member.

Dimension 4- Local Organizational Viability: as part of strengthening organizational viability, AMREF has continued to successfully raise funds for its projects, and recently raised USD 238,000 through AMREF Netherlands to bridge a funding gap experienced by this project. In order to foster organizational learning, AMREF conducts annual fora that enable staff to exchange experiences. Furthermore, AMREF has sponsored three project staff to undertake training in strategic leadership. Project staff is utilizing new/enhanced skills to effectively provide leadership, build the leadership capacity of CHEWs and selected CHWs, and facilitate organizational learning, as recently experienced with the integration of project processes.

AMREF has also leveraged new partnerships with like-minded organizations, including GLUK and KPA, in order to jointly address key research issues.

Dimension 5- Community Capacity: AMREF and DHMT are in the process of training CHWs to collect community level child and maternal health data and use it to develop action plans aimed at improving the health of people living in their jurisdiction. In FY3, AMREF and DHMT will build the capacity of CHCs so that they are able to provide the leadership needed to coordinate and facilitate community- based health activities at the village level. Project staff know, first-hand, the contribution that women make to community development when significantly involved and, therefore, ensures the active participation (or at least inclusion) of women in all key project processes. For example, women play a key role in the ongoing PDQ process, specifically, helping to define community's perceptions of quality.

PHASE-OUT PLAN

AMREF and DHMT will develop a phase-out plan in FY3, especially to address additional sustainability gaps not touched upon in the five dimensions outlined above.

F. RESPONSES TO ISSUES FROM DIP CONSULTATION (N/A FOR BCSP)

G. ASSESSMENT REPORTS NOT COMPLETED BY TIME OF DIP (N/A FOR BCSP)

H. SOCIAL AND BEHAVIOR CHANGE STRATEGY (N/A FOR BCSP)

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 system⁴ in disbursement/reimbursement of finances to the field, and financial returns are made based on the Sun System⁵ that is used by AMREF in Kenya. In this system, budget line items are coded according to donor reporting codes. This system has a number of advantages with regard to financial reporting, financial controls, and measurement of financial performance, as described in the first annual report. In year two, the project's financial performance was rated at 95 percent.

(ii) Human Resources

STAFF SKILLS

Most skill areas that are relevant to the project are available among project staff. If gaps in skills exist, the project has outlined areas in which technical support is needed (*see section C*). In addition to targeted staff development (*see below*), technical support is availed either through the AMREF USA office or through local contracting.

STAFF DEVELOPMENT

Staff members are continuously undergoing training and other staff development activities to build skills, as outlined below:

- In February 2007, the Project Training Officer attended a five-day refresher OR workshop organized by AMREF in Nairobi.
- In April and May 2007, the training officer attended the U.S.-based annual CORE Group spring meeting and gained key insights on capacity building approaches at the community level, which were later shared with the rest of the project staff.
- In June 2007, the project's BCC Officer attended and participated in the Child Survival Mini-university in the U.S., and made two project presentations.
- In June 2007, the Project Manager attended a three-day course on Advanced Project Management offered by KPMG in Nairobi, Kenya.

⁴ Float system is a cash management policy, whereby, a sum of money is released for utilization by the project based on the average level of activity spending. Once the project incurs and reports an expense, it is reimbursed for that expense.

⁵ Sun System is accounting software used by AMREF Kenya to record the organization's accounts and accounting transactions.

- In June 2007, the Project Manager, Training Officer, and M&E Officer attended a five-day course on Strategic Leadership in Health and Development Programmes offered by the AMREF International Training Institute in Nairobi, Kenya
- In July 2007, the Project Manager and M&E Officer participated in the child survival proposal development workshop led by AMREF USA and hosted by AMREF Uganda.

The BCSP's staff development plan is linked to annual 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 with staff to meet these needs.

ORGANIZATIONAL DIVERSITY

The BCSP has brought together staff and partners with diverse experience and a gender balance. For example, the Project Implementation Team's (PIT) two community representative positions are reserved for/filled by women in order to foster empowerment of women during the project's processes as well as to best represent the unique health needs of women. Project staff contributes diverse technical expertise that includes social science, nursing, economics, public health, and M&E.

(iii) Communication Systems and Team Development

Technical staff meetings (TSM) are held once a week (on Monday) to review activities carried out during the previous week and those planned for the current week. All-staff meetings (ASM) are held once per quarter to discuss issues that range from approaches to improve management of the project's resources such as transport, to issues that help with meeting staff needs.

To further foster intra-office consultation and sharing of information, BCSP has adopted an open office space and open door policy, further supported by a small office electronic network. Each project staff has unlimited internet and e-mail access. Additionally, project staff also participates in one staff retreat each year that is aimed at fostering team work.

AMREF recently revised the project communication matrix to ensure that it is comprehensive (*see appendix 8*).

(iv) Local Partner Relationships

AMREF enjoys a cordial relationship with the Busia DHMT, based on mutual respect for and recognition of one another. Formal and informal coordination mechanisms include PIT meetings, and informal mechanisms include day-to-day consultation between project staff and DHMT members. The PIT has membership from DHMT, MSF-Spain, World Vision, Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH), AMREF, and the community. In year two, the project conducted four PIT meetings.

(v) PVO Coordination/Collaboration in Country

Role of USAID Kenya Mission

The USAID Kenya Mission, based in Nairobi, is playing the critical role of fostering collaboration amongst the PVOs implementing child survival projects in Kenya. In May, AMREF Kenya's Malaria Program Manager and the BCSP Project Manager attended a child survival partners' meeting, convened by the Mission in Nairobi, and hosted by AMREF at its Headquarters in Nairobi. The meeting aimed to foster greater collaboration amongst child survival project grantees in Kenya. MOH representatives also attended this meeting. Highlights from the meeting include:

- ✓ Overview of each PVO's child survival project.
- ✓ Announcement of MOH plans to pilot a community IMCI (C-IMCI) initiative, which includes community-based distribution of Artemisinin Combined Therapy (ACT) and antibiotics by CHWs.
- ✓ Technical update on community-based newborn care presented by Doctors of the World (DOW) to highlight opportunities in African settings.

PVO collaboration

In September, the PVO child survival grantees in Kenya held a three-day annual from September 12 to 14, 2007 (*see section O, Results Highlights*).

(vi) Findings from the Project Financial Review

In August 2007, AMREF USA reviewed project financial information, in line with the requirement that CSHGP grantees exercise reasonable supervision and diligence to ensure that U.S. Government funds are being used in accordance with the terms of the grant. During the review, policies, procedures and controls related to procurement, human resources, payroll, allocations and cash management were examined and a sample of transactions reviewed in depth. Based on the review, AMREF USA is satisfied that the award is being managed properly.

(vii) Organizational Capacity Building

Based on the findings from the previous capacity assessment (described in the project's first annual report), AMREF and DHMT have addressed most of the identified capacity gaps as follows: (i) AMREF has shared information on project organization, communication plan, conceptual framework, and financial and human resource policies with key stakeholders; (ii) DHMT has installed a telephone system at its offices to facilitate timely bi-directional communication with health stakeholders; (iii) AMREF has shared procurement and financial procedures with project staff; and (iv) AMREF and DHMT will be developing a phase-out strategy in year three.

M. MISSION COLLABORATION

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

The BCSP fits well within Strategic Objective 615-003 of the USAID/Kenya Strategic Plan FY 2006-2011: *reduced transmission and impact of HIV/AIDS and improved reproductive, maternal and child health*. The project 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.

(ii) Collaboration with the Mission's Bilateral Programs

AMREF has initiated collaboration with the Mission's Aids, Population, and Health (APHIA) II Program. To this end, AMREF project staff has held initial discussions with APHIA II Western Region staff, and agreed on the need to pursue synergies between the BCSP and the APHIA II Programme (*see appendix 6, Action Plan for Partnership between BCSP and APHIA II Western*).

(iii) Frequency and Nature of Interactions with Mission Personnel

Interaction with Mission personnel occurs on an ad-hoc basis and through planned meetings held by the Mission. Ad-hoc interaction includes telephone and e-mail communication, usually aimed at seeking clarification and soliciting necessary documentation. The contact person at the USAID Kenya Mission is Dr Sheila Macharia. Planned meetings include: 1) annual CSHP grantee meetings that last three to four days and are convened by the PVO grantees; and 2) one-day CSHP grantee meetings convened by the Mission, during which PVOs share project experiences and the Mission communicates information aimed at improving program effectiveness, synergy, and visibility of USAID.

N. TIMELINE OF ACTIVITIES FOR COMING YEAR (FY 3)

Activities	Qrt 1			Qrt 2			Qrt 3			Qrt 4		
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Procure commodities (ITNs/LLINS, testing kits...) and equipment					X		X					
Training needs assessment will be conducted prior to each training		X						X				
Further review curricula and prepare training materials	X	X	X	X	X	X	X	X	X			
Design prioritized Operations Research protocols	X	X	X				X	X	X			
Implement OR study/studies (# TBD)	X	X	X	X	X	X	X	X	X	X	X	X

Activities	Qrt 1			Qrt 2			Qrt 3			Qrt 4		
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Distribute targeted subsidized ITNs/LLINs	X	X	X	X	X	X	X	X	X	X	X	X
Launch 4 centres of excellence (at least 1 will be launched by End of February 2008, and the others by end of June 2009)					X				X			
PDQ Step 4 (of 5) sessions implemented by CHEWs, CHWs, HF staff	X	X	X									
Quality of Care Workshop (1 session at 2 days for 22 DHMT/HF staff). Content will build on experiences from PDQ process.											X	
Advocacy to influence practice and policy within AMREF and at district, province and national forums	X	X	X	X	X	X	X	X	X	X	X	X
Produce branded T-shirts with BCC messages, for CHWs	X						X					
Orientation to the Child-to-Child, Child-to-Parent, Parent-to-Parent (includes Positive Deviance [PD] Approaches), and 5x5x5, (2 sessions at 1 day each for 7 CHEWs & 13 Public Health Technicians-PHT); 2 nd session is follow-up refresher training												
Project slogan/rallying call contest & launch of child-to-child approach		X										
Continue child-to-child activities in schools; monitor activities with teachers & students	X	X	X	X	X	X	X	X	X	X	X	X
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		
CHEWs orient CHWs on the PD approach and peer-clubs, mothers' and fathers' support groups (1 day) and develop action plans (40 CHWs will be oriented during two 1-day sessions of 20 CHWs each).		X										
CHWs formulate/identify father-to-father/mother-to-mother clubs and identify PDs		X										
Orientation to the 5X5X5 approach (20 different CHWs will be oriented during each of two 1-day sessions) and develop integrated action plans (MNC, Malaria & HIV/AIDS - <i>Reorientation of CHWs on Communication</i>)		X										
Implement communication Air of health messages via on radio stations							X	X	X	X	X	X
CHWs to implement 5X5X5 approach in phases on key household behaviors			X			X			X			X

Activities	Qrt 1			Qrt 2			Qrt 3			Qrt 4		
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Procure materials for C-HMIS (registers, chalk boards...)	X	X	X									
Training of CHWs in C-HMIS by CHEWs during 2-day sessions over a 4-month period until all 810 have been trained				X	X	X						
Roll out Community health information system data collection				X	X	X	X	X	X	X	X	X
TOT in anti-malarial treatment (two sessions at 2 days each for 7 CHEWs and 13 PHT)											X	
Training of 250 shopkeepers (during 2 sessions at 1 day each). Retail drug vendors will be trained in malaria prevention, home treatment & appropriate drug use.											X	X
CHWS cascade training (Phase 1)	X											
Orientation of CHW leaders and provincial administration for 2 days (phase 1)		X										
Orientation of TBAs for 2 days on how to women during pregnancy, delivery, and after delivery					X							
Train 40 CHWs in supporting PMTCT (2 sessions at 3 days each for 20 CHWs) (Phase 2)				X								
Cascade training of CHWs on supporting PMTCT (Phase 2)				X	X	X						
Training of CHWs in EOC (120 CHWs will be trained during 2 sessions at 2 days each) (Phase 2) ⁶				X	X	X						
Implement MAMAN with the support of Kenya Paediatric Association (KPA)	X	X	X	X	X	X	X	X	X	X	X	X
EOC training of 10 community midwives for 10 days						X						
Cross-visits between health facilities					X			X			X	
IMCI TOT (DHMT, HF staff; one 5-day session for 10 people)		X										
IMCI Case Management Training (HF staff; 2 sessions with 10 people each for total of 20 persons at 14 days)			X									

⁶The PMTCT and EOC training for CHWs will be delivered in the same workshop on MNC, in an effort to integrate the related concepts as well as the C-HMIS.

Activities	Qrt 1			Qrt 2			Qrt 3			Qrt 4		
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
IMCI follow-up training (DHMT, HF staff; one session at 2 days for 10 people)					X							
Training of 40 CHWs in malaria prevention, home treatment, appropriate drug use and ITN treatment and re-treatment (20 CHWs will be trained in 2 sessions at 2 days each) (Phase 3)								X				
C-IMCI TOT on dialogue approach (1 session at 5 days for 13 people) (Phase 3)								X	X			
C-IMCI follow-up training on dialogue approach (one 1-day session for 13 people) (Phase 3)										X	X	
C-IMCI training on dialogue approach for 240 CHWs (2-day sessions will be held for 20 CHWs simultaneously by each CHEW in each of 7 lots) (Phase 3)										X	X	X
Prepare annual progress reports	X											X
Hold annual project review with partners												X
Submit Annual Reports to CSHGP	X											
DIP refinement based on MTE												X
HF staff and Health Committee meetings			X			X			X			X
Project Implementation Committee (PIC) meetings	X		X			X			X			X
Technical Advisory Group (TAG) meetings			X			X			X			X
Facilitative supervisory visits at health facilities and community level		X	X	X	X	X	X	X	X	X	X	X
Routine Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
AMREF regularly update District Development Committee			X			X			X			X
Mid-term evaluation										X	X	
Documentation and dissemination of lessons learned and better practices	X	X	X	X	X	X	X	X	X	X	X	X
Annual staff retreat					X							
Develop phase-out plan	X	X	X	X	X	X						

Substantial Changes from the Original Work plan

- **Training needs assessments** were previously planned to be done in project-years one and two. While assessments have been done for most of the thematic areas, some still need to be done in project-year three (prior to the training events that have been re-scheduled for the same year). This reasoning also applies to the review of training curricula.
- **OR protocols** were to be finalized in project-year one. While the project has developed two research protocols, we have since reviewed our research agenda (*see section D, Substantial Changes from the DIP*), which resulted in the decision to develop new research protocols in project year three.
- **Renovation and equipping of COEs** have been completed. However, upcoming centres still need to meet accreditation criteria set by DHMT, PHMT, AMREF, and approved by the national Division of Child Health. AMREF and DHMT will continue to support the upcoming COEs through facilitative supervision, and expect that each will meet the set accreditation criteria in project-year three in order to prepare for ultimate accreditation.
- **PDQ sessions** are continuing into project-year three because of a delayed start in activities during project-year two.
- **Quality of Care (QoC) workshop** is part of the ongoing PDQ in that the quality of care workshop should build upon gaps identified during the PDQ process. Therefore, to optimize the value and content of the training, we have shifted it to the fourth quarter of project-year three. This way, the PDQ process will feed into the QoC workshop and allow project staff sufficient time to develop a “customer care in health settings” curriculum beforehand [Kenya does not have such a curriculum and, therefore, the TAG has requested AMREF to explore possibilities of working with the MOH to develop one].
- **Development/adaptation of BCC materials** is almost complete. CHW T-shirts bearing health messages will be procured in quarters one and three of the coming year.
- **Project slogan awards** will be made to school health club winners in the first quarter of the coming year (slightly behind schedule).
- **Orientation to parent support groups/PDs** will start in the first quarter of year three since it is related to the mapping exercise that will be conducted by CHWs, also in year three.
- **5*5*5 orientation of CHWs** was conducted on a pilot basis in two project lots during year two. Since then, the guidelines have been updated, based on year two experiences, and project staff will orient all CHWs on the updated 5*5*5 (BCC) approach during the first quarter of project year three.
- **TOT in antimalarial treatment** for CHEWS and PHTs will be conducted in the fourth quarter of year three. The TOT was not implemented during year two as planned because Kenya is currently undergoing policy transformation in home-based malaria case management. Therefore, it was decided that the TOT would be postponed until the policy is clarified in order to optimize the results of the training. The same reasoning applies to training of shopkeepers/retail drug vendors on malaria prevention, home treatment, and appropriate drug use.
- **Community-level (TOT and CHW) training in PMTCT and EOC** has been combined into Phase II (MNC training) and will be implemented during year three.

- **Community midwife EOC training**⁷ has been separated out from the facility health worker EOC training and will be conducted later than had been scheduled (second quarter of year three) due to different learning needs of the two groups.
- **Orientation of CHW Leaders and the Provincial Administration** has been incorporated into the work plan as a new two-day activity (funded by AMREF Netherlands) that introduces them to the project's community strategy.
- **The series of IMCI trainings** will be conducted amongst health facility staff during quarter one and two of the upcoming year. The delay is due to tight schedules during project year two.
- **Training in malaria and C-IMCI** has been consolidated into Phase III of project training, which includes CHW training in malaria prevention, home treatment, rational drug use; C-IMCI TOT and follow-up; and C-IMCI training of CHWs. Phase III trainings will be conducted during the third and fourth quarters of year three.
- **Orientation of TBAs** is a new activity that the project has adopted to rally TBAs to support safe motherhood (even though this is not yet policy). AMREF will conduct research to establish and document substantive tasks (other than delivery) that TBAs can conduct during pregnancy, delivery and after delivery (*see appendix 4, Research Questions*). The TAG has approved the research question.
- **Annual staff retreat** has been added to the work plan and will take place during quarter two.

O. RESULTS HIGHLIGHT

AMREF and DHMT are implementing four innovative ideas and one promising practice, described in this section, for closing the gap between communities and the formal health sector.

The first, **community strategy**, is a creative and potential solution adapted by AMREF and DHMT staff from the MOH strategy and the care group concept, and is being tried through the BCSP-vehicle. The second idea, **C-HMIS**, both supports and depends upon the success of the community strategy; it will fill a local gap for quality data and information if its processes are found valuable and are sustained by the community and district. The third, **PDQ**, is being applied and tested for the first time in the Kenyan context, having been applied by Save the Children in at least nine other countries; the fourth, **reaching hard to reach populations with LLINS**, is AMREF and DHMT's response to coverage inequalities in Busia. The fifth, **formalized PVO collaboration**, is a promising practice in which USAID-funded PVOs in the Western Region of Kenya are creating opportunities for synergy.

⁷Community midwives are qualified midwives who do not work at health facilities (i.e., retirement, private practice). The MOH in Kenya has, by policy, allowed them to conduct deliveries outside health facilities.

(i) Community Strategy

INTRODUCTION

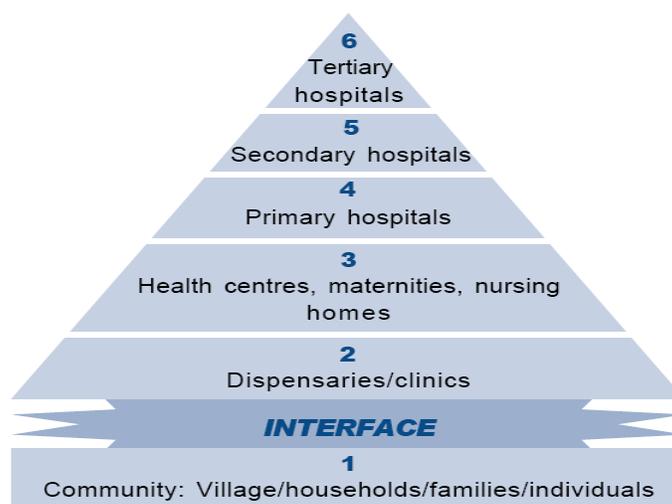
In line with the current National Health Sector Strategic Plan (NHSSP) 2005-2010, health care stakeholders in Kenya have developed a *community strategy* for making the health system more effective and accessible to people. In this strategy, the health system focuses on people and their needs, rather than simply focusing on diseases. Similarly, AMREF, in its new strategic plan (2007–2017), has committed to focus on creating a broad-based culture of health promotion, prevention and care in Africa, especially by working with poor and marginalised communities to bring them into an integral and vibrant relationship with their health system, and enabling them to achieve their full health potential as is their right. At the same time, AMREF will orient its capacity building efforts toward helping make health systems more responsive to communities.

In line with the NHSSP II and AMREF's strategy, programmes within AMREF are re-aligning to focus on the needs of people using six life-cycle cohorts: pregnancy and newborn, early childhood, late childhood, youth and adolescents, adulthood and elderly (*see appendix 9*). Each of these cohorts has special health needs. This cohort approach, called the Kenya Essential Package for Health (KEPH), aims to improve continuity of health care by emphasizing that the various phases of a person's life are connected.

In Kenya, health care for each of the six cohorts is provided at six different levels (see figure 1). The community is the first level of care at which CHWs work. Other health service providers such as traditional healers, traditional birth attendants (TBAs), and even shopkeepers who sell medicines also belong to this level. Importantly, sick people are first taken care of by their immediate family in the household. This explains why the community is the first level of care. It is a part of the health system.

THE PROBLEM

In figure 1, the “interface” refers to the linkage between the community and the rest of the health system to ensure that individual and community health needs are adequately met. Unfortunately, in Kenya, this is usually not the case especially among poor or remote communities such as in Busia. A “gap” therefore exists between the community and the rest of the health system and manifests in infrequent, irrelevant, and inadequate response to community health needs.

Figure 1: Levels of Health Care in Kenya

PROJECT'S INPUT

AMREF and DHMT have completed the following processes toward bridging the gap between communities and the formal health system:

Adapted MOH strategy to link the communities and the rest of the health system (*see appendix 1, Community Strategy Chart*), so that it now includes strong capacity building elements such as leadership strengthening, technical capacity strengthening, facilitative supervision, and interactive (i.e., peer-based) BCC processes. So far, AMREF and DHMT have done the following toward implementing the MOH strategy: developed materials for training CHWs; trained 16 facility based staff, 14 CHEWs, and 680 CHWs on various thematic areas; trained all 16 health facility in-charges in the project area on facilitative supervision; and worked with 48 school health clubs and more than 200 CHWs to implement behaviour change interventions in schools and in households (*see section A, Main Achievements*)

Identified capacity needs within the district health system comprised of: CHW teams, TBAs, CHCs, health facility management committees, chiefs and assistant chiefs, community midwives, primary schools, CHEWs, HF staff, and DHMT members.

Implemented the PDQ methodology to directly involve communities and health service providers in improving quality of health services. [See part (ii) of this section, PDQ]

Developed a C-HMIS model to test, which will foster a culture of data-based planning in communities and at health facilities. [See part (iii) of this section, C-HMIS]

THE MAGNITUDE OF THE INTERVENTION

Direct beneficiaries of this CSHGP initiative constitute 37.8% of the district population, and include 31,664 children 0-59 months and 49,858 WRA.

At the community level, the project is strengthening the leadership and technical capacity of 810 CHWs, 100 CHCs, 60 chiefs and assistant chiefs, and several community midwives. At the formal health system level, the project is strengthening the technical and leadership capacity of 14 CHEWs, about 50 HF staff and DHMT staff, and 16 HF management committees.

RESULTS

So far, AMREF and DHMT have achieved the health services uptake results outlined in *section A, Main Achievements and appendix 5, findings of the annual LQAS*.

(ii) Partnership Defined Quality

INTRODUCTION

PDQ is a five-step methodology for improving quality of health services developed by Save the Children. The five steps are: 1- *Planning and Design*; 2 - *Building Support*; 3 - *Exploring Quality*; 4 - *Bridging the Gap*; and 5 - *Working in Partnership*. The PDQ methodology equitably unites community members (users and non-users of health programs or services) with providers to define quality, identify and prioritize problems, and create solutions that strengthen the quality, access and use of services.

THE PROBLEM

The project is using PDQ to address the problem of poor quality and low utilization of MNC services at the health facilities identified during the baseline assessment. Using the PDQ model, we hope to improve quality of care provided by health workers in the project area, including the technical and human elements of care aspects. Its end result will be the creation of demand for MNC services provided at the health facilities.

THE PROJECT'S INPUT

AMREF and DHMT have done the following: developed an OR protocol to test the effectiveness of PDQ, and conducted the pre-intervention observation (*see appendix 7*); contextualized the Save the Children PDQ manual to the local setting, and implemented the first three steps of PDQ, ensuring involvement of communities and especially women in all the steps. The project will undertake subsequent steps in October, November, and December 2007, after which a post-intervention observation will be undertaken.

THE MAGNITUDE OF THE INTERVENTION

Direct beneficiaries of this CSHGP initiative constitute 37.8% of the district population, and include 31,664 children 0-59 months and 49,858 WRA. Thirteen health facilities in the project area serving the above beneficiaries are undertaking the PDQ process.

RESULTS

The project undertook pre-intervention observations, as part of OR, to assess quality of care being given in the health facilities before introducing PDQ. Key quality gaps identified during the pre-intervention observation are highlighted below (*see also appendix 7*):

- Less than a quarter (23%) of women attending ANC has an individual birth preparedness plan in place, largely because they are not provided with necessary information on IBP.
- Only about a quarter (27%) of women in labor at health facilities receive a correctly interpreted partograph with a correct curve.
- None of the mothers attending post-natal clinic had knowledge on cord care, and only slightly more than a third (36%) breast fed their newborn babies within one hour of birth.
- About half of clients felt that the HF staff did not take keen interest in what the client was saying, and less than a quarter (22%) felt that the staff examined them properly.
- Very few (3%) clients reported that the health worker gave them a chance to choose the date of the next visit

The post-intervention observation study will be conducted at least three months after targeted health facilities have undertaken the PDQ process, and the finding compared with those from the pre-intervention observation. It is then that the project can conclude whether PDQ approach is an effective model of improving quality and utilization of maternal and newborn care services.

(iii) Community Health Information System

INTRODUCTION

The district health management and information system (DHMIS) collects data on inpatient morbidity and mortality, outpatient morbidity, nutrition, immunization (and vitamin A supplementation), ANC, STIs, PMTCT and HIV/AIDS (VCT, DTC, TB and HBC).

Notably, most data on births and maternal and neonatal mortality at the community level is not captured by the DHMIS, largely because most deliveries and consequently most maternal and neonatal deaths occur outside health facilities. Developing a comprehensive DHMIS is essential to the DHMT's, CHEWs, HF staff, CHW, and CHC's ability to make decisions based on solid information.

THE PROBLEM

The current DHMIS has weaknesses in that it does not collect adequate community data for use by communities and health facilities. Even when community data are collected, they are not integrated into the health facility data. Moreover, community data is hardly ever used to make key health planning decision

THE PROJECT'S INPUT

AMREF and DHMT recognize that the DHMIS has weaknesses. To respond to the weaknesses, AMREF and DHMT have developed a C-HMIS model that intends to: provide quality community health data; integrate community health data collected by CHWs and local administrators into the existing DHMIS; strengthen the decision-making process at the community level by providing the data needed by each decision-maker.

In designing this model, the project undertook the following steps:

Stakeholders' involvement: in October 2006, AMREF, DHMT, and other district health stakeholders (30 participants) held a C-HMIS stakeholders' consultative meeting. During the meeting, AMREF and DHMT created awareness and garnered support from government departments and other health stakeholders. In December 2006, CHEWs held orientation meetings with 95 community representatives on C-HMIS. During the meetings, CHEWs created awareness and garnered support from the community leaders for the C-HMIS.

Information needs assessment and gap analysis: Between March and May 2007, project staff conducted the C-HMIS information needs and gap analysis that included the following tasks: formation of facilitation technical team; development of tools; data collection using focus group discussions and key informant interviews, and content analysis (*see appendix 3 for findings*).

Model design: In June 2007, AMREF and DHMT conducted a two-day C-HMIS information needs and gap analysis dissemination and model design workshop with 27 representatives from community, health facilities, GLUK, DHMT, AMREF, and Plan International. During the workshop, a draft C-HMIS model was designed. In July 2007, the model was improved by incorporating comments from reviewers, and 11 villages identified for piloting the model. The findings of the gap analysis and desk study informed the design of the model.

THE MAGNITUDE OF THE INTERVENTION

Akin to the other innovative ideas, direct beneficiaries of this CSHGP initiative constitute 37.8% of the district population, and include 31,664 children 0-59 months and 49,858 WRA. The household contact persons, CHWs, CHC, CHEWs, chiefs and assistant chiefs, PVOs, HF staff, HF management committees, and DHMT who are the users of the information generated by the C-HMIS will benefit through enhanced decision-making.

(iv) Reaching Hard to Reach Populations with LLINs through Mobile Outreach Services

THE PROBLEM

Poor access to nets and under-utilization contributes to high malaria mortality and morbidity in Busia. Malaria is the leading cause of death among Cu5 in the District, and significantly contributes to maternal morbidity and mortality.

During the baseline assessment, AMREF found that, although most (93%) of the mothers know that ITNs are a method of preventing malaria, net ownership is higher than net utilization as 77% of households had at least one ITN, but only 65% of the mothers of children 0-23 months and 70% of the children 0-23 months reported having slept under the net the previous night. AMREF and DHMT are committed to helping increase net coverage to at least 80% in recognition that when insecticide treated nets are used by 80 percent or more of a village, it creates a barrier that kills or drives off mosquitoes, protecting everyone in the area, including those without nets.

The baseline assessment revealed that long distances between households and net sources as well as poverty are key barriers to net ownership. These barriers are disproportionately distributed in the project area, since net ownership is lower in some areas than others; out of the seven project management units, two units were found to have net coverage well below expectation.

To address these gaps, AMREF and DHMT developed a strategy in which LLINS are distributed free of charge during mobile clinics. The objectives of applying this net distribution approach are to: increase access to LLIN/ITN in the intervention area; increase the proportion of pregnant women and CU5 in hard to reach areas that sleep under insecticide treated nets.

THE PROJECT'S INPUT

Involvement of formal health system stakeholders: AMREF worked with the Busia DHMT to develop the net distribution strategy. Project staff and CHEWs mapped mobile clinics, and collected the following information during mapping: name of facility; schedule of mobile clinics in year 2007; names of villages targeted by each planned mobile clinic; approximate distance from targeted cluster of villages to nearest health facility; organization supporting the mobile clinic; and approximated population that the mobile clinic reaches.

Community involvement: during the project's baseline assessment, a DHMT member cited "passive community participation" as a barrier to health service delivery in the district, and gave the example of situations where health staff conducts mobile clinics but mothers fail to utilize the services. In order to address this problem, HF staff work with assistant chiefs, CHEWs, and CHWs in the targeted villages to mobilize the community, especially pregnant women and CU5, to utilize mobile outreach services.

Targeting: AMREF and DHMT practice targeting in two ways during net distribution:

- ***Hard-to-reach populations:*** in order to achieve the objective of reaching underserved populations, net distribution is conducted in mobile clinics serving rural populations in areas that are underperforming as per the annual LQAS and mobile clinics serving other hard to reach populations (those that live more than 5 kilometers from the nearest facility). These populations are not likely to benefit optimally from the existing facility based net distribution processes managed by Population Services International (PSI) and the MOH.
- ***Vulnerable population:*** nets are being marketed to pregnant women and CU5.

Supervision: AMREF oriented CHEWs on the mobile clinic net distribution strategy. The CHEWs provide facilitative supervision by accompanying health staff who manages monthly

mobile outreach clinics during initial sessions to ensure smooth roll-out of net distribution, and proper record-keeping.

Monitoring

- (i) **Net register:** each participating health facility maintains a mobile clinic net register in which the following data is entered for each net recipient: name of recipient, age of recipient, name of head of household, residence (sub-location and village), and date of issue.
- (ii) **Stamping:** health workers give nets upon production of an ANC or CWC card, which is stamped to ensure the same person does not receive a net more than once.

THE MAGNITUDE OF THE INTERVENTION

Direct beneficiaries of this CSHGP initiative constitute 37.8% of the district population, and include 31,664 children 0-59 months and 49,858 WRA.

RESULTS

The project has distributed 3,290 LLINs in the project area using the mobile clinic distribution strategy. This has contributed to the following results: percentage of households with at least one net rose from 77% to 86%; percentage of children 0-23 months who slept under an insecticide-treated net the previous night rose from 70% to 80%, and access to nets among hard- to-reach populations improved.

(iv) Formalized PVO collaboration

In Kenya, Child Survival (CS) PVOs share responsibility for coordinating, facilitating and hosting fora through which innovations and promising practices are shared, and information, materials and tools are exchanged.

THE PROBLEM

In Western Kenya, there are currently two major USAID-funded initiatives, namely, the BCSP and APHIA II Western. Although the two initiatives are addressing related problems (HIV/AIDS, Maternal and Child Health), efforts of each have not been well coordinated in order to promote synergy and non-duplication.

PROJECT'S INPUT

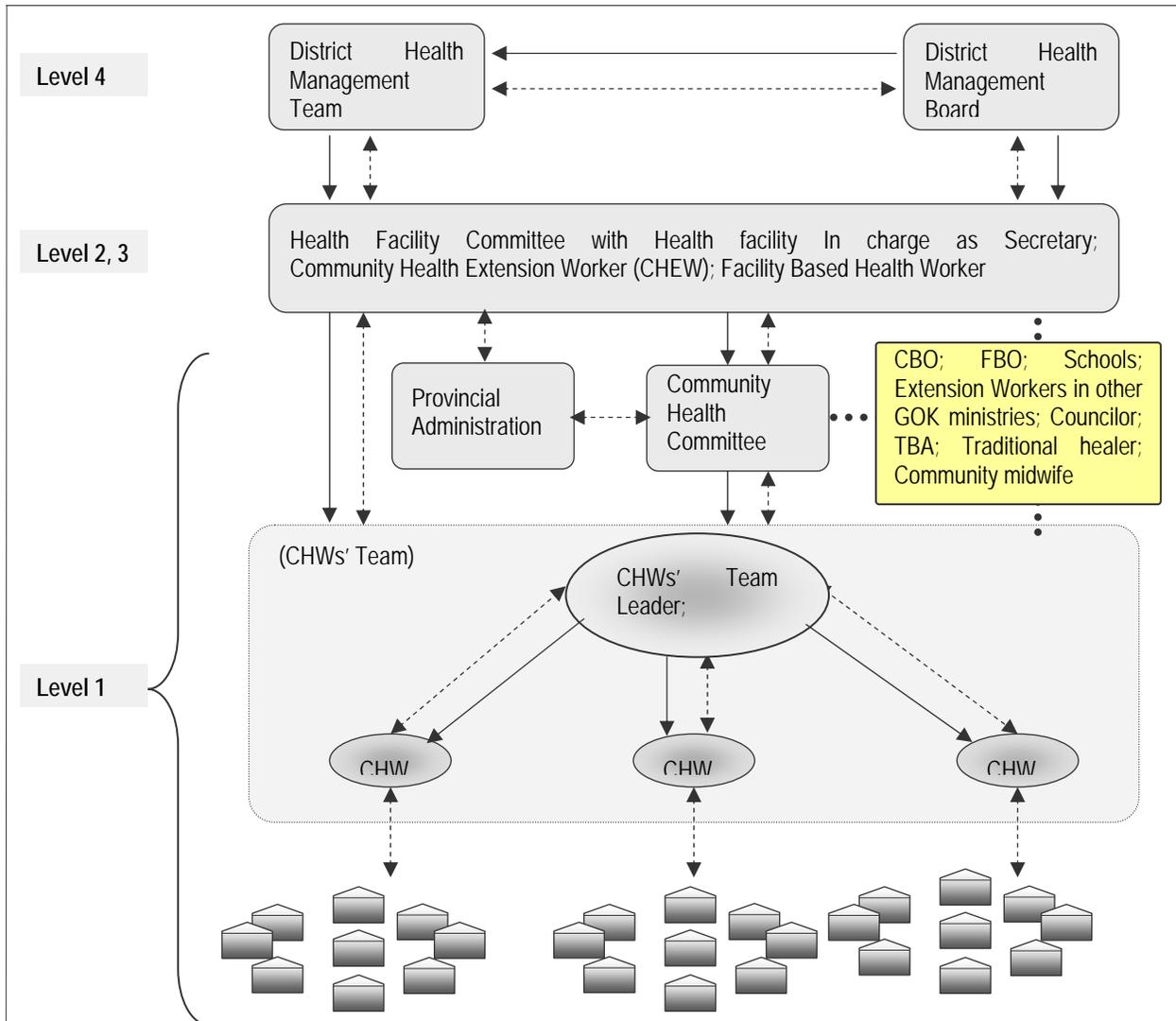
The CSHGP grantees in Kenya held the third annual *Child Survival and Partners Meeting*, from September 12 to 14. This year's forum, hosted by AMREF, brought child survival partners together to share field experiences and receive technical updates. The theme of this year's forum was "**partnerships and effective models for child health**", specifically referring to partnerships between child survival projects and the APHIA II Programme.

RESULTS

Twenty eight people participated from the following categories of organizations: MOH; Western Kenya's CSHGP PVO grantees (PLAN International, Catholic Relief Services, Doctors of the World, and AMREF) four APHIA II programme staff located in provinces with CS projects (APHIA II Western, APHIA II Eastern, APHIA II Nyanza, and APHIA II Coast); and local partners (MSF-Spain, AMPATH). During the meeting, BCSP staff and APHIA II Western Programme staff developed a joint plan on the way forward for collaboration (*see appendix 6*)

P. APPENDICES

Appendix 1: Community Strategy Chart



Key



CHW- Community Health Worker; TOT- Trainer of Trainers; CBO- Community Based Organization; FBO- Faith Based Organization; TBA- Traditional Birth Attendant

Appendix 2: Results of the MAMAN Baseline Survey

AMREF Kenya conducted the MAMAN baseline survey in November 2006. Survey activities included a two-day training of seven CHEWs and 14 interviewers on KPC data collection and supervision procedures, respectively. Data were entered into a computer, cleaned, and analyzed using SPSS. The coverage for each MAMAN indicator is shown below

Indicator	Description	Coverage
1. Tetanus Toxoid Immunization	Percentage of mothers with children age 0–11 months who received at least two tetanus toxoid (TT or Td) injections before the birth of their youngest child.	81.9%
2. Skilled attendance	Percent of deliveries with a skilled attendant*at birth.	27.8%
3. Clean cord care	Percent of births where cord was cut with a new or clean instrument or a clean birth kit was used.	75.2%
4. Active Mgmt	Percent of births within the past 12 months in targeted facilities that received active management of third stage of labor.	13.5%
5. Drying and wrapping	Percent of newborns who were dried and wrapped with a warm cloth or blanket, immediately after birth (before the placenta was delivered).	44.4%
6. Immediate initiation of breastfeeding	Percent of infants less than 12 months of age who were put to the breast within one hour of delivery.	21.1%
7. Prolactial feeds	Percent of mothers who did not give anything other than breast milk in the first three days after birth.	20.3%
8. Colostrum	Percent of mothers who gave colostrums.	91.0%
9. Postpartum visit (maternal)	Number and percent of postpartum visits made by appropriately trained workers** to mothers who delivered in facilities or at home within 3 days of birth.	25.6%
10. Postnatal visit (neonatal)	Number and percent of newborn care visits made by appropriately trained workers** to newborns delivered in facilities or at home within three days of birth.	20.3%

* Skilled birth attendant includes: doctor; nurse; midwife; clinical officer

**trained workers include: skilled birth attendant or trained community health worker, which includes trained traditional birth attendants

Appendix 3: Findings of the C-HMIS Information and Capacity Needs Assessment

Decisions, Information Needs, Methods and Tools

Decisions to be made, information needs, and methods and tools <u>by household members</u>		
Decisions	Information needs	Methods and tools
<p>Adopting key health behaviours:</p> <ul style="list-style-type: none"> ➤ maintain hygiene and that of the children ➤ pregnant mothers and children under five to sleep under ITNs ➤ pregnant mothers to attend ANC clinic as recommended by the health workers ➤ pregnant women and mothers to use PMTCT services offered in health facilities ➤ caretakers to take newborn babies for postnatal clinic (for neonatal care, BCG and polio immunization) ➤ pregnant women and mothers to adopt recommended feeding practices for themselves and their babies ➤ Mothers to go for postpartum clinic 	<ul style="list-style-type: none"> ➤ Knowing the key health behaviors (i) malaria prevention (ii) attending ANC and PNC (exclusive breastfeeding) ➤ Importance of adopting key health behaviours: ANC and PNC attendance and delivery in a health facility or with assistance from skilled birth attendant and exclusive breastfeeding ➤ Knowledge on environmental hygiene practices among pregnant women and caretakers. 	<ul style="list-style-type: none"> ➤ informal communication networks (advice from community members, parents, peers) ➤ listening to mass media; radio sports and reading newspapers ➤ feedback during household visitations by TBAs, community health workers and <i>ligurus</i> ➤ announcements during public gatherings like chief barazas, churches and funerals ➤ receive messages from school children ➤ health education and one-on-one talks by health workers in health facilities
<p>Providing home based care:</p> <ul style="list-style-type: none"> ➤ type of treatment to give, ➤ who to provide the home based care, and ➤ preparation for eventualities (storing drugs at home), ➤ when and where to refer a seriously sick patient 	<ul style="list-style-type: none"> ➤ Knowledge on signs and symptoms of malaria and other diseases. ➤ commodities required to provide home based care. ➤ Types of foods required. ➤ Community health workers available in the community and type of care they offer. 	<ul style="list-style-type: none"> ➤ informal communication networks (advice from community members, parents, peers) ➤ listening to mass media; radio sports and reading newspapers ➤ feedback during household visitations by TBAs, community health workers and <i>ligurus</i>

<p>Seeking outside care:</p> <ul style="list-style-type: none"> ➤ Where to seek services when a household member falls sick or needs care. <p>When to seek for outside care.</p>	<ul style="list-style-type: none"> ➤ knowledge of danger signs of diseases and high risk conditions such as pregnancy, labour and delivery ➤ type and quality of care given in health facilities ➤ distance to the health facilities ➤ the cost of services offered in health facilities ➤ health risks in certain conditions or complications ➤ the health status of pregnant women and the expected date of delivery 	<ul style="list-style-type: none"> ➤ informal communication networks (advice from community members, parents, peers) ➤ listening to mass media; radio sports and reading newspapers ➤ feedback during household visitations by TBAs, community health workers and ligurus ➤ announcements during public gatherings like chief barazas, churches and funerals
<p>➤ Decisions to be made, information needs and methods and tools by CHWs</p>		
Decisions	➤ Information needs	➤ Methods and tools
<ul style="list-style-type: none"> ➤ plan and make home visits to promote/counsel on key health behaviours ➤ refer high risk or severely sick individuals ➤ attend community meetings to provide health education ➤ targeting individuals, households with special needs ➤ selecting health education topics for home visits, Barazas ➤ following up on defaulters ➤ reporting cases of notifiable diseases 	<ul style="list-style-type: none"> ➤ individual knowledge and practice of key behaviours ➤ availability and costs of health services, food and commodities (drugs, IEC materials), ➤ have knowledge on counseling, especially families ➤ incidence and prevalence of HIV ➤ total number of latrines in the village ➤ availability of support groups ➤ environmental factors: water, sanitation, food, vectors (stagnant water points and unprotected springs), climate ➤ individual use of preventive services ➤ composition and characteristics of all households ➤ individual cases of notifiable diseases 	<ul style="list-style-type: none"> ➤ interviews and observation during home visits ➤ community referral form 2 (CRF) ➤ note books and papers

➤ Decisions to be made, information needs and methods and tools <u>by CHCs</u>		
➤ Decisions	➤ Information needs	➤ Methods and tools
<ul style="list-style-type: none"> ➤ prioritize health problems ➤ develop community action plans (home visitations, social mobilization and sensitization, health education, net retreatment, immunization), ➤ mobilization and allocation of resources ➤ give feedback to the CHWs and provincial administration ➤ submit data to the health facility 	<ul style="list-style-type: none"> ➤ knowledge on prevention and treatment of simple ailments ➤ demographic data of each household (number, sex and ages of household members) ➤ common diseases affecting community members ➤ HIV status of the community members ➤ children who are underweight ➤ statistics on early marriages and school drop-out rate (by gender) ➤ information on ANC attendance 	<ul style="list-style-type: none"> ➤ Public barazas ➤ interviews with the community members ➤ health education ➤ BCC activities (e.g., drama and cultural festivals), ➤ Role-modeling ➤ IEC materials (posters, brochures and pamphlets) ➤ facility records (including hospital) ➤ review of periodic CHW reports ➤ Constructive feedback from the health workers/DHMT and health facility committees
➤ Decisions to be made, information needs and methods and tools <u>by provincial administration</u>		
Decisions	Information needs	Methods and tools
<ul style="list-style-type: none"> ➤ Environmental factors (e.g., oiling of mosquito breeding sites) ➤ Holding barazas to discuss health issues ➤ Dissemination of information to and feedback from community members ➤ Registration of births and deaths ➤ Request for outreach services ➤ Home visits ➤ Report of notifiable diseases ➤ Enforcement of law and order (marital issues to ensure the vulnerable are protected) ➤ Promotion of key individual and household behaviours ➤ Mobilization of resources to support referral cases (emergency cases and terminally ill) 	<ul style="list-style-type: none"> ➤ Knowledge of health status of community members ➤ Risk status of community members (pregnant women, HIV-positive members) ➤ Status of community health workers (CHWs, TBAs, retired midwives, and other health workers) ➤ Effective interventions and referral points ➤ Composition and characteristics of all households 	<ul style="list-style-type: none"> ➤ Review of IEC materials ➤ Verbal communication by household members; in Barazas; at funerals ➤ Letters and circulars from superiors and MOH officials ➤ Notebooks, diaries ➤ Vital events registration book ➤ Constituency Development Funds (CDF) records, ➤ Periodic reports from health workers and CHWs

Capacities Required by Decision-Makers

CHWs require skills in leadership, data collection/compilation and manual data analysis, knowledge of roles and responsibilities and communication strategies.

To effectively perform their roles in relation to the C-HMIS they require bicycles, bags and folders, pens and pencils, erasers, notebooks, T-shirts and identification badges.

CHCs require skills in leadership, manual data analysis, interpretation, action-planning and supervision skills and community dialogue approaches. They also need to be knowledgeable on roles and responsibilities, communication strategies and team work.

They need files and folders, pens and pencils, erasers, notebooks, T-shirts and identification badges.

Provincial administrators need skills in leadership and knowledge of roles and responsibilities and communication strategies.

They need files and folders, pens and pencils, erasers, notebooks, T-shirts.

Health workers: require skills in leadership, data analysis, interpretation and integration of data and information, knowledge of roles and responsibilities in C-HMIS, team work, communication strategies, and supervision.

They need files and folders, pens and pencils, erasers, notebooks, T-shirts.

Appendix 4: Research Questions for Busia Child Survival Project

- (i) What approaches can be used to effectively supervise, motivate, and retain community health workers and community health committees?⁸
- (ii) What approaches can be used to ensure that the health-related decisions that communities and the formal health system make are based on data?
- (iii) What indicators can be used to measure and monitor the gap or strength of partnership between communities and the formal health system?
- (iv) What roles can Traditional Birth Attendants (TBAs) play to support maternal and newborn health?
- (v) What approaches can be used foster sustainable involvement of men in maternal and child health issues?
- (vi) What is the cost and effectiveness of implementing the community strategy recommended by Kenya's Ministry of Health in Busia, Kenya?
- (vii) What methods can be used to improve referral of mothers and children with complications from homes to health facilities in resource poor settings?⁹
- (viii) Does the Partnership-Defined Quality (PDQ) approach improve the quality of maternal and newborn care services and outcomes?
- (ix) What are the cost, effectiveness, and feasibility of the minimum activities for mothers and newborns (MAMAN) in Busia, Kenya?

⁸This research question includes establishment of the optimum CHW-to-household ratio.

⁹The project will develop and test model(s) of community emergency communication and transportation system.

Appendix 5: Findings of the Annual LQAS (2007)

Objective/Result	Indicators (by technical or cross-cutting intervention)	Baseline Value	Year 2 Target ¹⁰	Year 2 Actual	EOP Target
1. Increased proportion of women who attend antenatal clinic at least four times and postnatal clinic at least once	% of mothers of children 0-23 months who attend ANC at least four times during most recent pregnancy	32%	37%	41%	50%
	% of mothers of infants 0-5 months who attend postnatal care within two days of delivery	23%	27%	Not assessed ¹¹	40%
2. Increased proportion of women who delivered under supervision of a skilled health professional	% of children 0-23 months whose delivery was attended by a skilled health professional (nurses with midwifery training, doctors, midwives)	26%	30%	25%	40%
3. Increased proportion of women who deliver at a health facility	% of mothers of children 0-23 months who deliver at health facility	20%	24%	20%	35%
4. Increased quality of and access to basic Emergency Obstetric Care at health facilities	No. of health facilities providing basic EmOC (administer antibiotic, oxytocic drugs, anticonvulsants, performs manual removal of placenta, performs assisted vaginal delivery, performs manual vacuum aspiration)	0		Not assessed	6

¹⁰ The year two target is based on the premise that the project had FY1 for planning and development of management structures, and years FY 2, 3, 4, and 5 (four years) for implementation. Based on that, the gap between baseline value and EOP target is divided by 4, and the result added to the baseline value to generate the year 2 target e.g. for the first indicator, Year 2 target= 32% + ((50%-32%)/4)=37%

¹¹ This indicator and several others were not assessed because related activities had not been implemented, or because a related practice was being assessed e.g. knowledge on malaria prevention not assessed because practices related to LLINS/ITNs and to IPT were assessed.

Objective/Result	Indicators (by technical or cross-cutting intervention)	Baseline Value	Year 2 Target ¹⁰	Year 2 Actual	EOP Target
5. Improved knowledge and practice of malaria prevention and treatment at household and community level	% of mothers of children 0 – 23 months who know 2 ways (ITN & IPT) to prevent malaria	17%	28%	Not assessed	62%
	% of children 0-23 months taken to HF or Community Health Worker within 24 hours after onset of fever	7%	20%	33%	60%
	% of shopkeepers correctly dispensing anti-malarial drugs according to MOH protocol	15%	31%	Not assessed	80%
6. Increased proportion of WRA and CU5 who sleep under insecticide-treated nets	% of households with at least one ITN	77%	80%	86%	90%
	% of mothers of children 0-23 months who slept under ITNs the previous night	65%	69%	68%	80%
	% of children 0-23 months who slept under ITNs the previous night	70%	73%	80%	80%
7. Improved case management of malaria/fever among CU5 at health facilities	% of HF staff who assess, classify and treat malaria/fever according to MoH protocols	0%	10%	Not assessed	40%
8. Increased proportion of pregnant women receiving IPT	% of mothers of children 0-23 months who received at least 2 doses of SP for IPT during ANC.	21%	31%	29%	60%
9. Increased knowledge and understanding of PMTCT and ART among women of reproductive age (15-49 years)	% of mothers of children 0 – 23 months who cite at least two ways of preventing MTCT	23%	32%	23%	59%
	% of mothers of children 0-23 months who know that risk of MTCT can be reduced by ART	33%	37%	32%	50%
10. Increased access to HIV counseling and testing among pregnant women at ANC.	% of mothers of children 0-23 months counseled and tested for HIV at ANC during their most recent pregnancy	53%	57%	71%	70%
	% of mothers of children 0-23 months who know their HIV status	41%	46%	60%	60%
11. Increased # of HIV+ women and newborns who receive PMTCT	# of HIV+ mothers who received ART for PMTCT within the previous 12 months.	273	458	390	1011

Objective/Result	Indicators (by technical or cross-cutting intervention)	Baseline Value	Year 2 Target ¹⁰	Year 2 Actual	EOP Target
	# of newborns who received ART for PMTCT within the previous 12 months.	288	469	-	1011
	# of trained facility based health workers providing PMTCT services	17	23	48	41
12. Improved feeding practices among caretakers of children 0-5 months	% of children age 0-5 months who were exclusively breastfed during the last 24 hours	11%	18%	Not assessed	40%

Appendix 6: Action Plan for Partnership between BCSP and APHIA II Western

Priority interventions	Activity	Timeline	Responsibility
(i) HIV/AIDS (PMTCT) <ul style="list-style-type: none"> - Provide training in PMTCT - Buffer stocks (kits and other supplies) - Updates on new regimes - On-job-training - Provide ART and referral for ART, home based care and support groups - Provide equipment - Early infant diagnosis 	Hold consultative meeting	By 30th October 2007	MOH, BCSP and APHIA II western
	Develop a partnership framework	by 30th December 2007	MOH, BCSP and APHIA II western
	(ii) MCH/FP (EOC, IMCI, RH/FP) <ul style="list-style-type: none"> - Provide training - On-sight mentoring - On-job-training - Support supervision - Provide equipment 		
(iii) MALARIA <ul style="list-style-type: none"> - Provide updates - Provider capacity in management of malaria in pregnancy (FANC) - Support supervision 	Start joint implementation of partnership activities outline in the framework	By beginning of Feb 2007	MOH, BCSP and APHIA II western

Appendix 7: Findings on the Pre-intervention Observation for the Quality Improvement Research, JULY 2007

No.	Indicator	Results
1.	Percentage of pregnant women attending ANC who have been advised by a health worker during ANC visit on birth planning and preparedness	21%
2.	Percentage of pregnant women attending ANC with a birth preparedness plan in place	23%
3.	Percentage of mothers attending prenatal clinic who received the required TT doses	68%
4.	Percentage of deliveries in the health facility conducted by a skilled health professional trained on EOC	13%
5.	Percentage of health facilities with presence of enough (can last till the next order is delivered) or adherence to each of the following 9 items: <i>clean delivery surface with a plastic sheeting; availability of clean running water; availability of enough soap for hand washing; availability of sterile instrument for cutting the cord; availability of clean cloth to dry and wrap the baby; availability of sterile cord clamps or strings; availability of sterile delivery set; adherence to the universal standard precautions (IP pails, waste disposal containers, house keeping, use of disinfectants and antiseptics); availability of standard guidelines on clean deliveries?</i>	50%
6.	Percentage of clients in labor who receive a correctly interpreted partograph with a correct curve	27%
7.	Percentage of births in the last three months where the woman received active management of third stage of labor (AMTSL) by skilled birth attendants (SBAs)	87%
8.	Percentage of mothers attending postnatal clinic with knowledge on cord care	0%
9.	Percentage of mothers attending postnatal clinic who breast fed their neonates within one hour of birth	36%
10.	Percentage of mothers with an elevated temperature (>38°C) during labor who are given antibiotics	No cases
11.	% of clients who report satisfaction with the care they received during ANC, delivery and PNC	
	<i>Treatment with dignity</i>	
	<i>The health worker acted too business like and impersonal towards you</i>	31%
	<i>The health worker treated you in a very friendly and courteous manner</i>	95%
	<i>The health worker did not take keen interest in what you were telling him/her</i>	48%
	<i>Continuity and social supportiveness of care</i>	
	<i>The health worker gave you accurate direction when referring you for other services</i>	87%
	<i>The health worker advised you where to receive services at the community</i>	50%
	<i>You are able to get medical services whenever you need it</i>	72%
	<i>Quality of amenities and safety of care</i>	
	<i>The facility has clean toilets which are readily available for use</i>	63%

<i>It is easy to acquire other diseases when in this facility</i>	13%
<i>During your medical visits you were made to be comfortable before any procedures were made</i>	92%
Information	
<i>The health worker educated you on the danger signs during pregnancy/labour/delivery</i>	38%
<i>You managed to access relevant information about health when in the facility</i>	66%
<i>You managed to access relevant information about health when in the facility</i>	-
Promptness of care	
<i>It is easy for you to get medical care in an emergency</i>	49%
<i>You were kept waiting for too long before you saw the health worker</i>	42%
<i>First come, first serve principal works very well in this facility</i>	83%
Confidentiality/privacy	
<i>The room where you get medical care is conveniently placed</i>	97%
<i>When the health worker was examine/counseling you, you were only two of you and there was no interruptions from other people</i>	87%
<i>The information you have given about yourself will not be know by any other person other than the health worker</i>	84%
Fulfillment of client needs	
<i>The health worker was careful to check everything when physically examining you</i>	22%
<i>The were not able to receive some services/care because of lack of money</i>	24%
<i>The health worker was good at explaining how to take care of your health</i>	62%
Informed choice/autonomy	
<i>The health worker gave you a chance to choose when to make the next visit</i>	3%
<i>If you have a medical question, you can reach a health worker for help without any problem</i>	68%
<i>You can choose the health worker of your preference</i>	8%

Appendix 8: Revised Project Communication Plan

Stakeholder	What to communicate	How	When	Person
USAID (CSHGP)	Financial Reports	In accordance with cooperative agreement	Quarterly , End of Project	Bill Yaggy, Susan Gearon
	Project Performance Report	In accordance with cooperative agreement	Annually	Bill Yaggy, Susan Gearon
USAID (Mission)	Quarterly Progress Report	Electronic	Quarterly	Project Manager
	Annual Performance Report	Electronic, Print	Annually	Project Manager
	Project Summary	Electronic	Annually	Project Manager
AMREF in USA	Monthly Report	Electronic	Monthly	Project Manager
	Quarterly Progress Report	Electronic	Quarterly	Project Manager
	Financial Reports	Electronic	Quarterly	Project Accountant
	Annual Performance Report	Electronic	Annually	Project Manager
	Project Summary	Electronic	Annually	Project Manager
AMREF KCO	Monthly Report	Electronic	Monthly	Project Manager
	Quarterly Progress Report	Electronic	Quarterly	Project Manager
	Annual Performance Report	Electronic, Print	Annually	Project Manager
	Project Summary	Electronic	Annually	Project Manager
Project Staff	Monthly Report	Electronic	Monthly	Project Manager
	Monthly Activity Schedule	Print	Monthly	Project Manager
	Quarterly Progress Report	Electronic	Quarterly	Project Manager
	Quarterly Financial Report	Electronic	Quarterly	Project Manager
	Annual Performance Report	Electronic	Annually	Project Manager
	Project Summary	Electronic	Annually	Project Manager
MOH HQ: (DCH, DRH, DOMC, NASCOP)	Quarterly Progress Report	Print	Quarterly	Project Manager
	Project Progress Report	– Print – PPT Presentation	6 monthly (during TAG meeting)	Project Manager
	Annual Performance Report	Print	Annually	Project Manager
	Project Summary	Print	Annually	Project Manager
Child Survival PVOs	Project Progress Report	– Print – Presentation	Annually during PVOs meeting	Project Manager
Provincial Health Management Team	Quarterly Progress Report	Print	Quarterly	Project Manager
	Annual Performance Report	Print	Annually	Project Manager
	Project Summary	Print	Annually	Project Manager
District Health Management Team	Monthly Activity Schedule	Print	Monthly	M/E Officer
	Monthly Report	Print	Monthly	M/E Officer
	Quarterly Workplan	Print	Quarterly	M/E Officer

Stakeholder	What to communicate	How	When	Person
	Quarterly Progress Report	– Print – PPT Presentation	Quarterly	M/E Officer
	Annual Performance Report	Print	Annually	M/E Officer
	Project Summary	Print	Annually	M/E Officer
District Health Management Board	Quarterly Progress Report	Print	Quarterly	M/E Officer
	Annual Performance Report	Print	Annually	M/E Officer
	Project Summary	Print	Annually	M/E Officer
Project Implementation Team	Monthly Report	Print	Quarterly	M/E Officer
	Quarterly Workplan	Print	Quarterly	M/E Officer
	Quarterly Progress Report	Print	Quarterly	M/E Officer
	Annual Performance Report	Print	Annually	M/E Officer
	Project Summary	Print	Annually	M/E Officer
Community Health Extension Workers	Monthly Activity Schedule	Print	Monthly	M/E Officer
	Monthly Report	Print	Monthly	M/E Officer
	Quarterly Workplan	Print	Quarterly	M/E Officer
	Quarterly Progress Report	– Print – Presentation	Quarterly	M/E Officer
	Annual Performance Report	Print	Annually	M/E Officer
	Project Summary	Print	Annually	M/E Officer
Health Facility Committees	Quarterly Progress Report	Print	Quarterly	M/E Officer
	Project Summary	Print	Annually	M/E Officer
Health Facility Incharges	Project Summary	Print	Annually	M/E Officer
	Quarterly Progress Report	Print	Quarterly	M/E Officer
Provincial Administration	Quarterly Progress Report	Print	Quarterly	M/E Officer
	Project Summary	Print	Annually	M/E Officer
District Development Committee/ DDO	Quarterly Progress Report	Print	Quarterly	M/E Officer
	Annual Performance Report	Print	Annually	M/E Officer
	Project Summary	Print	Annually	M/E Officer

Appendix 9: The KEPH life cycle age groups

	Life cycle cohorts	Examples of promotive and preventive health services needed by the cohort
I	Pregnancy and newborn (up to two weeks of age)	Antenatal care and proper nutrition, PMTCT, safe delivery, postpartum care, exclusive breastfeeding, family planning, use of ITNs, hygiene, water and sanitation.
II	Early childhood (two weeks to five years)	C-IMCI, proper nutrition, growth monitoring, immunization, psychological stimulation, hygiene, and water and sanitation.
III	Late childhood (6-12 years)	School health programme, proper nutrition, use of ITNs, and exercise and recreation.
IV	Adolescence and Youth (13-24 years)	Reproductive health and family planning services, HIV/AIDs education, substance abuse counseling, proper nutrition, and exercise and recreation.
V	Adulthood (25-59 years)	Reproductive health and family planning services and healthy lifestyle (recreation, nutrition, etc).
VI	Elderly (60 years and above)	Annual medical examinations and social support