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IMPLEMENTING AGENCY
Plan Kenya Country Office
In partnership with:

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and AIDS Population & Health Integrated Assistance II Coast

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AKHSK-CHD	Aga Khan Health Services Kenya-Community Health Department
ANC	Antenatal Care
APHIA II	AIDS Population and Health Integrated Assistance program
ARI	Acute Respiratory Infections
BCG	Bacille Calmette Guerin
CBF	Community Based Facilitator
CBO	Community Based Organization
CDF	Constituency Development Fund
CHW	Community Health Worker
CHW/TOT	Community Health Worker /Trainer of Trainee
C-IMCI	Community Integrated Management of Childhood Illness
CLTS	Community Led Total Sanitation
CORP	Community Own Resource Persons
CTC	Child-to-child
CS	Child Survival
CSP	Child Survival Project
DA	Development Area
DASCO	District AIDS, STI Coordinator
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DMOH	District Medical Officer of Health
DHC	Dispensary Health Committee
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
IEC	Information Education & Communication
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Net
KEMRI	Kenya Medical Research Institute
KEPI	Kenya Expanded Program of Immunization
KEMSA	Kenya Medical Supply Agency
KID-CARE	Kilifi District Coastal Area Replication & Evolution
LATF	Local Authority Transfer Fund
LLITN	Long Lasting Insecticide Treated Net
LQAS	Lots Quality Assurance Sample
MOH	Ministry of Health
MOST	Mobile Ongoing Sustainable Training
NID	National Immunization Days
ORS	Oral Rehydration Solution
PD/Hearth	Positive Deviant Hearth
PITC	Provider Initiated Testing and Counseling
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
RESA	Region of East and Southern Africa

TT	Tetanus Toxoid
TOF	Training of Facilitators
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
SA	Supervision Area

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A. MAIN ACCOMPLISHMENTS

1. IMMUNIZATION

During the current report period Dispensary Health Committees (DHCs) conducted 248 immunization outreaches in hard to reach areas. Community volunteers (Trained CHW, CHW/TOTs and VHCs) intensified community mobilization of mothers and caregivers for service. While increased mentoring facilitated by CHW/TOTs, project and MOH staff kept many of the CHWs engaged. There has been some degree of increased access to immunization services through the opening of three new Health Facilities (Palakumi, Madamani and Roka Maweni) dispensaries. These efforts have contributed to improvement in the full immunization coverage for children aged 12-23 months from 62% at baseline to 70.8% (LOAS 5). Measles coverage for the same age group also improved from 64% to 82.3%.

TT2 coverage of pregnant women (by card) improved from 24.4% to 32.5% but a lot still needs to be done to reach the desired target of 60% by the end of the project. This year the district reported 10 confirmed cases of Neonatal Tetanus through the surveillance system. In June 2008, the project and MOH staff wrote a proposal to Plan USA for additional private funds to accelerate immunization coverage especially TT2 coverage among women of child bearing age. The proposal was accepted and funded for US\$ 40,000 for a period of one year. The government of Kenya through the MOH has also embarked on round three of Maternal Neonatal Tetanus (MNT) vaccination campaign (due October 2008).

28 Health Workers had a 5-day update on KEPI in June 2008, bringing the total number of health workers who have received updates on KEPI in the last two years to 66. The KEPI update includes cold chain maintenance, how to identify aspects of missed opportunity, reduction in vaccine wastage, surveillance and defaulter tracing through DHCs and CHWs. Two NIDs were held in November 2007 and May 2008 following intensive mobilization that resulted in immunization of many pregnant women and children below five years.

2. PNEUMONIA

There were no reported drug stockouts as the DHCs were able to acquire drugs directly from KEMSA. However there was a delay in supply of drugs in the month of May 2008 and the project supported 14 health facilities with buffer stocks. Strong partnership between the MOH, Plan and AKHSK-CHD, contributed to improved service delivery through frequent MOST and joint supervision carried out by the three partners. This ensured that the health workers trained in IMCI and DHCs trained in health facility management were able to implement activities effectively.

The percentage of children who received health care in general and those who received care from a health facility greatly increased well above the desired monitoring coverage targets. Children 0-23 months with cough/difficult breathing who received care from a health facility increased from 87% baseline to 97% (LOAS 5) slightly exceeding the monitoring target of 95%. Mothers who know danger signs of Pneumonia increased from 38% baseline to 61.2%.

3. MALARIA

Kilifi District falls among Kenya's malaria endemic regions and thus malaria control is one of the key interventions that the KID-CARE Child survival project implements. A lot of effort has gone into strengthening and supporting partners on the control of malaria especially among children less than five years and women of child bearing age. Among the key strategies employed by the project is to support MoH acquire LLITNs and distribute them to DHCs to be sold to pregnant women and children under five years at subsidized rate.

The MoH has also intensified efforts in combating malaria through distribution of free ITN to target population, administration of IPT to expectant mothers and assuring regular supply of Coartem tablets (current anti-Malaria drug) to all health facilities. The health workers are trained in dispensing Coartem tablets which is the first line of treatment for malaria.

This year the project facilitated distribution of 14,650 LLITNs to children aged less than five years and pregnant women through the DHCs. In addition 599 CHWs have been trained on c-IMCI thus equipping them with more knowledge on key family health practices that includes consistent use of ITNs and recognition of danger signs for a child with fever.

ITNs distribution to pregnant women and children aged less than one year and demonstration on how to fix and use of the ITNs was also done during the Child Health Mother Nutrition week. Children who slept under ITN last night has improved from 21% baseline to 72% in LQAS 5, however this is slightly below the 76% reported in LQAS 4 of April 2007. This could be attributed to the period the survey was undertaken in November/December 2007 during the dry weather and communities association of Mosquitoes/Malaria with rains. IPT uptake increased from 51% baseline to 74% (LQAS 5).

4. HIV/AIDS

The partnership with APHIA II Coast has greatly improved communities access to and use of VCT/PMTCT through skills-training and supportive follow-up of health workers in all 14 Health facilities, and creating awareness in the community. 27 health workers were trained on Provider Initiated Testing and Counseling (PITC) and are able to test and counsel clients.

According to LQAS 5, mothers who know 2 ways of avoiding HIV infection has improved from 41% to 58.4% and those accessing VCT from 18% to 67% . This improvement could be due to increased number of trained CHWs who are creating awareness on HIV/AIDS; more health facilities providing VCT services; improved uptake of VCT/PMTCT services by the community both at the facility and during outreach.

5. NUTRITION

Exacerbating factors for child malnutrition in Kilifi include severe food insecurity, irregular rainfall, poor weaning diets and high helminthes infestation. During the report period, the project and partners made impressive efforts to train CORPs on nutrition, to facilitate linkages with other programs to improve livelihoods and support community growth monitoring and rehabilitation of underweight children. Community growth monitoring was boosted with an additional 21 Salter scales being issued, bringing the total number in use to 72. Results from the growth monitoring records showed that Muryachakwe and Vitengeni SAs had the highest rates of malnourished children.

PD/Hearth was scaled up to Muryachakwe and Vitengeni SAs with an initial training of 150 CHWs/VHCs and community leaders. Eight villages each formed a hearth committee charged with enrolling children to hearths, follow up and linking the community activities with MOH and project staff. The eight villages commenced hearth cycles from April 2008 and have enrolled 77 children to date. Most of the children enrolled were aged above 2 years and had severe malnutrition. Out of these 77 children 10 have since graduated, 17 have improved from moderate to mild malnutrition and 8 have moved from severe to moderate malnutrition. The remaining 42 children have gained weight but yet to change their nutritional classification.

The result of these interventions is a significant improvement in all the nutrition indicators of the project compared to the baseline findings. According to LQAS 5, percentage of children ever breastfed has almost reached universal state at 99.5%. The percentage of children breastfed within the first one hour has greatly increased from 19% to 30.6%. The percentage of children that are underweight has reduced from 27% at baseline to 19.9% currently. Coverage of children with vitamin A supplementation has also improved from 61% at baseline to 82% presently - exceeding the monitoring target coverage of 80%.

6. DIARRHEA

The partnership with PSI has been instrumental in creating awareness, demand and distribution of water treatment kits. The MOH has also made commendable efforts in treatment of water pans in the community through provision of Chlorine in clay pots. The government has now adapted Zinc as part of the management of diarrhea and, consequently, the project supported 14 MOH health facilities with Zinc and ORS for the management of children with diarrhea during this reporting period.

The project adopted the Community Led Total Sanitation (CLTS) methodology and supported training of 45 MOH staff in CLTS in May 2008. This was followed by mentoring of CORPS and triggering of community action on sanitation. Currently there are 33 villages where over 75% of the households now proudly own and use pit latrines. The overall objective of each village is to achieve open defecation free status. The communities have also increasingly adopted good hand-washing practices.

As a result, monitoring indicators for diarrhea prevention and management have tremendously improved and exceeded the monitoring target coverage as detailed in the DIP M&E framework. The percentage of mothers with children 0-2 years who wash their hands before feeding their children increased from 4% at baseline to 38.3%, while children with diarrhea in the last two weeks that received increased fluids has increased from 48% to 76.8%. The percentage of children with diarrhea in the last two weeks that received ORS has increased from 31% baseline to 44.6%, while mothers who prepare ORS correctly has increased from 32% to 72.3%.

7. MONITORING

The project conducted the fifth (5) monitoring LQAS during the report period. This provided a training opportunity that Plan RESA used to equip participants drawn from 8 countries (Uganda, Tanzania, Malawi, Zimbabwe, Zambia, Ethiopia, Sudan and Kenya) with the skills to enable them conduct LQAS in their respective programs. The training included didactic sessions followed by collection and manual tabulation of data for five SAs. The project staff completed data collection, tabulation, and analysis for the remaining six SAs. Results from this fifth LQAS (see annex 1) show a marked improvement in all the indicators, implying that intensive mentoring and follow up of trained CORPs by project staff and MOH is beginning to pay dividends.

8. OTHER NOTABLE EVENTS

Coordination Meetings

Two Coordination meetings were held - one in February and another in June 2008. The meeting brought together key project partners that included Community representatives, MOH, APHIA II, PSI, KEMRI, Plan International and the project staff. Partners had the opportunity of sharing the MTE report, reviewing the recommendations and drawing up a practical action plan to address the recommendations made.

New health Facilities

The MOH has begun operating three new dispensaries (Roka Maweni in Bahari division, Palakumi in Ganze division and Madamani in Vitengeni division) that had been built through CDF and LATF. Operation of these facilities has assisted in increasing access to services for the affected communities. The project partnership with MOH, AKHSK-CHD has already trained the DHCs of these three facilities in governance, financial management and Health information system management. Follow-up after training has also been done.

VIP Visits

Please see Annex 6 (a).

B. ACTIVITY STATUS:

1. Objectives for Immunization

Objective	Activities	Status of Activities	Comments
<p>Increase from 62% to 74% children age 12-23 months fully immunized and increase from 64% to 80% children age 12-23 months who received Measles vaccine</p>	<p>Train dispensary staff in “missed opportunities” for vaccination</p> <p>Train nurses/TOTs in cold chain maintenance, reduction of vaccine wastage</p>	<ul style="list-style-type: none"> • 28 HW trained in KEPI and cold-chain. The training included the aspect of missed opportunity, cold chain maintenance and reduction in vaccine wastage. • The HWs also covered the Integrated Disease Surveillance Response and utilization of data for action at point of collection. • Full immunization coverage (for children aged 12-23 months) has improved from 62% baseline to 70.8% (LOAS 5), and Measles coverage from 64% to 82.3% 	<p>There was vaccine stock out in the district as a result of a national shortage. This led to a national outcry that required re-organization of the Kenya Medical Services procurement board which is currently being done.</p>
	<p>Conduct regular outreach facilitated by DHCs/VHCs, CBF and CHWs</p>	<ul style="list-style-type: none"> • 248 Outreaches were undertaken organized by the DHCs and now form one of their calendar events. 	<p>The outreaches have been well attended as CHWs, VHCs and DHCs conduct intensive mobilization.</p>
	<p>Support routine immunization</p>	<ul style="list-style-type: none"> • All health facilities provide routine immunization and access for community has been increased by the opening of three new dispensaries by the MOH. 	<p>APHIA II supported MOH with new refrigerators enabling all facilities to conduct immunization regularly.</p>
	<p>Support for NIDs</p>	<ul style="list-style-type: none"> • Supported Child Health Nutrition week in November 07 and May 08. Immunization Services were provided at static health facilities and in 7 outreach sites in Nov 2007 and in 13 sites in May 2008. 	<p>Partners participated in the NIDs with MOH providing personnel and vaccines, while the project supported with mobility and drugs. APHIA II provided VCT and PSI carried out demonstrations on water treatment.</p>
	<p>Routine collection of data, analysis and feedback by TOTs/VHCs</p> <p>Train VHCs/CHWs/Care groups in use of CBR for data collection</p>	<ul style="list-style-type: none"> • 599 CHWs trained in C-IMCI and the 325 VHCs that have been trained in PHC/CBHC to date covered CBR for data collection. The CBHIS tool includes information on number U5 deaths. 	<p>The cumulative number of trained CHWs stands at 1314 while out of these 599 have covered C-IMCI and 87 have further trained as CHW-TOTs in C-IMCI</p>
	<p>Train VHC identified CORPS (traditional healers, herbalists and TBAs) in mobilizing mothers for immunization</p>	<ul style="list-style-type: none"> • 599 CHWs and 331 VHCs trained in CBR for data collection. The CBHIS tool includes information on number of U5 deaths in the community. • Three sub-location Health Committees were trained covering 32 villages within the peri-urban areas of Kilifi Township 	

2. Objectives of Malaria Control

Objective	Activities	Status of Activities	Comments
Increase from 39% to 60% women who took malaria prophylaxis/treatment during pregnancy	<ul style="list-style-type: none"> Develop systems by which pregnant mother will be identified early and specifically targeted for IPT Educate mothers on use of IPT 	<ul style="list-style-type: none"> Mothers who require IPT are identified through care group meetings by CHWs and referred to health facility or outreach services Mentoring is on-going in the care groups where members are being equipped with health information and mobilized for action. 	<ul style="list-style-type: none"> Access is still an issue for some due to long distances to service delivery points.
	<ul style="list-style-type: none"> CHWs trained to administer IPT using Fansidar (under the supervision of Health Workers) and Iron supplementation for pregnant women 	<ul style="list-style-type: none"> 599 CHW's have been trained on C-IMCI; they however do not administer IPT but refer pregnant women to the health worker. 	<ul style="list-style-type: none"> Current government policy does not allow CHWs to administer malaria prophylaxis and iron supplementation
	<ul style="list-style-type: none"> Outreach facilitated by CBF, nurses, VHC and CHW ensures increased access to ANC services 	<ul style="list-style-type: none"> Out of the 248 outreaches, ANC services was provided in 208 sessions Mothers who took malaria prophylaxis/ treatment during pregnancy increased from 51% baseline to 73.5% (LQAS5). 	<ul style="list-style-type: none"> The outreaches are now calendar events for the DHCs, however the momentum has to be sustained.
Increase from 45% to 75% caretakers who sought treatment within two days (48 hours) after symptoms began	<ul style="list-style-type: none"> Training of CHWs in IMCI case management to treat malaria Behavior change interventions educate mothers and caretakers on recognition of danger signs, overlap of pneumonia and to seek immediate treatment from an appropriate provider 	<ul style="list-style-type: none"> 599 CHWs have been trained in C-IMCI. Their role is to educate caretakers on recognition of danger signs and immediately refer for treatment to an appropriate Provider. There are 87 CHW/TOTs who conduct follow ups and mentor CHWs on recognition of danger signs and timely referral. Caretakers who sought treatment within 2 days after symptoms began are 61.8% (LQAS5) an improvement from 45% baseline, however this is still below monitoring target of 75%. 	<ul style="list-style-type: none"> The government policy for those presenting with malaria symptoms is for treatment to be provided at no cost in all government facilities The training of CHWs in malaria treatment was shelved when the government policy on 1st line treatment for Malaria changed. Where CHW/TOTs have been trained, the mentoring of CHWs and knowledge of care takers improved greatly.

3. Objectives for HIV Prevention

Objective	Activities	Status of Activities	Comments
Increase from 41% to 70% mothers able to give 2 ways of avoiding HIV infection	<ul style="list-style-type: none"> Train VHCs and CHWs who will educate mothers/men on preventive behaviors 	<ul style="list-style-type: none"> 599 CHWs and 114 VHCs trained on HIV/AIDS prevention. 275 pupils from 7 schools reached with HIV/AIDS message during training. 	<ul style="list-style-type: none"> Mentoring is on-going in the care groups where members are being equipped with health information on

	(ABCD) and PMTCT	<ul style="list-style-type: none"> Mothers who knew at least 2 ways of avoiding HIV infection has increased from 41% to 58.4% (LQAS5). 	HIV/AIDS and mobilized for action.
Increase mothers availing of the VCT service from 18% to 30%	<ul style="list-style-type: none"> Support training of counselors and nurses in VCT as well as referral services options 	<ul style="list-style-type: none"> 27 health workers trained in Provider Initiated Testing and Counseling Two quarterly review meetings held in May and August 2008 Mothers availing themselves for VCT services have improved from 18% baseline to 67.3% (LQAS 5). 	<ul style="list-style-type: none"> 275 CTC members were sensitized in HIV/AIDS prevention

4. Objective for Pneumonia

Objective	Activities	Status of Activities	Comments
1. Increase from 38% to 60% mothers of children age 0-23 months who know one danger sign of pneumonia (fast breathing or chest in drawing)	Development of IEC strategies for pneumonia recognition, care-seeking behavior and home care	<ul style="list-style-type: none"> The project developed a job-aid on danger signs and produced 1000 copies and distributed them to all CHWs trained in PHC/CBHC. The project adapted a photo booklet job-aid on C-IMCI and produced 150 copies which have since been distributed to the CHW/TOTs trained in C-IMCI 87 CHW-TOT trained on C-IMCI given manual developed by MOH Kenya. Percentage of mothers of children aged 0-23 months who know one danger sign of pneumonia (fast breathing or chest in drawing) increased from 38% to 61.2% 	<p>The CHW/TOTs are using these booklets to educate community members on recognition of danger signs for pneumonia and timely care seeking during illness.</p> <p>CHWs use the job aid on danger signs to educate mothers during care group meetings.</p>
	Mobilize and Educate community members on strategies for pneumonia management	<ul style="list-style-type: none"> The trained CHWs are carrying out education on pneumonia management to communities during meetings and outreaches 	
	Supply timers to CHWs to count respiratory rate	<ul style="list-style-type: none"> Government policy is not permissive for Pneumonia treatment at home. CHWs motivate mothers to seek services early from appropriate providers (health facility). 	The project will not buy timers

5. Objectives for Nutrition

Objective	Activities	Status of Activities	Comments
Increase from 21% to 31% children aged 0-5 months who are fed breast milk only	Train CORPS, especially TBAs, to educate and motivate mothers to initiate breastfeeding and continue exclusive breastfeeding for 6 months and to practice age-appropriate complementary feeding	599 CHWs have been trained and are motivating mothers to initiate breastfeeding within 1 (one) hour after delivery and to practice exclusive breast feeding for 6 months and appropriate complimentary feeding of children thereafter	Some of the trained CHWs are TBAs sensitize pregnant women and refer them to health facilities for delivery.
Increase % of children who are enrolled into Hearth who complete it .And Increase % of children enrolled into Hearth who graduate	Nutrition education sessions through Farmer Field Schools, including home gardening lessons.	19 care groups have established kitchen gardens to provide nutritious foods for household consumption.	
	Community growth Monitoring	There are 72 weighing scales that are being used for community growth monitoring. In every sub-location, community growth monitoring is conducted on a monthly basis by the CHWs with support from CHW/TOTs, DHCs and VHCs.	Compared to the other SAs more children in Muryachakwe and Vitengeni area were severely malnourished. Malnutrition was more pronounced among children above two years.
	Training Volunteers in Hearth Trained VHCs and CHWs apply PD/HEARTH model	Trained CHWs identify underweight children and refer them to be enrolled for PD/hearth rehabilitation. 150 VHCs and CHWs trained in PD/ Hearth in Muryachakwe and Vitengeni SA.	
	Positive Deviance Inquiry	3 PDIs were carried out in Milore, Mrima wa Ndege and Madamani sub locations during the VHC/CHW training on PD/ hearth	
	Formation of Hearth Committees	A total of 8 Hearth committees comprising of VHC and CHWs were formed to co-ordinate the hearth activities in Milore, Mpango, Garichwa, Madamani, Shononeka, Matano Manne, Gabina and Malumbo villages	
	Conducting Hearth	A total of 77 children were invited to the hearth and 10 graduated by the second cycle.	A total of 146 children have graduated from the hearths.

6. Objectives for Diarrhea

Objective	Activities	Status of Activities	Comments
1. Increase from 4% to 14% mothers with children aged 0-23 months who report that they wash their hands with	Educate mothers/caretakers in hand washing (before :cook, eat, toilet, after defecation)	599 CHWs have been trained in C-IMCI and are carrying out health education on hand washing for mothers during care group meetings. 275 children trained in CTC approach and have initiated use of leaky	A best practice has been adopted by the project which is complementing control of diarrhea diseases through triggering communities to construct and

soap/ash before food preparation, before feeding children and after defecation, and after attending to a child who has defecated	Educate CHWs/care groups/CTC on hand washing practices	tins for hand washing in schools and their homes. 7 schools in Chonyi division participated in open day festivals where the children shared messages on hand washing with the community members and other children. Percentage of mothers who report proper hand washing with soap/ash increased from 4% to 38.3%	use pit latrines. This is commonly known as Community Led Total Sanitation.
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Please see Annex 6 (d)

C. FACTORS THAT HAVE IMPEDED PROGRESS

FACTORS	ACTIONS
Negotiations between the MOH and the community during piloting of Community Strategy in Matsangoni delayed the project's phase II capacity building and mentoring of CHWs that were already identified through the project's care-group model.	Project staff had to take part in the negotiations before continuing with implementation of activities in Uyombo area in Matsangoni SA within Bahari division.
Staff turnover for project, government and other partners.	On job training for new staff and update meetings for partners was done so as to bring everybody to speed.
Low uptake of postpartum Vitamin A supplementation.	The project sensitized the DHMT, MOH staff, community health workers and partners on the importance of vitamin A supplementation. Now the strategy is to reach these mothers with Vitamin A when they self present for immunization of their children at 6 weeks
Attrition of CHWs due to the different motivational strategies used by different stakeholders.	Giving out of T-shirts and certificates to active CORPs as a motivational factor. Refresher trainings and regular meetings with CHWs. Involving CHW-TOT in training of CHWs in C-IMCI. Facilitating the CORPs to start IGAs and linking them with financial services associations (FSAs) such as village banks.
Pre-election campaigns led to low turnout in trainings and meetings.	Meetings and trainings were put on hold until after the elections but continued on low scale where the situation was favorable.
Post election violence led to inactivity and feelings of uncertainty among the community members that hampered effective implementation.	The provincial administration held reconciliation meetings with the community to emphasize on the need to live together in harmony.

D. TECHNICAL ASSISTANCE

The project will require technical assistance in conducting Operation Research. Consultative meetings have been held between Plan and the MOH. The OR will focus on comparing and contrasting the MOH led Community Strategy for mobilization for services and the Care group model that the project has used to mobilize community for action. A transect drive has been undertaken of the areas where the OR will be held. The outline of the research methodology is being developed at the moment and implementation will take place in Quarter 2 and Quarter 3. Please see Annex 6(b)

The project has also undertaken data entry for all the five LQAS surveys and data analysis is being done. Further qualitative data from the community may provide opportunities for OR on other project interventions such as PD-Hearth and the CBHIS.

E. SUBSTANTIAL CHANGES

There has not been any substantial changes that would require the modification to the cooperative agreement.

F. SUSTAINABILITY AND PHASEOUT

The project partners conducted the second sustainability assessment in year three in preparation for the MTE. The findings showed that a lot of capacity strengthening had been undertaken for the various structures implementing the project. In the fourth year, the project staff conducted more follow up and mentoring sessions for trained groups. This has resulted in improvement of indicators as shown by the 5th LQAS results concluded in February 2008. It would have been ideal to conduct a third CSSA but this was not possible during the period under review as there were political challenges brought about by political campaigns in November and December 2007 that challenged community mobilization for services or training. The post election violence that ensued affected normal operations and created a sense of fear and uncertainty from 31 December 2007 to March 2008. It was therefore not prudent to update the CSSA framework as there were more pressing activities that were behind schedule.

The project partners held two Coordination meetings in February and June 2008 that discussed the phase down and phase out preparations.

It was resolved that:

- MOH to play a more active role in planning, organizing for meetings and events.
- The MOH staff at the rural facilities to be involved more in outreach and mentoring sessions for CHWs, VHCs and DHCs.
- The project to support training of 20 TOFs drawn from MOH and the Community who would then have the capacity to train Dispensary Health Committees on governance, Financial Management and Health Information system.
- Trained TOFs be equipped with additional skills in proposal writing as an aspect of resource mobilization both locally, nationally and internationally.

Status

- AKHSK-CHD facilitated a six days training for 20 TOFs drawn from Chonyi, Ganze, Bahari and Vitengeni divisions of Kilifi in the month of August 2008.
- The DMOH is actively involved in the project activities and has attended two Child Survival grantees PVO meetings; one convened by USAID Kenya mission in April and the Annual PVOs' meeting hosted by Doctors of the World in West Pokot in August 2008.
- The MOH included project activities in the District Annual Operation Plan 4 that was shared nationally.

- Joint supportive supervision have been undertaken for health workers trained in IMCI and Facility Health Committees. The joint team has included MOH, Plan and AKHS.
- The MOH took the lead in application of the sixth LOAS for the project concluded in September 2008, providing supervisors and data collectors. The MOH staffs have acquired knowledge and skills to carry out LOAS on their own and are a resource for other districts. Their active involvement has led to ownership of findings, for action.
- There is more presence of MOH staff during mentoring and follow up meeting of the trained CHWs, CHW/TOTs and FHCs (facility health committees).
- During the report period, there have been intense efforts towards Child and Maternal health that led to two National Immunization weeks in November 2007 and May 2008 that resulted in many children and women being reached with services.
- There has also been regular consultation during planning and implementation among the partners that has helped to forge team work.

G. MTE RECOMMENDATIONS

KIDCARE CSP MTE RECOMMENDATIONS

To address the MTE recommendations, the project implementing partners held a coordination meeting in February 2008 with the main theme being building consensus on what needed to be done by each partner and setting timelines for the same. The partners committed themselves to address some critical cross cutting issues that are required to strengthen the technical interventions. They agreed that there was need to invest more to achieve the technical indicators.

Cross cutting issues were:

- Mentoring of CHWs on detection of early signs and prompt referral for treatment.
- CHWs/TOT to carry out regular follow up of care givers, while the project staff and MOH will conduct follow ups to ensure messages are reaching the households.
- The project to organize for re-fresher training on BCC for staff and partners
- The MOH to strengthen referral linkages between CHWs and health workers by developing a standard form and a referral directory to be used by CHWs. This has been developed and is being pretested in a few villages.
- Regular review meetings between CHWs and health workers and provide regular updates.
- MOH to conduct training needs assessment and carry out On Job Training (OJT) of untrained health workers on IMCI.

Status

- Mentoring of CHWs by MOH, project staff and CHW/TOT has been strengthened resulting in the improvement of indicators.
- CHW/TOTs now carry out health education sessions and participate in the training of CHWs on C-IMCI at the community level.
- The MOH and DHCs hold quarterly meetings that bring together all trained community resource persons (CHWs, VHCs and CHW/TOT) and provide updates.
- Seven MOH staff at the district had their capacity strengthened as IMCI facilitators to enable them conduct On Job Training for facility health workers.
- The MOH in partnership with project staff carried out IMCI follow up of 18 HWs from 14 health facilities and on job training was undertaken.

NOTE:

The project partners did not manage to organize for re-fresher training on BCC during the period under review because of the special challenges occasioned by post-election violence.

Please see Annex 6 (c) for status of specific recommendations.

I. MANAGEMENT SYSTEMS**1. Financial management system**

The project uses standard procedures for financial management used also by Plan International Inc. During the period under review one internal audit was conducted and an external Audit is being conducted by Price Waterhouse Coopers. There were no adverse findings in the internal audit.

Challenge

The fluctuation of the exchange rate of the dollar to the local currency has led to use of more dollars for the same services and on occasion requiring scaling down on areas such as mobility (Vehicle maintenance and fuel have soared compared to the original budget for these items). The services and goods used have also been greatly affected.

2. Human Resources

All the expected staffs are on board; however for four months (May to August 2008) the project did not have an M&E program officer as the previous one had separated. An M&E officer was recruited in September 2008 and is undergoing orientation. One Community Based Facilitator (Front line staff) separated in January 2008 and was replaced in August 2008. As the project enters the final year, staff turnover may be expected to rise as they try to seek more permanent engagements.

Staff development during the report period;

- a). The staffs were trained on Community Led Total Sanitation for triggering community to take active role in ensuring there is no open defecation in their villages. This new approach to environmental sanitation has since been adopted by the government of Kenya's Ministry of Public Health and Sanitation.
- b) Training of Plan RESA health advisors in LQAS in November 2007 provided an opportunity for staff to share and learn from other countries on monitoring of programs.
- c) All staff participated in the two coordination meetings held in February and June and had the opportunity to make presentation on best practices and respond to issues raised by partners.
- d) 8 project staff attended a program conference organized by Plan Kenya Country Office in June 2008 that was facilitated by Robert Chambers and whose theme was "Whose reality Counts". There was a lot of learning on community facilitation in development.

Staffs were able to appreciate the different roles each one of us plays and the effect on programming. The staffs took time to attend thematic workshops of their choice.

3. Communication system and team development

The project received timely communications and updates from the Plan US headquarters, Plan regional office and Plan Kenya Country office, other PVOs and project partners.

Partners have enhanced team development through participation in Joint activities that include:

- National Immunization Days (NIDs) in November 2007 and May 2008.
- APHIA II Coast, MOH and the project jointly supported training of 27 health workers in PITC that has seen improvement in VCT uptake within the period of eight months.

- Coordination meetings in February and June 2008 that brought together Community representatives from 9 Health facilities, MOH, APHIA II Coast, PSI, AKHSK-CHD, Plan Kenya lead Health Advisor, Plan Coast region Health Advisor and Project staffs. There is regular consultation among the partners with joint planning being undertaken.
- The MOH and project staff wrote a proposal for accelerating Immunization coverage in the district that has since been funded by Plan USA.

4. Local Partner Relationships

4.1. MOH

During the Coordination meeting of February 2008 partners agreed that MOH should take a lead role in planning and project implementation as part of project phase down and phase out.

- The MOH took lead in the sixth LQAS that was conducted in September 2008 and provided adequate personnel as supervisors and data collectors. The data collection was completed within a week and is being analyzed.
- The MOH requested for capacity strengthening of staff in Community Led Total Sanitation. Plan Kenya Strategic Program Manager was the main facilitator and 45 MOH staffs participated in both theory and field work.
- The DMOH took a lead role in moderation during the two coordination meetings held in February and June 2008. The DHMT was well represented with members taking charge of interventions within their technical capacity areas. This then brought out more clearly their sense of ownership of project activities.
- The DMOH was invited to participate in Child Survival PVOs grantees meeting in April and August 2008 during which he co-presented the best practices of PD/Hearth and CLTS Kilifi experiences.
- Joint supportive supervision and follow up for IMCI trained health workers and Facility health committees have been undertaken with MOH commitment to continue the same for all health facilities within the district.
- The DMOH and members of the DHMT participated in the development of proposal on accelerated Immunization that has since been funded by Plan US.

4.2. APHIA II Coast

- The partnership with APHIA II Coast has led to capacity building of 27 MOH Health workers in PITC. Two follow-up meetings have since been held with APHIA II Coast participation.
- APHIA II Coast compliments the project and provides supportive supervision to health workers trained in PMTCT. The improvement in the indicator of VCT uptake may be as a result of increased access to services by the community. More health workers and facilities are able to offer the services.
- APHIA II Coast participated in joint immunization outreaches and provided VCT and PMTCT services. APHIA II Coast was also represented in the project coordination meeting held in February and June 2008 and made a presentation highlighting the contributions to the Child Survival project.
- APHIA II Coast sent a representative to the September 2008 PD/Hearth demonstration presented by the community at Tsangalaweni Primary school.

4.3. AKHSK-CHD

- In partnership with the MOH and the project, AKHSK-CHD conducted three trainings for Six DHCs drawn from Dida, Palakumi, Pingilikani, Chasimba, Roka-maweni and Madamani in governance, financial management and Health Management Information System.
- Jointly provided supportive supervision and on Job training was undertaken initially for 9 DHCs (Ngerenya, Kizingo, Ganze, Vitengeni, Jaribuni, Dida, Muryachakwe, Dzikunze and Matsangoni).

- AKHSK-CHD conducted training for 10 MOH staff and 10 community representative who were equipped with skills as TOFs in governance, financial management and Health Management Information System. The trained TOFs will be a resource for the community and MOH in future capacity building and follow up of health committees.
- The Director of AKHSK-CHD joined the project partners during the visit of Dr Sheila Macharia of USAID and observed the PD/Hearth nutrition demonstration by the Tsangalaweni community.
- As an institution AKHSK-CHD participated in the coordination meetings of February and June 2008.

4.4. PSI

- PSI has participated in CHW training and conducted demonstrations on use of water treatment kits and ITNs. During the NIDs held in November 2007 and May 2008, PSI added value to the outreaches through demonstration, skits and visual displays.
- PSI participated in the coordination meetings of February and June and shared the organization priorities that included prevention of diarrhea, Malaria and HIV/AIDS.

4.5. KDHSF

The project partners are members of the Kilifi District Health Stakeholders Forum (MOH, APHIA II Coast, AKHSK-CHD and Plan Kenya, Kilifi DA). The partners participate in quarterly meetings for sharing and hold annual Health Action Day that provides an opportunity to reach the community with integrated services.

5. PVO coordination/collaboration in country

The project partners have demonstrated team spirit during the period under review with most planned activities being undertaken.

- The two NIDs and a joint HAD organized by KDHSF saw high turn out of the partners including the community.
- All partners actively participated in the two coordination meetings that also had a higher representation of the community. Results of the fifth LQAS were shared in June 2008 and partners committed to increasing their level of effort to ensure the desired health practices was achieved and sustained.
- The project invited the DMOH to participate in two Child survival PVOs meetings one of which was organized by Dr Sheila Macharia in April 2008 in Nairobi. He made a presentation on PD/Hearth experience in Kilifi.
- The second Child Survival annual PVOs meeting was hosted by Doctors of the World in West Pokot. The DMOH and the project coordinator made a presentation on the new approach to environmental sanitation i.e. Community Led Total Sanitation that drew significant interest from many, especially those from communities that do not have or use toilets.

6. Other relevant management systems

The project is utilizing a Plan International Inc. corporate system called PPM Ndugu version 2 build 5 to write Project Outlines for the life of the project. This program monitoring system assists Plan globally in monitoring progress of its activities and expenditures. The system allows modifications to allow for rescheduling of activities and budgets when necessary.

7. Organizational capacity assessment (Financial or management audit)

During the review period, one internal financial Audit and one Program Quality Assurance Audit were carried out. Currently there is an external Audit being carried out by Price Waterhouse Coopers.

J. LOCAL PARTNER ORGANIZATION COLLABORATION AND CAPACITY BUILDING

1. DHCs

All 14 DHCs have had their capacity strengthened on governance, financial management and health information system. Some 20 TOFs have been trained to continue capacity strengthening of the various structures after project phase down and phase out.

87 CHW/TOTs have had their capacity strengthened and carry out on site training for CHWs on C-IMCI. They mobilize community for service and carry out mentoring of CHWs and care groups. They have become a strong resource in the community and preferred volunteers for development partners.

2. MOH staff

The MOH staff have had their capacity strengthened in monitoring, IMCI case management, CLTS, proposal writing and in facilitation of meetings/trainings. They strongly identify with the project structures and work with the community resource persons to mobilize people for services.

3. AKHSK-CHD

The AKHSK-CHD has contributed greatly to capacity strengthening of DHCs in governance, financial management and HMIS during the joint supervision and follow up training. The AKHSK-CHD has also gained from the project, for instance, recently when two of their staff acquired skills in CLTS which they are now implementing in their areas of operation.

K. MISSION COLLABORATION

In February 2008, the project partners requested Plan Kenya Country Director (Else Kragholm) to invite the US Ambassador to Kenya to visit Kilifi district and have an opportunity to see some of the changes the funding from the America people had made in the lives of children and community.

The visit to the project was included in the itinerary of the Ambassador on 22 September 2008 and Dr Sheila Macharia of USAID Kenya Mission (Reproductive Health Specialist) came to support the project and partners in the preparations. However, due to heavy rains on the night preceding that visit, the Ambassador's entourage could not reach the community. The planned activities went on with Dr Sheila Macharia representing the Ambassador as the chief guest. Others in attendance were the Provincial Medical Officer, Plan Kenya Country Director, a child guest, Provincial Administration, PSI, AKHSK, APHIA II Coast, DMOH and the DHMT, Mothers whose children had graduated from the health, Ganze DHC, CHW/CHW-TOTs, School children of Tsangalaweni, community and Plan Kilifi staff.

The community demonstrated a hearth session covering all the key stages that included weighing of children to identify those children who are underweight, display of readily available foods that the community used for hearth meal, cooking of the improved nutrient dense porridge and active feeding of children.

The trained CHW, CHW/TOTs then presented health education topics to the audience on exclusive breast feeding, family planning and importance of skilled delivery. The CHWs and Tsangalaweni CTC members each presented a song with messages on nutrition. The highlight of the day was a key address by Dr Sheila Macharia who thanked the community and partners for taking action to ensure the survival of children in Kilifi district.

M. ANNEXES

Annex 1: M & E Table

IMMUNISATION

INDICATOR	BASELINE	LQAS 5 (current status)	TARGET
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	62	71.8	74
Percentage of children age 12-23 months who received a measles vaccine	64	82.3	80
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	24	32.5	60
NUTRITION			
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	26.6	19.4	21.6
Percentage of children aged 6-23months who received vitamin A in the last 6 months	61	81.8	80
Child was breastfed within 1st hour of birth	19	30.6	31
Percentage of Mothers who received vitamin A within 6 weeks after delivery	5	9.1	30
PNEUMONIA			
Percentage of Children aged 0-23months presenting with cough and difficult breathing that received care from a health facility	87	97.1	95
Percentage of Mothers of children aged 0-23months able to know one danger sign of pneumonia	38	61.2	60
MALARIA			
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	21	71.8	60
Percentage of children aged 0-23month correctly treated for fever	74	34.2	90
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	74.2	74.2	-

Percentage of Mothers with children 0-23months who received SP2 during pregnancy	39	73.5	60
Percentage of Mothers with children aged 0-23months who had fever who sought treatment within 48 hours	45	61.8	75
DIARRHOEA			
Percentage of Children who received ORS for a diarrhea episode within the last 2 weeks	31	44.6	41
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	48	76.8	60
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	4	38.3	14
Percentage of children who received ORS for a diarrhea episode within the last 2 weeks	31	44.6	41
HIV/AIDS			
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	41	58.4	70
Percentage of mothers with children aged 0-23months utilizing VCT services	18	67.3	30

IMCI FOLLOW UP

Indicator	Baseline	Midterm	IMCI follow up
Children assessed for all five danger signs	21	6	59
Children assessed for presence of all main symptoms	26	33	56
Children whose weight was correctly checked	5	9	88
Children whose immunization status was correctly checked	53	61	67
Caretaker of child with diarrhea given ORS knows to give ORS at home, prep and amount to give	32	38	14
Caretaker of child given antibiotic and/antimalarial and/ORS knows how to give treatment	51	39	65

Caretaker knows all three rules of homecare (fluid, food, when to return immediately)	47	46	17
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Annex 2: Work Plan Table

#	Activity	2008 – 2009 (Qtr 1- 4)			
		1	2	3	4
	Project Monitoring				
1	Steering Committee meeting		X		
2	Coordination Committee Meeting	X	X	X	X
3	Production of Quarterly report	X	X	X	
5	HFA			X	
6	Qualitative Research				X
7	LQAS (including anthropometric study)			X	
8	Sustainability Assessment				X
9	Final Evaluation				X
10	Workshop for results dissemination				X
11	Annual program and financial report				X
12	Conduct operation research		X	X	
13	Joint supervisory visits at Facility level (MOST)	X	X	X	
Malaria: Reduced mortality and morbidity among U5 and pregnant women					
14	PSI/DHC/VHC distributions of bed nets	X	X	X	X
15	PSI social marketing of bednets, BCI on ITN, Malaria danger signs, IPT	X	X	X	X
16	Re-treatment of bed nets in community	X		X	
17	Procurement of IEC materials	X	X		
18	Mark the World Malaria Day			X	
Nutrition: Improved nutritional status of U5 and pregnant women					
19	Implement PD/Hearth	X	X	X	
20	Community education on feeding, Iron folic supplementation and vitamin A	X	X	X	
21	Initiation of Kitchen gardens	X		X	
22	Community growth monitoring and counselling on child feeding	X	X	X	X
23	CBNP, FSA and FFS linkages for education and micro-credit	X		X	
Diarrhoea: Reduced mortality and morbidity among U5 and pregnant women					
24	Educate mothers/caretakers on ORS use	X	X	X	X
25	Educate mothers/caretakers on Home chlorination and other household measures for water safety at point of use and hand washing	X	X	X	X
26	Procure ORS, water guard		X		
Pneumonia: Use of effective case management at facility level and healthy practices at					

community for U5 children					
27	BCI regarding Pneumonia danger signs	x	x	x	x
Immunization: Increased immunization coverage for children U5 and pregnant women					
28	HAD for immunization	x	x	x	x
29	Participate in NID	x		x	
30	CBR analysis and planning			x	
HIV/AIDS					
31	Strengthening VCT and PMTCT services in the community	x	x	x	
32	BCC for prevention of infection	x	x	x	x
Community Outreach and behaviour change activities					
33	HADs for all interventions	x	x	x	x
34	Community mobilization/BCI	x	x	x	x
35	VHC/CHW/TOTs maintains CBR	x	x	x	x
36	Home visits by CHWs/CHW/TOTs to care groups' members to assess immunization, peer education on key health family practices.	x	x	x	x
Training Plan 2008 to 2009					
#	Training and Participants	Period Y5			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4
1	C-IMCI concepts CHWs/TOTs and CHWs	x	x		
2	Recognition of childhood danger signs and timely referral	x	x		
3	IMCI follow up	x			
4	Weighing and counselling	x	x		
5	Water chlorination and hand washing	x	x		
6	CTC training on immunization, Malaria, hygiene and nutrition	x		x	
7	Governance and financial management follow up training	x	x		
9	HFA training and data collection			x	
10	LQAS training and data collection			x	
11	Qualitative research methods				x

Annex 4: Papers or presentations about project - Not applicable

Annex 5: RESULTS HIGHLIGHTS

A CHILD-TO-CHILD SCHOOL-BASED APPROACH AS A PROMISING PRACTICE

Child-to-child is one of the approaches used by the KIDCARE Child Survival Project to reach out to children in and out of school with health information for dissemination to their parents. The goal of the Project is to reduce mortality and morbidity among children under five years of age (CU5) and WRA in Kilifi district. The project has the following interventions: Malaria, Malnutrition, Diarrhea, ARI/Pneumonia, Immunization and HIV/AIDS.

Problem to be addressed

Inadequate knowledge on health information that lead to poor health seeking behaviors among the community members resulting in high mortality and morbidity of children U5 and WRA in Kilifi district.

The overall aim of the CTC School-Based Approach is to enable, encourage and support children's participation in health education and through this, to mobilize and stimulate the development of themselves, other children, their families and communities.

Status

Through participatory methods and processes, the trained adult facilitators/patrons introduce the child-to-child activities to the children. The knowledge imparted during the training is long term in that it prepares the children for responsible adulthood.

Children are trained on life skills as a method of passing information to fellow pupils as well as to community members. During the training they carry out mini-surveys on a subject of their choice and use the information gathered to bring positive change in the community. They also go through sessions on building self esteem which enables them to interact well with others and also influence behavior change among their peers.

The club members consist of both boys and girls. They meet once a week with support from their patrons and trainers for mentoring to ensure that more knowledge on messages that will improve the lives of the children within their community is imparted. This includes child survival and adolescent health messages. Children participate in preparation and passing of messages through songs, dances, poems, puppetry and drama performances. Traditional myths and misconceptions are replaced with knowledge. Example: myth: HIV& AIDS is a curse: Fact: HIV is a virus that causes AIDS, that is transmitted through unprotected sex, blood and other body fluids.

Contribution to scale-up



A total of 33 schools are using child-to-child approach. In the last one year CTC approach has been introduced to 6 schools. The approach as a promising practice has created demand for scaling up to other schools within and outside the project area.

B CARE GROUP MODEL AS A BEST PRACTICE



The care group model is one of the approaches being used by the KIDCARE Child Survival Project as a mobilization tool to reach out to the community with health messages. A care group is a structure that brings together 10 – 15 Health contacts. The care group model was adopted from the political mobilization strategy during campaigns where homesteads were grouped in a cluster of 10 to ensure that each homestead is reached. In the project, each homestead selected the Health contact or the representative. The health contacts drawn from neighboring Miji (homesteads), appoints or select a CHW preferably a woman from among themselves, a natural leader willing to serve them. The selected CHW is given the mandate to head the health representatives hence a care group who has a direct oversight over them. The CHW is instrumental in coordinating care group needs and providing support for project activities.

Problem being addressed

Poor health seeking behaviors that has led to high mortality and morbidity of children U5 and WRA in Kilifi district due to weak mobilization structures in the community for action.

The care group model was adapted as a structure to mobilize the caretakers for action and improve care seeking behaviors.

Status

- Formation of 1314 care groups in the 331 villages

- Training of the CHWs on primary health care/community based health care concepts
- Training of the 599 CHWs on C-IMCI majoring on key family health practices, identification of danger signs and timely referral
- Training of 87 CHW/TOTs in C-IMCI
- Mentoring of the care groups by the project staffs, CHW/TOTs and MOH frontline staff.

Some of the activities that go on in a care group include;

- Health Education on the interventions i.e. Malaria prevention and control, Nutrition, diarrhea control, HIV/AIDS prevention and control, Immunization and pneumonia case management.
- Home visits
- Advice and referral of sick children.
- Data collection, compiling and reports writing by the CHW and submission to the VHCs.
- Community based growth monitoring that is usually done on monthly basis and the data submitted to the health facilities.
- Environmental sanitation activities.
- Members in the care group normally provide peer support to one another especially through experience sharing during meetings. This enhances togetherness, such that others have started IGAs which has boosted their sources of income and livelihood
- Mobilizing community members for Outreaches in hard to reach villages.
- Enhance linkages with other structures in the community like VHCs and DHCs

Achievements

- Care group model has been established in 331 villages in the project area.
- 1314 care groups have been formed.
- Integration of livelihood activities into care group core activities
- 19 care groups have started IGAs which has boosted their sources of income and livelihood
- Improved health service utilization as shown in LOAS 5 ; fully immunized children, ITN utilization and VCT uptake

C PROVIDER INITIATED TESTING AND COUNSELING AS A PROMISING PRACTICE

In partnership with APHIA II Coast and the Ministry of the Health Kilifi, the KIDCARE Child Survival project adopted the Provider Initiated Testing and Counseling (PITC) methodology to increase opportunities for people to know their HIV status. This methodology was found to be cost effective as it takes 5 days to train a class of 25 people compared to 3 weeks for VCT which has a maximum class of 12 people. Also PITC does not require additional facilities such as a room with chairs but uses what is already available. Currently the district has 12 VCT sites mainly found at the main hospital and the health centres.

Emphasis during training is on interpersonal relationships that include how to approach the client first and enlist for testing as opposed to waiting for a client at a VCT site; health worker being given skills to carry out the test; counseling after the results and the subsequent care and referral.

The training acknowledges participants are health workers directly involved in clinical management of patients or provide preventive and promotive services such as immunization and family planning. The health workers are mainly nurses, clinical officers and laboratory staffs thus have a fair knowledge of HIV/AIDS situation and handle many clients daily in the

course of their work. Therefore it is easier for the health worker to integrate PITC as one of the core services to clients whenever they come for service at health facilities.

Project's inputs

In November 2007 the first PITC training was conducted for 27 health workers drawn from all the facilities in the district including neighboring Kaloleni district. The training was facilitated by members of the District Health Management Team, who had been trained earlier by APHIA II Coast.

Two review meetings have been held with those trained in PITC. The first meeting was held in May 2008 to review the practicability of the method. In this meeting all those trained reported to be testing clients but had difficulty in reporting as the recording form provided only for VCT. Another problem discussed was that the available testing kits are only for VCT/PMTCT and some facilities did not allow using them. In response to these two issues raised the DASCOS showed the participants how and where to report using the existing recording form. They were informed that the testing kits are the same the only difference being in the reporting and accounting.

The second review meeting was held in August 2008 and there was progress with 10% of all clients presenting to the outpatient being approached by the health workers implementing PITC. This was still low compared to the number of outpatients visiting the health facility for services. To improve performance it was agreed that everyone at the facility will offer testing and counseling to clients and account properly for the testing kits. It is hoped in the next review meeting performance will have improved.

Beneficiaries

Since January to July 2008 those who were approached to be tested through PITC were 16,277 out of which 10,346 were women. Those who agreed to be tested were 9818 of which 6850 were women. While those who visited the VCT sites during the same period were 11344 of which 6794 were women.

D COMMUNITY LED TOTAL SANITATION (CLTS) AS A BEST PRACTICE

Problem being addressed:

High prevalence of diarrhea disease among children under five years and one of the leading causes of morbidity and mortality in Kilifi district.

Project input to address

The project staff was sensitized on the approach by the Plan Water and Sanitation Advisor after which the project staff sensitized the DHMT and CHW/TOTs. Jaribuni village was chosen as a pilot village for CLTS. Community members were sensitized on CLTS concept and were the first to reach an open defecation free (ODF) status.

The entire Jaribuni SA celebrated the ODF status in a function that was attended by key stakeholders including the DMOH and it received considerable media coverage. The results were so encouraging that the DMOH requested for CLTS training for MOH staff in Kilifi district.

The project organized for the training which brought together Plan and MOH staff (DHMT, PHO/Ts from 6 divisions of Kilifi district namely Bahari, Chonyi, Ganze, Vitengeni, Bamba and Kikambala), Aga Khan Health Services and UNICEF

and a community member from Jaribuni village. The aim of the workshop was to share the concept of CLTS approach, share experiences in the approach from those who had initiated CLTS in Kenya and globally, and explore potential for scaling up sanitation programs in the district. During the workshop, five villages were triggered namely Kahingoni, Nyongoro, Mpenda Kula, Mwele and Mirihini villages. Out of 299 homesteads, 181 have now completed construction and are using pit latrines while the remaining homesteads have dug the pits and are now putting up superstructures. In total 33 villages have been triggered and have constructed 500 toilets that are in use. Other community members are at different levels of latrine construction.

In the past, several strategies had been used by Ministry of Health and NGOs to address the above issue without much success. The triggering process and openness made the communities realize they were eating their own faeces. This created fear, shame and disgust which led the community members to come up with resolution to construct and use latrines.

Social solidarity and co-operation between rich and poor is needed to achieve ODF status and to engage men, women, youth and children in a time bound campaign and local action to end open defecation. Often, ODF communities do not stop at achieving ODF status but move on to achieving other collective common goals.

Lessons learnt led to scaling up of the intervention to RESA region. A CLTS regional workshop funded by Plan office of South Africa was conducted and drew participants from the Ministry of Health (Assistant minister for Health) and all the public health officers in the country, representatives from RESA countries and Egypt. The workshop was facilitated by Dr Kamal Kar.

E PD /HEARTH AS A BEST PRACTICE

Problem being addressed:

The project carried out a baseline survey in 2004 and children aged 0-5 years were weighed. The survey results showed a high level of underweight children (over 30%) in Ganze, Jaribuni and Mryachakwe SAs.

Project input

The project staff and MoH staff were trained by a consultant, Donna Sillan, on PD/hearth in January 2006, after which two pilot hearths were initiated in two villages of Ganze SA which had highest number of underweight children.

During the initial implementation, the project identified gaps in the process of community engagement. Community volunteers (CHWs) that were to conduct home visits post hearth cycle lacked knowledge on PD/hearth. The project staff and MOH developed a guideline that was used to train all the community health workers. The training commenced with the community health workers weighing all children less than five years in their villages and identifying those who were under weight and the well nourished children.



The CHWs were facilitated to carry out wealth ranking exercise for all households in their villages. The poor households with underweight children, well nourished from poor households and underweight from rich households were identified. The CHWs visited the homesteads to observe and inquire from the caregivers and the fathers of the children about Care giving practices, feeding practices and health seeking practices for the children. The caregivers and fathers were not informed about the visits. After the training, the CHWs worked closely with project staff, the village health committees, and MOH staff at the local health facility, local administration and other community opinion leaders to initiate 12 hearths in Malomani, Vilwakwe, Kimbule, Tsangalaweni and Mwaeba Villages. The good practices identified formed the package for health messages shared with the mothers at the hearths.

The DHC Ganze further trained all CHWs in the SA on PD/Hearth using the already trained CHWs. The project has trained 150 VHC and CHW in PD/Hearth in Malumbo, Mpango, Garichwa, Gabina, Milore, Madamani, Matano Manne and Shononeka villages in Muryachakwe and Vitengeni SAs. 8 Hearths have been initiated in these two supervision areas.

Since initiation of PD/Hearth in 2006, the project has rehabilitated a total of 146 children who had varying degrees of malnutrition in Ganze, Vitengeni and Muryachakwe SAs. The children who have graduated have shown progressive improvement in their nutrition status. The younger siblings have also become healthy by benefiting from what the mothers learnt at the hearths.

The project has involved both men and women in the hearth processes. Underweight children from both very poor and rich families attend the same hearth sessions for rehabilitation. Each mother contributes to the hearth menu.

F LQAS AS A BEST PRACTICE:

Problem being addressed:

There exist gaps in regular monitoring of outcomes and knowing how to refocus resources to address poor performing indicators in child survival projects is the goal.

LQAS gives an opportunity for the project to regularly monitor project outcomes and know how different catchments areas are performing. Through LQAS, workable solutions in different SAs can be identified and shared with the poorly performing SAs.

Project input

In 2005, project staff, MOH and partners were trained in LQAS by an external consultant. During the training, the project area was divided into 11 supervision areas. One LQAS was carried out as a baseline and thereafter four more biannual LQAS' have since been conducted.

The project has utilised the LQAS results to regularly monitor project outcomes. The poor performing indicators are identified and strategies put down to address them.

The best performing indicators per SAs are also identified and lessons learnt shared with other SAs as well as during the co-ordination meetings. The LQAS 4 results also informed the mid term evaluation on the status of the project.

Lessons learnt on the use of LQAS as a monitoring tool were scaled up to Plan regional level. The project hosted the RESA LQAS training which drew participants from Ethiopia, Zimbabwe, Sudan, Malawi, Uganda, Tanzania, Zambia, USA and a representative from South Africa. The training was facilitated by Dr Laban Tsuma, Dr. Pierre Marie from Plan USA and Dr Owuor from Plan Kenya. The RESA training enabled the project to have data collected for five SAs and later the project staff completed data collection from the remaining six SAs.

Beneficiaries

The project works in Kilifi district in Kenya. It Covers 357 villages in Ganze, Chonyi, Bahari and Vitengeni divisions of Kilifi district. The project covers a total population of 257,522 with 46,354 Children U5 and 64,381 women of child bearing age.

The Ministry of Health, Dispensary Health Committees, Project staff and community health workers are the main beneficiaries of LQAS because it helps them know the status of various indicators and come up with appropriate strategies for action.

Annex 6 (a)

Special VIP Visits

On June 30th and 1st July 2008, the KIDCARE Child Survival project hosted the **Plan USA President/Chief Executive Officer (CEO)** Dr Ahuma Adodoadji accompanied by his wife Dr Eva Adodoadji and familiarized them with the Project

activities. On the first day of their visit the guests traveled to Kidutani Primary school Child-to-Child Club where they observed CTC projects like use of leaky tins for hand washing after use of toilet, tree nursery for re-forestation and a vegetable garden that is a source of income for the CTC members. Some of the personal benefits of the CTC clubs cited by the pupils included learning how to disseminate health messages using puppetry and orientation on life skills that have made them better equipped to avoid early pregnancies or involvement with drug abuse.

On second day, the CEO team visited Muryachakwe to observe a PD Hearth session in progress. The session was facilitated by two male CHWs. They witnessed preparation of the nutrient dense porridge and the CHWs demonstrating active feeding to some of the mothers. They later visited two care-groups in Kadziani and Kasemerini where members shared about their involvement with the project and benefits that they had derived from the engagement. These included: knowing danger signs of a sick child, and benefits of skilled delivery, ITNs utilization and use of Pit latrines. The two care groups have diversified their activities to include agriculture for domestic use and income generation. They keep dairy goats and provide breeding services from three special upgraded "He goats", grow crops using water saving technologies ("Zai pits") and plant fruit seedlings for sale. They requested assistance with funding for an irrigation system which the CEO undertook to help in sourcing for once a proposal/concept paper is sent to USNO.

Visit by USAID Kenya Mission Reproductive Health Specialist

In February 2008, the project partners requested Plan Kenya Country Director (Else Kragholm) to invite the US Ambassador to Kenya to visit Kilifi district and have an opportunity to see some of the changes the funding from the American people has made in the lives of children and community.

The visit to the project was included in the itinerary of the Ambassador on 22 September 2008 and Dr Sheila Macharia of USAID Kenya Mission (Reproductive Health Specialist) came to support the project and partners in the preparations for the visit. However due to heavy rain the previous night, the Ambassador's entourage could not reach the community. The planned activities went on with Dr Sheila Macharia standing in as the chief guest. Others in attendance were the Provincial Medical Officer, Plan Kenya Country Director, a child guest who spoke on behalf of CTC, Provincial Administration, PSI, AKHSK, APHIA II Coast, DMOH and the DHMT, Mothers whose children had graduated from the PD-hearth, Ganze DHC, CHWs and CHW-TOTs, School children of Tsangalaweni, community members and Plan Kilifi staff.

The community demonstrated a hearth session covering all the key stages including: weighing to identify children who are underweight, display of available foods in the community used for hearth meal, cooking of the improved nutrient dense porridge and active feeding of children.

The trained CHWs and CHW/TOTs then presented health education topics to the audience on exclusive breast feeding with one CHW giving a testimony of her personal experience. Three CHWs then presented a skit on family planning and importance of skilled delivery. The CHWs and Tsangalaweni CTC members each presented a song with messages on nutrition.

The highlight of the day was the keynote address by Dr Sheila Macharia who thanked the community and partners for taking action to ensure the survival of children in Kilifi district.

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Annex 6 (b)

Illustrative plan for Operational Research on Structure Effectiveness in Roll-out of the Community Strategy

Background

- The Ministry of Health has adopted the Community Strategy - a mechanism through which households and communities strengthen their role in health and health related development by increasing their knowledge, skills and participation - as the strategy for delivering the Kenya Essential Package of Health to the community level (Level 1).
- KIDCARE-CSP supports the Ministry of Health (MoH) to realize its objectives that relate to child health at the community level. The project's specific objectives are well aligned to those of the MoH as set out in the 2nd national health sector strategic plan (NHSSP II [2005-2010]).
- The Project begun roll out of their community-level child health activities in 2004 and adopted the "10-homestead care-group" structure to ensure interventions reached each and every household in the target community and to facilitate community participation.
- Later, in 2007, the MoH adopted a variant of the care-group structure – a "20-household care-group" - in rolling out the community strategy in pilot districts (amongst which is Kilifi).
- There are apparently subtle differences between the two structures that have considerable implications for the cost-effectiveness of the community strategy. The study will thus inform choice of the more cost-effective structure for rolling out the community strategy.

Postulates

- The structure adopted by MoH is more cost effective in delivery of outcomes at the community level compared to the KIDCARE project structure
- The structure adopted by MoH is more effective in facilitating community participation in improving health outcomes compared to the KIDCARE project structure

Study Location

- The study will be carried out near to Plan's child survival project in Kilifi District, Coastal Region, Kenya
- Three comparable communities outside the project area will be selected for studying implementation of the community strategy. One community will act as a control while awaiting roll-out of the community strategy as per the MoH schedule. The study will implement the community strategy in the other two communities using the MoH structure in one and the Project structure in the other.

Study Designs

- The research protocol will be reviewed by and carried out under the Kenya Medical Research Council.
- The study would be carried out in three comparable communities as per the table below.
- The three comparable study communities will be purposively selected from Kilifi district outside the current project area.
- Interventions will be assigned as per the tabulation below;
 - i. Current standard level 1 health service delivery;
 - ii. Community strategy with KIDCARE structure;
 - iii. Community strategy with MoH structure

NOTE: THIS TABLE IS ILUSTRATIVE OF A PROTOCOL TO ADDRESS THE RESEARCH QUESTION – FINAL PROTOCOL WOULD DEPEND ON NEGOTIATIONS BETWEEN THE KENYA MEDICAL RESEARCH COUNCIL, THE KILIFI DISRICT HEALTH TEAM, AND THE INVESTIGATORS

Selected Communities (comparable at baseline)	Site A:	Site B:	Site C:
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- Mentoring of CHWs and care groups is a joint responsibility for CHW/TOTs, project frontline and MOH grassroots' staffs now.
- The project and MOH supported IMCI follow up and on job training for 18 health workers with emphasizes on prompt assessment and treatment for fever. This has since led to improvement of all Children seen at the Health facilities who had fever receiving the recommended treatment for Malaria (as per IMCI follow up results).
- Increasing IPT uptake has been boosted through 248 outreaches conducted by DHCs and during two rounds of National Immunization Days in the months of November 2007 and June 2008 that saw intensified community mobilization for services.
- The MOH introduced a policy of increasing access to ITNs for Children below one year and pregnant women at no cost for the whole country. However efforts are now being focused on utilization of the ITNs through the use of IEC/BCC.

B). Diarrhea prevention and management

The Community, MOH, PSI and Plan committed to ensuring that proper hand washing, use of safe water (boiled water or use of chemicals), use of ORS for diarrhea Management, and emphasis on home made fluids before seeking care at the health facility and environmental sanitation were areas to be acted on.

Status:

- The project supported the 14 health facilities with ORS and Zinc for management of children with diarrhea.
- The project has standardized the health information package per intervention by adapting a C-IMCI manual that is being used by CHW/TOT. Messages on treatment of water at point of use, use of home made fluids for a child with diarrhea before seeking health care and proper hand washing continued to be disseminated by CHWs, CHWs/TOTs and DHCs to caretakers.
- The Project team and MOH adapted a new methodology for improving environmental sanitation through triggering communities to take a lead role in total sanitation. The methodology known as Community Led Total Sanitation (CLTS) successfully triggers community to take action in improving sanitation status without outside subsidy. CLTS emphasizes the ownership and utilization of latrines for individual households to avoid open defecation, while emphasizing on proper hand washing and use of safe water. 45 MOH staffs have been trained in use of CLTS and to date 33 villages have had triggering done with Jaribuni village becoming open-defecation free (ODF). The villages are at different stages of implementation and to date over 500 toilets have been constructed and are in use.

C). Pneumonia:

To identify danger signs at community level, C-IMCI reference materials in local language have been developed and distributed for use by CHWs/TOTs.

These include:

- C-IMCI photo booklet adapted from MOH Tanzania with messages localized to reflect key home care practices of the Kilifi Child survival project.
- One page laminated hand-out on danger-signs of a sick child used by CHWs, CHW/TOTs and VHCs.
- The project supported the orientation of IMCI facilitators to enable them carry out follow up of HWs for prompt assessment, treatment and referral of sick children. 18 HWs have since been followed up and on-job-training undertaken.
- The project supported the 14 health facilities with buffer stock of antibiotics for management of pneumonia.

D). Immunization

- Integrated health outreaches for hard to reach areas are on-going with CHWs playing critical role of mobilization. This has been boosted by two NIDs held in November 2007 and June 2008. Immunization of child bearing women at every opportunity with the 5 TT schedule was revisited and emphasized during the KEPI update for 28 HWs in June 2008.
- The MOH has commenced mobilization for MNT vaccination campaign in October 2008, (note this was supposed to have been done early in the year but due to the unfavorable political environment it was put on hold until October 2008).
- Fathers/Males that bring their children for immunization are given priority to encourage them (men) take active role in the health of their children.
- The MOH has come up with innovative ways of encouraging pregnant women to deliver at health facilities at no cost and provide them with food for the duration of confinement. In this way pregnant women are assured of safe delivery by being attended to by skilled birth attendants. The role of DHCs is to mobilize the pregnant women for this service.
- The MOH has established a referral network with all facilities being provided with telephone facilities and may request for ambulance when needed.
- APHIA II Coast, one of the project partners, is promoting family planning services that include male involvement.

E). HIV/AIDS

- To encourage inpatients and outpatients to know their HIV status, the project team, MOH and APHIA II held discussions aimed at strengthening HIV/AIDS prevention through increasing VCT uptake.
- In November 2007, 27 Health workers were trained in Provider Initiated Testing and Counseling (PITC) and two follow-up meetings have since been conducted and there is improved uptake of people being tested for HIV.
- All health facilities now provide HIV testing facilities with a recorded uptake of PMTCT at 98%.

F). Malnutrition:

- To strengthen community based growth monitoring, 21 more weighing scales were issued to DHCs to minimize the distance covered by the care givers. More follow-up sessions are being undertaken for CHWs to ensure accuracy of the growth monitoring records by MOH, APHIA II coast, DHCs and the project staff.
- CHWs and 19 Care groups have integrated livelihood into their activities to enhance household food security (Kasemerini care groups are keeping dairy goats and growing crops using modern technology).
- The MOH health workers and CHWs are encouraging mothers who deliver at home to access postnatal care that includes Vitamin A supplementation within the 1st 8 weeks.

2. Reduce the level of effort for conducting HFA which are resource intensive. Replace the Kenya HFA tools with the rapid assessment tools designed by CSTS for routine monitoring and improvement of quality of care.

As per the DIP, three HFA surveys were to be undertaken during the life of the project. The project will therefore use the standard HFA tool for the final evaluation due in June/July 2009.

3. Develop sustainability and/or scale up plans to sustain the gains achieved by the project in instituting community governance and health promotion structures

- The MOH, Project staff and AKHSK-CHD held discussions aimed at capacity building of structures to assist in the supervision of the CHWs, CHW/TOTs. Due to the high turn over of MOH staff a need was seen to have community TOFs included as a strategy for sustainable oversight of CHWs and CHW/TOTs. 10 TOFs were identified from the community and 10 from MOH comprising mainly of Divisional Public Health Officers. They were trained by AKHSK-CHD to mentor

the DHC and VHCs on governance, HMIS and Financial management. The TOFs will be taken through phase 2 training covering resource mobilization from diverse sources such as the private sector and government devolved funds for specific aspects of interventions in the community.

- Joint supportive follow-up for six DHCs was undertaken and among partners participating there was a higher representation of the MOH staff. The MOH staff committed to continue the already established follow-up system.
- 19 care groups have started Income Generating Projects to supplement their income and exchange visits will be encouraged for others to learn.

4. Re-examine staffing patterns and management oversight for the 357 villages to ensure support and supervision of community activities:

Status

- 20 TOFs have been trained by AKHSK-CHD to mentor the DHC and VHCs on governance, HMIS, Financial management and resource mobilization.
- The health facility in-charges share reports on the progress of CORPs during the monthly meetings with DHC and this in turn is sent to the DHMT.
- The PHO/PHT and project staffs have monthly meetings with VHCs and CHWs at the Sub-location level, reducing the number of small clustering that required frequent sessions at the beginning of the project. The monthly meetings are now initiated by the CHW/TOTs.

5. Examine the quality and effectiveness of the CBHIS and record the mortality rates for prompt action to be taken at the district and community level.

Status

Partners reviewed this recommendation and agreed on the way forward:

- The health facility HIS subcommittee, with support from MOH and project staff, to ensure that planning is based on community health information collected.
- The CORPs will collaborate with the provincial administration to capture deaths occurring in the community.
- The relevant data collected by CHWs is being incorporated in the MOH monthly reports especially growth monitoring, referrals, water treatment kits sold, ITNs, immunization status, CHWs work load and planned outreaches/meetings.

6. Strengthen and leverage organizational core competencies for child health and promotion through the child sponsorship, child-to-child and school health activities to scale up health promotion in the communities

- CTC activities have been scaled up to another six primary schools bringing the total number of schools actively participating in Kilifi district to 33.
- The school calendar was affected and teachers could only spare the pupils for training during the April school vacation.
- The CTC clubs in Chonyi division held a festival in June 2008 whose theme was living healthy. The festival brought children and their patrons together to learn and share best practices. There is a network of patrons who are key trainers.

7. Invest additional efforts on food security measures that have been initiated through kitchen gardening for the mothers and the school children and introduce/strengthen indigenous farming techniques.

- The Project, DHC and partners are promoting kitchen gardening among the CHWs and care groups especially in the dry regions of the project area. Two care groups have started demonstration gardens and use locally available resources to grow crops. They have been linked to the Ministry of Agriculture to learn technologies of conserving water for agriculture use.
- CTC clubs in schools have initiated Kitchen gardens that include growing vegetables and planting tree seedlings for forestation.
- PD/Hearth has been shared widely with staff, partners and the community during the NID weeks in November 2007 and May 2008 during which the theme was Child nutrition. There is more active participation of men in PD/Hearth especially in Muryachakwe and Vitengeni SAs.

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Annex 6 (d)
Status of Objectives

Objectives for Immunization

Objective	Activities	Status of Activities	Comments
1. Increase from 62% to 74% children age 12-23 months fully immunized and increase from 64% to 80% children age 12-23 months who received Measles vaccine	Train dispensary staff in "missed opportunities" for vaccination	<ul style="list-style-type: none"> 28 HW trained in KEPI and cold-chain. The training included the aspect of missed opportunity, cold chain maintenance and reduction in vaccine wastage. The HWs also covered the Integrated Disease Surveillance Response and utilization of data for action at point of collection. Full immunization coverage (for children aged 12-23 months) has improved from 62% baseline to 70.8% (LOAS 5), and Measles coverage from 64% to 82.3% 	There was vaccine stock out in the district as a result of a national shortage. This led to a national outcry that required re-organization of the Kenya Medical Services procurement board which is currently being done.
	Train nurses/TOTs in cold chain maintenance, reduction of vaccine wastage		
	Conduct regular outreach facilitated by DHCs/VHCs, CBF and CHWs	<ul style="list-style-type: none"> 248 Outreaches were undertaken organized by the DHCs and now form one of their calendar events. 	The outreaches have been well attended as CHWs, VHCs and DHCs conduct intensive mobilization.
	Support routine immunization	<ul style="list-style-type: none"> All health facilities provide routine immunization and access for community has been increased by the opening of three new dispensaries by the MOH. 	APHIA II supported MOH with new refrigerators enabling all facilities to conduct immunization regularly.
	Support for NIDs	<ul style="list-style-type: none"> Supported Child Health Nutrition week in November 	Partners participated in the NIDs with MOH providing

		07 and May 08. Immunization Services were provided at static health facilities and in 7 outreach sites in Nov 2007 and in 13 sites in May 2008.	personnel and vaccines, while the project supported with mobility and drugs. APHIA II provided VCT and PSI carried out demonstrations on water treatment.
	Routine collection of data, analysis and feedback by TOTs/VHCs Train VHCs/CHWs/Care groups in use of CBR for data collection	<ul style="list-style-type: none"> 599 CHWs trained in C-IMCI and the 325 VHCs that have been trained in PHC/CBHC to date covered CBR for data collection. The CBHIS tool includes information on number U5 deaths. 	The cumulative number of trained CHWs stands at 1314 while out of these 599 have covered C-IMCI and 87 have further trained as CHW-TOTs in C-IMCI
2. Increase from 24% to 60% number of mothers with TT2 coverage before birth of last child	Outreach activities to provide TT vaccinations	<ul style="list-style-type: none"> Out of 248 outreach sessions held, TT vaccinations were given in 85 sessions to women of Child bearing age. TT2 coverage increased from 24.4% to 32.5%. The percentage is still below the project target of 60%. Plan USA National office has provided private funds for a period of one year in response to a proposal written by project staff and MOH to accelerate TT2 Immunization uptake. 	<ul style="list-style-type: none"> The district reported 10 confirmed cases of neonatal tetanus. The MOH has embarking on a MNT campaign to be undertaken in the month of October 2008.
3. Increase from 0% to 30% women have their vaccination card checked during sick child visit, and from	Train dispensary staff in IMCI	<ul style="list-style-type: none"> 18 HWs previously trained in IMCI, were followed up and on-job-training undertaken. 28 HW trained in KEPI and cold-chain. The training 	

53% to 80% sick children who had their vaccination card checked during the visit		included the aspect of missed opportunity, cold chain maintenance and reduction in vaccine wastage.	
4. Increase from 28% to 50% number of children needing a vaccination who receive it on the day of the clinic	Conduct Surveillance of vaccine preventable disease (Measles, AFP, neonatal tetanus) using community mapping.	<ul style="list-style-type: none"> • 28 HWs trained in KEPI and cold-chain. The training included the aspect of missed opportunity, cold chain maintenance, reduction in vaccine wastage and steps in disease surveillance. 	<ul style="list-style-type: none"> • The health workers covered in detail the Integrated Disease Surveillance Response (IDSR) and the role of health care in effective community disease surveillance.
	Train VHC identified CORPS (traditional healers, herbalists and TBAs) in mobilizing mothers for immunization	<ul style="list-style-type: none"> • 599 CHWs and 331 VHCs trained in CBR for data collection. The CBHIS tool includes information on number of U5 deaths in the community. • Three sub-location Health Committees were trained covering 32 villages within the peri-urban areas of Kilifi Township 	
5. Caretakers with Children who are Correctly Counseled on Immunization	Train church pastors and community opinion leaders in advocating for full immunization	<ul style="list-style-type: none"> • Mentoring is on-going in the care groups where members are being equipped with health information and mobilized for action. 	Religious leaders are a part of those community members who attend community meetings. Some of them are also CHWs/VHCs/DHCs.
	Train CHWs and TOTs/VHCs in use of verbal autopsy community mapping	<ul style="list-style-type: none"> • 599 CHWs and 331 VHCs trained in CBR for data collection. • The CBHIS tool includes 	

	using PRA for recording deaths and events	information on number U5 deaths.	
	Routine collection of data, analysis and feedback by TOTs/VHCs		
	Conduct regular outreach facilitated by DHCs/VHCs, CBF and CHWs	248 outreaches undertaken that were organized by the DHCs.	The outreach is now in the calendar of events for the DHCs.

2. Objectives of Malaria Control

Objective	Activities	Status of Activities	Comments
1. Increase from 21% to 50% children who slept under ITNs the night prior to the survey	Develop IEC strategies and Train care group members and TOTs/CHWs on malaria control, treatment and prevention	<ul style="list-style-type: none"> The project adapted a photo booklet manual on C-IMCI and 150 were produced and distributed to CHWs, CHW/TOTs and have since been used as training manual. (The booklet is in Kiswahili language). The 87 CHW/TOTs facilitated the training of 599 CHWs on C-IMCI. Mentoring is on-going in the care groups where members are being equipped with health information and mobilized for action. Children who slept under an ITN the previous night in 	<ul style="list-style-type: none"> The trained CHWs/TOTs have appreciated the IEC materials and use them during on site training and mentoring. Inconsistency in ITN use during dry (warm) seasons and socio-cultural functions could be a factor in the reduced ITN utilization witnessed in LQAS 5

		baseline was 21%, and in LOAS 4 it was 76% and in (LOAS 5) it was 72%	
	<ul style="list-style-type: none"> Develop mechanisms by which ITNs will be easily accessible. 	<ul style="list-style-type: none"> 14,650 LLITNS distributed through the DHC network. 	<ul style="list-style-type: none"> Government policy in place that children below 1 year and pregnant women receive LLITNs at no cost
	<ul style="list-style-type: none"> Educate mothers/ caretakers and men on use of bed nets in pregnancy and its continued use, and re-treatment. 	<ul style="list-style-type: none"> Mentoring is on-going in the care groups where members are being equipped with health information and mobilized for action. 	
	<ul style="list-style-type: none"> Distribution of bed nets through VHCs 	<ul style="list-style-type: none"> ITNs being distributed to pregnant women and children under one year at no cost whereas those above one year purchase at a subsidized cost of 50Ksh 	<ul style="list-style-type: none"> Distribution of nets was done at the health facility and outreach.
	<ul style="list-style-type: none"> House to house re-treatment or through sentinel-dipping stations carried out by VHC and household members 	<ul style="list-style-type: none"> Indoor Residual Spraying was done in 19 houses in Uyombo Village. 	<ul style="list-style-type: none"> Not a preferred choice for malaria endemic regions and for Coast, ITNs are preferred. Recommended for use in institutions and the MOH was offering the same at no cost (however, individuals who needed it in the community had to meet the cost).
	<ul style="list-style-type: none"> Train VHCs and 	<ul style="list-style-type: none"> LLITNS are already treated 	

	household members in net re treatment	thus no re-treatment which is convenient for communities. However net re-treatment was done during outreaches since some community members still own the re-treatable nets.	
	<ul style="list-style-type: none"> • Link with village bank program to develop systems to increase access to the poorest. • Work with VHC/DHC to institute cost recovery mechanism and pricing for bed nets 	<ul style="list-style-type: none"> • By time of writing the DIP, the nets were being sold at 300 Kshs which was unaffordable, the government policy on the same has changed thus it is easy to access nets at low/no cost 	<ul style="list-style-type: none"> • Some facilities have come up with a mechanism where goods are exchanged for a net e.g. brooms or coconuts for nets.
	<ul style="list-style-type: none"> • Work with PSI for behavior change and social marketing of bed nets 	<ul style="list-style-type: none"> • PSI created awareness on importance of ITN use and demonstrated how to fix the nets during the (NID) Child, Mother Health and nutrition week, held in November 2007 and May 2008. • PSI participated in CHW/VHC trainings and conducted demonstration on how to fix ITNs for a variety of beds/mats 	
2. Increase from 39% to 60% women who took	<ul style="list-style-type: none"> • Develop systems by which 	<ul style="list-style-type: none"> • Mothers who require IPT are identified through care group 	<ul style="list-style-type: none"> • Access is still an issue for some due to long distances

malaria prophylaxis/treatment during pregnancy	<p>pregnant mother will be identified early and specifically targeted for IPT</p> <ul style="list-style-type: none"> Educate mothers on use of IPT 	<p>meetings by CHWs and referred to health facility or outreach services</p> <ul style="list-style-type: none"> Mentoring is on-going in the care groups where members are being equipped with health information and mobilized for action. 	<p>to service delivery points.</p>
	<ul style="list-style-type: none"> CHWs trained to administer IPT using Fansidar (under the supervision of Health Workers) and Iron supplementation for pregnant women 	<ul style="list-style-type: none"> 599 CHW's have been trained on C-IMCI; they however do not administer IPT but refer pregnant women to the health worker. 	<ul style="list-style-type: none"> Current government policy does not allow CHWs to administer malaria prophylaxis and iron supplementation
	<ul style="list-style-type: none"> Outreach facilitated by CBF, nurses, VHC and CHW ensures increased access to ANC services 	<ul style="list-style-type: none"> Out of the 248 outreaches, ANC services was provided in 208 sessions Mothers who took malaria prophylaxis/ treatment during pregnancy increased from 51% baseline to 73.5% (LQAS5). 	<ul style="list-style-type: none"> The outreaches are now calendar events for the DHCs, however the momentum has to be sustained.
<p>3. Increase from 45% to 75% caretakers who sought treatment within two days (48 hours) after symptoms began</p>	<ul style="list-style-type: none"> Training of CHWs in IMCI case management to treat malaria Behavior change interventions 	<ul style="list-style-type: none"> 599 CHWs have been trained in C-IMCI. Their role is to educate caretakers on recognition of danger signs and immediately refer for treatment to an appropriate Provider. There are 87 CHW/TOTs 	<ul style="list-style-type: none"> The government policy for those presenting with malaria symptoms is for treatment to be provided at no cost in all government facilities The training of CHWs in malaria treatment was shelved when the

	educate mothers and caretakers on recognition of danger signs, overlap of pneumonia and to seek immediate treatment from an appropriate provider	<p>who conduct follow ups and mentor CHWs on recognition of danger signs and timely referral.</p> <ul style="list-style-type: none"> Caretakers who sought treatment within 2 days after symptoms began are 61.8% (LOAS5) an improvement from 45% baseline, however this is still below monitoring target of 75%. 	<p>government policy on 1st line treatment for Malaria changed.</p> <p>Where CHW/TOTs have been trained, the mentoring of CHWs has increased and the knowledge of care takers improved greatly.</p>
4. Increase from 18% to 40% children getting the correct treatment within 24 hours of onset of fever (treatment commenced by 'next' day)	<ul style="list-style-type: none"> Train VHC identified shopkeepers in correctly dispensing anti malarial and fever drugs 	<ul style="list-style-type: none"> Government has adopted Coartem as 1st line of treatment for malaria which is only found at health facilities. 	<ul style="list-style-type: none"> The training of shopkeepers was shelved when the government policy on 1st line treatment for Malaria changed.
	<ul style="list-style-type: none"> Traditional healers and herbalists identified by VHC trained in identification of danger signs and in timely referrals to CHWs for case management 	<ul style="list-style-type: none"> The traditional healers are part of the community and among the large pool of 1314 CHWs out of which 599 CHWs have been trained in C-IMCI and 87 as CHW/TOTs . They are involved in educating mothers to identify danger signs and refer to health facility. 	
	<ul style="list-style-type: none"> Train dispensary staff in IMCI Case management 	<ul style="list-style-type: none"> 18 HWs trained in IMCI had follow up undertaken and on job training done 	

<p>5. Increase from 74% to 90% children who are correctly treated for fever (malaria)</p>	<ul style="list-style-type: none"> • Develop Mobile Ongoing Sustainable Training (MOST) in health facilities to provide on the job support to trained HWs and maintain IMCI recertification. 	<ul style="list-style-type: none"> • IMCI Follow Up was done for 18 HWs from the 14 Health Facilities in which all Health Workers assessed were found to treat malaria correctly. • The DMOH, has established an IMCI core team charged with Follow up led by the District Clinical Officer 	<ul style="list-style-type: none"> • The central MOH has modified the IMCI case management curriculum to include the new born care of 0-2 months and use of Zinc for diarrhea management. • HWs already trained in IMCI to soon have 3-day update.
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3. Objectives for HIV Prevention

Objective	Activities	Status of Activities	Comments
<p>1. Increase from 41% to 70% mothers able to give 2 ways of avoiding HIV infection</p>	<ul style="list-style-type: none"> • Train VHCs and CHWs who will educate mothers/men on preventive behaviors (ABCD) and PMTCT 	<ul style="list-style-type: none"> • 599 CHWs and 114 VHCs trained on HIV/AIDS prevention. • 275 pupils from 7 schools reached with HIV/AIDS message during training. • Mothers who knew at least 2 ways of avoiding HIV infection has increased from 41% to 58.4% (LQAS5). 	<p>Mentoring is on-going in the care groups where members are being equipped with health information on HIV/AIDS and mobilized for action.</p>
<p>2. Increase mothers availing of the VCT service from 18% to 30%</p>	<ul style="list-style-type: none"> • Support training of counselors and nurses in VCT as well as referral services options 	<ul style="list-style-type: none"> • 27 health workers trained in Provider Initiated Testing and Counseling • Two quarterly review meetings held in May and August 2008 • Mothers availing themselves for VCT services have improved from 18% baseline to 67.3% (LQAS 5). 	<ul style="list-style-type: none"> • 275 CTC members were sensitized in HIV/AIDS prevention

	<ul style="list-style-type: none"> Strengthen existing district hospital VCT and PMTCT centers and post test referral system 	<ul style="list-style-type: none"> 4 health facility providing care and support to those found positive. The rest refer the clients to the district for care and support. CHW encourage people for VCT and PMTCT services in their care groups and during other community forums. 248 outreaches were held out of which 30 sessions had VCT while 33 had PMTCT services being provided. APHIA II participated in World AIDS Day. It has also supported outreaches and has supported health facilities with storage pots for test kits thereby enabling many people to get the services. 	<ul style="list-style-type: none"> Working in partnership with APHIA II Coast has contributed greatly to the success achieved. The MOH policy recommends PMTCT services for all mothers attending ANC. All rural health facilities are able to store the testing kits using the special pots.
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4. Objectives for Nutrition

Objective	Activities	Status of Activities	Comments
1. Decrease from 26.6% to 21.6% the % of children aged 0-23 months who are less than 2 SD below the median weight- for-age for the reference	Train CHWs in weighing of children and counseling of care givers	CHWs are conducting growth monitoring and plotting weights in the CWC cards. There is an overall reduction of underweight from 26.6% at	The project has surpassed the targets for underweight due to the active health education carried out by the CHWs and good networking with the stakeholders.

population		baseline survey to 19.9% (LOAS 5)	
	Train CHWs in community IMCI to counsel and educate mothers	The 599 CHWs trained in C-IMCI and are now counseling mothers during care group meetings	The project focuses on training of CHWs and building their skills.
	Train VHC and CORPS members in weighing children and counseling of care givers	331 VHCs have been trained in PHC and are conducting community health education and support CHWs in mobilizing mothers for growth monitoring.	
	Provide weighing scales at community level as recommended by VHC/DHC	Initially, the project distributed 51 Salter scales to every sub location to trained CHWs and VHCs. This year, the project distributed an additional 21 Salter scales to the DHCs for community growth.	The caretakers are able to access sites for weighing easily.
	Link households with Plan micro-credit initiatives and CBNP for accessing loans and improved household food production.	Care group members have been linked to existing Financial Services Association (FSAs). Together with members of other groups within the community such as savings groups "merry go rounds" and women groups, they can make savings with the FSAs.	
2. Increase from 21% to 31% children aged 0-5 months who are fed breast milk only	Train CORPS, especially TBAs, to educate and motivate mothers to initiate breastfeeding and continue exclusive breastfeeding for 6 months and to	599 CHWs have been trained and are motivating mothers to initiate breastfeeding within 1 (one) hour after delivery and to practice exclusive breast feeding for 6 months and appropriate complimentary feeding of children thereafter	Some of the trained CHWs are TBAs sensitize pregnant women and refer them to health facilities for delivery.

	practice age-appropriate complementary feeding		
3. Increase from 92% to 95% children aged 6-9 months who received breast milk and solid foods in the last 24 hours	Train VHCs to conduct community education on weaning and appropriate complementary feeding	331 VHCs and 599 CHWs have been trained in C-IMCI and are carrying out community growth monitoring and counseling	The sample size of 6 to 9 months for LOAS 5 was too small to merit calculation of the percentage.
4. Increase from 5% to 30% mothers who received a vitamin A dose during first six weeks postpartum after delivery of the youngest child less than 24 months	CHWs trained to administer Vitamin A supplementation to postpartum women and children below 5	CHWs carry out community growth monitoring but the current government policy does not advocate for CHWs to keep vitamin A for supplementation. However, they educate the mother on consumption of foods rich in vitamin A. Trained community health workers, VHC and DHCs are educating mothers on importance of postpartum vitamin A supplementation.	The MOH policy does not allow the CHWs to store and administer Vitamin A
	Educate mothers on use of Vitamin A postpartum	Mothers who received a vitamin A dose during first six weeks postpartum after delivery of the youngest child have increased from 5% to 9%.	Vitamin A supplementation for post partum mothers is still below target. MOH does put emphasis on vitamin A supplementation and utilize opportunities when the mother visits the health facility.
Increase from 61% to 80% children 6 –23 months who received Vitamin A within the last	Link Vitamin A with Community Growth Monitoring	Vitamin supplementation is given during outreach sessions and at health facilities. Children 6 –23 months who	

6 months		received Vitamin A within the last 6 months have increased from 61% to 81.8%.	
5. Increase % of children who are enrolled into Hearth who complete it .And Increase % of children enrolled into Hearth who graduate	Nutrition education sessions through Farmer Field Schools, including home gardening lessons.	19 care groups have established kitchen gardens to provide nutritious foods for household consumption.	
	Community growth Monitoring	There are 72 weighing scales that are being used for community growth monitoring. In every sub-location, community growth monitoring is conducted on a monthly basis by the CHWs with support from CHW/TOTs, DHCs and VHCs.	Compared to the other SAs more children in Muryachakwe and Vitengeni area were severely malnourished. Malnutrition was more pronounced among children above two years.
	Training Volunteers in Hearth Trained VHCs and CHWs apply PD/HEARTH model	Trained CHWs identify underweight children and refer them to be enrolled for PD/hearth rehabilitation. 150 VHCs and CHWs trained in PD/ Hearth in Muryachakwe and Vitengeni SA.	
	Positive Deviance Inquiry	3 PDIs were carried out in Milore, Mrima wa Ndege and Madamani sub locations during the VHC/CHW training on PD/ hearth	
	Formation of Hearth Committees	A total of 8 Hearth committees comprising of VHC and CHWs were formed to co-ordinate the hearth activities in Milore, Mpango, Garichwa, Madamani,	

		Shononeka, Matano Manne, Gabina and Malumbo villages	
	Conducting Hearth	A total of 77 children were invited to the hearth and 10 graduated by the second cycle.	A total of 146 children have graduated from the hearths.

5. Objectives for Diarrhea

Objective	Activities	Status of Activities	Comments
1. Increase from 4% to 14% mothers with children aged 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children and after defecation, and after attending to a child who has defecated	<p>Educate mothers/caretakers in hand washing (before :cook, eat, toilet, after defecation)</p> <p>Educate CHWs/care groups/CTC on hand washing practices</p>	<p>599 CHWs have been trained in C-IMCI and are carrying out health education on hand washing for mothers during care group meetings.</p> <p>275 children trained in CTC approach and have initiated use of leaky tins for hand washing in schools and their homes. 7 schools in Chonyi division participated in open day festivals where the children shared messages on hand washing with the community members and other children.</p> <p>Percentage of mothers who report proper hand washing with soap/ash increased from 4% to 38.3%</p>	<p>A best practice has been adopted by the project which is complementing control of diarrhea diseases through triggering communities to construct and use pit latrines. This is commonly known as Community Led Total Sanitation.</p>
2. Increase from 1% to 10% households using chlorine for home water treatment	Train VHCs, CHWs and care groups in home chlorination. TOTs/CHWs to educate and conduct home chlorination	599 CHWs and 331 VHCs were trained on home water treatment. The trained TOTs/CHWs educate community members during care group meetings, public	

	with household members	<p>barazas, and outreaches and during health talks at the facilities.</p> <p>The MoH trained all Health Workers on use of chlorine pots for water treatment and facilitated provision of a total of 12 clay pots for treatment which were strategically placed at three different water pans per division.</p> <p>The Health facility committees sell water guard and PUR to community members during outreaches, at the facility and in the villages at subsidized rates.</p>	
	DHCs/VHCs to stock and distribute chlorine	DHC/VHC/CHW/TOTs stock water guard and PUR and sell to the community at subsidized rates.	
	Mechanisms in place which provide Water guard to OVC		As per the revised DIP, all community members access water guard without special focus on OVCs.
3. Increase from 31% to 41% children aged 0-23 months with diarrhea in the past two weeks who received ORS And Increase from 32% to 50 % mothers able to prepare ORS correctly	Educate mothers/caretakers on exclusive breastfeeding, appropriate weaning and increased use of ORS (Oralite) and home fluids.	599 CHWs trained in C-IMCI and are educating mothers/caretakers on exclusive breast feeding for 6 months, appropriate complimentary feeding and increased use of ORS and home fluids during illness.	VHC/CHW/TOTs do not stock ORS but encourage them to use home made fluids and make referrals.

	VHC/TOTs/CHWs stock and distribute ORS	<p>More mentoring sessions with care groups and trained CHW/CHW/TOTs and VHCs were held.</p> <p>The VHCs/CHW/TOTs/CHWs do not stock or distribute ORS.</p> <p>Percentage of children aged 0-23 months with diarrhea in the past two weeks who received ORS increased from 31% to 44.6% And Percentage of mothers able to prepare ORS correctly increased from 32% to 72.3%</p>	
4. Increase from 48% to 60% sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks	<p>Educate mothers on breastfeeding and fluid intake during illness</p> <p>Train CHWs on feeding during illness and IMCI case management</p> <p>Train VHCs on C-IMCI concepts</p>	<p>599 CHWs trained are educating mothers/care takers on breast feeding and home fluids during illness.</p> <p>The CHWs trained in C-IMCI also cover diarrhea prevention and management that includes identification of danger signs, referral and infant and young child feeding during illness.</p> <p>331 VHCs trained in PHC/CBHC</p>	<p>The percentage of sick children aged 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks increased from 48% to 76.8% (LOAS 5)</p> <p>Concerted effort by the key actors has contributed to surpassing of the target</p>
5. Increase functionality of ORT Corners in all Facilities	<p>HW IMCI Training</p> <p>MOST</p>	<p>A total of 18 IMCI trained health workers from 14 health facilities were followed up. During follow up, 43% of health facilities had ORT corners.</p>	<p>Currently all facilities have functional ORT corners.</p>

6. Objective for Pneumonia

Objective	Activities	Status of Activities	Comments
1. Increase from 38% to 60% mothers of children age 0-23 months who know one danger sign of pneumonia (fast breathing or chest in drawing)	Development of IEC strategies for pneumonia recognition, care-seeking behavior and home care	<ul style="list-style-type: none"> The project developed a job-aid on danger signs and produced 1000 copies and distributed them to all CHWs trained in PHC/CBHC. The project adapted a photo booklet job-aid on C-IMCI and produced 150 copies which have since been distributed to the CHW/TOTs trained in C-IMCI 87 CHW-TOT trained on C-IMCI given manual developed by MOH Kenya. Percentage of mothers of children aged 0-23 months who know one danger sign of pneumonia (fast breathing or chest in drawing) increased from 38% to 61.2% 	<p>The CHW/TOTs are using these booklets to educate community members on recognition of danger signs for pneumonia and timely care seeking during illness.</p> <p>CHWs use the job aid on danger signs to educate mothers during care group meetings.</p>
	Mobilize and Educate community members on strategies for pneumonia management	<ul style="list-style-type: none"> The trained CHWs are carrying out education on pneumonia management to communities during meetings and outreaches 	

	Supply timers to CHWs to count respiratory rate	<ul style="list-style-type: none"> Government policy is not permissive for Pneumonia treatment at home. CHWs motivate mothers to seek services early from appropriate providers (health facility). 	The project will not buy timers
2. Increase from 79% to 90% cases of cough and difficult breathing in children age 0-23 months which received any health care and to Increase from 87% to 95% cases receiving care from a health facility	Train dispensary staff in IMCI Case management	18 health workers were followed up on IMCI practice in 14 health facilities.	
	Develop Mobile Ongoing Sustainable Training (MOST) for health facilities to provide on the job support to trained HWs and maintain IMCI re-certification	<ul style="list-style-type: none"> 18 health workers were followed up on IMCI practice and other health workers were offered on job support. DMOH has established an IMCI core team led by the District Clinical Officer and charged with follow-up and on job training. 	
3. Increase from 26% to 60% Children with ARIs for whom 5 assessment tasks were completed according to case management protocol for Acute Respiratory Infections	Train dispensary staff, TOTs and CHWs in IMCI	18 HWs trained in IMCI followed up for compliance.	Please note this aspect was not captured in the follow up report.
4. Increase from 7% to 60% caretakers counseled on the importance of breastfeeding/giving food	<ul style="list-style-type: none"> Train dispensary staff, TOTs and CHWs in IMCI and C-IMCI 	<ul style="list-style-type: none"> 599 CHWs trained in C-IMCI and 18 HWs followed up. During follow up, 33% of 	

at home/giving fluids at home	<ul style="list-style-type: none"> Develop Mobile Ongoing Sustainable Training (MOST) in health facilities to provide on the job support to trained HWs and maintain IMCI re-certification 	care takers were counseled on the importance of breast feeding, giving food and fluids at home	
5. 80% of all Health facility has adequate stock of appropriate first line antibiotic	Improve local planning and decision-making at the dispensary level	<ul style="list-style-type: none"> During IMCI follow up, 14 Health facilities were visited and they had the first line antibiotics in stock. The MoH, AKHS-CHD and Project staff carried out two rounds of Joint supportive supervision for a total 15 DHCs. The DHCs held regular monthly meetings to review and plan activities that included availability of drugs. 	There were no drug stockouts in most health facilities because the DHCs were supplied with drugs directly from KEMSA
	Improve communication and feedback between dispensaries and the DHMT	<ul style="list-style-type: none"> All health facilities are facilitated with mobile phones, radio calls and directories containing emergency lines, mobile numbers of all health facility-in-charges and DHMT. DHC/HCC provide airtime to 	The MOH provides emergency mobility for referral to hospitals.

		the facility-in-charges to ease communication between the health facilities and DHMT	
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