

FINAL EVALUATION

Strengthening the Institutional Capacity of Aga Khan Health Service, East Africa's Community Health Department to Support Organizations Working in Community Health Service

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July 25, 2003 to December 31, 2003

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LIST OF ACRONYMS

AKDN	Aga Khan Development Network
AKF	Aga Khan Foundation
AKF USA	Aga Khan Foundation, United States of America
AKFED	Aga Khan Fund for Economic Development
AKHS, EA	Aga Khan Health Service, East Africa
AKHS, K	Aga Khan Health Service, Kenya
AMKENI	USAID-sponsored project managed by EngenderHealth
ASADIC	AIDS, Sanitation, Drugs and Infection control Consortium
CBO	Community-Based Organization
CEO	Chief Executive Officer
CHD	Community Health Department
CHW	Community Health Worker
CORPS	Community Own Resource Persons
DANIDA	Danish Agency for International Development Assistance
DFID	Department for International Development
DHC	Dispensary Health Committee
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
EOP	End of Project
FBO	Faith-Based Organization
FHI	Family Health International
FP	Family Planning
HACI	Hope for African Children Initiative
HIV/AIDS	Human Immune-deficiency Virus/Acquired Immune-Deficiency Syndrome
HMIS	Health Management Information Systems
ICS	Institutional Capacity Strengthening (Project)
IEC	Information, Education and Communication
ISO	International Organization for Standardization (English translation)
JSI	John Snow, Inc.
KEMRI	Kenya Medical Research Institute
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MIS	Management Information System
MG	Matching Grant
MTR	Mid-Term Review
NGO	Non-Governmental Organization
OD	Organizational Development
PHC	Primary Health Care
PMO	Provincial Medical Officer
PVC	(Office of) Private Voluntary Cooperation
PVO	Private Voluntary Organization
RH	Reproductive Health
TA	Technical Assistance
TOF	Training of Facilitators
TOT	Training of Trainers
USAID	United States Agency for International Development
UNISOL	Universities in Solidarity for the Health of the Disadvantaged

1.0 EVALUATION PROFILE

PVO name and Cooperative Agreement number: Aga Khan Foundation U.S.A. (AKF USA); Grant Agreement/Award No. FAO-A-00-98-00078-00

Country program sites, names of principal partners and duration of grant:

- *Strengthening the Institutional Capacity of Aga Khan Health Service, East Africa (AKHS, EA) Community Health Department to Support Organizations Working in Community Health*, implemented by Aga Khan Health Service, East Africa. Oct 1998 – Sept 2003
- *The Gujarat Health System Development Project (GHSDP)* implemented by Aga Khan Health Service, India (AKHS, I). Oct 1998 – Dec 2004
- *Building Capacity for Restructuring and Reforming the Health Sector (BCRR)* in Gorno-Badakhshan Autonomous Oblast (GBAO), implemented by Aga Khan Foundation (Tajikistan) in collaboration with the Department of Health (DoH), GBAO. Oct 1998 – Sept 2004
- *Rationalizing Pharmaceutical Policies, Practices and Management (RPPM)* in GBAO, implemented by Aga Khan Foundation (Tajikistan) in collaboration with the DoH/GBAO. Oct 1998 – Sept 2004
- *Improving Reproductive Health and Child Survival Services (RHCS)* in GBAO, implemented by AKF (Tajikistan) and DoH/GBAO. Oct 1998 – Sept 2004
- *Management, Monitoring and Institutional Learning (MMIL)*, implemented by Aga Khan Foundation U.S.A. Oct 1998 – Dec 2004

Beneficiary populations (by age/sex): Not applicable to project being evaluated.

PVC-PVO match totals: \$ 5,083,000 (USAID: \$2,000,000; Aga Khan Foundation U.S.A.: \$2,090,000; Other non-USG: \$993,000)

PVC-PVO match funds disbursed to date: \$3,944,450

Date DIP was first approved by PVC: October 1999; **Date changes made to DIP:** N/A

Evaluation start date and end date (submission of final report to PVC): July 24 – December 31, 2003

NOTE: The Evaluation team only reviewed the project in Kenya as the other five projects under this matching grant were granted no-cost extensions (see associated dates above). The final evaluations for the other projects will be carried out next year accordingly. After this is done, a final report will be submitted to PVC which integrates the evaluations of all six projects, drawing together joint themes and lessons learned.

1.1 SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1.1.1 Main Conclusions

Under the Institutional Capacity Strengthening (ICS) Project of the Matching Grant (MG), *the Community Health Department (CHD) of the Aga Khan Health Service, Kenya (AKHS,K) successfully accomplished its two objectives* – 1) to build the internal capacity of CHD to provide technical assistance to local stakeholders/partners, i.e., CBOs, NGOs, government entities and/or private sector and 2) to improve the capacity of local stakeholders/partners to provide health-related services to communities. In so doing, *CHD has directly and indirectly helped to ensure the sustained provision of primary care services and forward health sector reform in Kenya* by giving communities and local organizations more control over the management, provision and financing of their health services. CHD has developed and validated the effectiveness of a robust model for enhancing the confidence and competence of community organizations, i.e., the village health committees and the dispensary health committees.

Indicator data to measure progress against Objective 1 show significant improvements in administrative and management systems within CHD itself as detailed in **Section 1.3.2**, resulting in:

- Greater financial accountability
- Technical effectiveness
- Sound organizational management.

Progress against Objective 2 is clearly evidenced by – to name a few examples:

- Increase in numbers of NGO/CBO/government/private sector stakeholders who have benefited from CHD’s technical assistance (over 2000 participants in CHD trainings for almost 40 different stakeholders)
- Significant revenue generated and managed by community-run Dispensary Health Committees in support of primary health care facilities (ranging from KSh 60,000 to 600,000 per dispensary in 2002)
- Increase in utilization of dispensaries (ranging from a two- to ten-fold increase for services such as family planning and immunization)

With regard to its long-term sustainability, CHD has put into place systems that it can use to secure its future. It has also improved its ability to act in a more businesslike way and has made progress with leveraging new funds and diversifying its resource base. Challenges remaining include the need to develop better systems of grant/project-specific monitoring and evaluation as well as to determine the most efficient and effective way forward in replicating, i.e., “scaling up,” CHD’s interventions to have greater impact provincially, nationally and perhaps outside of Kenya.

1.1.2 Recommendations

The **main recommendations for CHD**, summarized below, are discussed in more detail in **Section 1.3.4**.

- **Clearly define the scope of services that CHD will offer based on current in-house capacity or that yet to be developed.** In this regard, the Evaluation Team suggests that CHD focus on its core competencies in health systems.
- **Do market research and develop a solid business plan** once CHD has defined the scope of services it wants to market. The business plan should include expense and revenue projections based on hard data collected from its market of potential clients.
- **Continue to develop, test, refine and revise its approaches with the communities and the MoH at the sites in Kwale, Coast Province in order to draw lessons from this work.** These lessons can be carefully documented and disseminated to a wide range of stakeholders to facilitate *replication* of these interventions through intermediaries (e.g. other NGOs, MOH, etc.) for greater impact and cost-effectiveness.

The **main recommendation for USAID** is to:

- **Consider providing another round of funding to AKF USA to continue to support the work of CHD in capacity strengthening.** This will ensure that the achievements made during the MG may be scaled up to have wider impact within Kenya and regionally. This would also directly support USAID/Nairobi’s strategic objectives in health sector reform as well as fulfill PVC’s mandate of capacitating local level NGOs and CBOs.

Secondary recommendations for CHD are to:

- **Determine the costs of each package of service and/or intervention.** CHD must determine the relative costs of its different approaches to building local capacity with the aim of reducing cost and time needed to replicate the dispensary model;
- **Develop better marketing and promotional materials.** CHD needs to develop better marketing and promotional materials, including brochures, which are more user-friendly and that better describe what CHD has to offer;

- **Collect baseline data at non-CHD intervention sites.** Collecting baseline data at non-CHD intervention sites, would give a basis of comparison to measure CHD's impact and show existing and new partners actual results -- a good marketing tool;
- **Consider adding new capacity building services in quality assurance and referral systems.** With AKHS, K's endorsement, CHD could tie into and benefit from the capacity that AKHS, K is developing in referral and supervisory systems as it expands its primary medical care infrastructure and vertically integrates this into its hospital network.

1.2 PROGRAM BACKGROUND

The purpose of the matching grant (MG) in Kenya was to strengthen the institutional capacity of Aga Khan Health Service's Community Health Department (CHD) to support organizations working in community-based health services. The project – hereafter referred to as ICS (for Institutional Capacity Strengthening) – was implemented from October 1998 until September 2003.

A provider of high quality health services in Kenya and Tanzania, the Aga Khan Health Service (AKHS) has an outstanding reputation for, and extensive experience in providing facility and community-based health care. AKHS is a member of the Aga Khan Development Network (AKDN), a multi-sectoral body of affiliated institutions which encourages and contributes to integrated social and economic development in the region. AKHS operates three hospitals in Kenya (one each in Mombasa, Nairobi and Kisumu) and one hospital and five Primary Medical Centers in Tanzania. Until 1997, AKHS also operated two primary health care projects in Kisumu and Mombasa (Kenya), which were managed by the Community Health Department. Headquartered in the Aga Khan Hospital in Mombasa, CHD's work is overseen by the Community Health Committee of the Aga Khan Health Service, Kenya's Board of Directors.

Although CHD provided valued primary care services to Kenyan communities, internal and external reviews of CHD's program in 1997 found that since it operated in isolation (that is, outside the government health care system), its replicability and prospects for sustainability were questionable. Moreover, under the health sector reform agenda in Kenya (and in East Africa) where the emphasis was to decentralize authority for health care service provision, the needs of communities were changing. Although local government, communities and other non-governmental groups had the authority to provide health care services, they lacked the management capacity to effectively take on this responsibility. Scarce resources at the central level meant interrupted or non-existent drug and other supplies in primary care facilities. Another pressing problem plaguing community-based services was fragmented health services and a poor referral system.

To make itself more relevant to the changing environment and needs of communities, CHD would undergo a "paradigm shift" and reengineer itself. Rather than providing health services *for* local organizations, CHD would provide technical services and training to *build the capacity of* these organizations to provide, manage and sustain primary health care services. CHD would offer TA and training in key health systems such as dispensary governance; management; financial management and transparency; information systems; and, program design, development and monitoring. **Section 1.3.1** discusses CHD's program approach and models used to build local capacity and where and with whom these models were applied. First, however, CHD had to build the capacity of its own management, financial, information, monitoring, evaluation and human resource systems, which would need strengthening if it were to become an effective technical resource organization for others.

1.3 PROGRAM EFFECTIVENESS

1.3.1 Program Model or Approach

Overall program approach. The overall approach of the ICS Project was to strengthen the capacity of CHD to provide technical assistance and other services to local organizations in health systems in East Africa. Building CHD's capacity would enable it to build local health systems capacity to ensure the sustained provision of high quality primary care services to communities. By doing this, CHD would help forward health sector reform in

East Africa, a major component of which was to give communities and other local organizations more control over the management, provision and financing of their health services.

Geographic focus. Although the intent of the MG was to disseminate CHD's work in Kenya throughout East Africa, the Mid-Term Review (MTR) conducted in May, 2001 recommended that CHD would be more effective if it continued to focus its work only in Kenya. This recommendation, which was accepted by AKF and CHD was based on the MTR's finding that the original MG proposal was too ambitious in scope.

CHD's approach to building local capacity. To strengthen capacity at the local level, CHD developed a three-pronged approach:

- I. *Providing consultative support* by helping groups and organizations assess their level of organizational development and management; identify gaps; review alternate strategies and suitable interventions; develop an action plan; and source needed resources to implement plans.
- II. *Helping groups establish or strengthen systems* including management information systems; financial management systems; managerial and administrative systems; and good governance systems.
- III. *Providing training support*, including customized, need-based short courses (three days to three weeks) and routine short courses on such topics as preparing master trainers and facilitators; dispensary management; data management; financial management; community-based social development; and proposal writing. A short description of CHD's training courses is found in **Annex F**.

Much of CHD's capacity building work at the community level was based on a program model, called over the course of MG the dispensary model or Kwale model (named for the district in Kenya where it was widely applied). CHD developed the model in response to lessons learned from its previous work in providing primary care. Although the model was first developed and pilot tested by CHD before start-up of the ICS Project with CBO partners in Kisumu, as a result of the MG it was replicated in Kwale District, Coast Province. The model was born out of CHD's conviction that increased accountability of healthcare providers would help to improve quality of care. CHD's approach to community-based health care had five objectives:

1. To establish good governance by encouraging genuine community representation on the dispensary health committee (DHC);
2. To build the management and leadership capacities of the DHCs;
3. To set up administrative systems for collecting revenues and managing expenditures of the dispensaries;
4. To create a basic health management information system that can be used by the DHC for identifying problems, raising awareness within the community about health issues, and deciding on action plans; and
5. To improve the quality of services offered by the dispensary.

The model itself had 10 key features:

- A functional DHC with representative membership from all villages in the catchment area;
- A constitution for the DHC that was formulated by the committee members themselves, and that clarified the roles and responsibilities of the representatives on one hand with those of the dispensary staff on the other. The constitution also addressed important issues related to fair representation, efficient administration, and quality health care;
- A legal standing for the DHC that came from registering it with the relevant authorities;
- An operational bank account with the signatories that were in full control of the DHC's finances;
- An efficient system for collecting and monitoring the DHC's finances that ensured accountability and transparency;
- A policy and guidelines on establishing fee levels and on exemptions and waivers for the very poor;
- A basic health management information system for the dispensary that facilitated the identification of community health needs, the planning of health care activities, and the display of key health statistics that could help raise the awareness of the community about health issues;

- Action plans that included outreach health care and health education across different groups in the community;
- A regular and sufficient supply of essential drugs, the procurement and supply of which were monitored by the DHC; and
- Protocols, charts and manuals available for health providers on the treatment of common diseases and conditions, and materials on display that informed the public about common health issues.

Another strategy of CHD in Coast Province was to strengthen the capacity of the MOH to collect, analyze and use the health data that was now being generated at the community level. In Kwale District, CHD helped the Ministry's office to review the system, which was then redesigned and automated to provide timely data for health planning and management at district level. CHD provided updated, user- friendly software (Visual Basic) as part of the package. The redesigned MIS package not only incorporated health status data but new data on health facility income and expenditures to help with financial management. Key elements covered by the new MIS included immunization, nutrition, morbidity, family planning, revenue collection and expenditure.

In Kisumu, Nyanza Province CHD focused on developing the capacity of Community-Based Organizations to manage their primary care systems. Working with CBO leaders, CHD developed key CBO systems such as performance improvement, strategic planning, leadership, team building, conflict resolution, proposal writing and fund raising, financial management, and management information systems. CHD brokered strategic partnerships between CBOs and the local NGOs and FBOs providing health services in their area. CHD also linked CBOs with a parastatal organization involved with pharmaceutical development, Kenya Medical Research Institute (KEMRI), and a pharmaceutical company, Modupharma Ltd. that supplied skin creams, vitamins and other medications to help patients cope with opportunistic infections from HIV/AIDS (a significant problem in Nyanza Province where HIV prevalence is high). To sustain these initiatives, CHD played a principal role in forming the ASADIC, an entity which represents 22 CBOs and NGOs with a catchment population of 2.2 million people.

Appropriateness and soundness of CHD's approach. With regard to the design and the relevance of this approach, the Evaluation team found that it was appropriate and responded to a real need in Kenya. Although there were a number of organizations in the country that focused on upgrading the clinical aspects of service provision, there was a huge gap in capacity building in local health systems – particularly management, financial management and the collection and use of information for better decision making and resource use. By first developing its own capacity, CHD was in a good position to develop the capacity of other local organizations to fill that gap. By building the capacity of intermediary organizations such as CBOs and NGOs, CHD probably had wider impact than it would have had if it only worked with individual communities. **Section 1.3.2, "Achievement of Objectives"** discusses the impact of the project on CHD and on local organizations and communities).

1.3.2 Achievement of Objectives

Because the description of the project objectives used to assess progress in the 2001 MTR differed somewhat from those in the project's Detailed Implementation Plan (DIP) submitted to USAID in May 1999,¹ the Team reconfirmed the objectives of the ICS Project by checking the MG proposal approved by PVC in 1998. These were consistent with the project objectives outlined in the DIP. The "immediate" objective of the MG (as stated in the proposal) was to enhance the management systems and training skills of CHD to provide assistance to local organizations. This objective was to be largely achieved during the first phase of the project (October 1998 through September 2000). During the second phase (October 2000 through September 2003), the strengthened CHD would provide management and other systems strengthening-related services to NGOs and CBOs throughout East Africa in order to enhance their capacity to sustain health-related activities in communities. Result indicators to measure progress were developed for each phase. Although implied, the second phase was

¹ The Detailed Implementation Plan (DIP)/Business Plan (BP) document that was made available to the team was a draft submitted in May 1999 to USAID/BHR/PVC. USAID's comments on the DIP/BP, dated October 5, 1999, were also shared with the team.

not specifically stated as a project objective in either the MG proposal or the DIP. That said, because a major purpose of this final evaluation was to determine the extent to which CHD has built the capacity of local partners to provide health-related services to communities, and since this was the principal focus of the MG's second phase, the Evaluation team treated this as a second project objective.²

A chart that summarizes the ICS Project's strengths and weaknesses by these two objectives is found in **Annex A**. A summary of the project's DIP results status is found in **Annex B**.

Objective 1: Build the internal capacity of CHD to provide technical assistance to local stakeholders/partners, i.e., CBOs, NGOs, government entities and/or private sector.

Indicators. Four Phase I indicators were developed to measure MG progress and determine whether CHD's strategies and activities were effective in achieving Objective 1.³

1. The development and routine use of the managerial, financial and personnel systems by CHD;
2. The preparation of precise personnel policies and job descriptions to ensure retention of trained managerial and clinical staff;
3. Increased requests by NGOs, CBOs and the government for technical assistance from CHD; and
4. The systematic documentation and dissemination of lessons learned by CHD and AKHS, K.

Effectiveness and appropriateness of main strategies and activities. Overall, the team found that *the main strategies and activities employed by CHD to achieve indicators for Objective 1 were effective and appropriate, and properly responded to local needs*. Rather than directly provide health care, CHD adopted an overall strategy of developing its capacity to become an "expert resource organization" by improving its own financial, program, human resource and information management systems and services, which it has done (see "Indicator Status at EOP," below in this section).

Strategically, CHD does face some future challenges. One of the concerns of the MTR was that CHD was in danger of being unable to say "no" to a body of requests that outweighed its capacity in terms of available human and financial resources. As a result, to help CHD better focus its work, the MTR recommended that it develop a well-defined strategic vision and mission statement as well as a plan and framework to carry them out. Internal capacity strengthening (such as hiring new personnel and developing CHD staff) as well as CHD's external capacity building services to other organizations should also be guided by this strategic plan and framework.

The Evaluation team found that CHD's Vision and Mission Statement were more sharply (and properly) focused on its core competencies of local capacity building in health systems than its strategic plan and framework.⁴ The strategic plan and framework were much broader, encompassing not only CHD's strengths in improving health system management, sustainability and governance at the community level but other areas such as addressing major communicable diseases affecting communities and improving reproductive health (RH) and child survival. The inclusion of communicable diseases, RH and child survival is partly the result of not wanting to say "no" to potential business opportunities that may generate some income for CHD (which is in line with the more business orientation of AKHS, K).

On the other hand, their inclusion is also the result of CHD wanting to fulfill its role as a social development institution that responds to the real and pressing needs of communities (which is more in line with the orientation of the AKDN within which CHD also operates). Balancing these two competing and seemingly

² During a pre-evaluation discussion that was held between AKF USA, the evaluation team's international consultant and PVC in mid-July 2003, PVC affirmed that the final evaluation should be conducted around these two principal objectives as well as CHD's future plans and next steps.

³ Although Phase I and II result indicators were developed as part of the MG proposal and restated in the 2001 MTR, they were not included in the 1999 DIP.

⁴ "CHD intends to be an expert resource organization, which provides technical support to health care providers in improving effectiveness and efficiency of health services. It aims at demonstrating ways of improving health care delivery systems...." (CHD Mission Statement quoted from *The Strategic Plan*, Community Health Department, AKHS, Kenya, 2001).

contradictory objectives and weighing the costs and benefits of adopting new strategic directions that fall outside of its core competencies are tasks that CHD has had (and will continue) to grapple with. For now, work in communicable diseases, RH and child survival has been limited and has not significantly distracted CHD from developing and disseminating its core strengths in health systems.

Indicator status as of the Mid-Term Review. The Mid-Term Review (MTR) of May 2001 found that CHD had largely achieved indicators 1 and 2, with the following caveats and recommendations for improvement: CHD should develop a strategic vision and plan to more effectively guide its organizational development and growth; CHD should develop a staffing and staff development plan that would reflect this vision; and that CHD should improve grant related reporting on performance indicators. The MTR also found that CHD needed to improve its efforts on documentation and dissemination of lessons learned on the ICS Project (indicator 4).

With regard to indicator 3, the MTR found that CHD had indeed received increased requests from NGOs, CBOs and the government for technical assistance, and was becoming the ‘*de facto* technical resource center for community-based health services for the country.’ At the policy level, the MTR cited CHD’s advocacy work as a founding member of a new network of NGOs, AfriAfya,⁵ and the fact that the MOH of Coast Province recognized CHD’s important contribution to health sector reform by empowering communities to effectively manage their health care.

Indicator status at EOP. For the final evaluation, the team reviewed progress on each indicator since project start-up as well as whether and how CHD implemented the recommendations of the MTR.

- **Indicator 1** – CHD has developed and routinely uses managerial, financial and personnel systems; and
- **Indicator 2** – CHD has prepared precise personnel policies and job descriptions to ensure retention of trained managerial and clinical staff.

Management Systems: CHD’s major program planning, management and monitoring tools were in the form of its annual work plan and related logical frameworks. CHD organized its log frames around activities rather than MG objectives. Each log frame detailed the program activity, its objective(s), expected results and targets, verifiable indicators, and the means of verification. Timelines for achieving each activity objective were also set and the person/department responsible was named. Targets were monitored monthly by analyzing data collected and a report was written on activity progress, strengths and areas of improvement. CHD performed monthly team reviews of progress against the log frame targets, adjusted workplans accordingly and generated progress reports that were reviewed at CHD and AKHS, K Board levels.

Financial Systems: In the area of financial management, CHD considerably strengthened its system since project start-up, and its external auditors, Coopers & Lybrand – which early in the MG found fault with CHD’s lack of documentation and proper authorizations for expenditures -- has had no issues with its accounts for the past three years.

The Evaluation team found that *policies and controls were in place to ensure transparency and proper fund use.* CHD set up one bank account for matching grant funds, and early in the MG hired a qualified finance and accounts specialist who had immediate responsibility for managing, reporting, and controlling the use of MG as well as all other funds from fees, grants and contracts. Comprehensive and complete income and expenditure statements, with balance sheets, cash flow projections and monthly variance analyses in CHD expenditures were produced monthly for review by management. CHD’s financial system also tracked income by source, including new funds leveraged by CHD as a result of the MG. The new financial management and reporting system allowed CHD to more accurately determine the real direct and indirect costs of all technical assistance and training services it provides. This proved valuable in helping CHD set fees for services for paying clients and in

⁵ Founded in April 2000, AfriAfya is comprised of 7 major NGOs operating in the health sector in Kenya: CHD, African Medical and Research Foundation, CARE, the Christian Health Organization of Kenya, World Vision, PLAN International, SatelLife, and the MOH (as an ex-officio member). The organization was formed to promote health knowledge management and communication, as well as to share experiences, best practices and lessons learned.

recovering some costs. Systems were also in place to guard against the misuse, loss and theft of real assets such as vehicles, furniture, computers, etc. **Table 1** details CHD’s progress in financial management controls as a result of the MG.

Table 1: CHD Financial Management Controls

Area	Controls: Procedures & Practices	Pre-Matching Grant (1997)	Today (2003)
Cash & Bank	Bank statements reconciled	Sometimes	Always
	Bank account opening/closing procedures & authorized signatories	Yes	Yes
	Check authorization limits	Yes	Yes
	Authorization & approval for payments	No	Yes
	Petty cash managed on imprest system	No	Yes
Procurement of Goods & Services	Approval and authorization controls	Sometimes	Always
	Three quotations obtained	Sometimes	Always
Fixed Assets	Fixed asset register	Yes, but not reconciled	Yes
	Physical identification and counting of fixed assets	No	Yes (counting) No (identification)
	Tendering for the disposal of fixed assets	No	Yes
	Controls over personal use of fixed assets	No	Yes
	Vehicle movement controls	No	Yes
	Paper & stationary use controls	No	Yes

By better tracking actual versus planned MG expenditures combined with increased operating efficiencies from improved program management, CHD substantially increased its MG “burn” rate from 2001 on. It will have fully spent MG funds by EOP.

Personnel Systems and Human Resource Development: Recruitment, review and human resource development policies were in place. CHD developed job descriptions for each position, with clear performance expectations. Each CHD staff member underwent a formal performance review twice a year in addition to monthly technical staff meetings where each staff person measured his or her own progress and efficiency. When performance did not meet CHD expectations staff were given two warnings before remediation.

At the outset of the ICS Project in 1998, CHD had only six employees (the Director, a financial manager, a MIS manager, a trainer, a part-time secretary and a driver); seven were on board at the time of the MTR. One of the recommendations of the MTR was that CHD should look more closely at its staffing needs in light of its new strategic plan, and hire new personnel in priority areas (such as additional field, technical and admin assistants to help existing training, financial management and MIS staff, and a community health nurse to provide TA). The MTR also recommended that CHD develop and execute a human resource development plan to continuously upgrade and motivate staff to reach their maximum potential.

CHD carried out all MTR recommendations, including hiring new staff in the above specialty areas. It now has 14 permanent staff members – 13 based in Mombasa and one based in Kisumu. A human resource development policy and plan were also in place that gave criteria for selecting all new hires. The policy also emphasized self-development (all staff set personal goals) and equal opportunity for growth. All staff underwent training to strengthen their areas of expertise (see **Annex E** for CHD’s current human resource development plan). Auxiliary personnel were also trained in dual functions to increase efficiencies: for example, the two drivers

were trained as community health educators and condom distributors. As a result of these policies and opportunities, staff turnover was reduced and productivity increased.

- **Indicator 3** – Increased requests by NGOs, CBOs and the government for technical assistance from CHD.

Throughout the life of the MG, CHD received requests by local partners that increased by year for technical assistance and training. Rather than numbers of requests from partners, CHD tracked actual outputs in terms of number and types of training and technical assistance packages actually provided. Found in **Tables 2, 3 and 4**, these show a substantial upswing in training and TA outputs from 1998 on, with one caveat. Because of its high costs in relation to fees actually charged, by 2002 CHD no longer provided Training of Facilitators (TOFs) and Training of Trainers (TOTs) to groups of less than 20 people. Instead CHD shifted to developing customized “packages” of trainings where TOFs and TOTs were combined with other key courses (for example, financial management, MIS, proposal writing, etc.). By doing this, CHD was able to charge its paying partners more of the real costs of providing TA and training and earn more income. (More on training and CHD’s partners is found under Objective 2, indicators 1 and 2, below.)

Table 2: CHD Short Courses Provided to Partners
Number of Trainees

Course Name	1998	1999	2000	2001	2002	2003	Total
Financial Information Systems		81		33	76		190
Management Information Systems	17	19	35		69		140
Community-based Social Development	24	20	27	11			82
Community Health Worker Training			28		80		108
Dispensary Health Committee Training		124	25	29	154		332
Project Planning, Design, Proposal Writing & Data Management and Analysis			24	21		13	58
Training of Facilitators	9	16	7				32
Training of Trainers	22	133	6				161
Organizational Development					30		30
Infection Control for HIV/AIDS patients					30		30
Total	72	393	152	94	439	13	1163

Table 3: CHD Customized Trainings Provided to Partners

Name of organization	Year of training	# of trainings	# of participants
World Vision	2000	1 (CHWs)	30
Pandipieri	2001-03	5 trainings (TOT, TOF, CHWs, Infection control and OD)	345
Kwale Eye Centre	2001	1 (TOT)	10

Table 4: Training and Technical Assistance Packages Provided to Partners

Course Name	Year of training	# of trainings	# of participants
Dispensary Management	2001-03	16	279
Financial Management	2001-03	5	123
MIS	2001-03	5	116

- **Indicator 4** – The systematic documentation and dissemination of lessons learned by CHD and AKHS, K

In response to the MTR, CHD developed a clearer documentation and dissemination strategy. However, rather than define who CHD's target audience was, which would help prioritize documentation and dissemination efforts (for example *which* lessons and best practices should be disseminated), the strategy was more of a list of guiding principles. These included: CHD will work with its partners to learn from field experience; CHD will use short courses to disseminate learning; CHD will publish manuals and briefs; CHD will disseminate its learning by developing and testing demonstration models; etc. The end result was a "soup-to-nuts" strategy that involved a variety of approaches to appeal to the widest possible audience. At the field level, CHD frequently took both national and international visitors to its six demonstration sites in Kwale District to show the actual results of its work. Visitors included government officials, donors and local and international NGOs. From outside of Kenya, visitors included World Vision from South Africa, and AKDN representatives from Zanzibar, Mozambique and Central Asia.

Local radio, internet and print media were used to also disseminate lessons learned. For example, Aga Khan Health Service featured CHD's work on both its website and in its bi-monthly newsletter, called *AKHS News*. CHD also produced a series of "Policy Briefs," which were not so much focused on policy as they were on lessons learned and best practices. Topics were chosen as a result of informal surveys of CHD's partners (including the Kenyan government) on what they felt were the most important issues in community-based development related to CHD's work. Three comprehensive but relatively short for easy reading documents were developed; these included some "how-to" guidance as well as best practices and lessons learned:

- "Building a Dispensary Health Management Information System" (Brief No. 1);
- "Preparing Nurses for Facility Management" (Brief No. 2); and
- "Best Practices in Community-Based Health Initiatives" (Brief No. 3).

One more Brief will be prepared and cover the topic, "Political Will and Interference in Governance." This will focus on how to plan for and mitigate political interference in community-based programming and implementation (a challenge that has affected some Dispensary Health Committees – see Objective 2), including the importance of building civil society.

Planning to combine documentation and dissemination with its promotion and marketing efforts, CHD also prepared a list of 300 to 400 NGOs and CBOs in Kenya that could benefit from CHD's technical services, to which it plans to send brochures that summarize each of CHD's major program areas as well as best practices and lessons learned.

Other important dissemination channels that CHD used included the two Kenyan-based forums where CHD was a founding member: the national level AfriAfya (see footnote 5) and the Kwale Health Forum, a group of 29 registered NGOs and CBOs implementing health and other development-related activities in Kwale District (Coast Province). Because the memberships of these two umbrella organizations included groups that CHD targeted for dissemination, CHD used these forums to share experiences and make formal and informal presentations.

On the international level, CHD is a member of the DFID-sponsored Health Systems Resource Centre, which is comprised of seven organizations active in health policy, financing and/or services.⁶ Dedicated to sharing institutional learning and resources, CHD's work has been posted on the Centre's website (www.healthsystemrc.org). CHD's work has also been posted on the London-based Institute for Development Studies website. Other national and international fora used by CHD to disseminate lessons learned included the Global Health Council, the Regional UNISOL Congress, Nairobi-based International Scientific Conferences, Regional (East Africa) Health Ministers Conferences, etc.

⁶ These include, AKHS CHD *Kenya*; Centre de Recherches et d'Etudes pour le Developpement de la Sante (CREDES) *France*; Curatio International Foundation *Georgia*; The Harvard School of Public Health Systems Group *USA*; The Institute of Development Studies *UK*; and The Institute of Policy Studies *Sri Lanka*.

Overall, the Evaluation team found that CHD did identify important lessons learned and disseminate them in a timely manner at local, national, regional and international levels. On the plus side, word-of-mouth from all of these efforts helped CHD to slowly build up a base of paying clients over the life of the MG. On the minus side, it was not clear who CHD's main target audience was, whether the lessons learned it chose to highlight were the most critical for its priority audience, and which dissemination methods were the most cost-effective in reaching that audience. That said CHD's scattershot approach to dissemination has indeed helped it to become relatively well known in Kenya and to establish both a national and international reputation for innovative work at the community level.

Impact. By achieving results indicators under Objective 1, CHD enhanced its capacity to provide TA and training services to partners (see below under Objective 2) and increased its program and financial sustainability (see **Section 1.3.3**, "Sustainability"). Moreover, CHD has now reached the stage in its organizational development that it is now working on getting ISO 9001 certification by the end of 2003. This is an internationally recognized, rigorous process that once obtained, would certify that CHD's internal systems, procedures and business practices are of the highest caliber. CHD believes this certification would be an asset for future business prospects, allowing it to better position itself to attract new grants and contract work from local and international organizations.

With respect to policy impact, the Provincial Medical Officer (PMO) of Coast Province -- the MOH's highest ranking provincial officer -- pointed out to the team that CHD played an important role in helping him implement the MOH's decentralization policy by strengthening local capacity. CHD's MIS, which is currently being replicated throughout Coast Province, also influenced policy and program decisions. For example, it was used by the PMO to direct donors to areas needing greatest attention. CHD's director was also appointed by the Secretariat for Health Sector Reform to be the lead consultant on the MOH's national M&E task force, which will study and make policy and program recommendations to improve the national health information system.

On the advocacy side, CHD also has the potential to have impact on policy. Being a founding member of two umbrella organizations created during the implementation of the MG, AfriAfya and the Kwale Health Forum, CHD has -- along with other members -- advocated for the refinement of policies affecting health services to make them more "relevant to the needs and expectations of rural and poor populations."⁷ Although the outcome (and ultimate impact) of this is not yet known, one very recent example of CHD's advocacy role has involved a pronouncement from the MOH that all malaria services (including drugs for treatment) must be given free. Since the MOH seldom provides sufficient drug supplies for its dispensaries and health centers, this edict has effectively prevented communities from charging fees to cover malaria drug costs. Rather than deplete funds reserved for replacing drugs, DHC's have suspended malaria treatment until supplies arrive -- an unlikely prospect. Thus, the MOH's policy could have a devastating impact in the Coast Province where malaria morbidity and mortality is extremely high. CHD and the Kwale Health Forum are currently engaged in policy dialogue with the Provincial Medical Officer in Coast Province to inform him (and ultimately MOH headquarters in Nairobi) of the negative consequences of this policy with the hope that it will eventually be changed.

Objective 2: Improve the capacity of local stakeholders/partners to provide health-related services to communities.

Indicators. Three indicators were developed to measure MG progress during the second phase of the ICS Project and determine whether CHD's strategies and activities were effective in achieving Objective 2.

1. The number of local partners using the managerial methods provided by CHD;
2. The number of local partners employing clinical skills packages; and

⁷ *The Strategic Plan*, Community Health Department, AKHS, Kenya, 2001.

3. The number of local partners measuring the impact of their systems in terms of improvements in accessibility, quality, acceptability, and sustainability of community-based health services.

Effectiveness and appropriateness of main strategies and activities. As a technical resource organization, CHD's main strategy was to develop the capacity of local partners to:

- Identify and analyze problems affecting the delivery of effective and affordable preventive and essential curative health care;
- Design, implement, monitor and evaluate appropriate health care interventions to improve the management and delivery of health care; and
- Develop the knowledge-based competencies of health service providers and managers (including oversight bodies such as Dispensary Health Committees).

As discussed in **Section 1.3.1**, CHD developed a local capacity building model (called the dispensary model) to foster good health facility governance; build the health management and leadership capacities of local organizations; set up administrative systems for collecting and managing revenues and tracking expenditures; create health MIS to identify problems, raise awareness and develop plans to solve these problems; and improve the quality of health services provided. To implement this model, CHD developed a series of training and technical assistance packages that responded to the level of local development and needs. At the outset of the MG, CHD offered five basic training courses; by the end of the project, the number had grown to 10 (see **Table 2** for the list of courses offered and **Annex F** for short course descriptions). These courses ranged from covering all aspects of the dispensary model itself, to focusing only on certain elements (such as financial management or MIS) or on certain audiences depending on the client's preferences.

The Evaluation team found that CHD avoided a "cookie cutter" approach in developing local capacity, which was entirely appropriate since the needs of individual communities and local organizations varied. As it gained more experience and learned more about health systems and governance needs at the community level, CHD modified, improved and expanded the type and number of training courses to better meet local needs. Responding to the needs of the marketplace, CHD also shifted its attention to developing individual "packages" of trainings and TA services that better fit the needs of individual partners and paying clients.

Challenges. CHD confronted and addressed several program challenges during the course of implementing the second phase of the ICS Project:

- *Lack of broad – including gender – representation in community management structures, including dispensary and village health committees.* Recognizing that this was a problem, CHD added to its DHC, TOT and TOF training the importance of including more women and non-elites in local health management bodies, and how to recognize and overcome negative personal biases. The Evaluation team noted that among the DHCs and Village Health Committees it met with at CHD intervention sites, women represented about 25 to 30 percent of the membership. This appeared to be an improvement over the norm where women were seldom on health management committees (the team was unable to make a comparison at non-CHD intervention sites). When asked, the Coast Province PMO told the Evaluation team that one of the greatest benefits of CHD's work was improving the participation of all community members -- including women -- in local health system governance
- *Conflicts between dispensary nurse and community.* In several instances, progress came to a grinding halt when there were serious conflicts between the dispensary nurse (an employee of the MOH) and the Dispensary Health Committee. Nurses tend to be more educated than community members and could have paternalistic attitudes. Some were reluctant to give up control, particularly of dispensary funds collected from the community, and community members were often afraid to challenge their authority. CHD responded to this by adding conflict management and resolution as part of its training and TA services, and revising its advice on how DHCs should write their constitutions to make roles and responsibilities (including how funds will be managed) clearer.

- *Political interference.* In some cases, political interference also impeded progress. For example, a locally elected official dissolved a very dynamic DHC to stack it with people who would be more likely do his bidding. In another, a popular nurse was dismissed who did not vote for the local official. CHD recognized that building the weight and influence of civil society was an effective counterbalance to this kind of power. In Coast Province, CHD also enlisted the help of MOH officials and District Health Management Boards to pressure local officials to stop interfering.
- *Community Health Worker retention.* CHD cut the turnover rate of CHWs from 50 to 25 percent because of better selection criteria. Some community members became CHWs in the unrealized hope of eventually receiving paid employment. Others – and these were the ones CHD learned to target for training – volunteered and carried on their work because they saw the benefits in the higher survival rates of children, in controlling disease and in improving the general level of health care in their communities. Understanding the positive effect they had on their communities helped CHW retention.
- *Local DHC and Community Health Worker training.* DHC members only served a three-year term. One of reasons for training DHC members as TOFs was to have them train newly elected members. The purpose of training DHC members and others as TOTs, on the other hand, was to build local capacity to train new CHWs. Although DHC members who were graduates of TOFS training did a better job in passing on their skills to new DHC members fewer community members trained as TOTs passed on their skills to new CHWs. Because TOTs have not been ineffective as CHW trainers, CHD eliminated this course.

Indicator status as of the Mid-Term Review. The Mid-Term Review of May 2001 primarily focused on evaluating progress under Objective 1. Since CHD was just embarking on work related to Objective 2, one recommendation of the MTR was that CHD should revisit Phase II indicators for accuracy and relevance. CHD did redo its strategic plan and related activity logical frameworks but did not modify or change any Phase II indicators. The Evaluation team found that in light of what CHD ultimately focused on with regard to strengthening the capacity of local partners, better Phase II indicators could have been selected. For example, indicator 2 measuring progress with capacity strengthening in clinical skills packages was de-emphasized in favor of a broader package of systems skills, including management information systems. Indicator 1, however, was too narrow as it only described capacity building in terms of “managerial methods” rather than the whole range of systems interventions that CHD ultimately provided.

Because CHD treated them as “learning sites” from which technologies would be transferred to new partners, CHD began implementing its dispensary model at six MOH sites in Kwale District early in the MG. The MTR did report that results from Kwale (which at that time did not include MIS since it was still under development) were “very encouraging” particularly with regard to increased utilization and communities’ ability to financially manage fees generated from services. Aside from this, training and TA services from CHD during Phase I were limited to providing short-term courses to international organizations and assisting the MOH with implementing Health Action Days⁸ in Kwale. There was little in the way of follow up. International organizations to whom CHD provided training during Phase I included CARE, JSI/DELIVER, DANIDA, Oxfam UK, Medecins Sans Frontieres, World Vision, Plan International, Family Health International, International Rescue Committee and others.

Indicator status at EOP. A review of indicator progress by the team found the following:

- **Indicator 1** – The number of local partners using the managerial methods provided by CHD.

The Evaluation team interpreted “managerial methods” under indicator 1 to encompass the full range of CHD health systems services and products (financial management, MIS, dispensary management, strategic planning,

⁸ Health Action Days are preventive care campaigns for rural areas aimed at improving immunization coverage and providing other preventive services such as family planning, growth monitoring, and general health education.

leadership, team building, conflict resolution, proposal writing and fund raising, etc.). CHD exceeded all planned targets. **Table 5** shows the planned targets for number of local partners using these methods, and actual achievement at mid-term and EOP.

Table 5: No. of Local Partners using CHD Managerial Methods

Partner	Target		Achieved		Comments
	Mid-term	EOP	Mid-Term	EOP	
CBOs	0	10	2	12	12 CBOs in Kisumu
NGOs	0	0	0	3	Plan International, AMKENI, Kwale Health Forum
Dispensary Health Committees/MOH Dispensaries	0	16	6	22	12 under Plan; 4 under AMKENI; 6 under CHD
MOH Districts (using MIS)	0	1	0	1 done, 6 underway	Kwale complete; underway in Kalifi, Malindi, Taita Taveta, Tana River, Mombasa & Lamu
Private Companies	0	0	0	1	Sun N' Sand Hotel

- **Indicator 2** – The number of local partners employing clinical skills packages.

As already discussed, over the course of the MG clinical skills packages were de-emphasized in favor of packages to strengthen health systems. Even so, CHD did improve the capacity of 716 community health workers (also called CORPS by the AMKENI Project) to deliver health education, growth monitoring, family planning and limited antenatal services to communities. CHD also prepared and sourced health awareness material for nurses and community health workers. This was in response to a review conducted with CHWs by CHD where they recommended that they be provided with technical material that was easy to read and understand, and could be used to promote health messages. During the fourth year of the MG, CHD prepared and distributed health education materials in local languages on family planning, bilharzia, antenatal care, immunization, and AIDS.

CHD also responded to partners' requests for help in certain clinical areas. For example, CHD helped its 12 CBO partners in Nyanza Province improve their infection control programs for HIV/AIDS patients. CHD also responded to a request from a private energy company, Tasvo Power, to help it organize Health Action Days and school-based programs to lower the incidence of bilharzia among children. Tsavo Power sets aside \$50,000 a year for social programs to benefit local communities, most of which goes to health. As a result of CHD's interventions, Tsavo Power helped reduce the incidence of bilharzia among school children from 90 to 15 percent.

- **Indicator 3** -- The number of local partners measuring the impact of their systems in terms of improvements in accessibility, quality, acceptability, and sustainability of community-based health services.

All 41⁹ of CHD's partners were trained to collect and analyze data to measure impact on service delivery and sustainability. Facility utilization and numbers of services delivered by service category served as proxy indicators for accessibility, quality and acceptability. The kind of data collected was fairly consistent across all partners, although a particular partner may have had more need for certain information than others. For example, for AMKENI, which was a FP/RH project funded by USAID, CHD emphasized the collection and analysis of FP data. To measure (and ultimately help ensure) service sustainability, all Dispensary Health Committees – be they connected to MOH or CBO-owned facilities – were taught how to cost and price services and properly keep records on expenditures and revenue generated from fees. Since the lack of drugs was a major reason for underutilized and/or closed dispensaries, the ability to collect and keep track of revenue to buy drugs and other

⁹ This figure includes: 12 CBOs, three NGOs, 22 DHCs/MOH dispensaries, one MOH Administrative District and one Provincial Medical Office in Coast Province and two private companies.

crucial supplies could also be considered a proxy indicator for accessibility and quality since it did have a positive effect on both by reducing drug stock outs and keeping facilities open. In addition to buying drugs, revenue was also used by communities to hire more health service personnel such as nurses, as well as dispensary clerks and watchmen.

Impact. To assess actual impact of CHD assistance on health services, the team looked at data from the original six dispensaries in Kwale that did not receive outside assistance from any group other than CHD. Technical services and training from CHD were provided from 1998 through 2000. Although CHD focused on improving health education and health systems and not on the clinical aspects of service provision, CHD inputs nonetheless did have a positive impact on utilization (see **Table 6**) and revenue collection (see **Table 7**), which continued even after CHD inputs had ended.¹⁰

**Table 6: Utilization Trend for 6 Dispensaries in Kwale District
(# of services delivered)**

Service	1997 (baseline)	1998	1999	2000	2001	2002
Antenatal care	-	3591	4316	4559	4104	4059
Family Planning	2362	4306	6275	7660	5902	5374
Immunization	1463	3883	4999	7217	12859	12709
Growth Monitoring	-	17636	23662	22441	18695	20457

**Table 7: Trends in Revenue Collection by Dispensary
(KSh)**

Name of dispensary	1998	1999	2000	2001	2002
Mazeras	14,860.00	256,514.00	374,480.00	427,445.00	600,637.50
Mtaa	0.00	52,065.00	103,447.00	89,971.00	61,337.00
Mwanda	13,675.00	191,085.00	217,941.00	264,115.00	254,522.50
Bofu	0.00	102,431.00	192,539.00	355,071.00	279,274.00
Mnyenzi	23,852.00	115,762.00	230,060.60	260,529.90	145,676.00
Kafuduni	24,887.00	252,536.50	365,924.00	349,357.00	228,612.00

Similar results were recorded at Plan International and at the USAID-sponsored AMKENI Project sites. Progress at AMKENI sites has even come to the attention of USAID staff in Nairobi who told the team that utilization rates for FP, immunization and antenatal services at facilities where CHD improved health systems were much higher than in facilities where these improvements were not made. Within the CBOs of Kisumu, there were positive effects as well. For example, as a result of organizational development and human resource strengthening and support from CHD the CBO, Pandipieri, saw staff morale rise as roles and responsibilities were clarified and management systems improved. Community utilization of its health services subsequently grew from 100 to 2400 cases a month and immunization coverage increased from 50 to 83 percent.

With regard to the impact of CHD's management information system, reporting from Kwale District in particular and the Coast Province in general significantly improved. In Kwale, where CHD's system was used in all dispensaries and health centres, the reporting rate improved from 47 to 92 percent. Data processing that used to take two months now took only two weeks. Unlike the central MOH in Nairobi, the Kwale District office could quickly generate data needed for annual reports (the one for 2002 was completed by February 2003). The most recent annual report released by the central MOH was for 1999. Because CHD's MIS generates reliable data on time for informed decision making, the Head of the Health Management and Information Systems Division at MOH headquarters in Nairobi is interested in having it replicated nationwide.

¹⁰ Utilization and services were adversely affected at Kafuduni dispensary, which was closed during most of 2002 because of serious conflicts between the nurse, a locally elected official and the Dispensary Health Committee. The conflict has been resolved and the dispensary has recently reopened.

1.3.3 Cross-Cutting Issues

Partnerships

CHD developed effective and durable partnerships with a large variety of organizations – both governmental and non-governmental. The keys to CHD’s success included:

- CHD – along with Aga Khan Health Service -- has been active in Kenya for many years and has an excellent reputation for providing high quality services. Local partners viewed CHD as essentially Kenyan and an integral part of the local context;
- CHD offered capacity building expertise and training that was valued by partners and which few other organizations had;
- CHD changed or modified its training and TA services to respond to the real needs of its partners. Thus, CHD’s services evolved as partner needs evolved; and
- CHD developed its program focus as a result of actual experience on the ground and continued to value “learning by doing” so that it remained relevant.

Major challenges and the impact of CHD’s work on the institutional capacities of local partners were discussed in **Section 1.3.2**, “Objective 2” above. **Annex C** contains a partnership matrix that lists the name of each of CHD’s partners, the type of organization, what interventions were done by CHD to strengthen partners’ organizational capacities and the outcome of those interventions.

Innovation and Creativity

Under the ICS Project, CHD explored and introduced a number of innovative and creative ideas to achieve MG objectives. These included:

- Simple to understand and attractive Information, Education and Communication (IEC) materials on various aspects of reproductive health and child survival. These were distributed to health facilities and CHWs, to partners and to community members during Health Action Days;
- Innovative training modules to develop the health systems capacity of partners;
- Two types of data collection and presentation tools-
 - Data collection forms were developed to capture data at project sites on key health and management indicators including morbidity and mortality, facility utilization, and collection and expenditure of revenue; and
 - Simple chalk boards that helped DHCs and CBOs compile and keep track of data were developed for use at project sites. Apart from being an asset in raising the awareness of communities about health issues, the boards greatly contributed to better transparency, governance and accountability at the community level;
- An interactive and simple to use software, which was developed to capture, process and tabulate health-related data;
- A simplified format for proposal writing for community-based organizations to attract new funding for important local projects; and
- Introducing bilharzia control and education programs in schools to reduce prevalence among children.

Sustainability

Program benefits for CHD and its partners are likely to continue after project completion although sustainability prospects may be influenced by a few challenges.

Community Health Department. With regard to program sustainability, CHD had systems in place that it could use to its advantage to secure its future. Over the course of the MG, CHD also showed that it could think in a more business-like way, marketing its courses and programs to prospective clients and tracking the real cost of its work (both direct and indirect) to better price its services. Responding to the marketplace, CHD suspended courses that were no longer meeting its objectives (e.g., Training of Trainers) or could not pay (e.g. Community-

Based Social Development). CHD also reorganized the way it conducted courses to take advantage of economies of scale and bring down the unit costs of training.

Over the course of the MG, CHD made progress leveraging new funds and diversifying its resource base. Depending on the client and its ability to pay, CHD charged anywhere from the full (direct and indirect) costs of training and technical services plus a 5 percent fee, to more subsidized rates (for example, direct costs only), to not charging for its services at all. Typically, only international donors, donor-sponsored projects (like AMKENI) and private sector clients were charged the full amount. During the past two years, CHD received contracts totaling about \$110,000, including \$33,000 from Plan International to provide training and TA for 12 community dispensary and health center sites in Kwale; three contracts totaling about \$67,000 from AMKENI to work in seven sites in Kalifi District, Coast Province (four of which have been completed); and a contract from Tsavo Power for \$10,000 to implement Health Action Days and a school-based anti-bilharzia campaign for children. These and other fees from training and technical services allowed CHD to cover about 16 percent of its operating costs during the last year of the MG.

Although a start, a 16 percent cost recovery rate will not secure CHD's financial future. Fortunately, CHD recently received from the Rockefeller Foundation a large grant totaling \$337,000 over the next two years to replicate the MIS developed for Kwale District to all MOH facilities throughout the Coast Province. This grant will give CHD some time to plan its next steps (see **Section 1.3.3**, "Lessons Learned and Program Recommendations, Future Plans and Next Steps").

CHD's international NGO and private sector partners paid most to all (depending on the partner) of the full costs of CHD's training and TA services, and have the financial and personnel resources to sustain their programs. For example, Plan International's technical staff members have the skills to provide follow up technical assistance to their dispensary sites. Another CHD client, the Sun N' Sand Hotel continues to cover the full costs of service provision at its community dispensary. CHD provided health education training for hotel-sponsored CHWs and MIS and financial management support to hotel dispensary personnel, who provide services to hotel employees, their dependents and the surrounding community. Tsavo Power has the financial resources to continue its health program but continues to rely on CHD for its implementation.

CHD's CBO partners. CHD helped CBO partners put into place systems and local institutions that assumed primary responsibility for carrying on activities after CHD inputs ended. In addition to developing local skills, CHD was instrumental in helping CBOs organize themselves as a consortium, played the role of broker to help CBOs develop strategic alliances between organizations both inside and outside the consortium, and developed their ability to design and write proposal to attract new funding for local projects. For example, at Kajulu, which represented 52 villages with a total population of 40,000, the CBO raised enough money among members to build and staff a new dispensary and five community-based pharmacies. All health systems and services put into place by CHD were being sustained. Project development, design and proposal writing training given to Kajulu from CHD resulted in new funds for social development projects with grants from UNICEF for child health and education activities and from Africa Now for water projects. Like Kajulu, the CBO, Pandipieri, successfully attracted new grants from donors such as the Hope for African Children Initiative (HACI), Save the Children and Stichting Respect (Netherlands) because of its improved project design and proposal writing skills.

CHD's Dispensary Health Committee partners. Although in the future they may need some limited TA – and the MOH has been slowly building its capacity to provide this TA -- most DHCs have the capacity and the resources to continue their work. These community governance structures are more likely to be sustained because community members select their own representatives. Governance (including financial management) is transparent with safeguards to prevent abuse and fraud. The ability to guarantee adequate drug supplies by charging fees and keeping good expenditure and inventory records for reordering drug supplies are among the most important DHC functions being sustained for the community. Some DHCs are also finding other ways to bring in additional revenue. At Mazeras Dispensary, the DHC built rental housing for dispensary staff, socially marketed insecticide treated bed nets, and offered photocopying, telephone and laboratory services for a fee (when they functioned). One challenge to sustainability that looms on the horizon concerns the edict from the

MOH that malaria treatment and services to children under five must be given free. It is unclear how long this would remain in effect but was worrisome to every DHC the team talked to.

Ministry of Health. The MOH has been dependent upon donors for new programs and equipment. The cost of CHD's work with DHCs and MOH dispensaries was covered by the MG and other donors. Likewise, the MOH has not paid CHD for its MIS services (program costs in Kwale were covered by the MG; replication in new districts was being covered by Rockefeller Foundation; the cost of forms and computer hardware is covered by DANIDA). However, the MOH has sustained the MIS in districts where it is in operation, and is committed to seeing it replicated in the Province. Inevitably, there will be staff turnover and computers will need to be replaced. It will be interesting to see how the MOH will deal with new training and equipment needs. As more major donors return to Kenya the MOH may have an easier task in attracting new funds to cover these costs.

1.3.4 Lessons Learned and Program Recommendations

Lessons learned from CHD's local capacity building models and approaches

At CHD. In Kenya, CHD's approach to building local capacity in management, finance and the collection and use of information for better decision-making and resource use has filled a gap left by other organizations, which are more focused on the clinical aspects of primary care and service delivery. By first developing its own systems, CHD has put itself in a good position to develop the health systems of other local organizations and carve out a market niche. Staying focused on this market niche has allowed CHD to learn from experience, respond to the needs of its target market, and enrich and diversify its products and services, abandoning what did not make sense (or generate enough revenue).

Because working at the community level is labor and resource intensive, by working through and building the capacity of intermediary organizations such as CBOs, NGOs and the MOH, CHD probably has had wider impact at less expense than it would have if it had only worked with individual communities. Unfortunately, the relative cost-effectiveness of different approaches to replicating the dispensary model has not yet been studied. By EOP CHD should have been able to answer the question posed by the MTR: how can the dispensary model be replicated more rapidly and less expensively? It is important, for example, to know the relative cost-effectiveness of working directly with DHCs as compared to working through CBOs, NGOs and the MOH. Although CHD has not focused on answering this question, it probably does have much of the retrospective financial and program data to do so.

At the community level. Some of the most important conditions for community members to develop their capacity to mobilize, organize and sustain their primary care programs and services are: being inclusive by allowing women and others who are not community leaders have a real voice in decision making; being able to identify and prioritize their own health needs; being willing to contribute funds for the construction and maintenance of their health facilities (and water points); being able to foster the support of the MOH, donors and NGOs engaged in health care and health education; and being able to select, support and train new DHC members and CHWs when needed.

With regard to MIS in particular, members from even relatively poor and rural communities can be trained to competently manage simple but effective data collection and information systems. To be cost-effective, such data must be collected regularly and routinely – not as part of a special study. These systems can improve the quality of care by: identifying the most common diseases that need attention; sounding an alert about sudden outbreaks of diseases such as malaria, cholera or meningitis; establishing a basis for action planning; providing tools for monitoring and evaluation activities; and keeping the whole community well informed about health issues. With training, community members can recognize this link between health information and its impact on quality of care and can use such data to make better resource allocation decisions.

At the dispensary level. To avoid conflicts between primary care providers such as dispensary nurses and community management bodies such as DHCs, a clear distinction must be made between the clinical matters

that are the concern of the nurse, and the management functions that are the business of DHC members. Each must clearly understand and appreciate their complementary roles and management functions.

A valuable tool to minimizing misunderstandings between DHC members and dispensary nurses is the DHC constitution, which clearly spells out the roles and responsibilities of all parties. Training plays an important role as well: both community members and nurses need training in conflict resolution and in improving their administrative and management skills. CHD found that it was useful to train nurses and DHC members together so that they can jointly define or clarify their specific management functions and determine the most effective ways of working together. Enhanced conflict resolution skills on both sides are extremely important in resolving disputes before they get out of hand.

To enhance prospects for success, CHD found that training also must involve changing the attitudes of DHC members and dispensary nurses. DHC members need to be taught to realize that even if they do not have direct authority over dispensary nurses (e.g., their hiring, firing, or day-to-day supervision) they can still creatively exert an important influence over them. Likewise, nurses need to be sensitized that even though DHC members might not have clinical experience they have other important skills that can be extremely useful in managing the dispensary.

Lessons learned about CHD's work with local partners

CHD's success with replication in Coast Province was in good part due to the strong support it cultivated from influential provincial and district MOH officials. This support was key to the dissemination and replication of CHD's models and systems. The Provincial Medical Officer and his district medical officers saw a direct link between the work of CHD in strengthening local governance and capacity and their ability to implement mandated health sector reforms. These officials also realized the benefit of having an increased ability to collect and interpret health data and use limited resources more efficiently as a result of CHD's MIS services.

At the community level, CHD found that in addition to strengthening skills, efforts to build the capacity of CBOs and DHCs had to include changing traditional attitudes toward outside support. To avoid creating dependencies CHD had to make it clear to CBO leaders and DHC members at the outset that they must take primary responsibility for managing their health care programs and seek close and positive collaborative relationships with the MOH (as well as with any NGO and private health care providers working in their area). To avoid raising unrealistic expectations, CHD also had to be frank about the limited extent of assistance to be provided and the low possibility of permanent (and paid) employment. CHD also found that building trust and stimulating community participation in health service delivery could take a long time but when community members saw the positive results of their efforts they worked hard and made sacrifices to sustain them. This helped mitigate some of the negative effects of increased poverty on CHW's willingness to volunteer their time.

Although word-of-mouth from CHD's work helped it to build up its base of partners over the life of the MG, it was not clear who CHD's main target audience for dissemination was (or should be). Thus, it was not clear whether the lessons learned it chose to disseminate would be the most critical for its priority audience, and which marketing and promotional methods would be the most cost-effective in reaching that audience. Likewise, CHD also did not clearly define which among its partners (actual and potential) should comprise its target market. By not doing this, some paying clients (e.g. Tsavo Power) were able to draw CHD away from its core competencies in health systems strengthening and into other areas such as controlling infectious disease.

Potential for scale-up or replication

Prospects for the scale up and/or replication of CHD's work are promising. With regard to MIS, CHD is already scaling up its system throughout Coast Province with a grant provided by the Rockefeller Foundation. Outside of Coast, the PMO of Rift Valley is interested in replicating the MIS in his province, and the head of the MOH's Health Management Information System Division in Nairobi would like a similar system to be scaled-up nationwide. At the moment, neither the HMIS Division nor the Rift Valley PMO have the funds to implement CHD's MIS, which would involve upgrading antiquated computer hardware, adopting a new software technology and training. One possible source of funding could be USAID/Nairobi. A USAID official involved

with Kenya's health sector reform program told the Evaluation team that USAID might possibly be interested in helping scale up a revised MIS for the MOH to further its decentralization program.

Because of CHD's close relationship with the MOH, there are also good prospects for replicating the dispensary model in Coast Province. As a result of the PMO pushing it, the model has been incorporated into all district health plans. However, the MOH does not have the capacity to replicate the model in the province and wants CHD to continue to play this role. The stumbling block is finding donors to pay for its implementation. DANIDA has been the major donor in the province, and its funds have gone directly to the MOH (at the insistence of the PMO). However, CHD has good relations with DANIDA officials who are aware of the situation, and discussions are ongoing. USAID/Nairobi has also noted the positive impact of CHD's interventions on AMKENI-supported service delivery points in Coast Province. Although USAID cannot give a direct contract to CHD for this kind of work, they can be helpful by giving positive feedback to AMKENI management to continue to use CHD services at new sites. In Western Kenya, both World Vision and CARE have expressed interest in replicating the model in Nyanza Province, although it is unclear to what degree they are willing to support CHD to do this.

In addition to uncertain funding, there are two other challenges that may influence the potential for scale up or replication of the dispensary model: local conflicts and political interference. Conflicts between community management entities such as DHCs and health service provider staff could become even more frequent as community members become more "empowered" to take a larger role in the provision of their health care. Thus, scaling up CHD's dispensary model must anticipate and plan for mitigating emerging conflicts between nurses and community members that could impede progress. To prepare the ground for scale up, a clearly defined DHC constitution must be in place, and conflict resolution must be part of training to improve management and other systems skills. Likewise, a scale up of CHD's dispensary model must plan for political interference, which is a longer-term problem. By developing the capacity of civil society to take responsibility (and even protest disagreeable decisions made on their behalf), groups like CHD are helping to provide an effective counterweight to the power and influence of local political officials.

CHD's future directions

The Aga Khan Development Network and Aga Khan Health Service have long been a part of the local fabric of East Africa. They are important development institutions with long-term planning horizons; as one Aga Khan official in Kenya put it, "we are here to stay." Both AKDN and AKHS see the CHD as a viable technical resource center and an integral part of their programs. They will continue to support it but want the organization to have a clear vision and strategy for the future that will help AKDN and AKHS achieve their goals.

CHD, however, is operating in a changing environment that could affect its future. The scourge of HIV/AIDS and new policies from the MOH that affect the ability of communities to levy fees for services present both threats and new opportunities. Likewise, the environment within AKHS is undergoing some change. AKHS, K has a new Board of Directors, and AKHS, EA a new CEO. Both will have new priorities. For example, AKHS, K wants to establish outreach clinics for primary care and vertically integrate services with its hospitals. As part of this, AKHS-Kisumu plans to open three primary medical care facilities, which are expected to be largely self-sustainable. One idea currently being floated is to have CHD act as a kind of broker between community-based clients and AKHS, generating new business in such areas as school health checkups. The new CEO of AKHS, EA also has a primary and preventive focus but is clear about CHD's need to operate in a businesslike manner with a strong strategy for sustainable growth. This also could mean that CHD must play a more regional role.

CHD itself is also at a crossroads. It has focused on its core competencies in capacity building for systems development but at the same time has strayed outside of that niche to take advantage of other opportunities as they came their way in infectious disease control, RH and child survival. Although CHD has a strategic plan (which reflects this broader, more opportunistic vision), it has not yet developed a plan or road map to ensure its long-term sustainability. CHD's main audience for much of its work has been the MOH, CBOs and individual communities/DHCs. However, these partners have only limited resources and are the least likely to pay for CHD's training and technical services unless they are covered by donors. Many of CHD's NGO partners have

been more generous, paying for most if not all training and TA-related expenses. There is no doubt about the huge numbers of primary care facilities in need of health systems strengthening (for example, 46 and 57 respectively in Kalifi and Kwale districts alone). There is also a lot of expressed interest in CHD's TA and training services in not only Coast but also Nyanza Province where high HIV/AIDS prevalence has drawn many donors and international NGOs. However, currently CHD has no hard data on how large this market might actually be in terms of potential income, which to date has only covered a small part of its operating costs.

CHD has also attracted two partners from the corporate sector and is interested in exploring it as a future market for its services. One (the hotel) did not pay CHD for training or TA services, although it has said that in the future it will pay for any additional training it may receive. The other (the power company) did pay CHD the full cost of its assistance. Another large company – FrigoKen – located north of Nairobi and outside of the two provinces where CHD works may be interested in upgrading its company-provided preventive health services and could pay for assistance. So far, CHD has only had limited experience working with this type of client and knows relatively little about the potential of this market and its actual willingness to pay.

Recommendations and Next Steps for CHD

The MG allowed CHD to consolidate its organizational structure; refine its core approaches, strategies and competencies; and develop a market for its services. That CHD has as many options as it does for its future is as much a tribute to its success as it is an issue that needs addressing. In light of this and the fact that AKHS,K and AKHS,EA are currently formulating a new strategic plan which will include guidance for CHD, the Evaluation Team has developed the recommendations outlined below.

The **primary recommendations for CHD** are to:

- **Clearly define the scope of services that CHD will offer based on current in-house capacity or that yet to be developed.** It appears that CHD has been involved in health systems strengthening (finance, MIS and dispensary management), health education, clinical skills training and other areas. At this juncture, it would behoove CHD to clearly delineate what scope of services it will want to offer after the close of the MG. This will help CHD to think and plan strategically and be a more effective implementer. In this regard, the Evaluation Team suggests that CHD focus on its core competencies in health systems. The team understands that AKHS, K will have its own internal needs and preferences for CHD's future direction. However, given its current size and the fact that the nature of its work is labor intensive, the team is concerned that going off in too many directions might undermine CHD's ability to deliver high quality services in its current niche area.
- **Do market research and develop a solid business plan** once the above scope of work has been defined. This business plan should include expense and revenue projections based on hard data collected from its market of potential clients. The market assessment and business plan should look at all sources of potential revenue: grant, contract and fee income. Because CHD has already developed extensive contacts, a solid reputation and a business presence in Coast and Nyanza Provinces, the team suggests that CHD should focus on these areas first. CHD should systematically contact all potential donor (and donor-sponsored projects), NGO and private sector partners operating in these two provinces to discuss what it can offer, assess potential partners' interest in CHD's services, and determine what they might be willing to pay. Likewise, after giving it some thought, CHD (with help from AKF and/or AKDN) should contact prospective donors to gauge their interest in supporting grant proposals to scale up or replicate CHD's work in health reform in the public sector. CHD could also consider partnering with other organizations that have complementary strengths (for example, FHI/Impact Project for HIV/AIDS) to go after larger grants and contracts.
- **Continue to develop, test, refine and revise its approaches with the communities and the MoH at the sites in Kwale, Coast Province in order to draw lessons from this work.** In this context, Kwale would become a "research and development" laboratory for CHD. Kwale would remain an area of central focus and operations. CHD would include the materials and lessons learned from Kwale in its *policy and good*

practice briefs and the training programs marketed to others, primarily the community-based organizations and the non-governmental organizations. These organizations would be responsible for *replicating* the dispensary model and its refinements at other locations in Kenya (and beyond). As outlined, replication and scaling up would be done indirectly by CHD and indirectly and directly by other organizations. This approach to scaling-up and replication could control the costs of CHD while proving the validity of CHD's models and training through the work of others.

The **main recommendation for USAID** (in Washington and in Nairobi) is to:

- **Consider providing another round of funding to AKF USA to continue to support the work of CHD in capacity strengthening.** This will ensure that the achievements made during the MG may be scaled up to have wider impact within Kenya and regionally. From the team's discussions with health staff at the USAID mission in Nairobi, CHD's work falls squarely in line with USAID's strategic objective of advancing the agenda of health sector reform in Kenya. Similarly, CHD's work with Kenyan NGOs and CBOs directly justifies and supports PVC's recently revised mandate of strengthening civil society organizations overseas. Moreover, CHD could benefit from an expanded relationship with AKF both in Washington and in Nairobi in terms of provision of technical oversight; brokering partnerships between CHD and other AKDN and non-AKDN partners outside of Kenya to effect wider impact; facilitating policy dialogue on health sector reform at an international level; and leveraging USAID and AKF funds against other donor contributions.

Secondary recommendations for CHD are to:

- **Determine the costs of each package of service and/or intervention.** CHD must determine the relative costs of its different approaches to building local capacity with the aim of reducing cost and time needed to replicate the dispensary model;
- **Develop better marketing and promotional materials.** CHD needs to develop better marketing and promotional materials, including brochures, which are more user-friendly and that better describe what CHD has to offer. CHD uses jargon for training courses and services (for example, TOFs and TOTs training) that some potential clients would find hard to understand. Some names for services are used interchangeably (Kwale model/dispensary model) and names for some of the same training courses that CHD offers differ between Nyanza and Coast Provinces. Because of its solid position in the marketplace, CHD needs to continue to use the AKHS logo on all of its marketing materials.
- **Collect baseline data at non-CHD intervention sites.** Although CHD does collect baseline data at intervention sites, it does not collect data, even as a special study, at non-CHD intervention sites (both NGO and public health facilities). Doing this, even as a special study, would give a basis of comparison to measure CHD's impact and show existing and new partners actual results -- a good marketing tool.
- **Consider adding new capacity building services in quality assurance and referral systems.** As an expert technical resource organization in systems strengthening, assuring the continued quality of care by strengthening the supervisory, monitoring and support systems for DHC members, dispensary nurses and community health workers would be an appropriate new service for CHD to provide to clients. CHD could also consider adding expertise to strengthen referral systems, which are weak above the primary care level. CHD could tie into and benefit from the capacity that AKHS is developing in referral and supervisory systems as it expands its primary medical care infrastructure and vertically integrates this into its hospital network. This recommendation assumes, of course, that AKHS,K is in favor of this type of expansion for CHD.

1.4 PROGRAM MANAGEMENT

Management Approach

CHD's approach to program management was flexible, appropriate and adequate although some improvement was needed in grant monitoring and evaluation (see below). Inputs were converted into outputs and outcomes well within the five-year timeframe of the project although there were no data or comparable models to determine cost-effectiveness. CHD's management system is discussed in more detail in **Section 1.3.2**, "Achievement of Objectives, Objective 1".

Quality and Status of Detailed Implementation Plan (DIP)

Neither CHD nor AKF USA found the DIP to be a useful document during project implementation. It was not a requirement at the outset of the MG, and was not developed until eight months after the project had started. The DIP that was developed served more as a business plan than a management tool.

The project objectives in the DIP mirrored those in the proposal developed by AKF USA and CHD for the MG, however there were no indicators, targets or baseline data in the DIP. As a result, during project implementation CHD used the logical framework methodology as a management tool to track progress rather than the DIP. For the Final Evaluation, CHD and the team measured progress against the indicators, targets and baseline situation described in the MG proposal.

Financial Management

The adequacy of CHD's financial management, including financial controls and systems established under the grant is discussed in detail in **Section 1.3.2**, "Achievement of Objectives, Objective 1." CHD's progress with leveraging additional resources (beyond the match) is discussed in **Section 1.3.3**, "Cross-Cutting Issues, Sustainability, Community Health Department."

Monitoring and Evaluation System

CHD saw its role in monitoring and evaluation (M&E) not as an auditor but as an outside catalyst whose responsibility it was to highlight problems and develop the capacity of local partners to identify and execute their own solutions. To conduct monitoring visits, CHD developed a checklist system for its staff. One checklist covered a review of the data collected by the MIS (revenue, health statistics, utilization data, etc.); the second covered governance and involved a review of the minutes of DHC meetings; the third covered finance, which involved a review of dispensary and DHC books. CHD's monitoring personnel were trained to spot red flags such as when the amount of revenue collected did not reflect clinic utilization; when the number of prenatal visits did not match recorded deliveries; or when MIS reporting dropped below 70%. Project progress and data collected were reviewed in monthly staff meetings.

The Evaluation team found that CHD's M&E system allowed the organization to access the data and information it needed to track progress as well as anticipate and correct problems in a timely manner. However, the team noted that developing log frames by program activity rather than by MG objective (as discussed in **Section 1.3.2**, "Achievement of Objectives, Objective 1") made it more difficult for CHD to monitor the progress and outputs that solely concerned the MG, particularly as CHD leveraged new grants and contracts. Bi-annual and annual reports submitted by CHD did not restate MG objectives and did not report against a consistent set of MG indicators. This made it more difficult to determine how well CHD was doing at any one point in time. Not restating objectives and indicators in reporting also allowed MG objectives to become a sort of "moving target" reflecting concerns of the moment. For example, the MTR added an objective on policy that was not in either the DIP or MG proposal.

CHD should also have followed the recommendation of the MTR and revised its Phase II indicators (for Objective 2). Indicators could have been developed that would have been more useful for CHD by better describing how partners were benefiting from its various capacity strengthening services, especially since clinical skills packages were de-emphasized. Instead of tracking numbers of partners using "managerial

methods,” for example, indicators concerning the use of CHD’s data tracking systems, the automated MIS, financial management tools, facility governance systems, etc. could have been developed.

No special studies were conducted by CHD to assess program impact on partners however these data were routinely collected at the dispensary level by the MIS. With regard to the increased capacity of partners to monitor and evaluate their work, document program achievements and use data, CHD’s MIS allowed them to access and use data for decision-making (see **Section 1.3.2**, “Achievement of Objectives, Objective 2, Indicator 3 and Impact”). The main beneficiaries were DHCs, CBOs and the MOH.

Information Systems

A major focus of the MG was to increase local partners’ access to information technologies and systems (see **Sections 1.3.2 and 1.3.3**, “Achievement of Objectives and Cross-Cutting Issues”). CHD has also shared its program information and learning with a wide audience (see **Section 1.3.2**, “Achievement of Objectives, Objective 1, Indicator 4”).

Staffing and Supervision

The team only looked at the adequacy of staffing and program supervision at CHD. There was insufficient time to assess the status of staffing and program supervision of its partners.

To assure the adequacy of its supervision and backstopping systems, over the course of the MG, CHD considerably beefed up its capacity in Mombasa by hiring additional staff with expertise in community health, financial management, administration and MIS. The Evaluation team recommended that additional technical and administrative staff was needed for CHD’s office in Kisumu if program activities there were scaled up (see **Section 1.3.3**, “Lessons Learned and Program Recommendations”).

PVC Management

As five out of the six projects funded under this cooperative agreement have been given no-cost extensions, PVC’s management and backstopping will be given intensive consideration next year at which time the other projects (including Headquarters) will be evaluated. For this reason, the Evaluation team did not spend time exploring this issue.

Program Management Lessons Learned and Recommendations

Relevant lessons learned regarding program and financial management, staffing and information systems were already discussed under **Section 1.3.3**. With regard to program management and M&E, the DIP/Business Plan format did not seem to be a useful tool for this project, which focused on capacity building. Instead, CHD used logical frameworks. However, by developing its logical frameworks by program activities rather than by MG objectives, it was harder for CHD to monitor the progress of MG indicators and outputs, particularly as it leveraged new grants and contracts.

In light of this, the team recommends that:

- **CHD tighten its grant monitoring systems, and consistently report against a clear set of objectives and indicators.** By developing log frames by project objectives and by consistently tracking project progress and reporting against these objectives (and related indicators), CHD should eliminate any confusion over what it is responsible for achieving – particularly as new grants and contracts are added to its portfolio. In addition, as it gains new knowledge from implementation experience, CHD needs to periodically review project-related indicators for their relevancy and revise them as appropriate.

1.5 EVALUATION METHODOLOGY

The Final Evaluation team was comprised of two external members: an international consultant who was the team leader and responsible for producing this report, and a local consultant who provided expertise in the local context and translation support. A representative of AKF USA who was the technical point person for the MG also accompanied the team and provided it with valuable background information, an historical perspective on the evolution of the project and help with finalizing the report.

To conduct the Final Evaluation, the team used multiple methods including:

- A desk review of all relevant project documents including the Mid-Term Review, CHD's strategic plan, annual reports, budgets and financial reports;
- Interviews with AKDN, AKHS and CHD staff and representatives from stakeholder agencies and partners including USAID/Nairobi, USAID/PVC, NGOs, CBOs, the private sector and the MOH at the district, provincial and national levels;
- Site visits in Kwale and Kilifi Districts and in Mombasa and Kisumu to agencies with whom CHD has worked; and
- Focus group discussions with Dispensary Health Committees, community groups and dispensary nurses.

Annex G contains the schedule and sites visited for the Final Evaluation; **Annex H** contains the list of groups, organizations and persons interviewed by the Evaluation team; and **Annex I** contains the bibliography used by the team for the Final Evaluation and report.

ANNEXES

Annex A	Summary of Program Strengths and Weaknesses
Annex B	Detailed Implementation Plan Results Status
Annex C	Partnership Tables
Annex D	Final Evaluation Scope of Work
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Annex F	Description of CHD Training Courses
Annex G	Final Evaluation Schedule and Sites Visited
Annex H	List of Groups, Organizations and Persons Interviewed
Annex I	Bibliography

Annex A Summary of Program Strengths and Weaknesses

Program Objectives	Strengths	Weaknesses
1. Build the internal capacity of CHD to provide TA to local stakeholders/partners	Has developed and is using effective program, financial, personnel and information management systems.	MG monitoring and evaluation systems need some improvement.
	Has developed and is implementing a strategic plan.	Strategic plan and related activities could be more focused on core competencies in health systems
	Systematically documenting and disseminating lessons learned.	Could better define its target audience to more cost-effectively select and document lessons learned, and identify the most cost-effective channels for reaching this audience
	Has developed innovative program models and packages of TA and training services	Need to determine most cost-effective ways of delivering program models and services
	Is receiving increasing requests for TA and training services	Some stakeholders/partners, including CBOs, DHCs and the MOH, have limited ability to pay CHD for its services and must depend on donors
2. Improve the capacity of local stakeholders/partners to provide health-related services to communities	Exceeded MG targets in terms of numbers of stakeholders/partners whose capacity was strengthened by CHD.	
	Increased utilization and revenue collected at dispensaries that received support from CHD	Proxy indicators for quality, accessibility and acceptability
	Reporting rate for data collected in Kwale Province increased from 47 to 92 percent as a result of CHD's MIS.	
	MIS being replicated in MOH facilities throughout Coast Province.	
	HIV/AIDS infection control programs of CHD's CBO partners has improved and bilharzia among children at CHD supported schools has decreased from 90 to 15 percent	Although an impressive achievement clinical activities fall outside of CHD's core competencies and could affect CHD's ability to scale up and deliver high quality health systems services.

Annex B Detailed Implementation Plan Results Status

DIP Objective	DIP Indicators	Baseline	Target		Achieved?		Data verified?	Comments
			MTR	EOP	MTR	EOP		
Build the internal capacity of CHD to provide technical assistance to local partners i.e. CBOs	Personnel policies and procedures in place and used in hiring, performance appraisal; staff development	Not there	Should be developed	Should be developed	Done	Done	Yes	
	Number of CHD Personnel with expertise in MIS, Financial management, grant management, training and program management	1	5	5	5	6	Yes	
	3.MIS, M& E, Financial management/grant management and audit systems in place and operational	0	4	4	4	4	Yes	
	4. Strategy vision and mission articulated, shared and understood	Not there	Should be in place	Should be in place	Done but need revision	Revised	Yes	
	5. Packages of CHD products and technical services developed and promoted (DMC, MIS, CBSD, ToT, ToF, CHWs, OD, Dispensary Management)	2	6	8	6	10	Yes	Extra 2 developed were on Infection control and CORPs
Improve the capacities of partners to provide health related services to communities	1. Number of CBOs and NGOs with improved capacity	1	0	10	2	15 (12 IN KISUMU) (3 in Kwale -Plan -AMKENI -1 Consortium)	Sample (pandipieri, Kajulu, Plan, AMKENI, Consortium)	
	2. Number of Government and privates (for profit) partners with improved capacity	6	0	16	6 Kwale MOH	<ul style="list-style-type: none"> ▪ 12 PLAN (Kwale MOH) ▪ Four AMKENI (Kilifi MOH) 	Sample (Mtaa, Kafuduni, Mazeras, Mogomboni, Sun n' sand,	

Annex B Detailed Implementation Plan Results Status

DIP Objective	DIP Indicators	Baseline	Target		Achieved?		Data verified?	Comments
			MTR	EOP	MTR	EOP		
						<ul style="list-style-type: none"> ▪ Six (Kwale MOH) ▪ 1 Sun n'Sand ▪ 1 Tsavo Power Total = 24	Tsavo)	
	3. No of District with upgraded HIS	0	0	1	0	1 done 6 underway in Coast Province: Kilifi Malindi, Taita, Taveta, Tana River, Mombasa Lamu	Yes	
	4. No. TA packages provided to partners	0	0	8	0	10		
	5. No. of participants trained	0	0	360 (120 per year)	*617	**546		

Annex C Partnership Tables

Partner Type	Name of organization	Organization Type	Agreement Type Example: MOU, sub-grant, contract or no formal agreement	Role/Main Responsibilities	Funds received From PVO And (As a percentage of total income)	Quality and Outcomes of Partnership
Primary in country partners receiving PVO MG Funds	AKF, K	Social development	Sub-grant	Grant management Monitoring	\$548, 300 (% unable to be determined)	
Main partners of primary partners also receiving MG funds	CHD/AKHS, K	Health Service Company	Sub-grant letter	Implementing agency	(% unable to be determined) \$548, 300	
Other key partners who do not receive MG funds	1.PLAN	Social development NGO	Contract	Implementing agency	0	See Annex C attachment
	2.AMKENI	Reproductive Health NGO	Contract	Implementing agency	0	See Annex C attachment
	3.Kwale Health Forum (KHF)	Consortium	MoU	Implementing agency	0	See Annex C attachment
	4. Mwikunga	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	5. Kajulu PHC	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	6. TEMAK (Teenage Mothers and Girls Association of Kenya)	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	7. Kenya AIDS Victims, Street Children, Preparation and Care Services (KAVSCAPACS)	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	8. SPRINGS MINISTRIES	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment

Partner Type	Name of organization	Organization Type	Agreement Type Example: MOU, sub-grant, contract or no formal agreement	Role/Main Responsibilities	Funds received From PVO And (As a percentage of total income)	Quality and Outcomes of Partnership
	9. MIWANI location PHC Program	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	10. Manyatta Aids Community Based STIs Services Organization (MACOBASS)	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	11. Kendu Bay Child And Family Program	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	12.REACH OUT	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	13.Pandpieri	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	14.Local Initiatives Development Association (LIDA)	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	15.Activated Initiatives Association (ACTINA)	CBO	No formal Agreement	Implementing agency	0	See Annex C attachment
	16.MoH	Public sector	MoU	Implementing agency	0	
	17.Sun N Sand	Private	No formal agreement	Implementing agency	0	
	18.Tsavo	Private	No formal agreement	Implementing agency	0	
	19.Afri Afya	Consortium	MoU	Implementing agency	0	

CHD Partner CBOs

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
Kendubay Child & Family Program Affiliate of CCF	72,770 at West Karachunyo Division of Kendubay district	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Stated but not clear to all. Yearly plan only. Yes but clear to a few. Not very clearly.</p> <p>Not there.</p> <p>Not clear. Not there. They're for senior staff.</p> <p>Yes but in name Yes but unshared Yes Yes Not regular Not very clear</p> <p>Not there, Yes both externally and in kind from Com Executive Committee "</p> <p>Not very clear.</p> <p>Not very clear Yes, Committees Yes but untrained. Up to a point. Yes Not clear Yes (affiliated to CCF) Managed well enough Not there.</p>	<ul style="list-style-type: none"> • Needs assessment. • Training community based leaders. • Health Action Day for infection control • Training Staff • Monitoring 	<ul style="list-style-type: none"> • Activities still going on. • Orphans support and managed to go through school. • 95% of supported children self-employed. • Have accessed more child sponsors 	<ul style="list-style-type: none"> • Project self-sustaining with leadership mainly community leaders. • Improved income per capita. • Older orphans supporting their siblings through education.

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
Kajulu PHC	30,000	<p>Organization Development: Presence & Use of: * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers</p>	<p>Yes Yes Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Yes Not regular Not there</p> <p>Not clear Internally. Have once got external funding The proprietors The proprietors Not very clear.</p> <p>Yes Committees slackened Only volunteers Yes Yes Not very active Not closely followed</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring Evaluating 	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>19,540/- profit realized from sales of infection control antiseptics.</p> <p>Referral linkages established with other organizations like Pandipieri Community Based Program.</p> <p>50 CBOs reached in the entire Nyakach in terms of capacity building.</p> <p>Resources Information shared/disseminated at different forums.</p> <p>Received 350,000/- from Constituency AIDS Committee (CAC) for Home based Care activities</p>	<ul style="list-style-type: none"> Project well sustaining CBHWs very active Leaders being cobbled by other organization Dispensary constructed 5 pharmacies constructed bringing treatment and drugs closer to the people.

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<ul style="list-style-type: none"> * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability 	Yes			
Mwiku nga	15000 people at central Bunyore location of Vihiga district	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives.</p> <ul style="list-style-type: none"> * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans <p>Governance & Management: Presence & use of</p> <ul style="list-style-type: none"> * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either <ul style="list-style-type: none"> - Internally or - externally * Who controls the finances * Who approves payments <ul style="list-style-type: none"> • Records of accounting • <p>Project's operations & Management: Presence & use of:</p> <ul style="list-style-type: none"> * An Organogram * Human structures * Adequate workers 	<p>Not there</p> <p>Not there</p> <p>Not there</p> <p>Yes but on monthly basis.</p> <p>'Do what you are told'</p> <p>Not there</p> <p>Not existing</p> <p>Not there</p> <p>Only for the leaders</p> <p>Not there</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Not regular</p> <p>Not there</p> <p>Not clear</p> <p>Internally. No external funding</p> <p>The proprietors</p> <p>The proprietors</p> <p>Not there.</p> <p>Not there</p> <p>In active Committee</p> <p>Only volunteers</p> <p>Not very well</p> <p>Yes</p> <p>Not there</p>	<ul style="list-style-type: none"> • Needs assessment. • Training community based leaders. <p>Health Action Day for infection control</p> <ul style="list-style-type: none"> • Monitoring 	<p>Received grade cow from Kenya Finland Project to rotate among the members.</p> <p>Received 10,000/- from Constituency AIDS Committee (CAC) for dissemination of HIV and AIDS activities</p> <p>Received mosquito nets for control of malaria.</p> <p>6 members benefited from benevolent activities.</p> <p>MoH accords mobile services on a monthly basis and attendance has increased to at least 30 infants every visit.</p>	5 Members have received their cows producing more milk in the area and so improving children's health

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<ul style="list-style-type: none"> * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability 	<p>Not there No grant so far Not there</p>			
TEMA K (teenage Mothers and Girls Association of Kenya)	Active in Kisumu and Nyando districts with indirectly serving a population of about 800,000	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietors The proprietors Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there</p>	<ul style="list-style-type: none"> • Needs assessment. • Training community based leaders. • Health Action Day for infection control • Training CORPs. • Assess progress • Assist with proposal writing • Linking CBOs with donors <p>Monitoring Evaluating</p>	<p>Well established All organization development structures in place. Has human structures managing group. Have recently been raised to NGO Have received many different small grants from different sources – recently being \$ 9,700 from Afri Afya</p>	<ul style="list-style-type: none"> • Sustainable • Improved health of all people • Well established

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<ul style="list-style-type: none"> * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability 	<p>Not there No grant so far Not there</p>			
Kenya AIDS Voctims, Street Children, Preparation and Care Services (KAVS CAPA K)	21 schools and their environs covering a population of 15,400 youths of which 8,400 youth are still in school, 7000 youth are out of school and 250 teachers and their families in Kisumu district	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin.</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietor Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> • Needs assessment. • Training community based leaders. • Health Action Day for infection control • Training CORPs. • Assess progress • Assist with proposal writing • Linking CBOs with donors • Monitoring Evaluating 	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use.</p> <p>Opportunistic infections reduced from 80% to 45%.</p> <p>An Anti AIDS clubs formed in all the 15 schools and communities.</p> <p>10 widows attending tailoring course in the community</p> <p>35 community health promoters undergoing training currently (two phases finished) and a survey carried out in the community to determine their households' coverage.</p> <p>Received 17,000/- from Constituency AIDS Committee (CAC) for Home based Care activities</p>	

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<ul style="list-style-type: none"> * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability 				
SPRINGS MINISTRIES	50,000 Kisumu town	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives.</p> <ul style="list-style-type: none"> * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans <p>Governance & Management: Presence & use of</p> <ul style="list-style-type: none"> * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting <p>Project's operations & Management: Presence & use of:</p> <ul style="list-style-type: none"> * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures 	<p>Mission & goal only</p> <p>Not there</p> <p>Not there</p> <p>Yes but on monthly basis.</p> <p>'Do what you are told'</p> <p>Not there</p> <p>Not existing</p> <p>Not there</p> <p>Only for the leaders</p> <p>Not there</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Not regular</p> <p>Not there</p> <p>Not clear</p> <p>Internally. No external funding</p> <p>The proprietor</p> <p>The proprietors</p> <p>Not there.</p> <p>Not there</p> <p>In active Committee</p> <p>Only volunteers</p> <p>Not very well</p> <p>Yes</p> <p>Not there</p> <p>Not there</p> <p>No grant so far</p> <p>Not there</p>	<ul style="list-style-type: none"> • Needs assessment. • Training community based leaders. • Health Action Day for infection control • Training CORPs. • Assess progress • Assist with proposal writing • Linking CBOs with donors • Monitoring <p>Evaluating</p>	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use</p> <p>15 orphans supported with high school fees</p> <p>56 orphans in primary schools supported</p> <p>74 women given grants for IGAs and trained</p> <p>15 patients given care and support</p> <p>22-orphaned children fostered at Children's home and taken to schools with all their needs supplied.</p> <p>Launched orphanage home.</p> <p>Skin infections reduced drastically from 75% to 24%.</p> <p>Received 300,000/- from HAPAC for Home based Care activities.</p> <p>Received 350,000/- from John Elton Foundation for support</p>	<ul style="list-style-type: none"> • Added life into the days of the terminally ill. • Provided home to orphans that have nothing • Added spiritual nourishment the challenged • Project more focussed and presenting better. • Sustainable activities.

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<ul style="list-style-type: none"> * Grant management * Plans for sustainability 			<p>IGAs and vocational training for the orphans.</p> <p>Received an orphanage centre complete with three permanent buildings for over 100 orphans from well-wishers in UK.</p> <p>Received a laptop, clothing and other materials for office use and the orphans by well wishers in the USA.</p> <p>Received 100,000/- from well wishers for production of a widows' and watchman's books and establishment of IGAs for widows.</p> <p>Launched 'A Widow's book' and 'The security guard's book. Received 1.2 million from NACC</p> <p>Widows have strengthened IGAS giving them income</p> <p>Home based care project supporting both caregivers and patients.</p>	

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
MIWANI location PHC Program	15000 in the Winam division of Kisumu district	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietor Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring <p>Evaluating</p>	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use.</p> <p>Received 15,000/- from well-wishers for drugs replenishing.</p> <p>Pharmacy well stocked</p> <p>Been able to carry out a survey to plan for the future.</p> <p>Have been visited by CACC for potential funding</p> <p>Have established a village bank where members are borrowing from</p>	<ul style="list-style-type: none"> Project better organised Drugs and treatment accessible and consistent. CHPs strengthened through village bank Income per capita improved due to credit facilities available in area.

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
Manyata Aids Community Based STIs Services Organization (Macobass)	46,765 people Winam division of Kisumu District	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietors Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring <p>Evaluating</p>	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use.</p> <p>Pharmacy has an increased number of people seeking counseling services from 5 clients per month to at least 150 clients per month.</p> <p>80% of orphans attached to the project are either in formal school, have joined colleges, or are in vocational trainings.</p> <p>Initiated or strengthened IGAs for widows attached to the organizations have enabled at least 75% of them to manage several personal financial commitments.</p> <p>Improved environmental sanitation has led to control of diarrhoeal diseases bringing it down from 45% to 20%.</p> <p>Received support from world vision for orphans and widows.</p> <p>Received training for orphans in from John Elton Foundation</p>	<p>Improved health of the windows 75% of orphans are in school will required needs. 80% of older orphans are in vocational training centres. All older orphans who had completed vocational training initiated self-employment activities.</p>

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
ACTIN A (Activated Initiative Association)	11,000 people of Chiga sub-location of Kolwa West in Winam Division of Kisumu District	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietors Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring <p>Evaluating</p>	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use.</p> <p>Pharmacy has an increased number of people seeking counseling services from 5 clients per month to at least 150 clients per month.</p> <p>80% of orphans attached to the project are either in formal school, have joined colleges, or are in vocational trainings.</p> <p>Initiated or strengthened IGAs for widows attached to the organizations have enabled at least 75% of them to manage several personal financial commitments.</p> <p>Improved environmental sanitation has led to control of diarrhoeal diseases bringing it down from 45% to 20%.</p> <p>Proposals written to</p> <ol style="list-style-type: none"> KCDF has yielded a funding of 0.95 million NACC 1 million Afri Afya US \$ 10,000 for implementing direct. 	

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
LIDA Local Initiatives and Development Association (Nyakach)	46,765 people Winam division of Kisumu District	<p>Organization Development: Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietors Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring <p>Evaluating</p>	<p>Vision, Mission and objectives and work plan are in place</p> <ul style="list-style-type: none"> Activities still going on. Orphans support and managed to go through school. 95% of supported children self-employed. Have accessed more child sponsors <p>KCDF has yielded 0.9 Million NACC 1.2 million</p>	<ul style="list-style-type: none"> Mobilized adequate funds for its Sustainability Established reference centre Home based care project fully supporting those infected. <p>Trained health promoters educating community members</p>

CBO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
Pandipieri	320,000 people in the peri urban area of Kisumu District	<p>Organization Development: Presence & Use of: * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p>Governance & Management: Presence & use of * A board of governors * A constitution * Registration * Executive Committee * Regular meetings * Mechanism for accountability and transparency * Reporting channels * Is project funded either - Internally or - externally * Who controls the finances * Who approves payments * Records of accounting</p> <p>Project's operations & Management: Presence & use of: * An Organogram * Human structures * Adequate workers * Integrated activities * Involvement of admin. * Mechanism to track/monitor progress * Written policies & procedures * Grant management * Plans for sustainability</p>	<p>Not there Not there Not there Yes but on monthly basis. 'Do what you are told' Not there</p> <p>Not existing Not there Only for the leaders</p> <p>Not there Yes Yes Yes Not regular Not there</p> <p>Not clear Internally. No external funding The proprietor The proprietors Not there.</p> <p>Not there In active Committee Only volunteers Not very well Yes Not there Not there No grant so far Not there</p>	<ul style="list-style-type: none"> Needs assessment. Training community based leaders. Health Action Day for infection control Training CORPs. Assess progress Assist with proposal writing Linking CBOs with donors Monitoring Evaluating 	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <p>Have drawn up performance improvement tools, which are in use.</p> <p>Funding received from: CORDAID, HACI, Stitching Respect, NACC, Apso WIRE International Save the Children UK Church Contributions Friends Fund from Netherlands and England.</p> <p>With Funding HIV/AIDS activities are addressed. VCT/MTCT+ services Home based Care for the infected & affected. Counselling Services. IGAs/Revolving Fund for Post club members for those that are infected. Child counselling. Memory book initiative. Nutrition promotion. Immunizations. Safe deliveries Rehabilitation of the physically challenged. Prevention of STIs. Infections Control Laboratory Services.</p>	<p>Expansion of the program.</p> <p>Immunization Status up by 20%. Highest turn up for VCT services by 100% Traumatized children rehabilitated. 8 members have been able to go public about their HIV status. Controlled cases of malnutrition down from 35% to 15%. All TBAs now delivering with gloves. All staff are computer literate. 75% have accessed Information services. Medical Centre now uses this information for their training. Centre has received internal recognition where external students from higher learning circles are visiting to study. Staff received international recognition to share their findings at different forums abroad.</p>

AMKENI

NGO	POP N SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME
AMKENI	36616	Governance <ul style="list-style-type: none"> ▪ Extent to which the DHCs/HCC are representative of all the villages within the catchment area. ▪ Extent to which the DHCs/HCC were democratically elected. ▪ Gender representation in the DHCs/HCC ▪ Planning and Coordination of Health Activities. ▪ Supervision 	<ul style="list-style-type: none"> ▪ 50% of the DHCs/HCC were not representative. ▪ Elections were not democratic, as most of the Committee members were appointees of the local chief. ▪ Involvement of women was less than 10% ▪ DHCs/HCC were not aware that this was their responsibility. ▪ DHCs/HCC were not aware that they had a responsibility to supervise activities at the Dispensary/Health Center and at the village level. 	<ul style="list-style-type: none"> ▪ Sensitizing Community on need to have well representative democratically elected DHCs/HCC ▪ Training needs assessment done in the area of Governance support. ▪ Trained DHCs/HCC ▪ Monitoring and Supervision 	<ul style="list-style-type: none"> ▪ DHCs/HCC are now democratically elected. ▪ More than 80% of the villages within the catchment area of the DHCs/HCC are represented. ▪ Women representation is more than 38%. ▪ DHCs/HCC are now aware of their roles and responsibilities in delivery of health care and are taking lead in such events as Health Action Days. ▪ Greater involvement of the DHCs/HCC in supervision of activities both at facility and village level.
		Financial Management <ul style="list-style-type: none"> ▪ Banking of revenue ▪ Financial Procedures ▪ Financial records. ▪ Financial Trends ▪ Financial Systems ▪ Transparency and accountability 	<ul style="list-style-type: none"> ▪ rarely done ▪ DHCs/HCC were not aware of procedures ▪ None of the facilities had a cashbook, debtors register or exemption register. ▪ DHCs/HCC did not have any knowledge of how much revenue was collected, banked and how much was spent ▪ Not in place ▪ Lacking 	<ul style="list-style-type: none"> ▪ Training needs assessment done in the area of Financial management. ▪ Trained DHCs/HCC on Management of Finances ▪ Instituting Financial Management Systems ▪ Monitoring and Supervision of the Financial Management System. 	<ul style="list-style-type: none"> ▪ All facilities are now banking their finances on a regular basis. ▪ DHCs/HCC aware of financial procedures. ▪ Cashbook, Debtors Register, Exemption register are now in use. ▪ DHCs /HCC are aware of monthly income, expenditure and banking. ▪ Financial Stems in place. ▪ Financial Systems transparent.
		HMIS <ul style="list-style-type: none"> ▪ Managing information ▪ Knowledge and use of HMIS tools. ▪ Use of HMIS for decision making and strategic planning. 	<ul style="list-style-type: none"> ▪ No systematic way of managing health at the Health Center/Dispensary. ▪ DHCs/HCC Not aware of the existence of these tools ▪ Not done 	<ul style="list-style-type: none"> ▪ Training needs assessment done on HMIS needs. ▪ Trained DHCs/HCC on HMIS. ▪ Instituting of HMIS System 	<ul style="list-style-type: none"> ▪ Management of information is systematic. ▪ DHCs/HCC exposed to HMIS tools. ▪ MIS in use for decision making and strategic planning.

NGO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME
		<ul style="list-style-type: none"> ▪ Management of MoH Tally sheets 	<ul style="list-style-type: none"> ▪ Unsatisfactory 	<ul style="list-style-type: none"> ▪ Monitoring and Supervision of the HMIS System. 	<ul style="list-style-type: none"> ▪ MoH Tally sheets are now being managed in an efficient manner.
		<p>Family Planning Utilization</p> <p>Total Utilization</p>	<ul style="list-style-type: none"> ▪ 2001- utilization was 1588. ▪ 2001- Total utilization was 36,160 	<ul style="list-style-type: none"> ▪ Consultation with DHCs/HCC on service statistics. ▪ Health Action Days 	<p>2002- utilization was 3847 142% improvement.</p> <p>2002 Total utilization was 54,062. Improvement 49.5%</p>

PLAN International

NGO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
PLAN Kwale Child Survival Project (CSP)	120, 931	<p><u>Governance & Management:</u> Presence & use of</p> <ul style="list-style-type: none"> • A constitution • Registration • Regular meetings • Mechanism for accountability and transparency • Reporting channels • Plans of action 	<ul style="list-style-type: none"> • 10% of women represented in DHCs • Women's participation/role in decision-making lacking • Constitution not comprehensive • Lack of good working relations between CORPS, VHCs and DHCs • DHCs roles in Dispensary Management not clear • No supervision of Dispensaries/Health Centres by DHMT • No plans of Action • No functional organization structure of DHC 	<ul style="list-style-type: none"> • Trainings Needs Assessment • Training of DHC members on Governance (Roles and responsibilities of DHC, Conflict resolution etc) • Follow up of trained staff/Monitoring of activities in the health facilities • Discussion with DMO/DHMT on the need to have supervisory visits 	<ul style="list-style-type: none"> • At least 30% of DHC representation is comprised of women • Women more actively involved in discussions and decision making • Constitution reviewed and now incorporating ownership, duties of the Dispensary/Health Centre committees • DHC meetings held monthly • DHC functional with schedule for meetings and plans of action • Supervisory meetings by DHMT now carried out 	

NGO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
		<p><u>Financial Management</u></p> <ul style="list-style-type: none"> • Banking • Financial procedures • Financial records • Collection/Income and Expenditure • Transparency and Accountability • Financial Systems <p><u>Management Information Systems</u></p> <ul style="list-style-type: none"> • Managing information • Knowledge and use of data collection tools • Use of MIS for decision making and strategic planning • Setting service targets • Catchment area details • Data collection, analysis, interpretation and use 	<ul style="list-style-type: none"> • Meetings not held regularly • Banking not done • DHC could not justify how service fees had been determined • No strong financial systems e.g. use of cash books, debtors books, petty cash voucher etc • Most facilities had no criteria for exemption • DHCs/HCCs were not aware of procedures • Financial details (Income, Expenditure not recorded on MIS board) • Only 2 facilities had a system of managing health information • Reports from the villages not 	<ul style="list-style-type: none"> • Training Needs Assessment done in the area of Financial Management • DHC/HCC trained on management of finances (3 trainings conducted) • Follow up of trained staff/monitoring of health facilities' progress • Training Needs Assessment done in the area of MIS DHC/HCC trained on management of information (2 	<ul style="list-style-type: none"> • 60 (sixty) DHC members trained on Financial Management • Banking now done in all facilities • DHCs/HCCs aware of financial procedures • Cashbooks, Debtors' Registers and exemption registers now in use • Criteria for exemption set in all facilities • Service charge/fee set out by DHCs/HCCs in all health facilities • Financial details (Income, Expenditure, Cash at hand) now recorded on MIS board • 8 PLAN CSP staff and 40 DHC members trained on MIS • Health facilities have a system of managing health information • Catchment area population and service targets available in the facilities • DHCs now able to analyze and interpret reports (Information now used in decision-making) 	

NGO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
			<p>submitted regularly to the DHCs</p> <ul style="list-style-type: none"> • DHC not analysing reports • No interpretation done • No service targets • No catchment area details e.g. population • Tools used not refined • No feedback to village based health workers • Service utilization figures i.e. ANC, Family planning, Immunization, OPD, morbidity etc not recorded on MIS board 	<p>trainings conducted)</p> <ul style="list-style-type: none"> • Follow up of trained staff/monitoring of health facilities' progress • MIS software developed and installed to reinforce link to the MoH 	<ul style="list-style-type: none"> • Data collection tools revised • Feedback now given to village/community based health workers • Service utilization figures for ANC, Immunization, Family Planning now up dated on the MIS boards • Reporting by CHWs and VHCs to the DHCs/HCCs improved 	

Kwale Health Forum

NGO	POPULATION SERVED	PARAMETERS	BASELINE STATUS	WHAT INTERVENTION WAS DONE	OUTCOME	IMPACT
Kwale Health Forum (KHF)	536, 244 (population of the district being served collectively by all the stakeholders in Kwale)	<p><u>Organization Development:</u> Presence & Use of : * Vision, Mission, Values, Goals & Objectives. * 5 year Strategic plan * Annual work plans * Workers & volunteers understand & link their roles, work plan to project's mission. * Job descriptions for both project workers/volunteers * Indicators for reviewing performance. * Mechanism for performance appraisal * Workers' Development plans</p> <p><u>Financial Management</u></p> <ul style="list-style-type: none"> • Collection/Income and Expenditure • Transparency and Accountability • Financial Systems • Registration for legal purposes <p><u>Management Information Systems</u></p> <ul style="list-style-type: none"> • Information tools • Database 	<p>Stated but not clear to all.</p> <ul style="list-style-type: none"> • Financial Systems not in place • Not registered with appropriate institutions for legal purposes. • No Information Systems database 	<ul style="list-style-type: none"> • Needs Assessment • Training on Organizational Development • Needs Assessment • Training on setting up Financial System • Assisted in linking up for appropriate registrations • Helped designed monitoring tools • Database development • Training on database management and on use of information 	<p>Have mission, vision, values, goals, objectives, activities, indicators at process, outcome and impact levels drawn out and in use in implementation of activities.</p> <ul style="list-style-type: none"> • An assets register is in place • KHF keeping a fixed float of imprest • A register for donations received in terms of cash and in kind now maintained • Registered with Income Tax, NSSF and NHIF • Database developed and is in use 	<p>Have been able to launch joint action plans like Health action days</p> <p>Too early to determine impact on the health of people in terms of reduction of mortality and mortality.</p>

Annex D
Final Evaluation Scope of Work

PROJECT: STRENGTHENING THE INSTITUTIONAL CAPACITY OF AKHS, EA'S COMMUNITY HEALTH DEPARTMENT (CHD) TO SUPPORT ORGANIZATIONS WORKING IN COMMUNITY HEALTH

MISSION: FINAL EVALUATION MISSION

1. PROGRAM CONTEXT

The Aga Khan Foundation USA (AKF USA) has been funded by the Matching Grants Program of the Office of Private and Voluntary Cooperation Bureau for Democracy, Conflict and Humanitarian Assistance (DCHA/PVC) of the United States Agency for International Development (USAID) for a grant entitled, *Promoting Health Reform in Three Countries in Central and South Asia and East Africa through Institutional Capacity Building, Partnership Strengthening and Documenting and Disseminating Best Practices*. The grant period is five years (1998-2003).

The goal of this Matching Grant program is to achieve sustainable improvements in the health status of women and children in South and Central Asia and East Africa. In so doing, this set of projects seeks to:

- Introduce or refine policies that support greater efficiency, effectiveness and sustainability of basic health services.
- Enhance prospects for sustainable financing of basic health services at the local or regional level.
- Improve the accessibility, quality and equity of basic health services.

One of the projects funded under this Matching Grant program is *Strengthening the Institutional Capacity of AKHS, EA's Community Health Department to Support Organizations Working in Community Health*, implemented by AKHS, Kenya. In the first phase (Oct.1998-Sept. 2000) the project focused on strengthening the internal capacity of CHD to equip itself to strengthen other health care providers. CHD is currently in the last year of the second phase of this Project and is now testing its ability to strengthen the capacity of other health care providers.

2. OBJECTIVES OF THE EVALUATION

As derived from the Detailed Implementation Plan (DIP):

- 2.1** Determine the extent to which CHD has built internal capacity to provide technical assistance to other stakeholders, i.e., CBOs, NGOs, government entities and/or private sector
- 2.2** Determine the extent to which CHD has provided technical assistance to other groups to build their capacity to provide health-related services to the community

2.3 Evaluate future plans and next steps for CHD beyond the end of the Matching Grant and give recommendations for refinement

3. EVALUATION QUESTIONS

The issues to be studied within the scope of this evaluation are outlined below:

Design & Relevance

- Did the project make sense in terms of the conditions, needs, or problems to which it was intended to respond? Were the hypotheses and assumptions underpinning the program model sound?
- Consistency with needs and priorities of targeted beneficiaries, based on a sound understanding of the local context.

Appropriateness/Efficiency

- Were the resources, capacities, and selected strategies sensible and sufficient to achieve intended results?
- Stakeholder satisfaction with and commitment to intended results and methods chosen to achieve them.
- Resources and services designed and delivered in a manner that effectively respond to conditions (including risks, needs, or problems) identified.
- The appropriateness of methodologies.

Impact

- Determine the major successes, challenges and constraints in achieving each output
- Did long term change take place in terms of improved policies and practice among government and other entities?
- The quality and impact of the program on beneficiaries.
- Assess the program's impact on strengthening the capacity of CHD to deliver services
- Discuss any unintended impacts to date – positive or negative

Documentation and Dissemination of Lessons Learned

- Were CHD's documentation efforts effective, timely and appropriate?
- Was CHD able to effectively identify and disseminate lessons learned at a local, national, regional and, if appropriate, international level?

Sustainability

- Are the Project's benefits (for CHD and for the stakeholders) likely to continue with the completion of project activities?
- Will the stakeholders be able to sustain the benefits, i.e., adequate institutional capacity (at CHD and at other stakeholder agencies) and on-going relevance to maintain benefits.
- What are the barriers or challenges to achieving sustainability?
- Potential for scale-up or replication

Partnerships

- Assess the effectiveness of CHD's approach to building in-country partnerships. Identify the key elements to success.
 - Identify local partners and cite changes in their institutional capacities that occurred as a result of the program partnerships; what key activities contributed positively in this regard?
 - Cite changes in CHD's institutional capacities as a result of learning from the partners.
 - Discuss the major determinants of building durable and productive partnerships
- Innovation and Creativity**
- Did the Project explore new ideas and approaches to achieve its results?
 - What new tools/guidance, approaches or program standards were developed under this program and what are their wider applicability?
 - Lessons learned from innovations recorded, reported and disseminated.
.Application of lessons learned from development experience.

Appropriate Human Resource Utilization

- Were suitable human resources involved and used well?
- Good match between project needs and knowledge, expertise, and personal skills of all participants.
- Adequate management of project personnel.

Informed and Timely Action

- Did project anticipate and respond to change based on adequate information, e.g., were mid-course changes in implementation made as a result of the MTE recommendations?
- Effective networks and processes to identify and assess important trends and events in project environment.
- Effective monitoring and reporting systems and appropriate and timely response to opportunities and problems.

Post-project Plans

- What is the strategic vision for CHD in the medium and long term after the EOP?
- What further capacities need to be built within CHD to fulfill its vision?
- What further linkages and partnerships are envisioned to be pursued for the future?
- Has CHD developed an adequate sustainability plan?

Financial Management

- Are adequate financial control systems in place?
- Is CHD and/or AKF leveraging additional resources (beyond the match)?

Monitoring and Evaluation System

- Does the M&E system supply accurate, reliable and timely performance data?

- Assess if the partner agencies have increased their capacity to monitor and evaluate their work, document program achievements and use data for decision-making and program advocacy.
- Assess quality and utility of any special studies undertaken to assess program impact.
- Assess partner and CHD's use of data to make management decisions.
- How can the M/E systems be improved?
- Verify data pertaining to a random sample of indicators.

Information Systems

- Has CHD increased in-country partners' access to information technologies?

Quality and Status of the DIP

- Discuss the quality of the DIP, i.e. the clarity and adequacy of the objectives, indicators, baseline studies and activities.
- Comment on the utility of the DIP as a management tool for CHD and for AKF, their partners and PVC.

4. METHODOLOGY

To enable the evaluation exercise to be as useful as possible, the evaluation experts will adopt a participatory approach in assessing progress and engaging stakeholders in the process of review and reflection. The evaluation will be based on:

- 4.1 A desk review of the relevant project documents, including the midterm evaluation report, annual reports and budgets and financial reports.
- 4.2 Interviews with AKF and CHD staff and representatives from stakeholder agencies including, NGOs, CBOs, private sector and district and provincial government.
- 4.3 Site visits in Kwale District, Mombasa and Kisumu to agencies with whom CHD has worked.
- 4.4 Focus group discussions with community groups and Dispensary Health Committees.
- 4.5 Tentative field schedule: (to begin July 25, 2003)
 - Meet with AKF(Kenya) in Nairobi and travel to Mombasa (1 day)
 - Overview of project and discussions with staff at CHD in Mombasa (1-2 days)
 - Site visits in Kwale District and other relevant locations in Coast Province (2 days)
 - Rest day and travel to Kisumu
 - Site visits in Kisumu (2 days)
 - Debrief with AKF(Kenya) and USAID/Nairobi if needed (1 day)
- 4.6 Additional time needed for international consultant to complete evaluation activities
 - Preparation time (1.5 days)
 - Report writing including revisions (5 days)

- Travel to Washington to discuss evaluation findings with PVC and AKF USA if needed (1.5 days)

5. EVALUATION TEAM AND ROLES

5.1 International Consultant: Ms. Cathy Fort will be the team leader as the international consultant. As such, she will be responsible for the following:

- Travel to Kenya and to project sites to carry out field assessment.
- Perform task outlined in Methodology in Section 4.0 above.
- Recommend changes as needed to the itinerary and activities in the field.
- Perform a preliminary debriefing on evaluation findings with the staff of CHD at the conclusion of the site visits.
- Produce a draft evaluation report for AKF USA's review within two weeks of completing field assessment.
- Be available to discuss evaluation results with CHD, AKF and PVC as needed.
- Finalize report within six weeks of completing field assessment.

5.2 Local Consultant: A high-caliber local consultant experienced in conducting health sector evaluations will be hired to join the evaluation team. This individual will be responsible for the following:

- Accompany team leader on all field activities.
- Provide expertise and local context as needed during the evaluation.
- Provide translation and interpretation services to the evaluation process as needed.
- Assist team leader in drafting evaluation report as requested.

Other participants:

CHD: Dr. Salim Sohani, Director of CHD, will be responsible for facilitating all logistics and meetings relevant for the evaluation. He will also accompany the team, or designate staff members to accompany the team, as appropriate to all site visits.

AKF USA: Ms. Supriya Madhavan, the Health Program Officer backstopping this MG project, will accompany the evaluation team for the field site visits. She will provide additional assistance with logistics as needed and be responsible for liaising with the consultant and CHD and DCHA/PVC staff in discussing and finalizing the evaluation report.

Annex E CHD Human Resource Development Plan

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
Project Driver 1	October 2002	Financial Management Course for DHCs	Basic concepts in financial management, financial data interpretations and analysis. By Aga Khan Health services in conjunction with the Plan international Kenya	<ul style="list-style-type: none"> · Increased knowledge and experience in governance of finance in the health centre point of view · Obtained knowledge on PR, and community concepts on finance interpretation 	<ul style="list-style-type: none"> · ICDL Part I & II to gain computer skills to work more efficiently
Project Driver 2	10 th April 2001	Automobile Association, Nairobi	Defensive Driving	How to avoid accidents	<ul style="list-style-type: none"> • Computer skills
	7 th August 2002	Automobile Association, Nairobi	Maintenance	Keep vehicle well to stay longer	
	11 th Sept 2002	Automobile Association, Nairobi	Fleet Management	Cut vehicle expenses.	
Accounts Assistant	May to July 2002 (evening classes)	International Computer Driving License-Part I	Microsoft Windows, Word, Information services & Basic Concepts in IT	I learnt better ways of using the computer effectively.	<ul style="list-style-type: none"> • ICDL part II • ACCA part I completion • A Course Report Writing - so as to gain skills in that area
	July to November 2002 (evening classes)	ACCA part I	Preparing Financial Statements, Managing People & Financial Information for Management	Better understanding of preparing financial statements and how to manage people at the work place	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
Field Officer	February 18-22, 2002	<u>Managing Dispensary</u> Facilitated by Community Health Dept, AKHSK	Course was aimed at giving an orientation to the key features of the Dispensary Model.	Training helped in giving me a deeper insight on the management model and to strengthen my capacity as trainer for the model. After the training, I am in a better position to connect project objectives with what is happening on the ground during field supervision.	<ul style="list-style-type: none"> • Pursue Masters Degree in Public Health
	May 28-30, 2002	Main Areas of Concentration are on Family Health, Reproductive Health and Child Survival. AMKENI Project (a project of Engender Health)	Course was aimed at strengthening facilitation skills.	Bulk of my work involves facilitation at different levels i.e. in community meetings as well as training. As result of this training. <ul style="list-style-type: none"> ▪ My facilitation skills have improved in particular; there is diversity in training methodology. ▪ I am in better position to understand factors that inhibit learning. ▪ Training has also helped me learn how certain controversial issues can be articulated with relative ease. i.e. Family Planning 	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	July 1-19, 2002	Health Systems Research and Management By Aga Khan University, Karachi	The course was aimed at strengthening the professional expertise and organizational /Managerial skills in Health Systems Research and Management.	The course has enabled me <ul style="list-style-type: none"> ▪ Acquire skills in health systems management; this was an opportunity for me to appreciate role of management in health. ▪ I am now able to use skills such as quantitative techniques in operations research, which I use in my work. ▪ I have gained appreciation of how health policy directly affects community. 	
Information Assistant 1	28-30th May 2002	Facilitation skills training for Field Agents	Facilitation skills for field based gents <ul style="list-style-type: none"> • Facilitation skills • Qualities of a good facilitator • Good facilitation skills 	<ul style="list-style-type: none"> • Able to facilitate better 	<ul style="list-style-type: none"> • Pursue Masters Degree in Public Health
	April to July 2002	International Computer Driving License-Part I	Microsoft Windows, Word, Information services & Basic Concepts in IT	<ul style="list-style-type: none"> • Competence in computer applications (Word processing, spreadsheets and Access) • Timely preparation of reports 	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	1 st -30 th August 2002	Epidemiology, Biostatistics & Surveillance	Research Skills (Quantitative & Qualitative), Incidence & Prevalence, Sampling Methods, Descriptive and Analytical Epidemiology, Inference Statistics, p-value, chi-square tests etc	<ul style="list-style-type: none"> • Ability to write reports better • Ability to conduct research • Ability to interpret, analyze data and write scientific reports. • Critique scientific papers 	
	30 th June-11 th July 2003	Introduction to Project Design, Data Management & Report Writing	Research Skills, Planning Cycle, Log Frame Analysis (LFA), Research & Project Proposals and Report Writing	<ul style="list-style-type: none"> • Conversant with principles and application of LFA • Gained skills in Report Writing • Gained knowledge and skills in writing Research & Project Proposals 	
Information Assistant 2	30 th June-11 th July, 2003	DMC Facilitated by Community Health Dept, AKHSK AKU & Adelaide university	Course Was aimed at giving skills in data management, report writing & analysis.	Training helped in giving me a deeper insight in data management, report writing & analysis to strengthen my capacity in managing data.	Pursue Diploma in Computer Science

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	May 28-30 , 2002	World space technology Facilitated by World space Foundation & AfriAfya	Course was aimed at strengthening the capacity of maintaining managing world space digital receiver and it accessories. And the procedures of downloading ICT information.	My work involves facilitating ICT training in the community. Training the community on the use of ICT. For the community to have the knowledge of downloading information by themselves without assistance. Training also helped me learn how certain high education is not a limitation to knowing computer skills.	
	July 1-19, 2002	Communication and Documentation Exchange UK & AfriAfya	The course was aimed at giving good communication & documentation skills	The course has enabled me Acquire skills in documentation & communication and its roles.	
MIS Specialist	November 20 – December 1, 2000 Ten day course	Project Design, Research, Data Management & Analysis, And Report Writing	Project Development Using Logical Framework Analysis, Quantitative Methods of Research, Qualitative & Participatory Action Research, Protocol, Proposal and Report Writing Data Management & Analysis, and Basics of Epi Info Statistical Package. Facilitated by the Community Health Sciences Department, The Aga Khan University, Karachi, Pakistan and Aga Khan Health Services Mombasa	Improved in project development using an Logical Framework Analysis and Qualitative & Participatory Action Research	Masters in Public Health or PhD.
	20th – 22 nd September, 2000	Seventh Scientific Conference	Presented a paper “ Involving Community in Malaria Control and Management”	Generally was informed on different research topics and findings, Learnt different methods of research and areas of application, different ways of information presentation, and on going research in other AKDN organizations	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	11 th – 14 th June 2001 - 4days	Regional Uni-Sol Congress	Re-sourcing Public Health - The Role of University in coalition with the Civil Society in improving the health for disadvantaged Communities	Exposure in the presentation of papers & Networking with other local & international organization.	
	Aug- Sept 2000 One month Course	Management for District Health Systems	Community diagnosis, needs assessment, project planning, Management of resources at district level including Human resource development, Communication, Budgeting and financing, monitoring and evaluation by DSE -Berlin	Management of District Systems, Health In Community diagnosis, needs assessment, project planning, Management of resources at district level including Human resource development, Communication, Budgeting and financing, monitoring and evaluation	
	25 th April - 12 th may 2000. Three week course	Community Based social Development	Essential concepts in Social Development, Self awareness and social change and participatory methodology by Aga Khan University and Aga Khan Health Service Kenya	In Participatory methodologies, Community interaction without prejudice i.e. Social Development, Self awareness and social change	
	August 2002	Monitoring and Evaluation from Makerere University & Measure Evaluation	M&E techniques in HIV/AIDS/STI, maternal health, reproductive health, and child health and nutrition. Core elements of the course include: <ul style="list-style-type: none"> • Program design frameworks • Indicator and data source selection • Impact evaluation study design • Health Management Information Systems • Qualitative research method 	Networking and improved in <ul style="list-style-type: none"> • Program design frameworks • Indicator and data source selection • Impact evaluation study design • Health Management Information Systems • Qualitative research methods 	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	2001 Sept & February 2002	ICDL (International Computer Driving License) Course with IAT	Use PC & manage files, Microsoft Word 97, Information & Communication, Basic Concepts of IT, Microsoft Excel 97, Microsoft Access 97 & Microsoft Power Point 97.	Updated my computer skills and improve performance.	
	July 1-19, 2002	Communication and Documentation Exchange UK & AfriAfya	The course was aimed at giving good communication & documentation skills	I acquire skills in documentation & communication using various methods.	
	June 27 th 2003	Developing local content Exchange UK & AfriAfya	How to develop local content material for communication	Improved my focus on documenting and communicating local messages for the rural communities using various channels including the internet.	
Financial Management Specialist	25 th April - 12 th May 2000. Three Week Course	Community Based Social Development	Essential Concepts in Social Development, Self Awareness, Gender and Participatory Rural Appraisal by Aga Khan University Karachi & Aga Khan Health Service Kenya	Assisted in the interaction with the community especially in the communication skills. Gained knowledge on Gender and PRA methods especially in assessing the community needs	Masters in Financial Management
	20 th - 22 nd September 2000 - 3 days	Seventh Scientific Conference	Presentation of Papers related to Health by Aga Khan Hospital Nairobi	Exposure in the presentation of papers & writing of papers as well as being informed on new health research & technologies.	
	11 th – 14 th June 2001 - 4days	Regional Uni-Sol Congress	Re-sourcing Public Health - The Role of University in coalition with the Civil Society in improving the health for disadvantaged Communities	Exposure in the presentation of papers & Networking with other local & international organization.	

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
	16 th - 20 th July 2001 - 5days	Improving Quality of Care: Foundations in Economic Evaluation in Uganda (By Regional Centre For Quality Health Care Makerere University & Population Council)	Financial Management & Economic Evaluation	The course was very relevant since it entails areas of financial mgt. in terms of monitoring of budgets as well as economic evaluation in terms of cost-effective analysis.	
	19 th - 30 th November 2001 - 10 days	Project Design, Research, Data Management & Analysis & Report Writing	Project Development using Logical Framework Analysis. Quantitative Methods of Research, Proposal & Report Writing & Basics of Epi Info Statistical Package	It enlightened me in the project development using LFA, quantitative research and basic knowledge on Epi Info Statistical budget.	
	2001 Sept & February 2002	ICDL (International Computer Driving License) Course with IAT	Use PC & manage files, Microsoft Word 97, Information & Communication, Basic Concepts of IT, Microsoft Excel 97, Microsoft Access 97 & Microsoft Power Point 97.	It improved my computer skills and also my work performance in terms of use of Computers	
	July 1 – 19 th 2002	Health Systems Research & Management (By Aga Khan University, Pakistan)	Team Building, Principle centered leadership, Principles of Health Care Planning, Program Management, Management Information systems, Health Systems Research, Financial Management, Total Quality Management & Institutional Management	Improved team work skills and strengthening knowledge on health care, management information systems, TQM, health research and Program Management	
Project Secretary		1. Upper Course in Secretarial 2. Basic Accounting 3. Advance Office administration	1. Secretarial 2. Accounting 3. Advance Office administration	Made me more efficient and effective in my secretarial and administrative work	Management course

Name and designation	Date	Course/Conference	Course/ Conference Content	Self Impact/Improvement	Courses Desired in future
Community Health Nurse	8 th April 2003 To 19 th April 2003	I.M.C.I	Childhood illness To classify and treat childhood illness Follow-up Counseling of the mother Referrals Drugs for treating childhood illness.	Has improved my capacity to manage a sick child effectively Timely referral of a sick child Improve the management of a child in the dispensaries	Professional Counseling on H.I.V / AIDS Reproductive Health better practices Quality Health Care
	Nov 2002	Filariasis Awareness workshop	The definition Cause – Agent The life cycle Signs and symptoms Incubation period Management / treatment Public awareness	Has improved my social mobilization to the public about the disease. Has updated me on the treatment of filariasis	
	May 2003	Guidelines for orphan made vulnerable by H.I.V AIDS	Writing the guidelines	Has improved my ability to contribute at a national conference	
	May 2002	ICDL- Part One Computer Course	Microsoft Windows Microsoft Word Information / Communication Basic concepts	I learnt how to use and operate a computer more on word processing	

Annex F Description of CHD Training Courses

1. TRAINING OF TRAINER (TOT) COURSE

The 3 weeks course of Training of Trainers creates a situation where people with different backgrounds can come together and learn to work as a team, both for sensitizing and mobilizing communities and for training CHWs. The training process allows trainers to develop the right attitude to community work and for them to go through a process of self-discovery. The course includes adequate theoretical training and community work to ensure the necessary skills, attitudes and knowledge to fulfill the demands of the role outlined previously. At the end of the training the trainer must have developed social-process skills as well as specific training ability and the technical competence required to manage the priority problems in the community. This requires well selected learning situations, group work, consistent encouragement and reinforcement and feedback on areas needing more effort, as well as use of relevant teaching/learning materials.

In the training process, a balance should be struck between emphasis on imparting and developing social-process and communication skills, training ability, and technical knowledge and skills. The first two are bases, take longer to develop and are more difficult to ensure, but the technical know-how is also needed according to the demands of the community.

Training methodology

The course is learner-centered, participatory and incorporates field visits, case studies, group work assignment, plenary discussions, brainstorming sessions and individual assignments. This allows the participants to develop a self-drive that propagates them to make rational decisions in relation to their work context.

Target group

This course is designed for field officers and health professionals in government as well as non-governmental organizations, community based organizations and MoH extension workers.

2. TRAINING OF FACILITATORS (TOF) COURSE

This is a 21-days course and is one level higher than the TOT. It prepares those who have already received TOT training. Its main emphasis is on the facilitation skills. The aims and objectives of Training of facilitators (TOF) is to produce skilful, enthusiastic, self motivated facilitators of TOT workshops who are also able to give constructive follow up support and continuing learning reflection for trainers at the village level.

TOF are resource people who can facilitate learning of specific topics and issues and introduce new health concepts to the community.

Training Methodology

Training is participatory involving inductive learning, which mainly applies in adult learning. This method provides the trainees with basic facilitation skills that are appropriate in adult training and are applicable at the community level. These methods include Role Plays, case Studies, Proverbs and real life situations.

Target Group

This course is designed for field officers and health professionals in government as well as non-governmental organizations, community based organizations and MoH extension workers who

have already received training of trainers and are interested in developing human resources at the community level.

3. HEALTH MANAGEMENT INFORMATION

This is 1 week training with an overall objective to introduce the importance of information and its utilization. It is expected that at the end of the training, all the participants will be clear on reporting mechanism (forward and feedback), roles and responsibilities at each level, reporting periods, detailed information collected and how to use a particular information. This information should be used in planning and making informed decisions at all levels.

Training Methodology

Training is participatory involving Group work and presentations, plenary discussions, illustrations, practical in filing formats, exercises and field visits.

Target Group

This course is designed for Community based organizations, Extension workers of MoH and other NGOs.

4. FINANCIAL MANAGEMENT

This is 1 week training on financial management mainly aiming to equip the trainees with the basic knowledge of book keeping, maintaining financial records and making budgets. It also helps participants to appreciate on how to manage resources including supplies in a transparent way. Session on financial information prepares the trainee on maintaining the records that can be shared with the wider community or any one who intends to audit it. This will enable them to maintain proper records and manage their finances effectively.

Training Methodology

Training is participatory involving Group work and presentations, plenary discussions, Questions and answers and field visits.

Target Group

This course is designed for Community based organizations, Extension workers of MoH and other NGOs.

5. ORGANIZATIONAL DEVELOPMENT (OD) COURSE

This is a 1-week course prepared by CHD and offered to CBOs and NGOs. This course is provided to assist the NGOs and CBOs identify the gaps and problems that they have been experiencing in their implementation of activities. This is aimed at developing participants' knowledge and skills on Programme Planning and Management, clarifying vision and mission, setting goals and objectives, making a monitoring plan and improving communication within organization.

Training Methodology

Training is participatory involving psycho socio method of discussions, Questions and answers, group work and role plays.

Target Group

This course is designed for community leaders, leaders of CBOs, Dispensary Committee Chairmen, dispensary nurses, and members of DHMTs.

6. INFECTION CONTROL COURSE

Infection control is a 1-week course prepared and offered by CHD to health care providers and community health workers in order to control the spread of skin infections caused by exfoliative Staphylococcus Aureus, new skin infections caused by Staphylococcus Scalded Skin Syndrome (the SSSS condition). The course prepares community health care workers to be able to control food and water poisoning caused by toxigenic E. coli. Other objectives of the course include education on current nutrition problems in Kenya and improvement of well being of the sick by use of immune system boosters. This course is prepared in partnership with KEMRI who provides clinical back up.

Training Methodology

Training is participatory and includes discussions, teaching and demonstration of preparations.

Target Group

This course is designed for trained health workers, practitioners, Community Health Promoters, care givers and MoH extension workers.

7. DISPENSARY MANAGEMENT COURSE

This is a three-week course aimed at equipping the Dispensary Health Committee (DHC) members with the necessary knowledge, skills and values in good leadership and conflict management, financial management, and management of health information. The objective of the course is to see that the participants are able to:

- Demonstrate understanding in facilitation of good leadership, effective communication and conflict resolution and management.
- Acquire knowledge and skills in preparing financial records and managing dispensary finances.
- Demonstrate understanding in collecting, analyzing, interpreting and using information about the health status of the communities within the dispensary catchment area.
- Coordinate various health activities within the dispensary and its catchment.

Training Methodology

The training methodology used is participatory and interactive facilitation in plenary. Several short exercises are carried out as a group. Role plays are used to highlight the issues faced in managing dispensary. The field work includes visit to a dispensary providing opportunity to interact with the community members to learn from using real life scenario.

Target Group

This course is open for DHC, Village health committee (VHC), Dispensary health workers, DHMT members and NGO project staff that deal with Health systems strengthening.

8. INTRODUCTION TO PROJECT DESIGN, PLANNING, RESEARCH, DATA MANAGEMENT AND ANALYSIS & REPORT WRITING (DMC) COURSE

This is a 10-day course offered by CHD in partnership with the Aga Khan University. The course aims at strengthening the participants' capacity and skills in project design and planning, research (data collection), data management and report writing. The specific course objectives include strengthening the capacity among the participants for developmental work, develop skills to identify and analyze a problem using systematic approach and determine appropriate problem solving strategy. The course also introduces writing proposal using the same approach.

Training Methodology

Training is participatory and includes lecture in plenary and demonstrations in small groups, Questions and answers, Group exercises and presentations, Computer lab for practical and field visit.

Target Group

The course targets project managers, middle level managers, Monitoring & Evaluation officers, DHMT staff, project staff involved in data management in health and development sectors.

9. COMMUNITY BASED SOCIAL DEVELOPMENT

Community Based Social Development Course is designed to explore the interrelationships between self awareness, leadership skills, effective communication strategies, community mobilization, and health and social development. This training course is aimed to provide an understanding of the social determinants of health and development and the importance of participatory methods in community mobilization and empowerment. The course is composed of three elements, and their relationship constitutes the quintessence of the course. Remove one element of the course, and its purpose will be compromised. The purpose of the course is to develop in the course participants an integration of knowledge, self awareness, and skills. The three together prepare the participants to strive for people-centered social development.

Training Methodology

The course provides an interface between experiential learning and use of critical thinking. Participants are accustomed to making their own decisions about events which affect them. The facilitators will obtain participants input by conducting needs assessments, asking participants to articulate their learning expectations, or by disseminating predetermined goals enabling potential participants to decide whether the course will meet their needs. The facilitators provides learning activities which require participants to be involved actively, instead of passively, in the learning process. Participatory tools for reflection, case-studies for analysis, simulation-games and exercises will be used. Participants are required to verbalize; as well as write out their feelings, thoughts and analysis. Other methods of learning that is used includes small and large group discussions and presentations, video presentations and field visits. At the end of the course, each participant will be expected to give a presentation on a project that they would undertake in their respective programs.

Target Group

This training is most suited for the field staff of NGOs that deals with the community, Extension workers, CBOs and DHMT staff who are expected to interact with the community members.

10. COMMUNITY OWN RESOURCE PERSONS (CORPS)/CHWs TRAINING

The CORPS/ CHWs training is given to groups of people in health service delivery who are usually selected from the community. These are mainly community members who have been through formal school and are able to read and write. The aim of training these people is to equip the learners with desired knowledge, skills and attitudes so that they can educate the community on their common health problems and how to prevent them. The CORPS/CHWs are trained and sent back to the community with the intention that they will stimulate demand for health service through education of the community members. Before the CORPS/CHWs are called for training, there is normally a vigorous selection of those trained in order to get the suitable candidates for the job. This is a participatory process to ensure that the community prepare and own the criteria for selection of the CORPS/CHWs and in turn thoroughly explain to participants on the requirements of the CORPS/CHWs.

Training methodology

The course is learner-centered, participatory and incorporate case studies, group work assignment, plenary discussions, brainstorming sessions and individual assignments. This allows the participants to develop a self-drive that propagate them to make rational decisions in relation to their work context.

Target group

This course is designed for community based health workers.

Annex G Final Evaluation Schedule and Sites Visited

July 25th	Friday		
Time	Activity	Participants	Remark
	Arrival to Kenya		
2.00 – 05.30	Meeting with AKF	AN, AN, SH, SS, evaluators	AKF's office at ICEA building, Nairobi
Late evening	Flight to Mombasa	Asifa, Supriya, evaluators	Asifa to coordinate logistics

Field Work CHD team to coordinate (contact person at CHD is Teresa Saliku)

July 26th	Saturday		
Time	Activity	Participants	Remark
8.30	Pick up from Hotel	Boniface	CHD driver
9.00	Welcome at CHD office (Mombasa) Introduction to the CHD team Agreeing on the agenda and schedules	Full CHD team and AN in attendance	
9.40 – 10.30	Presentation by CHD	SS, TS	CHD team & AN to join in
10.30	Coffee break – posters on CHD's work		
10.45 – 12.30	Presentation, clarification and discussion	Evaluators	
12.30 – 1.30	Lunch	MN, ZD of AKH-M joins for lunch	
1.30 – 3.30	Discussion with CHD team, review of the documents	CHD team and Evaluators	
3.30	Coffee break		
3.45- 05.00	Discussion continues	CHD team and Evaluators	

July 27th	Sunday		
Time	Activity	Participants	Remark
9.30	Pick up from Hotel	Musa	
10.00 – 12.30	Discussion with CHD team	SS, TS, JK, MS, SMS AN, SH, Evaluators	
12.30 – 1.30	Lunch		
1.30 – 3.30	Discussion with CHD team, review of the documents	Evaluators and CHD team	
3.30	Coffee break		
3.45- 05.00	Discussion continues		Evaluation team to decide if they want to take off to review the CHD documents

July 28th	Monday		
Time	Activity	Participants	Remark
8.00	Pick up from Hotel		Boniface/Musa
8.40	CHD office (Mombasa)		

9.00 – 12.45	Meeting DMO, Kwale and PMO, Coast	DMO, DHMT, PMO, Evaluators	MoH, to review the partnership, capacity building work, HMIS
1.00 – 2.30	Travel to Mtaa (packed Lunch on the way at Shimba hills)		
2.30 – 4.30	Mtaa dispensary	DHC, Nurse, Evaluators	To review the capacity building work at the community dispensary, Meet DHC ¹¹ , VHC members, review the innovative ICT project
4.30 – 6.00	Travel back to Mombassa to Hotel		

July 29th			
Time	Activity	Participants	Remark
8.00	Pick up from Hotel		Boniface/Musa
8.40	CHD office (Mombasa)		
8.50 – 11.00	Field visit to the community groups at Mazeras	DHC, Nurse, evaluators	A success story
11.00 – 11.30	Travel to Kafuduni		
11.30 – 1.30	Meeting Dispensary committee, community members at Kafuduni	DHC, Nurse, evaluators	Site with challenges: Visit a Dispensary grappling with Challenges. Factors leading to difficulty, CHD addressing constraints in development
1.30 – 2.30	Travel to Magomboni in Kilifi		To review the capacity building work at the community dispensary, Meet DHC ¹² , VHC members, review the innovative ICT project
2.30-4.30	Meeting Dispensary committee, community members at Magomboni		A site where CHD has provided Technical assistance to an NGO for strengthening Health systems
4.30 – 6.00	Travel back to Mombassa to Hotel		

July 30th			
Time	Activity	Participants	Remark
8.00	Pick up from Hotel	Boniface/Musa	
8.30 – 11.00	Sun and Sand	Nurse, management, Evaluators	A private sector received the TA from CHD in starting community Health Intervention
11.00 – 1.00	PLAN International (Mombasa)	Dr. Tsuma and his team, evaluators	Meeting with Dr. Tsuma of PLAN – received the TA from CHD on strengthening MIS and FM and to replicate Dispensary model

¹¹ **DHC:** Dispensary Health committee; **VHC:** Village Health Committee; **ICT:** Information communication Technology; **HMIS:** Health Information System; **DMO:** District Medical Officer; **MoH:** Ministry of Health

¹² **DHC:** Dispensary Health committee; **VHC:** Village Health Committee; **ICT:** Information communication Technology; **HMIS:** Health Information System; **DMO:** District Medical Officer; **MoH:** Ministry of Health

			PLAN staff had also participated in CHD's short trainings
1.00-2.00	Lunch (CHD office)	Lunch meeting with George Kagwa of AMKENI and Christine of Kwale stakeholder forum	Meeting with George Kagwa of AMKENI received the TA from CHD in Kilifi CHD is founding member of Kwale stakeholder forum including all the players in Health in Kwale district – recipient of OD support from CHD
2.00 – 4.30	Free time –		
4.30– 5.00	Debriefing to mombasa Team	Evaluators and CHD team	
Evening Flight 6.30	Nairobi Over night stay -	Evaluators, SH,AN, SS	Asifa to coordinate, hotel reservation - Stanley
8.15 -	Dinner meeting with AfriAfya (members are AMREF, World Vision, CARE, Christian Health Association, MoH, CHD-AKHS,K and SatelLife	Caroline Nyamai, Dr. Wood, Evaluators	CHD is the founding member of this group which is a national level Health NGO consortium Suggested venue is Stanley

July 31			
Time	Activity	Participants	Remark
Early morning	Flight to Kisumu,	Evaluators, SH, AN, SS	Asifa to coordinate
8.30	Arrival in Kisumu		JK to organize pick up
9.00 – 0930	Curtsey call AK Hospital CEO	CEO, AN, SH, evaluators	
0930- 10.00	Discussion with Jesca	Evaluators, JK, SH, AN, SS	Kisumu office
10.00 – 12.30	Pandipieri community Health Program	Sr. Bernadts, Evaluators	CBO recipient of CHDs assistance
12.30 – 1.30	Lunch		
1.30 – 5.00	Kajulu	Evaluators, SH, AN, SS	CBO recipient of CHDs support
Evening flight	Back to Nairobi		Asifa to coordinate, hotel reservation - Stanley

August 1			
Time	Activity	Participants	Remark
8.00 – 9.00	USAID	Evaluators, SH, AN, SS	USAID will nominate officer
09.00- 0945	Travel to MoH		
10.00 – 110	MoH head quarter	Ogara evaluators, SH,AN, SS	Meeting with Dr. Ogara, Head of HMIS at MoH
110 – 11.30	Tsavo Power	Michael Fox,	Private sector group that provided

		CEO	finances for CHD activity and is recipient of CHDs Technical support for health promotional activities in Kwale, Mombassa
11.00 – 12.00	AKHS,K board	Evaluators, AKHS,K	Chair, Regional CEO and or member of AKHS,K board – CHD within AKHS,K
12.00 – 12.30	Lunch		
Afternoon	Preparing for debriefing		

August 2			
Time	Activity	Participants	Remark
9.30 – 12.00	Debriefing	Evaluators, AN,SH, AN, SS, USAID, AKHS	

Participatns:

AN : Arif Neki
AM : Aaron Mulaki, Field Officer, CHD
AN : Asifa Nurani, AKF,EA
BHC : Boni Hroun Chamtu, messenger , CHD
BM : Boniface Mutua , Driver, CHD
CX : Charles Xavier, Info. Assistant, CHD
FA : Felix Agoi, Data entry Clerk, CHD
JK : Jesca Kola, Community Trainer, CHD
LF : Lynne Fanjo, Account Assistant, CHD
JM : James Mutuku, Community Nurse, CHD
MS : Marystella Barasa, MIS specialist, CHD
MJ : Musa Juma, Driver CHD
MN : Mahmood Nurany, Aga Khan Hospital, Mombasa
NM : Noor Ali momin, CEO Aga Khan Hospital, Kisumu
SB : Stephen Batt, Regional CEO of AKHS in East Africa
SM : Supriya Hasnain, AKF USA
SMS : Swafiya M. Salim, Financial Magt. Specialist, CHD
SS : Salim Sohani, Director CHD
TS : Teresa Saliku, Project coordinator, CHD
ZD : Zubeda Dadani, Aga Khan Hospital, Mombasa

Annex H List of Groups, Organizations and Persons Interviewed

Community Health Department (Mombasa)

Dr. Salim Sohani, Director
Swafiya M. Salim, Financial Management Specialist
Marystella Barasa, MIS Specialist
Teresa Saliku, Project Coordinator
Jesca Kola, Community Trainer (based in Kisumu)
James Mutuku, Community Nurse
Aaron Mulaki, Field Officer
Charles Xavier Ombwa, Information Assistant
Agnes Makomere, Secretary
Felix Agoi, Data Entry Clerk
Lynne Fanjo, Account Assistant
Musa Juma, Driver
Boniface Mutua, Driver
Buni Haron Chamutu, Office Messenger
Justine Ochieng, Young Development Professional (based in Kisumu)

Aga Khan Health Services, East Africa (Nairobi)

Stephen Batt, Chief Executive Officer

Aga Khan Foundation, East Africa (Nairobi)

Arif Neky, Regional Chief Executive Officer
Asifa Nurani, Regional Director

Aga Khan Health Services, Kenya (Nairobi)

Azim Virjee, Chairman, Board of Directors
Shahinoor M. Visram, Chairman, Community Health Committee & Member, Board of Directors

Aga Khan Health Services – Mombasa

Zubeda Dadani, Aga Khan Hospital, Mombasa
Mahmood Nurany, Aga Khan Hospital, Mombasa

Aga Khan Health Services – Kisumu

Noorali Momin, CEO Aga Khan Hospital, Kisumu

Aga Khan Foundation, Kenya (Nairobi)

Noreen, Kassam, Chairman, Board of Directors

Aga Khan Foundation (based in Geneva, Switzerland)

John Tomaro, Programme Director, Health

USAID/DCHA/PVC

Karen Nelson
Regine Douthard

USAID/Nairobi

Sheila Macharia, Office of Population and Health
Bedan Gichanga, Office of Population and Health

Ministry of Health

Dr. S.K. Sharif, Provincial Medical Officer, Coast Province
Dr. Philip Muthoka, District Medical Officer, Kwale District
David C. Baya, District Health Education Officer, Kwale District
Gilbert Nzumo, District Health Information Officer, Kwale District
Esther Ogara, Head, Health Management Information Systems Division, Nairobi
Booker Olmoch, HMIS Division, Nairobi
Abdullahai K. Gobanae, HMIS Division, Nairobi
Francis Gukunda, Health Records Officer, Nairobi

AMKENI Project (Nairobi)

Feddis K. Mumba, Area Manager, Coast Province
George Kaggwa, Behavior Change and Communications

Plan International (Mombasa)

Ruth Momanyi, Provincial Health Advisor
Winnie Mjambili, Project Coordinator for Child Survival

Tsavo Power Company (Nairobi)

Michael R. Fox, Chief Executive Officer

Sun N Sand Hotel (Mombasa)

Mahmud Visram, Hotel Owner
Fredrick Andimilleh Makumbi, General Manager
Kiema Paul, Dispensary Nurse
Jasmine George, Dispensary Administrator

AfrifAfya (Nairobi)

Dr. Christopher Wood
Stephanie Nduba, International Training Coordinator (African Medical and Research Foundation Representative)

Kwale Health Forum (Mombasa)

Christine Ndegwa

Kajulu Community-Based Organization (Kisumu)

Samson Okumu, Chairman
Rafael Omolo, Secretary
Joseph Chiaga, Disaster Chairman
Paul Ogalo, Board member
Wilson Ogundu, Board member
Lois Amotht, Board member
Judith N'Getich, Dispensary Nurse

Pandipieri Community-Based Organization (Kisumu)

Sister Bernadette Nealon, Program Coordinator
Jim Adede, Program Manager
Sylvanie Opiyo Angir, Administrator

Mtaa Dispensary (Kwale District)

Peter Mwero, Chairman, DHC

Dick Ndegwa, DHC member
Clement Nyamawi, DHC member
Masudi Chaka, DHC member
Mwijo Mwasuka, DHC member
Jonathan Kombe, DHC member
Riziki Kombo, DHC member
Mwanakombo Mangale, DHC member
Mdata Kulemba, DHC member
Nyondo Makanga, DHC member
Francis Beuchi, DHC member
Ngoro Nyawa, DHC member
Zawadi Nyae, DHC member
Nyamvula Kombo, DHC member
Moses Kamau, Dispensary Nurse

Mazeras Dispensary (Kwale District)

Elvis Kazungu, Chairman, DHC
Esther Kombo, Vice Chair, DHC
Francis Kenyatta, Secretary, DHC
Ali Kobo, Vice Secretary, DHC
Julius Katuna, Treasurer, DHC
Yusuf Nev, DHC member
Sarah Nixon, DHC member
Sophie Lipula, DHC member
Samson Katana, DHC member
Charles Mlole, DHC member
Mambo Tungwa, DHC member
Tabu Magongo, DHC member

Kafuduni Dispensary (Kwale District)

Joseph Chikonde, Chairman, DHC member
Abdalla Mbundya, Vice Chair, DHC
Ramadhan Kaingo, DHC member
Christine Hassan, Treasurer, DHC
Stephen Oka, Secretary and Dispensary Nurse
Anthony Lukuni, DHC member
Hamida Jumaa, DHC member
Japhet Mwero, DHC member
Edward Kunbi, DHC member
James Nyana, DHC member
Rose Nwambire, DHC member
Harris Nyandu, DHC member
Mgandi Ndurya, DHC member
Mwana Hanis Stanly, DHC member

Magomboni Dispensary (Kilifi District)

Winstone Mgute, Chairman, DHC
Winnie Mwatete, Vice Chair, DHC
Cecelia Ngoro, Secretary and Dispensary Nurse
Neilly Mwasuga, Vice Secretary, DHC
Johnathan Ndarawe, Treasurer

Mary Ndarawe, DHC member
Johnathan Tsuma, DHC member
Margaret Sanga, DHC member
Dorris Kalenga, DHC member
Robert Ndatani, DHC member
Dickson Tsuma, DHC member
Mbuche Johana, DHC member
Shadrack Daye, DHC member
Janet Mkanzi, DHC member

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