



Partnership for Maternal and Neonatal Health - West Pokot District Child Survival and Health Program

West Pokot District - Kenya
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LIST OF ACRONYMS

AMTSL – Active Management of Third Stage of Labor
CHEW – Community Health Extension Worker
CHW – Community Health Worker
CBHIS – Community Based Health Information System
CBO – Community Based Organization
CORPs – Community’s Own Resource Persons
CSH – Child Survival and Health
CSHGP – Child Survival and Health Grants Program
DOW – Doctors of the World
DASCO – District Aids and STI (Sexually Transmitted Infections) Coordinator
DHMT – District Health Management Team
DHRIO – District Health Records and Information Officer
DHIS – District Health Information System
DIP – Detailed Implementation Plan
DPHN – District Public Health Nurse
DRHF – District Public Health Forms
DRHTST – District Reproductive Health Training and Supervision Team
ELCK - Evangelical Lutheran Church of Kenya
EmONC – Emergency Obstetric and Newborn Care
FANC – Focused Anti-Natal Care
HENNET – HEalth Ngo NETwork
HFA – Health Facility Assessment
IPT – Intermittent Preventative Treatment (against malaria)
ITN – Insecticide Treated Nets
KPC – Knowledge, Practice and Coverage
M&E – Monitoring and Evaluation
MNC – Maternal and Newborn Care
MNHC – Maternal and Newborn Healthcare
MOH – Ministry of Health
MOU – Memorandum of Understanding
PHMT – Provincial Health Management Team
PMO – Provincial Medical Officer
PAC – Post-Abortion Care
PRHTST - Provincial Reproductive Health Training and Supervision Team
QIC – Quality Improvement Committee
QI/QA – Quality Improvement/Quality Assurance
SBC –Social and Behavior Change
USAID – US Agency for International Development
TAG – Technical Advisory Group
TBA – Traditional Birth Attendant
TRM – Technical Reference Material
TT – Tetnus Toxoid
WHIVP – Wharton Health International Volunteers Program

A. MAIN ACCOMPLISHMENTS

a. General

Doctors of the World-USA (DOW) completed a series of baseline assessments and information gathering activities as the first activities of its Partnership for Maternal and Neonatal Health in the West Pokot District (hereafter referred to as “the project” or “the CSH project”). A Knowledge, Practices, and Coverage (KPC) survey was conducted with mothers of children 23 months old and younger. Kenyan consultants were retained to lead the KPC process, and local surveyors were trained to conduct the survey. This was followed by a comprehensive Health Facility Assessment that was conducted focusing on availability, utilization and quality of Emergency Obstetric and Newborn Care (EmONC) at the nine target health facilities. Consultants from Columbia University’s Averting Maternal Death and Disability (AMDD) program assisted in implementing the HFAs, particularly adapting tools to the Kenyan context. In addition, focus groups were conducted with mothers, traditional birth attendants (TBAs), and Health Facility Providers. A summary and analysis of all results were shared in the Detailed Implementation Plan (DIP). DOW’s baseline assessments marked the first time most of these qualitative and quantitative data were ever gathered and analyzed for the program location.

In March 2007, DOW shared the results of the KPC survey, as well as the original draft of the DIP, at a meeting of stakeholders in Kapenguria. These included representatives of the District Health Management Team (DHMT), Provincial Health Management Team (PHMT), Provincial Administration (Chiefs, Divisional Officers), local community-based organizations (CBOs), and faith-based organizations (Evangelical Lutheran Church of Kenya, Ortum Mission Hospital). The presentations led to a lively discussion during which stakeholders openly shared their thoughts on their role and what they may be able to do to improve the state of maternal and child health in West Pokot.

The original DIP was submitted to USAID on April 16, 2007. USAID and external reviewers provided feedback to DOW in writing and at the Child Survival and Health Grants Program (CSHGP) Mini-University. DOW revised the DIP based on these comments. DOW also requested and received approval for the new Project Director, Eunice Okoth, who was hired after the untimely departure of the first Director, Owade Manases. Ms. Okoth and DOW HQ staff also hired the M&E Coordinator, Thomas Onkieki.

In April 2007, the West Pokot District was divided into the Districts of North and West Pokot. Two of the facilities targeted by this project fall in the new North Pokot District. As the DHMT for North Pokot has been staffed up, DOW staff have been in touch with this team, and have signed a Memorandum of Understanding (MOU) to guide activities undertaken through this project. In this report, the North and West Pokot Districts will, on occasion, be referred to as the Greater Pokot Area. The focus facilities for the CSH project, as well as the five divisions that comprise the program location, remain the same.

In July 2007, the final revised DIP was submitted to USAID and approved, with information requests addressed later in this Annual Report. Ms. Okoth and Mr. Ondieki contributed

significantly to further developing the strategies and implementation details for the final DIP. Subsequently, the Social and Behavior Change (SBC) Coordinator, Mercy Muthoni, and the Training Coordinator, Nelly Chitaha, were hired by Ms. Okoth with HQ input, completing the project team in the field.

On September 05, 2007 a community event was held to formally announce the launch of the CSH project. The meeting was hosted by the Evangelical Lutheran Church of Kenya (ELCK) and facilitated by senior nursing staff from Ortum Hospital, both partners in project activities. Key participants included Dr. Sheila Macharia from the USAID Kenya Mission, representatives from West and North Pokot DHMTs, staff of partner health facilities, faith-based organizations, other international organizations (e.g., AMREF, Sentinelles, and Family Health International), local community women's groups, and the Kapenguria Youth Drama group. Representatives from AMREF's CSHGP project in Busia, the APHIA II Rift Valley initiative, and DOW HQ were also in attendance. The event was successful, with much enthusiasm from everyone participating.

During her time in West Pokot, Dr. Macharia visited one of the project's target health centers, where she had a discussion with the staff and a group of TBAs. One of the key suggestions gleaned from the TBAs during this discussion was that community health worker (CHW) selection criteria should be based on literacy and age to ensure effective service to the community. Interviewees also commented that one major reason for home delivery was that the health facilities were excessively cold, with thin blankets, bare wards and no source of warmth. At the launch event, Dr. Macharia cited this as an example of the kind of pragmatic information not always picked up by technical surveys; Dr. Macharia noted the need for the Partnership for Maternal and Neonatal Health to keep practical challenges and solutions in mind. A press release about the launch was distributed through DOW's website and media outlets such as Reuters' Alertnet. This generated queries from national media sources within Kenya, and will hopefully lead to coverage of maternal and newborn health issues in the North Rift Valley.

In September 2007, Ms. Okoth and Ms. Ann Reiner (the Director of DOW's ongoing HIV/AIDS project in the District and DOW's lead representative in Kenya), visited the Provincial Medical Officer (PMO) in Nakuru. The PMO, who was appointed after the assessment and project development process, committed to supporting the activities undertaken through the CSH project by providing trainers for the Maternal and Newborn Care (MNC) skills trainings and promising to preside at one of the trainings himself.

In September 2007, Ms. Okoth and Mr. Ondieki attended the CSH Grant Implementers and Partners meeting held in Busia, Kenya. Ms. Okoth and Mr. Ondieki presented an overview of DOW's CSH project; it was determined that DOW would host the next Partners meeting, in 2008. Further information on this and other collaboration activities in Kenya is provided below.

b. Objective 1: Strengthen the Capacity of nine focus West Pokot District health facilities to provide quality maternal and newborn care, in accordance with Ministry of Health policy.

Sharing Health Facility Assessment Results Empowers Facility Staff

The results of the Health Facility Assessment (HFA) conducted in February 2007, were shared individually with all nine facilities targeted by the project. Facility staff showed active interest, sharing ideas of what they could do to improve services. An important result of this information sharing was the realization among facility staff that they could make changes without waiting for a directive from the DHMT.

This was also the case at Ortum Hospital, the only private hospital among the target facilities, where perceived lack of support from the Hospital Administration, lack of a stakeholders agreement and of basic knowledge and skills in the QA/QI process had led to stagnation. Ortum had an existing Quality Improvement Committee (QIC), however it had never met due to lack of direction –they had never been oriented on the Quality Improvement (QI) process and available tools, and believed that that the hospital directors must be present in order for the Committee to meet. An external facilitator was needed to jump start the process. The sharing of the HFA results by DOW led to discussions on Quality Assurance (QA) and an expressed desire by hospital management to activate the existing QIC as soon as possible. In October DOW staff conducted a six hour workshop on the QI/QA process resulting in the formal launch of the process at Ortum Hospital. The comprehensive health facility assessment and the CSH team's ability to communicate key information in an empowering manner, keeping providers' daily work contexts in mind, was an important factor in getting the facility staff's attention on MNC and quality issues.

A DHMT Training Team is Mobilized and Takes the Lead in Coordinating Training Schedule

The Kenya MOH had given a directive for the formation of District Reproductive Health Training and Supervision Teams (DRHTST) in November 2002. However, with little direction from the PHMT, which was responsible for implementing the directive, this team was never formed in West Pokot.

The DOW project staff contributed to bringing this team together in West Pokot and initiating the training planning meetings. The DRHTST consists of:

- The District's Reproductive Health Coordinator (the Deputy District Public Health Nurse has been appointed in this role)
- District Health Record Information Officer (DHRIO)
- District AIDS and STD Control Officer (DASCO)
- OB-GYN at Kapenguria District Hospital
- District Medical Laboratory Technologist
- District Public Health Officer (DPHO)
- District Public Health Nurse (as needed)
- District Nursing Officer (as needed)

The team has become an active partner in the planning and implementation of trainings, taking the lead role in establishing the time table for clinical trainings, determining selection criteria for participants and related coordination efforts. DOW and the DRHTST have also secured the

support of the Provincial Medical Officer (PMO) who has committed to providing a lead trainer for the MNC trainings and training materials to support the District team, through the Provincial Reproductive Health Training and Supervision Team (PRHTST). The DRHTST has also been actively involved in adapting curricula and course materials. The strong partnership that has developed between DOW and the DHMT over the course of this first year is promising for the sustainability of the capacity built through the CSH project. As DHMT postings have been incomplete and short-lived in North Pokot (where two focus facilities are located), DOW has focused on the West Pokot DHMT in planning trainings, and will include staff from the North Pokot facilities in these. It is anticipated that the North Pokot DHMT, as well as DRHTST, will be stronger partners in Year 2 and onward.

The commitment of key DHMT officials has fostered the involvement of the DHMT in every step of the process. The resulting numerous consultations with the DHMT have nurtured an in-depth understanding of the concept of partnership and realistic timetables for key activities that require DHMT support for sustainability. Another contributing factor was the relevance of the project interventions to MDG goals 4 & 5, which are priorities of the MOH Rapid Results Initiative (RRI) being rolled out in the North Rift Valley. Finally, good interpersonal relationships between the DOW team and DHMT officials were also part of the foundation for this success.

HIV/AIDS and Malaria Refresher Trainings for Providers Held

DOW conducted refresher trainings to ensure an accurate base of knowledge for the other two areas targeted by the project, HIV/AIDS and malaria. Two facility-based trainings were held, reaching 129 providers from the nine facilities targeted by the project. The HIV/AIDS training was led by the DASCO, and the malaria training was led by the District Malaria Control Coordinator. DOW staff led the Infection Prevention and Control training component, which was integrated into both the malaria and HIV/AIDS trainings. Both trainings were conducted using curricula developed by the MOH.

At the malaria training, long-lasting insecticide-treated nets (ITNs) were also distributed to staff for each facility to distribute to pregnant women free of charge, as an incentive to complete antenatal care (ANC)/post-partum visits, or to deliver at the facility. These ITNs had been procured at the District level months earlier, but not distributed due to logistical deficiencies until the DOW-convened trainings. A team of one DHMT member and one DOW staff made follow up visits to every health facility after the training to assess the providers' use of the newly learned skills, distribute more nets, and provide on-site support for proper reporting of malaria and HIV/AIDS services.

Table: Refresher Trainings on HIV/AIDS and Malaria

Providers	# in Attendance	Topics Covered
Medical Officers	0	1. Malaria prevention and control. Malaria Infection transmission cycle Malaria control.(ITNs, IPT, IRS health Education &ANC) Malaria Treatment Malaria in Pregnancy 2. HIV/AIDS – overview Modes of transmission Prevention and control (PMTCT), PEP, ART, VCT, counseling and support 3. Universal precautions in infection prevention (integrated into both trainings)
Clinical Officers	8	
Nurses	108 (malaria) / 111 (HIV)	
Auxiliaries	10	
TOTAL: Malaria HIV/AIDS	126 129	

c. Objective 2: Strengthen community awareness of and demand for quality maternal and newborn care

The majority of activities under this objective are scheduled to begin in Year 2 of the project. During the past year, the SBC strategy was completed (see Section H for details) through a series of meetings with community leaders and other stakeholders. Furthermore, the Project Director and BCC Coordinator participated in a workshop hosted by the Division of Child and Adolescent Health of the MOH in Nairobi to develop the National Curriculum for Community Health Workers (CHWs). While the National CHW Curriculum is still being finalized, the workshop contributed to the project’s SBC strategy, and provided a number of CHW job aids and reporting and supervision tools, which will be utilized by the DHMT and DOW in administering the community outreach component of the project.

With the participation of DOW staff in this forum and the development of the project’s community outreach strategy, DOW is enabling the roll-out of Kenya’s new National Community Strategy in West Pokot and the new District of North Pokot. The Kenyan Government has just begun the roll-out of this new initiative elsewhere in Kenya. As experience with most prior new policies, programs, and tools has shown, it is very likely that this Community Strategy would not have been implemented in the greater Pokot area for several years without the DOW project’s involvement.

d. Objective 3: Improve access for local communities in the district to quality MNC services.

Feasibility Study on Use of Voucher Program Conducted

A team of three volunteer consultants from the Wharton School of Business Health International Volunteers Program (WHIVP) conducted a feasibility study on the introduction of a voucher system to increase utilization of maternal and neonatal care services at the project’s nine target facilities. They used market research methodologies including a

comprehensive review of similar models implemented in Kenya; in-depth interviews with UNICEF; key national government bodies; organizations/companies overseeing the implementation of previous models; and focus groups with TBAs, health facility staff and mothers from the target community.

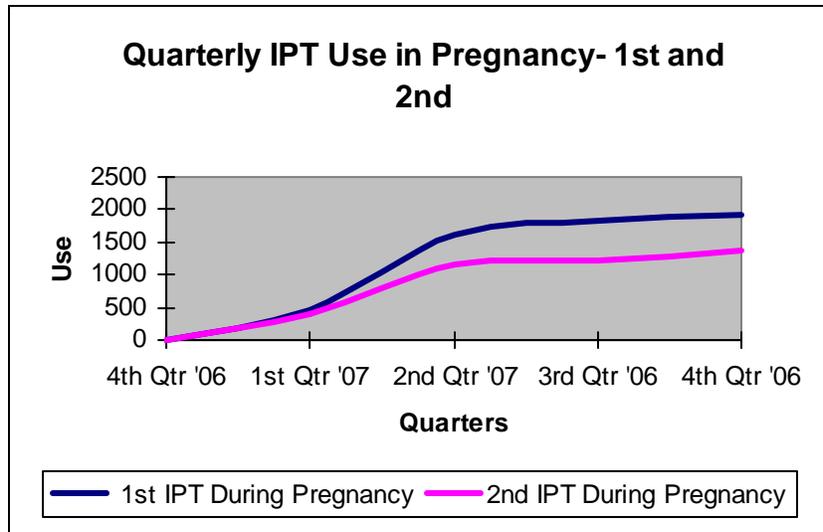
In their recommendations, the WHIVP team presented two models for a potential future voucher system to be implemented by DOW in West Pokot. DOW is now carefully considering the logistical, security, and sustainability factors for each model and plans to hold discussions with the DHMT and other stakeholders on the issue prior to making a final decision by the end of Quarter 2, Year 2. See Annex I for the presentation of the consulting team's findings and recommendations.

e. Objective 4: Strengthen the District Health Information System with particular attention to maternal and newborn health.

New District Reproductive Health Forms Introduced

The presentation of the KPC results sensitized DHMT officers to the need for reliable data and the large gaps that existed within the current reporting system. During subsequent meetings with the DHMT, specifically with the DHRIO, who oversees all data collection and reporting, specific gaps in data reporting for maternal and neonatal care were identified, including the complete absence of data on key services that were being provided but were omitted from reporting forms [i.e. tetanus toxoid (TT) shots to pregnant women, PMTCT, ITN distribution]. With the help of DOW's M&E Coordinator, Thomas Ondieki, the District Reproductive Health Form, which was being used by facilities to report maternal and neonatal health data on a monthly basis, was re-designed. The new forms were introduced to all nine facilities in July 2007 (see ANNEX II for a sample form). Data collected over the several months since the new forms were introduced show an increase in proper reporting (i.e. significantly more forms being turned in properly and completely filled).

In addition, the process of revising the form led to visits to the facilities by the DHRIO (accompanied by the DOW M&E officer) for the first time in a long time. This gap had been due to a combination of factors, including poor roads and a lack of proper means of transportation. The increased focus on proper and complete reporting has also led to reporting of key services that were on the previous forms but not being reported on due to negligence and lack of supervision (i.e. provision of intermittent preventative treatment (IPT) for malaria in pregnant women – see graph below). Another important outcome of this process was the demonstration of the impact of routine supervision to DHMT officials.



Development of New District Health Information Reporting Tool

In collaboration with the DHRIO and student aides supporting the DHRIO's office, the DOW M&E Coordinator led the development of an automated District Health Information Reporting Tool (DHIRT), which consists of several Excel-based worksheets that automatically compile data and calculate key indicators from information entered into the DHMT's database from the monthly reports submitted by facilities. This tool will give DHMT officials timely access to the information they need to make key decisions, without the need to be trained in statistics. Seven modules have been developed thus far including: Population, Mortality, Morbidity, Tuberculosis, EPI and Vitamin A, Reproductive Health, and HIV/AIDS (see Annex III). The modules are now in the final testing and editing stages.

Contributing Factors

Several factors were key to these early successes, namely that there has been no turnover in the position of the DHRIO in this time and the official in the position demonstrates dedication to improving the current system. The DOW M&E Coordinator's previous experience in upgrading local health information systems and his ability to effectively communicate with government officials in the little time he is allotted at each meeting are also important assets.

ACTIVITIES BY OBJECTIVE

Project Objective	Key Activities (as outlined in the DIP)	Status of activities/comments
Strategic objective 1: Strengthen the capacity of nine health facilities to provide quality maternal and newborn care, in accordance with MOH	Hired new project director and M&E coordinator	Completed
	BCC and training coordinator hired in October 2007	Completed
	Conducted health facility assessment in February 2007	Completed and results being used in our plans
	Completed and submitted DIP in July 2007	Approved
	Conducted renovation needs assessment and developed renovation plan	So far done with Konyao Dispensary, Serewo Dispensary and Kabichbich Health Centre
	Develop QI/QA Strategy with facilities	DOW staff conducted a 2 hour QA/QI sessions for 2 days with Ortum Hospital on the concepts and process of QA/QI. Other facilities are scheduled for the current quarter
	Shared KPC results with DHMT members and other stakeholders to explore deeper into the causes of poor MNC results	Strategies being developed on the way to go in our interventions
	Identify training topics based on baseline assessment results	Completed
	Health Facility Assessment findings were shared with the nine facilities individually	Completed and staff incorporating some interventions in their RRI strategies
	Health facility staff identified areas of interventions without necessarily waiting for DHMT	Attempt being made to deal with those areas that don't require DHMT
	Conducted MNC equipment review at facilities with DHMT	List compiled and submitted for soliciting quotations
	Identified training topics based on KPC results	Done
	Identified and reviewed curriculum for trainings to suit the local needs	Done
	Conducted refresher trainings on malaria and HIV/AIDS to all providers and other staff	Completed
Strategic 2: Strengthen	Hold Community Meetings to develop BCC	BCC strategy developed

community awareness and demand for quality MNC services	Strategy; Complete BEHAVE Framework and Narrative	Community meetings scheduled for this quarter
	Shared KPC results with community and stakeholders in March 2007	Completed and valuable inputs being considered
	Conducted discussions on KPC results with TBAs and community groups to explore further on MNC issues	Done and further discussions on-going
	Held a community event in on 5 th September 2007 to officially launch the CSH project	Completed; Dr. Sheila Macharia of USAID Kenya office attended event, and conducted field site visits to Kabichbich Health Centre to discuss with health providers and TBAs on issues of MNC and the TBAs view of the role of CHWS. Discussion was helpful in structuring criteria for TBAs and for health facility renovation.
	Presented behavior change awareness messages through youth drama groups and community women groups on “playing our role” during the CSH launch	Preparing to work with the drama groups in our BCC activities
	Attended an Annual PVO meeting hosted by AMREF in Busia; included attending community sessions and facilities to familiarize ourselves with the work being done by AMREF	Lessons learnt being applied and DOW preparing to host the next annual PVO as resolved
Strategic objective 3: Improve access for local communities in the district to quality MNC services	Attended a one day workshop in Nairobi hosted by the MOH on Community Strategy and the package to improve community access to quality services	Developing the strategy at district level
	Conducted market research on the use of a voucher system to improve access to MNC services (with UNICEF, Population Council, and National Council for Population and Development)	Report on the same presented by the consultants with recommendations
	Conducted a voucher feasibility study with West Pokot DHMT, health facility staff, TBAs, and	

	expectant mothers.	
	Established contacts with PSI on the ITN distribution assessment	Assessment requested, yet to be done
	Distributed ITNs to facilities for pregnant mothers and children under 5 during training sessions	Continuing and ITNs use statistics have greatly improved after the distribution
Strategic 4: Strengthen the District Health Management Information System (DHMIS), with particular attention to maternal and newborn care	Conducted data quality validations routine visits at clinical level (service delivery points)	Continuing and reporting has improved from facilities to district
	Entered and analyzed baseline assessment data	Completed
	Reviewed data collection tools with the District Health Records Information Officer (DHRIO)	A number of the tools reviewed to-date
	Successfully reviewed and improved the Reproductive Health Reporting Form and rolled it out from July 2007	Completed and RH data reporting has improved in quality and timeliness
	Reviewed health facility monthly reports with DHRIO to identify gaps and data quality	Completed and the reviewed tools are available in all facilities
	Developed a new district health information system tool with modules relevant to MNC and broader community health	Undergoing test run
	Visited health facilities with the DHRIO on routine supervision of data reporting	Continuing

ACTIVITIES BY INTERVENTION

Technical Intervention	Key Activities (as outlined in the DIP)	Status of activities/Comments
Maternal and Neonatal Care	Identified training topics based on baseline assessment results	Completed
	Discussed KPC results with TBAs, DHMT and other stakeholders	Completed
	Identified and reviewed curriculum to be used in MNC trainings	Completed
	Shared KPC results to explore main causes of MNC issues	Continuing
	Conducted Health Facility Assessment in February 2007	Completed
	Shared health facility assessment findings with individual facilities	Completed

	Conducted a six hour workshop on QA/QI to Ortum hospital staff	Continuing
	Launched the CSH project in a community event on 5 th September 2007	Completed
	Conducted MNC equipment review at facilities with DHMT	Completed
	Review of health facility monthly reports for consistency, completeness and timeliness	Continuing
	Reviewed RH tools to capture FANC and delivery details (normal, abnormal and CS)	Completed
	Conduct a renovation needs assessment in a number of facilities	Continuing
	Improved reporting tools to capture TT shots that were completely missing	Completed
	Conducted a feasibility study on the use of a voucher system in improving access to MNC services	Completed and report with recommendation submitted
Malaria	Conducted Refresher training on malaria control, malaria treatment, malaria in pregnancy, IPT and IRS.	Completed
	Distribution of ITNs through facilities for pregnant mothers and children under five years	Continuing
	Carried out follow-up visits to emphasize on IPT use and reporting and malaria in pregnancy	Continuing
	Reviewed RH tools to capture IPT1, IPT2 and IPT3, malaria in pregnancy and ITN distributions	Completed
HIV/AIDS	Reviewed the RH data collection tool to capture PMTCT activities	Completed
	Carried out health facility visits to emphasize on the importance of reporting HIV/AIDS counseling and testing as services	Continuing
	Conducted refresher trainings on PMTCT, counseling, testing, ART update and PEP (Post Exposure Prophylaxis)	Completed

B. CHALLENGES & IMPEDIMENTS

a. Project Management Challenges

- The sudden departure of the first Project Director prior to the completion of the first draft of the DIP left the project with no full time field staff at a critical time in the development of the project, leading to delays in developing the DIP and implementing the project interventions.
- DOW encountered serious challenges in the implementation of the KPC by the selected consultants, particularly the usage of the Lot Quality Assurance Sampling methodology; a failure to over-sample for certain indicators and age groups led to baseline indicators with inappropriately large confidence intervals and challenges for target-setting.
- Both these challenges required the HQ Program Manager to spend significantly more time than anticipated in the field, to assist in the implementation of the KPC and HFAs, and to interview candidates for the replacement of the Project Director.

b. Health System/Political Challenges

- The splitting of the district into two has contributed to staff mobility, redefinition of boundaries, and an incomplete leadership team in the North Pokot District. Because of this change, North Pokot officials, faced with a weaker health infrastructure (e.g., no functioning hospital), are seeking to upgrade two of the focus health facilities to a higher level; the Kacheliba health center is intended to become a hospital, and the Serewo Dispensary is intended to become a health center. Because of the significant capacity gaps at these facilities in relation to their current designation, DOW will continue to aim to help these facilities reach MOH standards for those current designations. In Years 2 and 3, DOW will assess whether it is possible to support the facilities in achieving MNC standards for their new designations.
- Understaffing and low revenue in the proposed target facilities are major, intertwined challenges to garnering gains in quality and utilization, and sustaining them. Dispensaries are run by only one qualified nurse and supported by a CHW engaged by the community and paid with funds raised by the dispensary through service fees. Low utilization leads to low revenues, which maintains the low staff and quality, and contributes to continued low utilization. While DOW intends to intervene on both demand/utilization and quality, challenges will remain. The MOH abolished service fees for certain health services at Health Centers and Dispensaries as of early 2007. It is unclear how the facilities' community employees, including CHWs, data clerks, watchmen and support staff (at health centers), previously paid through the collected fees, will be paid in the future.
- The Greater Pokot Area is graded as a hardship area by the MOH. Most providers who come from outside the North Rift Valley do not stay long. Within one year most key DHMT members have been replaced at least twice.

- October and November are an electioneering time in Kenya; this falls when the project is beginning to pick up and needs to conduct many key activities at all facilities. This may further impede the implementation as the priority of stakeholders may be focused on political events.

c. Lifestyle/Cultural/Environmental Challenges

- Most of the inhabitants of the project location are pastoralists; with the area being semi-arid. Men are often away from home taking cattle to graze and sometimes even crossing over to the neighboring country in search of pasture; this may pose a challenge in helping women develop birth plans, access resources for facility delivery and transportation, and make the decision to seek care. Male involvement in this project will need to be examined with this unique lifestyle in mind.
- Related to the above, women are often the sole guardian and home-maker in their households when men are absent; in the event that pregnant women have to go to facilities for delivery or other care, they are faced with the question of who will care for the rest of the family. Women often must either take the children with them or not go to the hospital for delivery. To address this challenge, DOW may need to go beyond medical equipment and supplies in the focus facilities to upgrading and introducing maternity shelters that are big enough for women and their children. DOW will assess the costs of this response, and determine whether to equip facilities with these shelters.
- Focus groups with community members have shown that cultural beliefs around pregnancy and child birth are very strong and any birth complication is questioned and may be attributed to the fault of the woman; this is likely to contribute to poor support from the husband. DOW will address this issue in the project's SBC strategy.
- The literacy level of the likely CHW candidates is very low (e.g., in this area, almost all TBAs are non-literate) and yet, in this geographically marginalized area, there is a need to train them in skills that may require some level of literacy. Community members and health facility staff have also requested that literacy be a criterion in the selection of CHWs.
- The harsh terrain and occasional cattle rustling episodes cause displacement of the households; thus, ensuring continuity of care is likely to be a challenge.

C. AREAS REQUIRING TECHNICAL ASSISTANCE

As noted in the revised DIP, technical assistance is being sought by the project both from HQ in New York and from field staff in Kenya.

DOW HQ and field staff have been attending relevant learning opportunities to gather as much information as possible from comparable MNC programs and experiences (see section L). DOW HQ will consult with the ACCESS and POPPHI projects as needed to further discuss implementation of operations research strategies and how to overcome in introducing new skills

such as AMTSL and PAC. DOW HQ will also continue to partner with the AMDD program at Columbia University, which was instrumental in enabling DOW to carry out a high-quality HFA during baseline assessments. Finally, DOW HQ will continue to request assistance from the CSTS team, which has been extremely helpful as staff have worked through issues related to data collection and analysis, as well as monitoring and evaluation plans and targets.

DOW-Kenya has held regular phone calls and meetings to seek guidance from PSI, UNICEF, AMPATH, and the OB/GYN department at Moi Teaching and Referral Hospital. More specifically, DOW worked with UNICEF to discuss the feasibility of a community-based newborn care pilot and shared culture-specific challenges to using ITNs with PSI in order to find a more appropriate net for the Greater Pokot Area. DOW-Kenya has also held coordination meetings with partners and stakeholders including the Division of Reproductive Health (DRH) at the MOH, Population Council, and APHIA II. Through its partnership with the WHIVP volunteers, DOW was also able to receive guidance on output-based aid mechanisms, specifically reimbursement vouchers to promote facility-based deliveries, from UNICEF, the NCAPD, Price-Waterhouse, and Population Council.

These organizations will continue to serve as an informal technical advisory group (TAG) that DOW will continue to consult when the need arises. As noted in the DIP, DOW will also attempt to convene biannual group meetings of the TAG either in West Pokot or Nairobi, but this has proven difficult due to conflicting schedules of key individuals and geographic distance. If group meetings continue to be challenging to organize, DOW will provide biannual updates by email to members of the TAG and solicit feedback in this manner.

Also as noted in the revised DIP, DOW welcomes technical assistance in the following specific technical areas:

- **Malaria Interventions:** Although DOW has achieved technical competence in HIV/AIDS and MNC programming, the acute malaria burden in West Pokot requires use of new resources and approaches. We welcome recommendations for resources (for behavior assessment, training, etc.) that would help us integrate best practices related to malaria programming. The TRMs for malaria (and for MNC) provide an important starting point, but other suggestions are welcome.
- **MNC and FGM:** DOW recognizes the definitions of basic and emergency obstetric care that are globally accepted (and promoted by the DRH), and their implications for what services should be available at what facilities (e.g., C-sections are part of comprehensive obstetric care, and should be at referral/tertiary facilities). However, in the program location, over 97% of women experience the most extreme form of FGM – infibulation. We have obtained a few technical resources on managing MNC among infibulated women (including recommendations for care to be provided during ANC). We anticipate identifying creative responses to this issue during the program, but will request further guidance from the Population Council in Nairobi and local experts such as Dr. Hillary Mabeya, an obstetrician who is a DOW-Kenya board member and who has managed hundreds of infibulated women over the years and performed dozens of fistula repairs in the region.

D. CHANGES FROM DIP

a. Title Correction – DIP page 55

In the DIP, CORPs (Community-Owned Resource Persons) is referred to as the MOH’s new term for CHWs. Please note the following correction: CORPs is a broader term referring to the entire cadre of community volunteers who may be serving in various sectors (education, microfinance, agriculture, etc.). CORPs who are serving the health sector maintain the title Community Health Worker (CHW).

b. Hiring of Community Health Extension Workers (CHEWs) – DIP pages 55-56

The DIP states that CHEWs will be reporting directly to DOW. To promote sustainability, DOW is currently in discussion with the Provincial Health Management Team (PHMT) and the DHMT to consider a number of options by which CHEWs could be introduced to the Greater Pokot Area as employees of the DHMT, reporting directly to the DHMT from the beginning, as envisioned by the National Community Strategy. Since West Pokot is not one of the Districts selected for initial roll-out of the strategy, funds for hiring and training CHEWs have not been dispersed. As such, it is understood that DOW will need to subsidize the costs and work closely with the DHMT to select, train and supervise the CHEWs.

c. Changes to Child Health Rapid CATCH Indicator Targets – DIP page 95

As recommended by Michel Pacque of CSTS+, DOW will not be reporting child health related Rapid CATCH indicators against targets since the project will not be implementing any interventions to directly impact these indicators.

The revised portion of the project’s M&E Framework, originally appearing under the heading OTHER RAPID CATCH INDICATORS, appears below:

Other Rapid CATCH Indicators	Numerator	Denominator	Baseline	(95%) CI	EOP Target
Anthropometrics					
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for age, according to the WHO/NCHS reference population)	17	186	9%	[9%, 19%]	N/A
Prevention of Illness/Death					
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	88	186	47.3%	[37.3%, 57.3%]	N/A

Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	17	33	51.5%	[41.5%, 61.5%]	N/A
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	14	33	42.4%	[32.4%, 52.4%]	N/A
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	7	12	58.3%	[48.3%, 68.3%]	N/A
Percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	6	12	50%	[40%, 60%]	N/A
Percentage of children age 12-23 months who received a measles vaccine	5	12	41.7%	[31.7%, 51.7%]	N/A
Management/Treatment of Illness					
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	8*	22	36.4%	[26.4%, 46.4%]	N/A
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	9	30	30%	[20%, 40%]	N/A
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	17	65	26.2%	[16.2%, 36.2%]	N/A

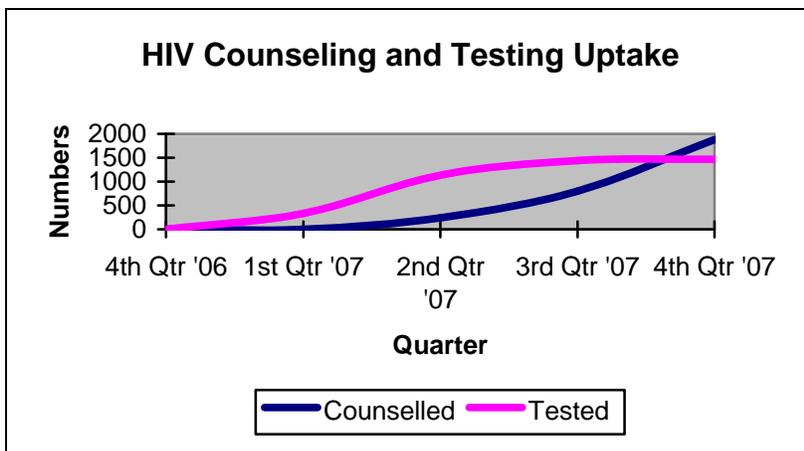
E. MONITORING AND EVALUATION UPDATE

a. Monitoring Plan

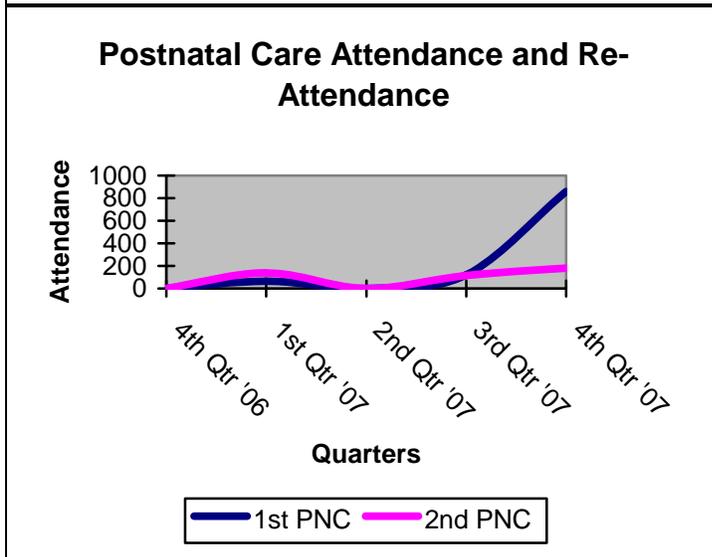
Annex VII presents the project's monitoring plan, listing the input and process indicators which will be used to track progress on the major activities being implemented. The process indicators will inform project management decisions as well as allow specific feedback on progress to project partners and stakeholders. Outcome indicators remain the same as those presented in the DIP.

b. Key Monitoring Activities

Tracking Utilization Rates – To document changes in health facility utilization rates resulting from new report forms and procedures, service quality improvement, community outreach, and social and behavior change (SBC) activities, the DOW Monitoring and Evaluation Coordinator is compiling utilization data as reported in monthly District Reproductive Health Forms. To establish a proper baseline, utilization rates from reports for the four quarters prior to the implementation of any intervention were compiled (Q4 2006 to Q3 2007). Monitoring graphs for key MNC services were developed allowing easy visual interpretation of changes as the project continues (two examples appear below). Changes in utilization are already evident after the introduction of new District Reproductive Health Reporting Forms due to improved documentation of services provided and greater awareness among providers who are trying more actively to get patients to utilize the services.



After the presentation of the KPC results, DOW staff visited health facilities to re-emphasize the importance of recording all clients that receive counseling and testing services. The reporting was initially confined to those who only accepted to be tested.



The graph shows postnatal services (not necessarily emergency postpartum care) that examine mothers and newborns within 48 hrs of delivery. By the 4th quarter, there are improvements in 1st PNC and small improvements in 2nd PNC services. This may be attributed to changes in reporting after visits to health facilities in the process of revising reporting forms, actions that stakeholders took after the KPC presentation and a media campaign by the MOH that was conducted. [Emergency postpartum care is to be established within the project since these services are now not available in the program location.]

Training Follow-up Visits – Within the two to four weeks after every provider training, the DOW staff member who led the training, along with a member of the DRHTST, visit every facility to ensure trainees have been able to apply their new knowledge and skills and provide

additional coaching. Difficulties being encountered by providers and other observations made are recorded in a log which will be referred to when planning refresher trainings on that topic.

F. SUSTAINABILITY PLAN

a. General

DOW and the project partners carefully analyze all possible approaches for activities being undertaken by the project for their sustainability potential. In the effort to ensure project activities are most sustainable, DOW is ensuring that:

- There is true MOH/DHMT buy-in by involving them at every level of planning and implementation.
- The project uses available structures both at community and MOH level to implement the program, building their capacity to undertake project activities as needed.
- Engagement with stakeholders is maximized to nurture ownership of agreed courses of action and to define roles and pool resources.
- Project activities advance adherence to MOH policies and complement or build upon MOH initiatives.

Much of the capacity building that the project will undertake to ensure sustainability of project interventions will take place through the implementation of a QI/QA process at the DHMT, facility and community levels. Careful consideration is being given to the implementation details of the project's QI/QA strategy at every level. The CSSA framework will be used to demonstrate the results of project's sustainability efforts. The indicators for the CSSA framework will be finalized when the details of the QI/QA strategy are finalized, expected by the end of Quarter 1, Year 2.

b. Government Level

At the core of the project's sustainability efforts is the implementation of simple yet effective supervision, supply chain and health information systems; building the DHMT's capacity to manage and utilize the systems; instilling commitment to continuous quality improvement. A key prerequisite in introducing sustainable solutions is to gain the respect and commitment of key individuals. We have made great progress to this end thus far through the engagement of the DOW M&E Coordinator with the DHRIO and other DHMT members in the process of revising key reporting tools and the creation of new ones (see Section A: Accomplishments for more details). Meetings held by the project team with key officials from the PHMT and other coordination meetings with the DHMT have also contributed to building a good foundation.

Much of the project's capacity building efforts at the government level will come through the implementation of the QI/QA process, which will aim to put the DHMT in the lead with DOW serving a facilitative role.

The high turnover of DHMT officials continues to be one of the greatest challenges to sustainability at the government level. For this reason, DOW is looking to introduce interventions that do not require a long learning curve such as the new District Health Information Reporting Tool, which automatically calculates key indicators from data entered from monthly facility reports.

c. Facility Level

The project is seeking to introduce far reaching changes at the facility level, upgrading several facilities, introducing new services at all nine target facilities and quality improvement measures for existing services. To sustain the significantly higher quality of services expected to emerge from the project's efforts, several factors are essential:

- An effective continuous training program
- A regular, precise supervision system
- Sufficient supplies and equipment
- Dedicated staff empowered to introduce changes when necessary
- A strong link with the community

The first three factors will be addressed as part of capacity building efforts at the DHMT level. The QI/QA process to be launched within each facility entails a highly participatory approach touching providers and facility staff at all levels with much attention paid to community feedback. The goal will be to bring about the realization among staff of their role in improving the quality of service provided at the facility and empowering them to suggest and implement changes without fear. The QI/QA system should also serve to make facility staff feel valued, which may reduce the high turnover that currently hinders sustainability.

Due to the particular cultural context of the Greater Pokot Area communities, the facilities' ties with the community is of paramount importance. Mechanisms promoting regular dialogue between the facility and the community are needed so that the facilities can be responsive to the community's needs and the communities can gain a more favorable view of health facilities, especially as they come to understand the challenges the facilities face. The Facility Health Committees were the first step towards creating this important link, however the Committees for the nine target facilities vary greatly in their functionality. DOW will seek to revive these Committees and address the factors that contributed to their inactivity.

The new role of CHEWs and CHWs will also contribute greatly to solidifying the facilities' link to the community. CHW meetings held at the facility will allow them to become familiar with the facility grounds and staff. In this way they will also become aware of the challenges the facility may be facing. The same is true for the TBAs who will be meeting at the facility monthly.

d. Community Level

The project's sustainability efforts at the community level focus on the following issues:

1. The need to create effective, sustainable incentives for CHWs so that demand to become a CHW remains high, therefore allowing the selection of those most suited to the position and turnover within limits. Incentive options are described in Annex VI, the Project's SBC Strategy.
2. The need to create effective sustainable incentives for TBAs to refer mothers for delivery. There are many barriers to this behavior as the TBAs are being asked to act against their own livelihoods. Options are being considered.
3. The need for continued health education and mobilization activities. DOW will be working with several organizations in implementing the project's SBC activities. DOW will select those deemed to be most effective and provide them with additional capacity building support so that they may continue the activities. See Annex VI the project's SBC strategy for more details.
4. The need to increase utilization by community members by addressing the logistical barriers the community faces (lack of transportation, long distances to facility requiring overnight stay, need to bring children along as mother is sole daytime caretaker, etc.) Several options for a voucher system are being considered with components to address multiple barriers. A decision on which model to implement will be made by Quarter 2 of Year 2.

G. INFORMATION REQUESTED IN FINAL DIP REVIEW

The following are responses to questions/requests from the e-mail sent by Erin Boyd on August 21, 2007 approving the DOW final DIP submission.

a. "Will there be overlap between HIV/TB CORPS and MNH CORPS?"

There will be overlap between CORPS now working with the HIV/TB program and those who will be selected to work with the MNH program. The primary reasons for this are:

- There are a number of issues which cross both areas of care and behavior.
- A significant segment of the population the project will serve has been touched by issues pertaining to HIV or TB and would benefit from CORPS who are knowledgeable in HIV/TB issues and MNH.
- DOW's experience working with TBAs and others serving as CORPS with our HIV/TB program helped us identify individuals who are committed to and capable of doing this work.

b. "Please go into more detail about using food as an incentive" for CORPS.

After further consideration, it was decided that a food incentive program would not be feasible nor sustainable. However, other incentive methods will be explored. See Section H: SBC Strategy for further details.

c. Inclusion of final Social and Behavior Change Strategy in First Annual Report

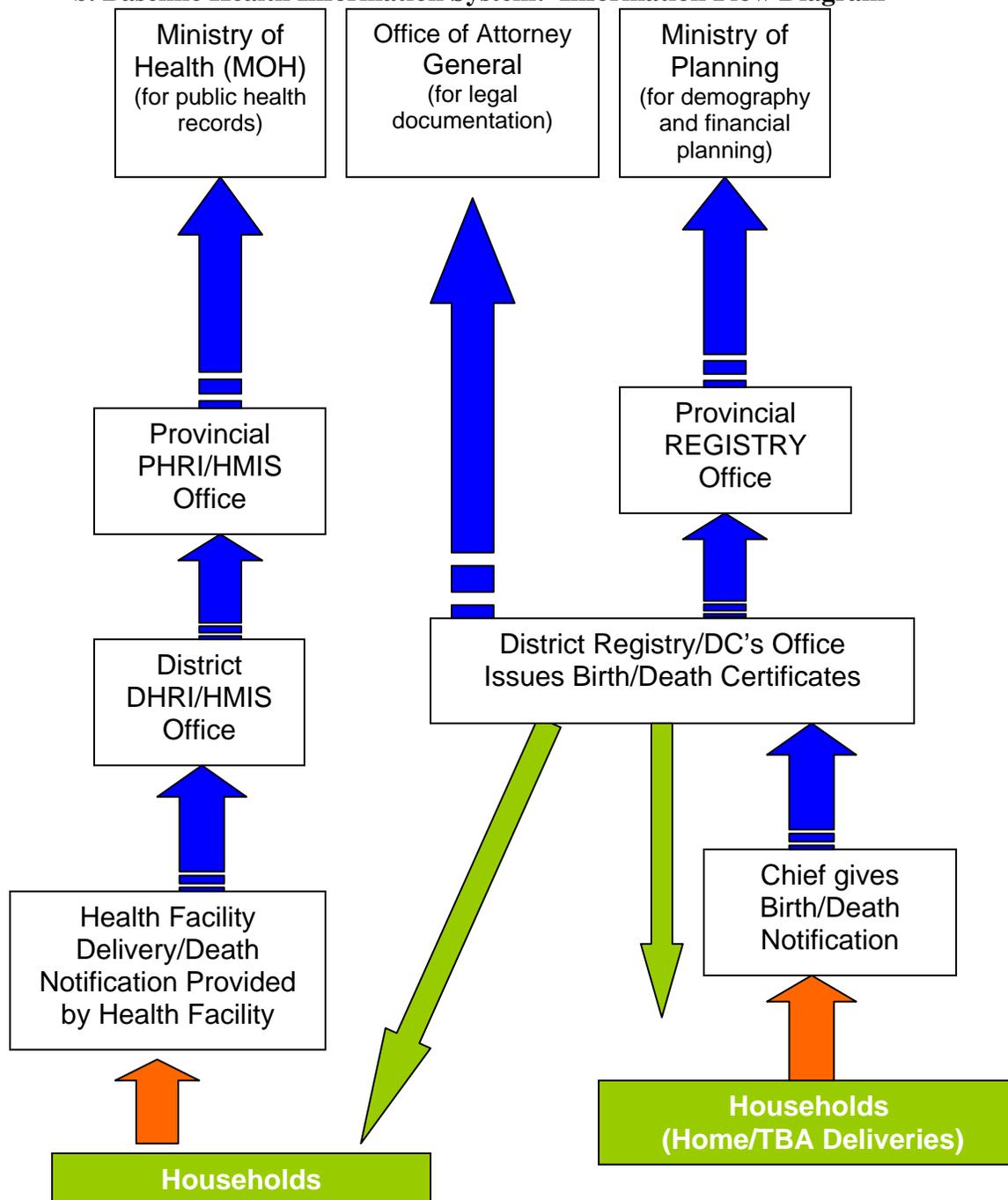
Please see Annex VI for the project's complete SBC Strategy and the complete BEHAVE framework.

H. BASELINE DATA/ASSESSMENT RESULTS NOT IN DIP

a. Maternal and Newborn Care Equipment Needs Survey

A comprehensive review of MNC-related equipment at all nine facilities was conducted with support from the DHMT. Through subsequent discussions, DOW and the DHMT agreed upon a list of equipment needed at each facility (based on MOH policy and the MAMAN framework) to be procured through project funds (see Annex IV for the Equipment Needs Inventory).

b. Baseline Health Information System: Information Flow Diagram





The above diagram depicts the health information system. There is a disconnect in the system with regards to birth and death information. Although the District Registry and the District Health Management Team are supposed to be sharing information regularly, currently this is not occurring effectively. The DOW M&E Coordinator, the DHMT and the District Registry are now in discussions to harmonize the two systems.

c. Social and Behavior Change (SBC) Strategy

Please see Annex VI.

- I. FOR PROJECTS IN FINAL YEAR - NOT APPLICABLE**
- J. FOR PROJECTS WITH FAMILY PLANNING INTERVENTIONS – NOT APPLICABLE**
- K. FOR PROJECTS WITH TB INTERVENTIONS – NOT APPLICABLE**
- L. PROJECT MANAGEMENT SYSTEM**

a. Financial Management System

The project is financially managed at the country level with backstopping from headquarters. Monthly funds requests are prepared by the CSH Project Director and the Accountant at the DOW-Kenya field office. These are reviewed first by the DOW HIV/AIDS Project Director in Kenya, who functions as DOW’s representative in-country, and then by both Program and Finance staff at HQ prior to being authorized. No advances to the field are made without the review and approval of the HQ Program Manager or, during the period that this role has been vacant, the Program Director.

The Accountant in the field prepares monthly expense reports, which are sent to HQ for review and approval by Program and Finance staff. To monitor project expenses against the budget at HQ, DOW uses an accrual-based accounting system that records costs by individual expense, program, and funder allocation. The Accountant also ensures compliance of tracking and management with laws governing NGO activities in Kenya, and maintains all financial records, payment, projections and advance requests, financial reports, compliance with donor requirements, procurement, and payroll for the country office.

The Finance Manager at HQ, with the oversight of the Finance and Administration Director, provides backstopping for these tasks, as well as management and tracking of HQ staff costs funded under the approved budget. At present, no factors have influenced this area positively or negatively; but, it is possible that fluctuations in the exchange rate may have an impact on project costs.

For all DOW's projects, the HQ-based Finance and Administration Director is responsible for establishing HQ and field office financial management systems to ensure that controls and procedures are followed. In addition, the Finance and Administration Director will perform at least two reviews in the field over the life of the CSH project. Finally, DOW is audited annually by an independent accounting firm, which includes an A-133 audit focusing on specific government programs.

b. Human Resources

All job descriptions (JDs) are prepared with input from the Program Manager at HQ, as well as the Program Director and the Finance and Administration Director. Positions are advertised locally for local hires, as well as on the DOW website. All local staff are hired with an initial probation period of three or six months, depending on the context; the contract is extended after the initial probation period ends, and renewed annually thereafter. Due to an extensive JD preparation process, staff qualifications and expected duties are clearly defined. The CSH Project Director supervises all CSH staff directly, and reports to the Program Manager at HQ via biweekly progress reports in a template designed to allow reporting on ongoing activities, challenges, lessons learned, resources gathered, etc. In addition to direct line management from HQ, the CSH Project Director also receives in-country guidance and supervision on financial and administrative tasks from the HIV/AIDS Project Director (who serves as DOW's Country Representative in Kenya).

Since project inception, several new staff have been hired. The field staff include: a CSH Project Director, Ms. Eunice Okoth; an M&E Coordinator, Mr. Thomas Ondieki; a SBC Coordinator, Ms. Mercy Kamau; and a Training Coordinator, Ms. Nelly Chitaha. A Project Assistant and Driver has also been recruited, and the project shares accounting staff with DOW's HIV/AIDS project. There has been some turnover in the HQ backstops: The HQ Program Manager, Kavita Bali, departed DOW due to personal circumstances on July 31, 2007. DOW has conducted a search to fill this position, and expects to request USAID approval for a new Program Manager in November 2007. The HQ Program Associate, Rebekah Wheeler, also departed DOW to continue her education, an expected departure. In her stead, Rozalin Davoodnia, who holds a Master of Health Sciences from the Johns Hopkins School of Public Health, joined HQ as a Program Associate. As has already been discussed with USAID, the first CSH Project Director, Owade Manases, departed DOW at the end of 2006 due to unexpected circumstances.

During the period when there has been no Program Manager, Program Director Vandana Tripathi has taken on direct management and backstop responsibilities. Having traveled to DOW's program location in Kenya several times, conducted the initial CSH assessment in Kenya, and developed DOW's proposal to USAID's CSHGP, Ms. Tripathi is very familiar with the needs and context of this program, and has worked closely with HQ and Kenya-based staff to ensure continuity during the Program Manager search.

DOW also retains a team of committed advisors serving on the Program Committee of the Board of Directors who provide additional technical support. Advisors include Dr. Allan Rosenfield, Dean, Mailman School of Public Health at Columbia University; Dr. Mary Ann Chiasson, Vice

President, Research and Evaluation, MHRA; and Dr. Victoria Sharp, Director, HIV/AIDS Center for Comprehensive Care (CCC) at St. Luke's – Roosevelt Hospital.

c. Communication System and Team Development

Daily emails and frequent phone calls maintain contact between HQ backstops (Program Manager, Program Associate, and Program Director) and field office staff. In Kenya, regular communication with local partners (particularly DHMT staff) has sometimes been a challenge due to workload and infrastructure gaps, but staff persistence has led to due maintenance of regular communication.

As email service is frequently interrupted in Kapenguria, where the CSH office is located, phone communication is particularly important in ensuring timely decision-making and feedback between staff. However, extremely slow internet connections, electricity cuts, phone outages, and other issues do make communication a challenge. Several focus facilities are located in parts of the Greater Pokot Area without mobile telephone coverage, and many facilities are several hours apart, even with adequate vehicles. Faster internet connectivity, through VSAT stations, remains prohibitively expensive in Kenya.

The Program Manager from HQ (or the Program Director, when this position is vacant) has visited the field office on a quarterly basis, at which point meetings with partners have also been arranged. Initially, these visits were important for ensuring adequate baseline data collection and determining roles and responsibilities for the activities detailed in the DIP; now they provide an opportunity to monitor the project activities and any potential setbacks.

The participation of CSH project staff in the DIP development and presentation, as well as the community launch, have allowed for significant teambuilding in the country office as well as with local partners. The CSH staff have now been working alongside the DOW HIV/AIDS project staff for several months, and have collaborated on some joint activities beyond regular all-staff meetings.

DOW has identified opportunities for CSH leadership to strengthen their technical capacity. Ms. Okoth was supported by DOW to attend a course on “Enhanced maternal and neonatal survival by training of non-doctors for comprehensive emergency obstetric care in settings with scarcity of human resources for health: experiences and prospects,” in Gotland, Sweden, in August 2007. Ms. Okoth brought back new information, tools, and training resources from this course. DOW also applied for and received a scholarship for Ms. Okoth to attend the Women Deliver conference on women's health in London, in October 2007. This conference presented recent data from numerous initiatives on maternal and newborn care, including in areas with high HIV/AIDS and malaria burdens.

DOW will identify opportunities for management and financial systems training for key CSH project staff in 2008.

d. Local Partner Relationships

The most important local partners for this CSH project are the DHMTs in West and North Pokot. Their role in activities and progress to date is described above in Section A. DOW has developed close working relationships with DHMT members, particularly those in West Pokot (North Pokot, being a brand new District, is still completing its leadership teams.) Along with the DPHN and DRHIO, other key partners have included the members of the DRHTST and staff at the focus health facilities across West and North Pokot.

As the community outreach and SBC strategies were finalized close to the end of Year 1, there have not yet been any concrete program activities with local/FBO partners, beyond the presentation of DIP research and community meetings to launch the project.

Other authorities, including the District Commissioner and the PMO, are kept apprised of project activities and outcomes, provide feedback and guidance, and ensure coordination between project activities and evolving MOH/Division of Reproductive Health (DRH) policies.

The visit by pro bono consultants from the Wharton WHIVP to help DOW determine the best approach for introducing vouchers to promote facility-based delivery, also helped DOW reach out to and partner with other government and NGO partners – see the presentation, Annex I, for more information on this process and its outcomes. In particular, DOW expects to coordinate activities with the National Coordinating Agency for Population and Development.

No formal assessment of DOW has been conducted among partners yet; this will be carried out as part of the formal Mid-Term assessment, and informally in the coming months.

e. PVO Coordination and Collaboration in Country

As noted above, the DOW CSH Project Director and M&E Coordinator attended the Third Child Survival Grant Implementers and Partners Meeting on September 12-14 in Busia, Kenya. This meeting was hosted by AMREF, whose CSH project in Busia is targeting similar issues to DOW's project in West and North Pokot. This meeting's theme was "Partnerships and Effective Models for Child Health." Attendees included MOH staff (from the DRH and the Division of Child Health), as well as CSH grant implementing PVOs (e.g., PLAN International, Catholic Relief Services, in addition to AMREF), and representatives of several of the USAID-supported AIDS, Population, and Health Integrated Assistance (APHIA II) programs from across Kenya. This mix of stakeholders and partners made the meeting a very useful learning as well as networking opportunity for DOW's CSH staff. The meeting included a visit to AMREF'S CSH project site, presentations on health issues in Kenya and the outcomes of other CSH projects, and case studies on linkages between CSH projects and the APHIA II initiatives. DOW will host this meeting in 2008.

AMREF, FHI, and APHIA II were also in attendance at DOW's own CSH project launch in West Pokot, further strengthening our relationships with these other PVOs. DOW has also joined the Kenyan Health NGOs Network (HENNET), a consortium of Kenyan and international organizations, including PVOs, NGOs, and FBOs. DOW staff have attended HENNET membership meetings and other collaboration events in Nairobi.

DOW has continued its ongoing collaboration with the Indiana University/Moi University Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH), our technical and management partner for HIV/AIDS treatment and support projects in West Pokot. DOW has also begun to develop concepts with FHI for collaboration in the APHIA II program in the North Rift Valley, extending lessons learned through providing HIV/AIDS treatment in West Pokot to other rural Districts. Although these partnerships focus on HIV/AIDS, they provide support for the HIV/AIDS activities in DOW's CSH project and a foundation of collaboration with other PVOs that can support the expanded impact and sustainability of CSH activities in West and North Pokot.

Finally, PSI is an important PVO partner, as DOW will collaborate with PSI to ensure ITN access at health facilities and in households across the program location. DOW has been in communication with PSI to schedule an assessment visit by PSI staff in the West and North Pokot area, to determine the best approach for partnership.

f. Other Relevant Management Systems

In addition to the in-country collaboration systems noted above, DOW has joined several partnerships to ensure access to the most up-to-date technical information related to maternal and newborn health. DOW is a member of the Partnership for Maternal, Newborn, and Child Health, as well as the White Ribbon Alliance. DOW has also maintained active participation in the Child Survival Collaborations and Resource (CORE) Group, particularly its Safe Motherhood working group.

g. Organizational Capacity Assessment

Because the project has only been operational for one year, DOW did not perform an organizational capacity assessment related to the Kenya CSH project during Year 1. However, during Year 2, a formal mid-term review will be conducted, which will also consider financial and management systems. As noted above, DOW's A-133 audit is conducted annually; the 2006 audit is being finalized by an external audit firm in October 2007, and the 2007 financials will be audited under the same process.

M. USAID MISSION COLLABORATION

DOW has greatly appreciated the support and guidance of the USAID mission, from the very beginning of this project.

USAID mission staff, including Mike Strong and Sheila Macharia, provided DOW staff with information about USAID programs and health priorities during the 2005 assessment that led to the development of the CSH proposal. As soon as the project was funded, Mission staff in Kenya were in contact with DOW HQ staff, and have offered guidance to both the field and HQ on procurement procedures, staff recruitment, and numerous other matters. Dr. Macharia also provided detailed feedback on the original DIP submission.

Dr. Macharia attended DOW's community launch of the CSH project in Kapenguria on September 5, 2007, and used that opportunity to visit focus health facilities and meet with providers, TBAs, and community women. Dr. Macharia also visited the Kapenguria District Hospital, meeting with the OB-GYN stationed at the hospital and visiting the HIV/AIDS treatment clinic being supported by DOW through a separate initiative. Dr. Macharia was instrumental in helping DOW connect with the APHIA II initiative in the North Rift Valley, and in facilitating their participation at the community launch of the CSH project in Kapenguria. Dr. Macharia has encouraged DOW to seek linkages with APHIA II activities whenever possible in the CSH project, and local staff will continue to be in close communication with FHI, the Rift Valley implementing agency for APHIA II.

As noted in the DIP, DOW was encouraged to develop this CSH program after discussions with the USAID mission, and the sense of both DOW and the Mission that few partners were engaged in strengthening MNC services in the West Pokot District. This project will advance objectives in the USAID Mission's Integrated Strategic Plan for 2001- 2005 (extended to 2008).¹ The program will contribute to these Intermediate Results (IRs):

IR3.1: Improved enabling environment for the provision of health services

IR3.1.3: The program will improve quality of health services at focus health facilities, as well as those delivered by facility providers in the community, through strengthening of facilities, increasing the scope of services, and training providers in practices endorsed by USAID, PVO partners, and MOH.

IR 3.2: Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS

IR 3.2.2: The program will enlist a network of local NGO/FBO partners, as well as MOH staff and CBHRPs, in SBC interventions to ensure increased knowledge and practice of HIV prevention behaviors.

IR 3.2.3: The program will strengthen the ability of health facilities to screen for and respond to HIV/AIDS and STIs among pregnant women.

IR 3.3 Increased customer use of FP/RH/CS services

IR 3.3.1: The program will expand availability of RH/CS services, particularly those advancing MNH.

IR 3.3.2: The program will include extensive community education and mobilization efforts to increase demand for and use of facility-based RH/CS services.

IR 3.3.3: The program will apply best practices from PVO and MOH RH/CS interventions to the program location, enabling improved programming for MNH and CS in the West Pokot District.

In the CSH project, DOW plans on applying tools developed and lessons learned by other PVOs that have been supported by the mission. Throughout this project, we also hope to promote strategic expansion of policies (e.g., the National Community Strategy developed by the MOH) and methods that have been piloted in certain Districts, but not yet rolled out in the greater Pokot area (e.g., CHEWs, vouchers for facility-based delivery). The Mission's guidance on these expansions, and support in feeding back what DOW learns to national decision makers and agencies, as well as other PVOs, will be greatly appreciated.

¹ USAID/Kenya Integrated Strategic Plan 2001-2005.

N. YEAR TWO ACTIVITIES/UPDATED WORKPLAN

a. Changes to the Workplan

For project management purposes, the workplan has been reorganized with line items related to certain categories of activities being grouped together. Some items mentioned in the final DIP that were not in the workplan have been added and some line items have been broken down into several steps represented by new line items. Due to scheduling conflicts with the DHMT and MOH and delays in finalizing plans to upgrade certain facilities, clinical trainings originally scheduled for Quarter 4 of Year 1 have been rescheduled to Quarter 1 and Quarter 2 of Year 2. These include trainings on Focused Antenatal Care; Normal Delivery, Assisted Vaginal Delivery, Active Management of Third Stage of Labor, and Emergency Obstetric Care. However, the malaria and HIV/AIDS refreshers were moved ahead to Quarter 4 of Year 1. These changes are noted in the revised work plan below.

b. Year Two Activities

In the second year project activities will focus on conducting all initial provider and community level trainings, renovation and upgrading of equipment in facilities and the implementation of the QI/QA strategy.

c. Workplan

Please see Annex IX for the updated workplan.

O. RESULTS HIGHLIGHTS

Results Highlights will not be submitted as the project is still in the early implementation phase; they will be submitted for Year 2 when preliminary results from project interventions will be available.

ANNEX I

Wharton Health international Volunteers Program

Maternal-Neonatal Services Utilization Project

August 2007

Presented to Doctors of the World-USA

Contents

- 1 **Context**
- 2 **Landscape Analysis**
- 3 **Voucher Design and Operations**
- 4 **Appendices**

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- 1 **Context**
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Project goal focused on maternal care

Reduce maternal and neonatal morbidity and mortality
in the West and North Pokot regions
by designing a sustainable incentive scheme
to increase utilization of maternal services

Note: The government's annualized operations plan for the Rift Valley region targets an increase of deliveries conducted by skilled attendants to 28% in 2007 from a baseline of 20% in 2006. However, the plan did not define a strategy to meet these ambitious goals.

Methodology focused on primary market research

Suppliers

In-person interviews with experts in Output-based Aid (OAB)

- UNICEF
- NCAPD
- Population Council
- PricewaterhouseCoopers

In-person interviews with Ministry of Health Officials

- District Medical Health Officer
- District Public Health Nurse - West Pokot
- District Public Health Nurse - North Pokot

In-person interviews with clinic staff

- Ortum Mission Hospital
- Kabichbich Health Center
- Sigor Health Center
- Lomut Dispensary

In-person interviews with Traditional Birth Attendants
(community midwives)

- 40+ women from Kabichbich district

In-person interviews with Mothers

- 10+ women from Kabichbich district

Consumers

Two-sided problem leads to sub-optimal healthcare

Demand-Side

- Women are reluctant to seek institutional deliveries for three reasons: cost, convenience, and culture
- Reliance on home deliveries without skilled attendants results in high rates of maternal and neonatal morbidity and mortality*

Supply-Side

- Few women currently seek institutional deliveries so maternal services are not a reliable source of revenue
- Sustainable strategies to improve and maintain quality of care, in general, at health facilities have not been identified

*Source: According to the 2003 KDHS - Millennium Development Goal (MDG) is to reduce maternal mortality rate to less than 175 maternal deaths per 100,000 live births from 410 maternal deaths / 100,000 live births (2003)

Three issues work against institutional deliveries

Cost

“husbands control the money”

“if the TBA has a ceremony at a future date the woman feels obligated to donate more money since the TBA had helped the woman in the past”

“some TBAs will also accept other forms of payment such as maize or sugar”

“it could cost a cow to pay for taxi but not always possible to sell the cow in time to raise the money”

Convenience

“most important thing would be to have a place at the health facility where we could come ahead of time and stay until we give birth”

“many women live in places that do not have accessible roads”

“once a mother begins labor at home it is difficult to hire a vehicle to transport her to the health facility”

“relatives are responsible for transporting the mother to the health facility”

“there isn't enough time to recover at the health facility before having to travel home”

Culture

“the attitude of the staff is unfriendly, especially the woman nurse – we pray we get male nurses instead”

“TBAs are around for you after giving birth to help when you need something”

“TBAs may perform female circumcision on the mother as a young girl, creating a long-term relationship with her”

“women fear having surgery if they go to a health facility”

“women are seen as heroic giving birth at home and home delivery is the accepted way of giving birth”

Downward spiral in quality of maternal care

Demand for Maternal Services

Limited consumer demand of clinical services due to (1) cost (2) convenience and (3) culture

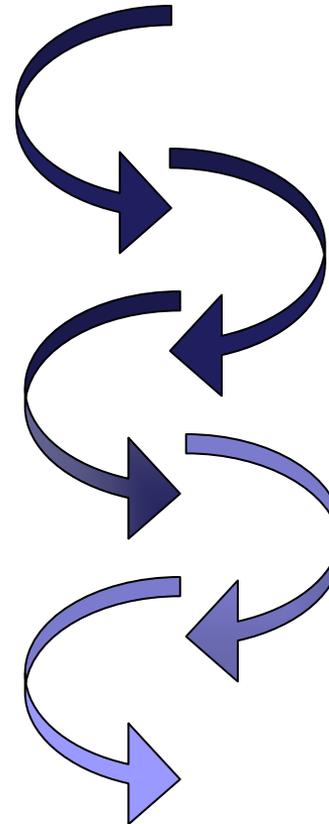
Cycle is repeated without drivers to induce change in consumers' behaviors

Consumers negative perceptions towards institutional deliveries remain and tendency toward home delivery perpetuates

Supply of High Quality Healthcare

Clinics lack adequate funding or sources of income to improve health care services

Quality of care continues to decline as clinics face challenges to maintain facilities and buy even basic supplies



OUTCOMES:

- Existing clinics are poorly utilized
- Consumers lack quality healthcare

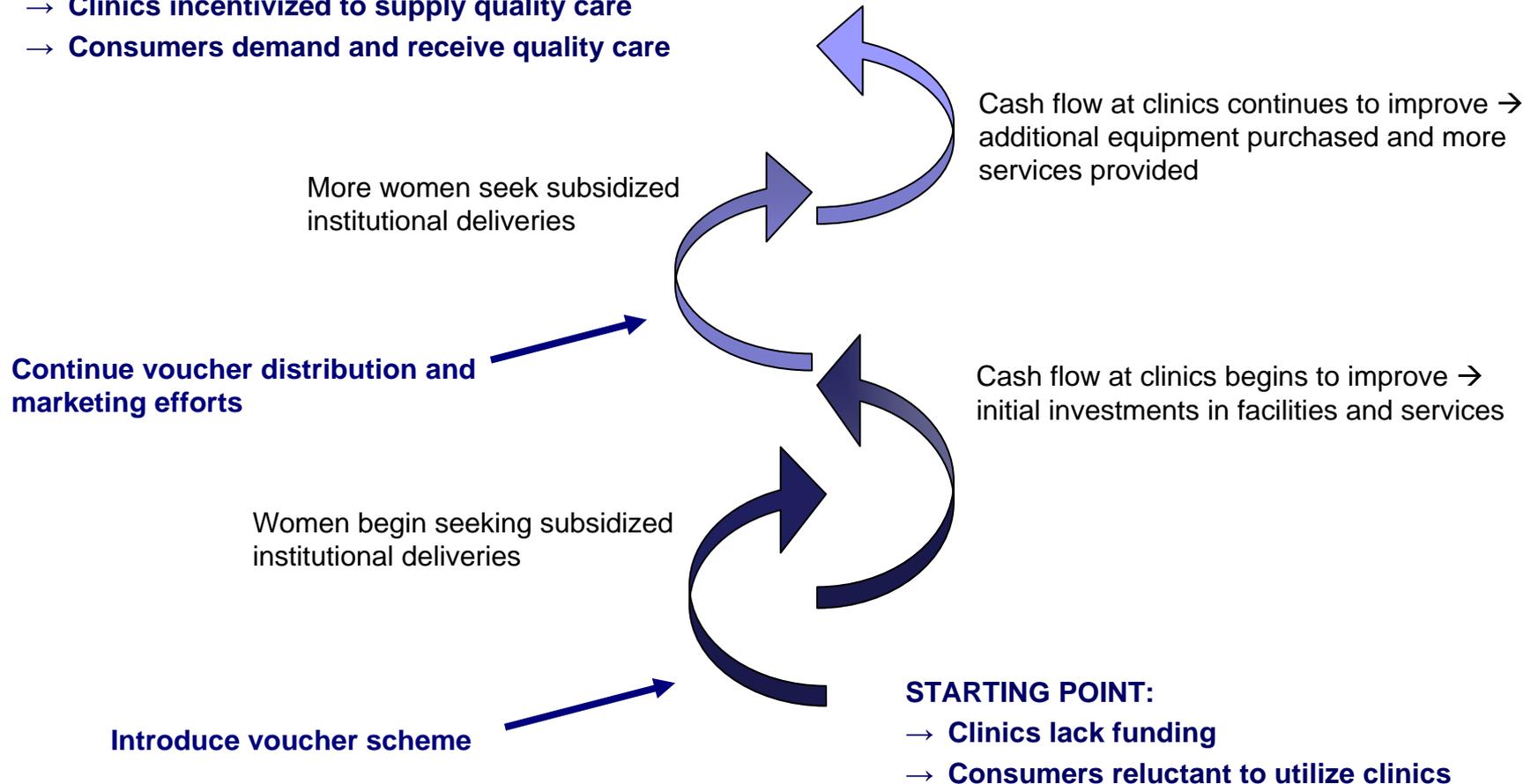
Conceptualized solution to improve maternal care

Demand for Maternal Services

Supply of High Quality Healthcare

OUTCOMES:

- Clinics incentivized to supply quality care
- Consumers demand and receive quality care



Assumptions influence our recommendations

- Nine facilities in West and North Pokot are being targeted for the pilot

District Hospitals

- Kapenguria District Hospital
- Ortum Mission Hospital

Health Centers

- Chepareria
- Kabichbich
- Kacheliba*
- Sigor

Dispensaries

- Konyao
- Lomut
- Serewo*

- Facilities will receive adequate supplies and equipment from Doctors of the World prior to voucher implementation
- Program addresses antenatal care and delivery but does not cover post-partum services
- With appropriate incentives, community key opinion leaders and TBAs will advocate women to deliver in health facility
- Clinics will modify behavior in accordance with the increased demand created by incentivized patients and reinvest effectively in their facilities

* Kacheliba health center is in the process of becoming a sub-district hospital and Serewo dispensary is expected to upgrade to a health center within the next year

MOH ambitions have uncertain outcome

- Future of free delivery services is uncertain
 - MOH recently announced all delivery services will be free at health center and dispensaries
 - MOH did not provide any guidance on how clinics will fund provision of these services
 - Clinics are not currently abiding by mandate but some have reduced delivery fees
- Similarly, MOH's Millennium Development Goals ambitiously call to reduce maternal mortality by ~75% (deaths per live births)
 - No plans have been announced to realize these goals
- Voucher program could provide a solution to both of MOH's mandates

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Comparison of existing voucher systems

	UNICEF	NCAPD
Eligibility	All women in Northeastern Kenya	Women identified through poverty tool in 5 regions in Kenya
Cost	Free	200ksh
Benefit	Any delivery procedure	Any delivery procedure ANC visits
Value	400ksh – 6,000ksh	5,000ksh – 20,000ksh
Funding	Funneled to clinics through MOH	Sent directly to clinics by 3 rd party vendor
Distribution	Commission-based (100ksh)	From commission-based to salaried employees
Impact	<i>Program ongoing / data not available</i>	During one year, delivered over 17,500 babies with ~\$2.7M (~\$160 per birth)

Lessons learned inform best practices

Lessons Learned	Recommended Action	Source
Funding mechanisms to clinics must be predictable	Reimburse clinics every 1-2 months at first	UNICEF
Avoid MOH bureaucracy	Send payments direct to clinics	UNICEF
Mothers will not value something free	Introduce element of ownership by charging nominal fee	NCAPD
Facilities can't track vouchers	Hire dedicated management agency	POP Council
Fraud can occur anywhere	Diligently monitor and change course as needed	NCAPD
Initial volume spike caused delays	Ensure adequate staff coverage of financial management	NCAPD
Gain endorsement from community	Communicate clear messages upfront through Key Opinion Leaders	POP Council
Health facilities should invest funds	Allow Health Facility Development Committee to oversee investments	NCAPD, UNICEF
Encourage competition among clinics	Reward facilities for meeting targets (recognition, cash rewards, ambulances, etc.) Do not restrict which facility the woman can attend	NCAPD, UNICEF
Adapt program to region	Tailor voucher to address region-specific barriers	NCAPD

Stakeholders' inputs inform DOW program design

Lessons Learned	Recommended Action	Source
Clinics have no money to cover initial cost of providing services before reimbursement	Give expected first month's reimbursement to clinics in advance and have it paid off over time	DPHN – North Pokot
Major barrier related to transportation is inability of mother to stay at / near health facility prior to birth due to lack of infrastructure	Consider creating dormitories to house woman in days prior to delivery date to ensure safe transport of woman from house to health facility	Sigor Health Center Ortum Mission Hospital
TBAs cause many of complications referred to hospital and have proven difficult to train	Carefully consider processes by which TBAs are incorporated into voucher distribution plan	Ortum Mission Hospital

SWOT assessment indicates voucher scheme feasible

Strengths

Output-based aid

- Addresses demand-side problems
- Addresses supply-side issues

Past precedent for success

- Used successfully in Kenya (including poor, rural regions) by NCAPD and UNICEF to increase institutional deliveries

Weaknesses

Extra expenses

- Necessary to create extra administrative infrastructure to manage voucher system
- Necessary to invest in fraud-prevention systems

Previous experiences highlight challenges

- Unique challenges to poor and rural regions
- Distortions inevitably will be introduced

Opportunities

Potential to leverage NCAPD investments

- Administrative / financial management systems for similar vouchers already exist and are being successfully implemented

Potential transition to MOH in 2010

- NCAPD intends to transfer its voucher program to MOH in October 2007 to achieve sustainability

Threats

Sustainability not guaranteed

- Program may not survive beyond pilot if alternative funding sources can't be identified

Political uncertainty

- Uncertain outcome of 2007 Kenyan presidential election could introduce new priorities / initiatives at MOH

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Benefits could vary, depending on funding availability

	Option A	Option B
Eligibility	All women in West and North Pokot	All women in West and North Pokot
Cost	100ksh (\$1.50)	100ksh (\$1.50)
Benefit	ANC services Any delivery procedure Transportation arranged and paid for by facility in case of referral	ANC services Any delivery procedure Transportation arranged and paid for by facility in case of referral Temporary accommodation*
Budget**	Operations - \$230,000 Administration - \$90,000 Total - \$320,000	Operations - \$415,000 Administration - \$165,000 Total - \$580,000
Impact	9,668 babies delivered	10,958 babies delivered <i>conservative estimate of 10 percentage points increase in utilization with temporary housing benefit</i>

* Benefit depends on facility; five facilities (Sigor, Kabichbich, Lomut, Kanyao, Serewo) require investment of temporary tents or other structures; remaining four facilities have preexisting dormitories. All facilities require funding for maintenance of accommodations.

**Operations includes reimbursement for clinical services, referral transportation, accommodations, distribution incentive and voucher production. Administration represents 28% of total budget (NCAPD benchmark) and includes financial management and marketing.

Value to provider consistent within facility types

Facility	Normal Delivery Fees	Caesarean Delivery Fees	Referral Transportations Fees	ANC Fees	Pre-delivery Housing
Kapenguria District Hospital	500ksh	2,500ksh	1,000ksh – 3,000ksh	40ksh	700ksh
Ortum Mission Hospital	2,500ksh	20,000ksh	1,000ksh – 3,000ksh	40ksh	700ksh
Chepareria Health Center	200ksh	-	-	40ksh	700ksh
Kabichbich Health Center	200ksh	-	-	40ksh	700ksh
Kacheliba Health Center	200ksh	-	-	40ksh	700ksh
Sigor Health Center	200ksh	-	-	40ksh	700ksh
Konyao Dispensary	200ksh	-	-	40ksh	700ksh
Lomut Dispensary	200ksh	-	-	40ksh	700ksh
Serewo Dispensary	200ksh	-	-	40ksh	700ksh

500ksh = \$7.57
3000ksh = \$45.45

Proposed voucher program is financially feasible

■ Important cost drivers

- 100% of child-bearing women are eligible for voucher
- Penetration starts at 12% to 20% and grows to 25% to 60% under voucher program
- Assume all women who utilize delivery benefit also utilize ANC benefit (and temporary accommodation benefit)
- Five health facilities that currently do not have existing accommodation infrastructure will each receive up-front investment of \$5,000

■ Costs per output produced

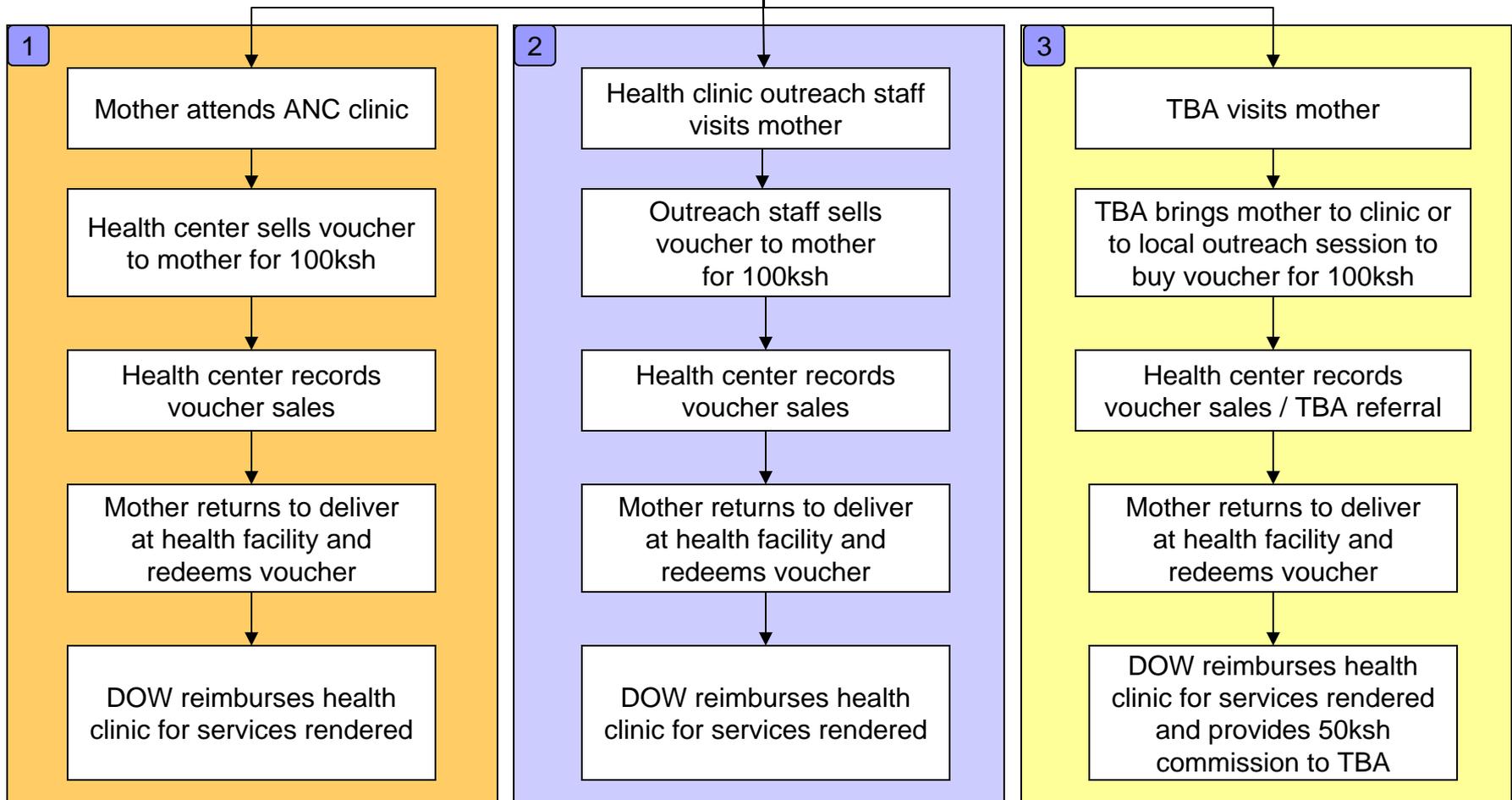
- Option A: \$37.00
- Option B: \$53.00

■ Sensitivity of penetration rate (+/- 10% of given assumptions) indicates total cost for each Option could be:

- Option A: Ranges from \$315,000 to \$405,000
- Option B: Ranges from \$515,000 to \$640,000

Program utilizes three-pronged distribution scheme

DOW sells voucher pack to health clinic



Spot checks of health center records will monitor for fraud

Voucher mechanics*

* DOW should consider standardizing its design to NCAPD vouchers if DOW wants to expand PwC's management to cover West and North Pokot

In local Pokot language (English on other side)	Serial Number: 00001 Value = 100ksh	Serial Number: 00001 Value = 100ksh	Serial Number: 00001
	Participant Name _____ Location _____ Date _____ Referral _____	Participant Name _____ Location _____ Date _____ Referral _____	Participant Name _____ Location _____ Date _____ Referral _____
	Health Facility _____	Health Facility _____	Health Facility _____
Services Performed:		Services Performed:	
Total Value _____	Total Value _____	Total Value _____	Total Value _____
Voucher Status: Sold Redeemed Paid	Voucher Status: Sold Redeemed Paid	Voucher Status: Sold Redeemed Paid	Value = 100ksh
			
<i>Expires 1 year from issuance date</i>		<i>Expires 1 year from issuance date</i>	

↓
Section 1 – remains in booklet; distributor submits empty voucher booklets to management agency to be reconciled against Section 2a upon remittance

Section 2 – both subsections given to mother at time voucher is sold

Watermark to prevent counterfeits

↓
Section 2a – clinic retains section and submits to management agency for reimbursement; receives portion back with payment

↓
Section 2b – mother retains section as proof of services received

Multilayer approach will combat fraud

Voucher Production

- Print watermark on the voucher to prevent counterfeit production
- Print voucher cost (100ksh) on the voucher to avoid higher selling prices

Voucher Distribution

- Distribute vouchers only at health care facilities or through their outreach programs
- Do not allow Chiefs or TBAs to be involved in financial transaction of vouchers

Monitoring and Spot Checks

- Collect all voucher packet records from health care facility to discourage fraud and allow DOW to statistically track the program's uptake by health facility
- Conduct random spot checks every month during the pilot to ensure that woman whose information is recorded, actually received those services
- Conduct sampling of exit interviews from mothers post voucher redemption

Implement, monitor and evaluate...

Negotiating contracts

- Conduct competitive bidding process to select management agency
 - Consider benefits from using PwC to leverage previous investment and knowledge base
- Assignment of program steering committee

Training

- Educate on benefits
 - Targeted audiences: mothers, health providers, and community
- Educate on distribution and redemption processes
 - Targeted audiences: health facilities, TBAs, chiefs, and management agency

Monitoring

- Track who receives services, which services are most utilized, and outcomes
- Compare with current utilization rates and outcomes recorded for each clinic
 - Extension of DOW needs assessment document
- Ensure data collected will actually be utilized

Performance Metrics

- Define measures of success prior to pilot implementation
- Set baseline benchmarks and proposed targets
- Potential metrics
 - Percent of births at facilities increases from ~20% to reach 45% by 2010
 - Qualitative increase of perceived quality of clinic
 - Number of complaints of poor service decreases from X to Y

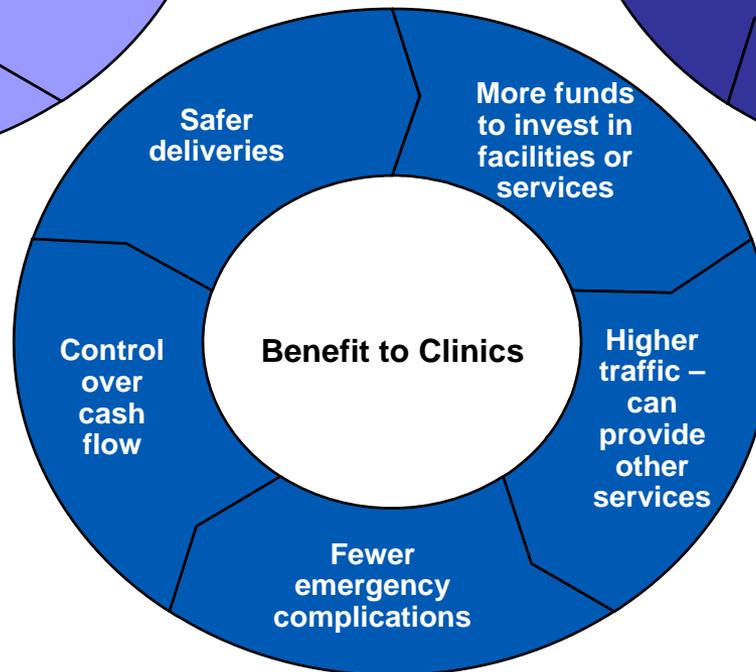
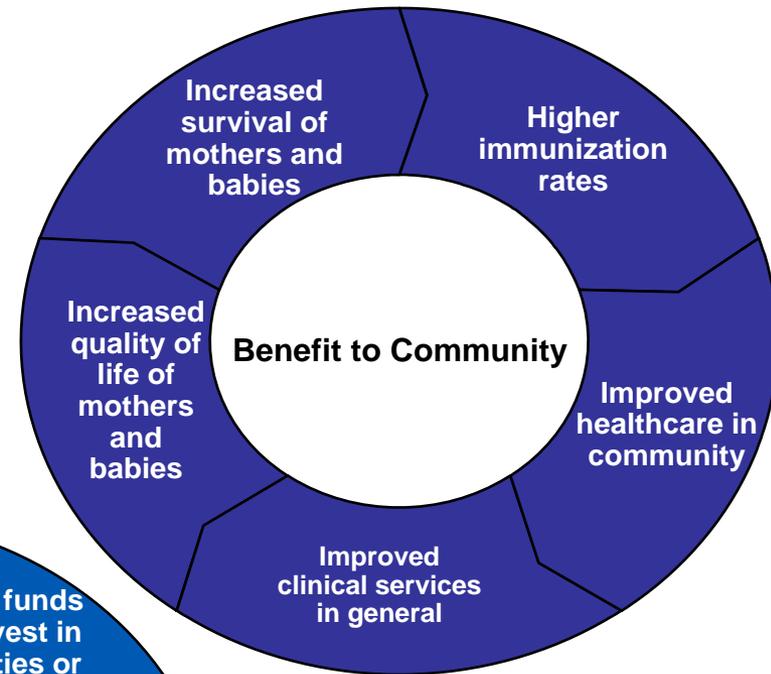
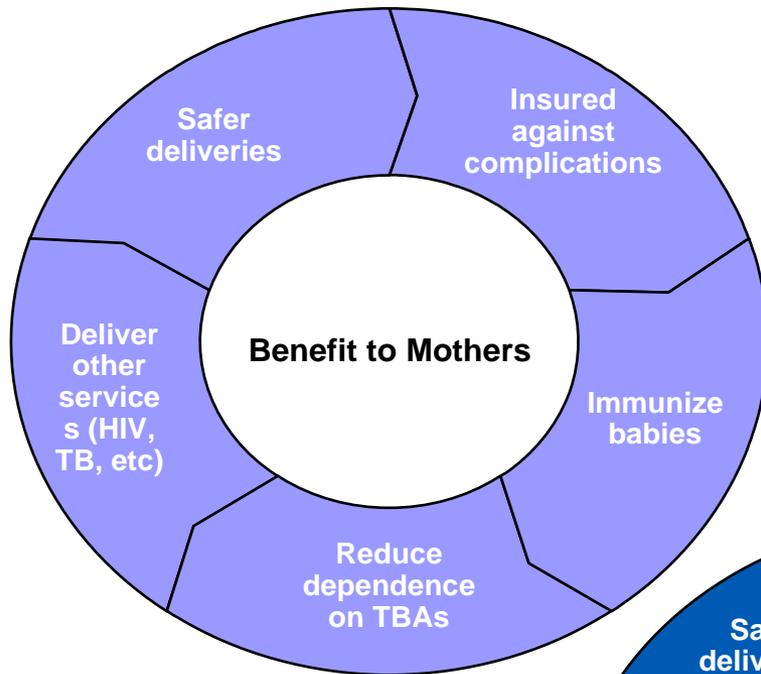
Financial management should be outsourced

- Use 3rd party vendor to manage reimbursement calculations and transfer funds to clinics
 - Consider PwC as vendor to provide common link between DOW voucher program and NCAPD voucher program
 - Benefit from up-front set-up costs to design reimbursement scheme, documentation and tracking processes
 - Provides stronger argument to include West and North Pokot in MOH transfer, assuming NCAPD is successful with intentions (Fall 2007)
- Ensure voucher program takes into account all perspectives by establishing program steering committee including representatives from:
 - DOW
 - 3rd party management agency
 - MOH
 - Each level of health care facility (hospital, health center, and dispensary)
 - Select community opinion leaders
- Each facility's Health Facility Management Committee should decide how to spend clinic's earnings

Social mobilization will ensure successful launch

- Launch marketing messages / education program one month prior to launch of voucher scheme
- Collaborate with community leaders to educate and promote program
 - Design training materials such as posters and flyers (same look and feel as voucher)
 - Organize “village meetings” or utilize pre-existing congregations
 - Engage chiefs and churches to communicate (1) benefits and (2) processes
 - Phase in TBAs to reinforce messages and bring information to new wave of mothers

Marketing messages differ by targeted audience



Conclusion: the voucher program can serve approximately 4,000 mothers every year

Problem

Reliance on home deliveries without skilled attendants results in high rates of maternal and neonatal morbidity and mortality

Solution

Design and implement a sustainable incentive scheme to increase utilization of institutional deliveries by addressing the three major barriers: cost, convenience, and culture

Cost

Option A: \$320,000

Option B: \$580,000

Impact

Paradigm shift in maternal health in the West and North Pokot regions leading to ~10,000 deliveries over 2.5 years

Considerations for future WHIVP projects

- Design performance metrics to measure success of voucher program
- Construct flexibility of program features in case problems arise during early months of pilot implementation
 - Assess feasibility and impact of postpartum services
 - Assess feasibility and impact of pre-delivery transportation
 - Assess alternative distribution channels if three-pronged approach proves ineffective

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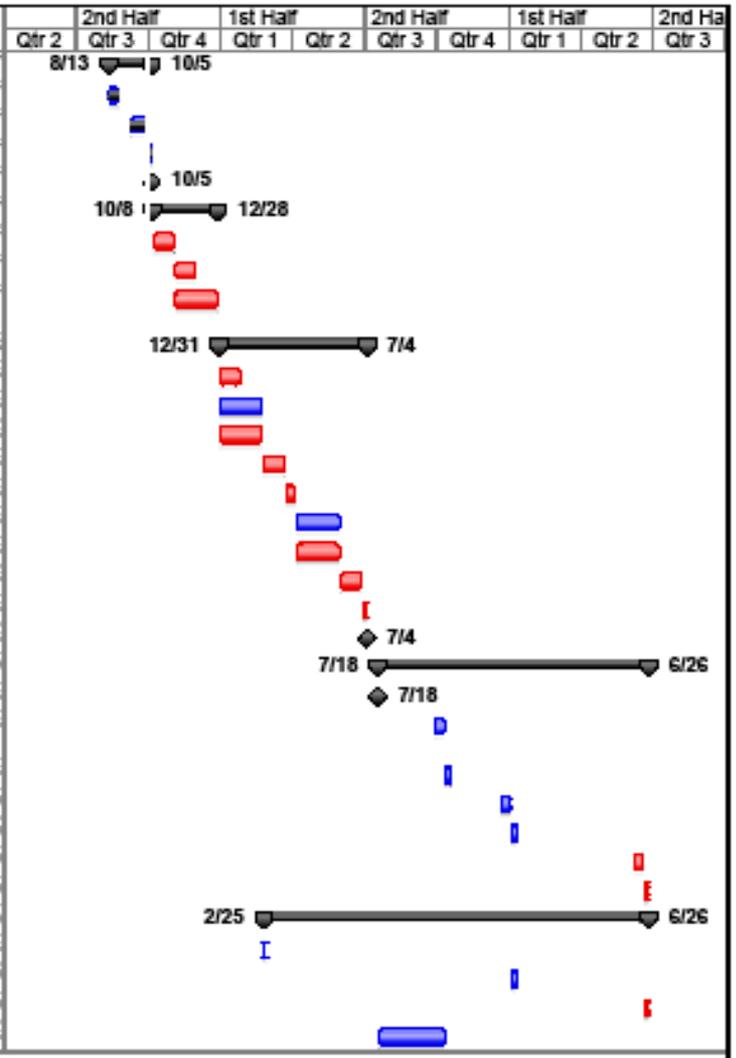
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Details on Proposed Voucher Scheme

Proposed timeline to reach project launch

Task Name	Duration	Start	Finish	2nd Half		1st Half		2nd Half		1st Half		2nd Ha
				Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2
Feasibility Assessment	40 days	Mon 8/13/07	Fri 10/5/07									
✓ Gather data and requirements	2 wks	Mon 8/13/07	Fri 8/24/07									
✓ Analyze and integrate learnings	3 wks	Mon 9/10/07	Fri 9/28/07									
✓ Refine recommendations	1 wk	Mon 10/1/07	Fri 10/5/07									
Present recommendations to DOW Headquarters	0 days	Fri 10/5/07	Fri 10/5/07									
Design Voucher System	60 days	Mon 10/8/07	Fri 12/28/07									
Review recommended voucher scheme	4 wks	Mon 10/8/07	Fri 11/2/07									
Design contracts for health facilities	4 wks	Mon 11/5/07	Fri 11/30/07									
Identify requirements for health facilities to meet baseline accreditation	8 wks	Mon 11/5/07	Fri 12/28/07									
Secure Voucher Management	135 days	Mon 12/31/07	Fri 7/4/08									
Define needs for facility accreditation	4 wks	Mon 12/31/07	Fri 1/25/08									
Define needs to manage daily operations	8 wks	Mon 12/31/07	Fri 2/22/08									
Define needs to manage financials	8 wks	Mon 12/31/07	Fri 2/22/08									
Solicit bids for voucher management	4 wks	Mon 2/25/08	Fri 3/21/08									
Sign contracts with vendors and sites	2 wks	Mon 3/24/08	Fri 4/4/08									
Begin accreditation process	8 wks	Mon 4/7/08	Fri 5/30/08									
Verify costs at clinics for each service	8 wks	Mon 4/7/08	Fri 5/30/08									
Design voucher / processes	4 wks	Mon 6/2/08	Fri 6/27/08									
Review management systems	1 wk	Mon 6/30/08	Fri 7/4/08									
Voucher system ready	0 days	Fri 7/4/08	Fri 7/4/08									
Conduct Pilot Program	245 days	Fri 7/18/08	Fri 6/26/09									
Kick-off voucher program in 9 facilities in W/N Pokot	0 days	Fri 7/18/08	Fri 7/18/08									
Conduct 3-month review with ongoing data collection / monitoring	2 wks	Mon 9/29/08	Fri 10/10/08									
Report findings of 3-month review	1 wk	Mon 10/13/08	Fri 10/17/08									
Conduct 6-month review	2 wks	Mon 12/22/08	Fri 1/2/09									
Report findings of 6-month review	1 wk	Mon 1/5/09	Fri 1/9/09									
Conduct 12-month review	2 wks	Mon 6/8/09	Fri 6/19/09									
Report findings of 12-month review	1 wk	Mon 6/22/09	Fri 6/26/09									
Ensure Sustainability	350 days	Mon 2/25/08	Fri 6/26/09									
Present voucher plan to MOH	1 day	Mon 2/25/08	Mon 2/25/08									
Report 6-month findings to MOH	1 wk	Mon 1/5/09	Fri 1/9/09									
Report 12-month findings to MOH	1 wk	Mon 6/22/09	Fri 6/26/09									
Begin identifying grants to sustain voucher program	3 mons	Mon 7/21/08	Fri 10/10/08									



Voucher Distribution Options

Options	Logistics	Challenges Faced
<ul style="list-style-type: none"> ■ ANC clinics 	<p>Due to staff shortage, employ one distributor per facility to handle sale of vouchers. Best to align with heavy traffic (market) days and to have same person visit multiple visits</p>	<p>Limits voucher reach to only mothers attending ANC Inefficient use of employees' time Competing with TBAs for deliveries</p>
<ul style="list-style-type: none"> ■ ANC clinics ■ Local chiefs 	<p>See above for ANC logistics Provide voucher packets to chiefs to sell to mothers and determine collection method for voucher records</p>	<p>Assumes chief has regular contact with community and is aware of pregnancies Properly motivating chiefs to be advocates and actively involved in the selling process Logistically challenging to manage collection of vouchers from chiefs Competing with TBAs for deliveries</p>
<ul style="list-style-type: none"> ■ ANC clinic ■ TBAs – option 1 	<p>Transaction handled by ANC clinics TBAs refer and bring mothers to the clinic to buy the voucher. TBAs earn a commission of 50ksh for every referral redeemed at a health facility to be distributed to the TBAs through the clinic after clinic receives compensation from DOW</p>	<p>Assumes 50ksh is adequate incentive to overcome lost revenue from conducting a home birth TBAs may not accept the requirement to come to clinic to collect commission</p>
<ul style="list-style-type: none"> ■ ANC clinics ■ Local chiefs ■ TBAs – option 2 	<p>Transaction handled by ANC clinics or chiefs Provide monthly stipend of 400ksh plus 50 ksh commission for redeemed vouchers to TBAs. Require at least one referral (not necessarily redeemed) every four months to remain on payroll Management agency holds monthly meeting to distribute TBA payment and hold educational sessions</p>	<p>Could be most expensive option Requires additional administrative costs to hold monthly meetings Could create hostile environment for mothers (TBAs may be too aggressive with sale)</p>
<ul style="list-style-type: none"> ■ ANC clinics ■ Local chiefs ■ TBAs – option 3 	<p>TBAs purchase voucher packet from DOW upfront, then sell the vouchers to gain back their money</p>	<p>TBAs do not have much disposable cash to buy upfront TBAs may not be convinced it is a good investment TBAs are not best vehicle for voucher transaction (potential fraud)</p>

Voucher Model Specific Assumptions

- West and North Pokot region population growth rate is on par with Kenya national population growth rate of 2.6% per year or 0.2% per month
- Each child-bearing woman will receive 4 ANC visits
 - Each ANC visit is reimbursed for 40ksh
- One-way inter-facility transport is 1,500ksh
- Each child-bearing woman may stay utilize pre-delivery accommodation for up to 14 days
 - Each day of accommodation is 50ksh
- 2 out of 3 vouchers sold would be redeemed (66.7%)
- Annual discount rate of 10% or 0.8% per month
- Distribution incentive of 50ksh
- Exchange rate of 67ksh / \$

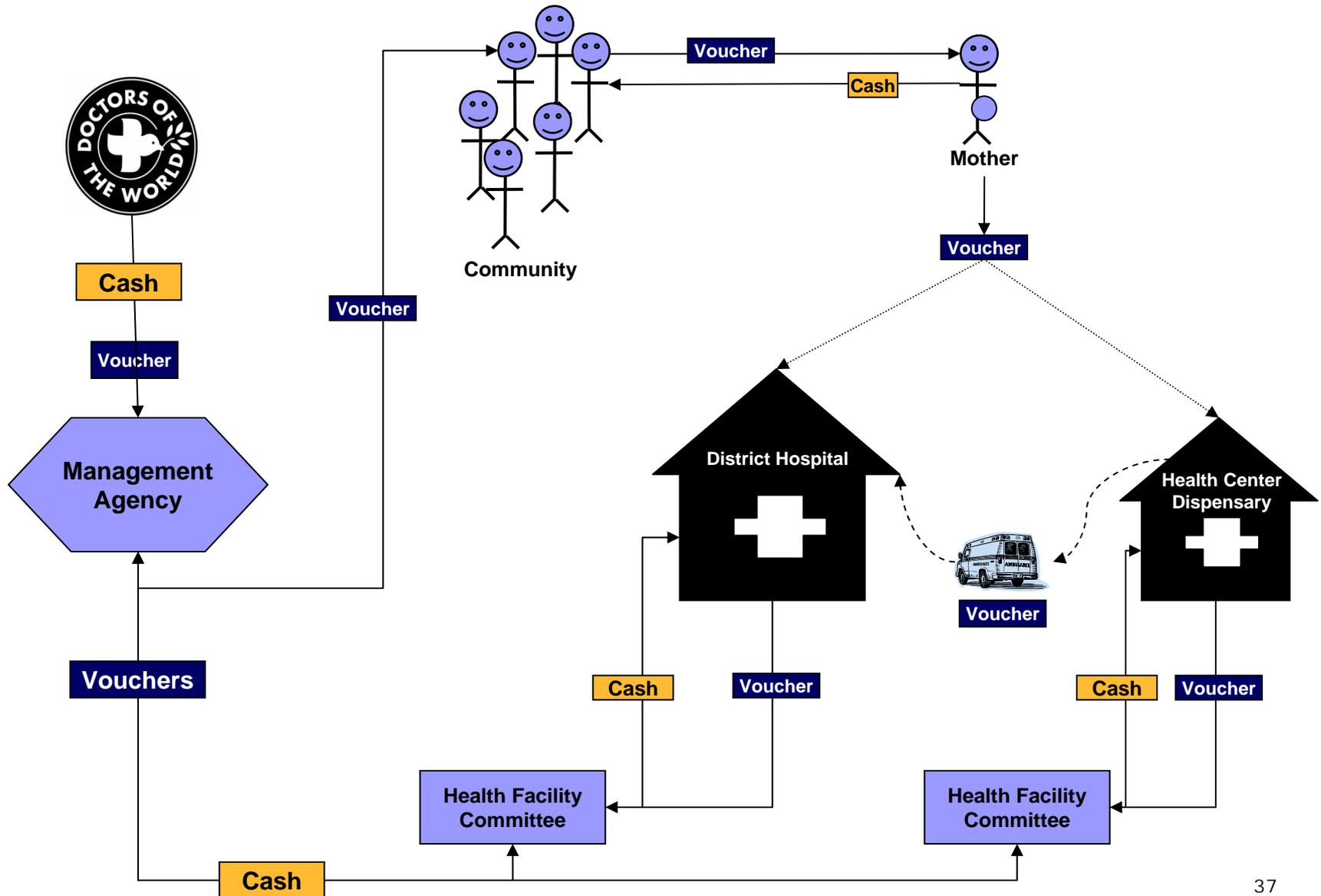
Penetration Assumptions – Option A

- Kapenguria District Hospital and Ortum Mission Hospital are assumed to reach 50% target rate from existing rates of 30% and 20%, respectively
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 50% over 24 months
- Health Centers are assumed to reach 30% target rate from existing rate of 20%
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 30% over 24 months
- Dispensaries are assumed to reach 25% target rate from existing rate of 12%
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 25% over 24 months and plateaus

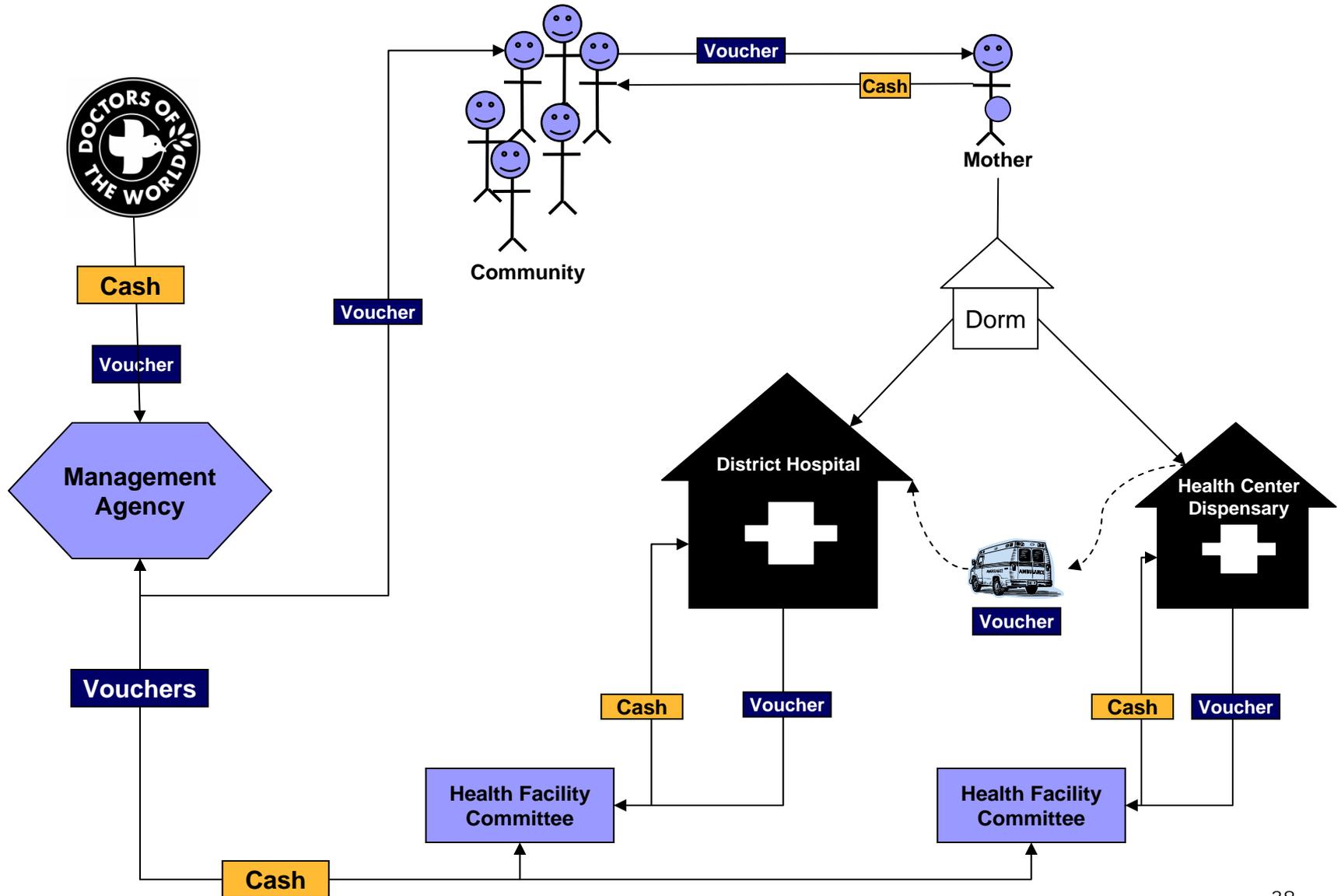
Penetration Assumptions – Option B

- Kapenguria District Hospital and Ortum Mission Hospital are assumed to reach 60% target rate from existing rates of 30% and 20%, respectively
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 60% over 24 months
- Health Centers are assumed to reach 40% target rate from existing rate of 20%
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 40% over 24 months
- Dispensaries are assumed to reach 35% target rate from existing rate of 12%
 - Penetration rate is assumed to stay stagnant for the first six months of launch, then gradually increasing to 35% over 24 months and plateaus

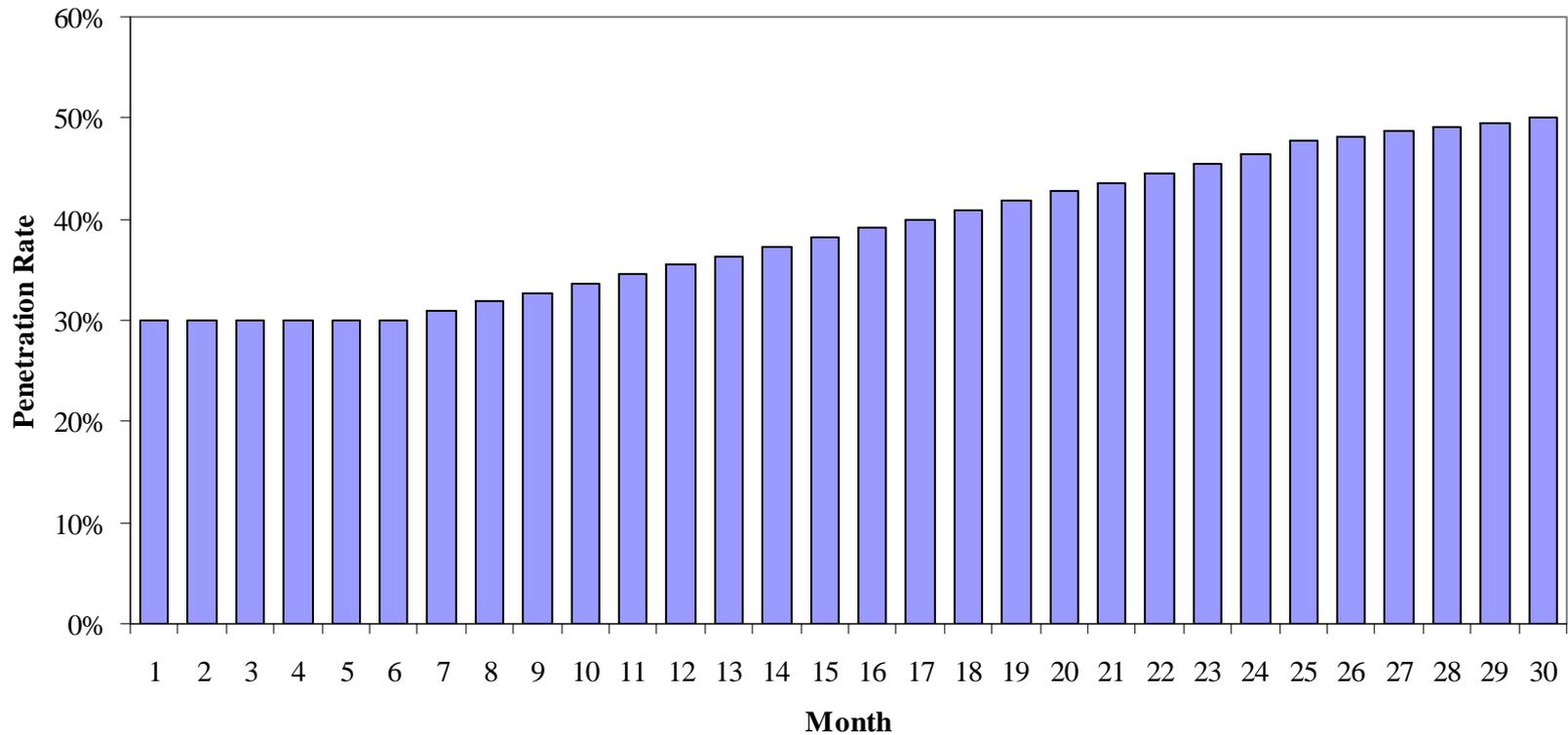
Option A overcomes cost barriers



Option B improves convenience leading to higher utilization



Penetration Rate Trending



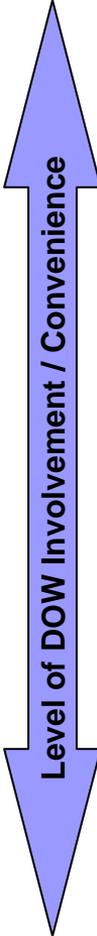
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Details on Transportation Alternative and Existing Voucher Programs

Pre-delivery Transportation Alternative

- The option to reimburse pre-scheduled transportation was seriously considered by our team but discarded in favor of strictly focusing on providing temporary housing at health facilities
 - Introducing too many changes at one time to the existing infrastructure could be overwhelming and counter-productive
 - The sheer complication of managing transportation logistics is a barrier; message to mothers must be clear
 - Reimbursing transportation for women who decide during labor that they want to go to a health facility works against the change in behavior objective of planning ahead
- However, DOW should keep the transportation option in mind if it proves relevant at later stages of the pilot

Pre-Delivery Transportation Options



Options	Logistics	Challenges Faced
No reimbursement	Mother walks to nearest health facility or arranges or transportation	Transportation hurdle may be deterrent to woman delivering in clinics
Partial reimbursement to nearest health facility	Mother arranges vehicle ahead of schedule Facility pays for taxi cost upon mother's arrival and submits for DOW reimbursement at 50%	Convincing taxi drivers that they will be reimbursed upon arrival Educating women to pre-arrange ride Road access – can taxi reach house Availability of vehicle Burden of 50% transportation cost
Fully reimbursed, pre-arranged one-way ride to nearest health facility	Mother arranges vehicle ahead of schedule Facility pays for transportation cost upon mother's arrival and submits for DOW reimbursement at 100%	Convincing vehicle drivers that they will be reimbursed upon arrival Educating women to pre-arrange ride Road access – can vehicle reach house Availability of vehicle
Matatu takes woman to nearest health facility	Facility pays for transportation cost upon mother's arrival and submits for DOW reimbursement at 100%	Woman must transport herself to matatu pick-up location Matatus may not run frequently or reliably Convincing matatu drivers they will be paid upon arrival Assumes dormitories are available to house women prior to delivery if arrive early
Scheduled stops in community to pick-up multiple women and bring to facility	Facility tracks delivery dates of women in catchments Facility arranges for pick-up location using vehicle in community or facility vehicle (if available) Arrangements communicated during ANC visit	Facility must plan ahead Woman must attend ANC visit Assumes dormitories are available to house women prior to delivery
Phone in for vehicle when woman needs to travel to health facility	Transportation arranged by woman when needed	Phone networks non-existent or unreliable Unknown availability of vehicles at last minute

Existing Voucher Programs – Overview

Program	UNICEF	NCAPD
Purpose	<ul style="list-style-type: none"> Output-based aid to promote safe motherhood through increased utilization of ANC services and skilled delivery 	<ul style="list-style-type: none"> Output-based aid – finance agreed upon outputs of a pre-defined quality through voucher system where service providers refunded for services
Scope	<ul style="list-style-type: none"> Health facility / skilled attendance at delivery 	<ul style="list-style-type: none"> (1) Safe motherhood, (2) Family Planning and (3) Gender-based violence
Timeline	<ul style="list-style-type: none"> 2003 - 2007: Needs assessment / Planning (2yrs), Pilot (2yrs) 	<ul style="list-style-type: none"> 2004-2007: Planning (1.5yrs), RFP / contracted management selection (0.5yrs), Pilot (1yr)
Partners	<ul style="list-style-type: none"> AMDD – monitors and assesses voucher scheme 	<ul style="list-style-type: none"> Population Council – quality control PricewaterhouseCoopers (PwC) – financial management Lowe Scanad – marketing Marie Stopes – poverty tool <p><i>(chosen by competitive bidding process)</i></p>
Funding	<ul style="list-style-type: none"> UNICEF – core funds used to launch in 2 northeastern districts EU – funding to expand into additional districts 	<ul style="list-style-type: none"> Gov't of Kenya – funding of €0.16M Gov't of Germany through KfW Bankengruppe – funding of €6.579M Independent disposition fund with set amount; spend must be reconciled before additional funds dispersed
Cost of Pilot	<ul style="list-style-type: none"> Unknown 	<ul style="list-style-type: none"> ~130M ksh for safe motherhood only (~\$2M or ~€1.4M) ~4M ksh for family planning and gender violence (~\$50K or ~€40K)
Impact	<ul style="list-style-type: none"> Unknown 	<ul style="list-style-type: none"> 14,652 natural deliveries 2,798 caesarian section deliveries

Existing Voucher Programs – Design

Program	UNICEF	NCAPD
Recipient Eligibility	<ul style="list-style-type: none"> ■ Women at risk (due to distance from health facility, displacement, poor nutrition, etc) ■ Consider all women at risk; therefore target is 50% of all pregnant women 	<ul style="list-style-type: none"> ■ Participants identified with Poverty Tool; tailored by region (didn't capture % eligible) ■ Objectively measured housing, access to health services, water source, security, sanitation, daily income, etc
Recipient Benefit	<ul style="list-style-type: none"> ■ Delivery irrespective of method and location 	<ul style="list-style-type: none"> ■ 4 ANC visits ■ Normal delivery or complicated delivery at referral facility (includes transport between facilities) ■ 6-week post-delivery check-up
Recipient Cost (Price of Voucher)	<ul style="list-style-type: none"> ■ Free 	<ul style="list-style-type: none"> ■ 200ksh
Provider Eligibility	<ul style="list-style-type: none"> ■ 20 clinics in Northern Kenya district (piloted with 5 clinics) ■ Any facility with skilled attendants in OBGYN eligible to participate ■ Disqualification if detection of fraud or failure to maintain standards 	<ul style="list-style-type: none"> ■ 5 project sites – Kisumu, Korogocho, Viwandani, Kitui, Kiambu ■ Only clinics accredited by NHIF could participate (54 facilities approved) – allowed several months for clinic to reach baseline level of quality
Provider Reimbursement	<ul style="list-style-type: none"> ■ Funding flows from UNICEF → MOH (DMOH) → District clinics ■ DMOH is reimbursement officer ■ HFDC (health facility development committee) manages the use of reimbursed funds 	<ul style="list-style-type: none"> ■ Submit form with following info: <ul style="list-style-type: none"> <input type="checkbox"/> general patient information <input type="checkbox"/> report on services provided <input type="checkbox"/> referral / follow-up required <input type="checkbox"/> cost of service provided <input type="checkbox"/> service provider declaration <input type="checkbox"/> thumb print ■ PwC transfers funds within 2 weeks or 1 month at latest

Existing Voucher Programs – Implementation

Program	UNICEF	NCAPD
Value	<ul style="list-style-type: none"> ■ 400ksh at HC or sub-DH ■ 1000ksh for referrals to DH ■ 3000 – 6000ksh for emergency obstetric care referrals (depends on distance to next referral point) 	<ul style="list-style-type: none"> ■ 5,040ksh for normal delivery ■ 20,500ksh for cesarean section
Voucher design	<ul style="list-style-type: none"> ■ 2-part voucher ■ In future will have security marks for authenticity 	<ul style="list-style-type: none"> ■ 3-part voucher ■ Has security marks and bar codes for tracking
Community Marketing / Education	<ul style="list-style-type: none"> ■ CORPS and ANC clinics 	<ul style="list-style-type: none"> ■ TBAs and community opinion leaders
Distribution of Vouchers	<ul style="list-style-type: none"> ■ Through ANC clinics and by trained CORPS ■ 100ksh for each delivery CORPS facilitated through voucher system 	<ul style="list-style-type: none"> ■ 83 voucher distributors contracted (of which 10 contracts were cancelled) ■ 25% commission (50ksh) for each voucher sold ■ ~30,000 vouchers sold / ~17,500 deliveries conducted
Monitoring	<ul style="list-style-type: none"> ■ Record checked for trends in ANC, delivery and immunizations ■ Regular supervision of participating facilities ■ Random follow-up with recipients 	<ul style="list-style-type: none"> ■ Exit interviews conducted with random sampling of voucher recipients
Fraud Prevention	<ul style="list-style-type: none"> ■ Not a major problem ■ In future identification controls will be introduced much like for currency 	<ul style="list-style-type: none"> ■ Client needs to produce voucher before services provided ■ Check ID cards and note ID number
Sustainability	<ul style="list-style-type: none"> ■ MOH / MOF takes over funding in 2008 	<ul style="list-style-type: none"> ■ MOH takes over in Oct 2007

Contents

- 1 Context
- 2 Landscape Analysis
- 3 Voucher Design and Operations
- 4 **Appendix Three**
Market Research Summaries

Interview – Overview

Organization	Description	Contact	Date
UNICEF	Non-profit organization working for children's rights, their survival, development and protection	Dr. Kennedy Ongwae – Project Officer Safe motherhood / District Health System	8/13/07
Population (POP) Council	Organization seeking to improve the wellbeing and reproductive health of current and future generations around the world	Wilson Liambila – Program Office	8/13/07
National Coordinating Agency for Population and Development (NCAPD)	Semi-autonomous government agency that formulates, coordinates, and implements population policies and programs for sustainable development	Francis Kundu – Population Officer Peter Nyakwara – Regional Population Coordinator, Coast	8/14/07
District Medical Office of Health	Three divisions below the Ministry of Health	Dr. Kipotich - District Medical Office of Health (West Pokot District)	8/16/07
Sigor Health Center	Health facilities in West Pokot District	Mr. Simiyu S. W.	8/17/07
Serewo Dispensary Kacheliba Health Center	Health facilities in North Pokot District	Medical Staff	8/20/07
District Public Health Nurse for West Pokot and North Pokot	Major decision makers regarding policies and distribution of resources in health facilities. Works directly under DMOH	DPHN W. Pokot, based at Kapenguria DPHN N. Pokot based at Kacheliba	8/21/07
West Pokot Women Focus Group	Facilitated discussion on voucher scheme to incentivize institutional deliveries	~10 mothers from Kabichbich area	8/22/07
West Pokot TBA Focus Group	Facilitated discussion on voucher scheme to incentivize institutional deliveries	~40 TBAs from Kabichbich area	8/22/07
Ortum District Hospital	Mission-funded hospital	Medical Staff	8/23/07
PricewaterhouseCoopers	Financial management contractor for NCAPD program	Julius Kitheka	8/30/07

Interview – Summary

MOH	<ul style="list-style-type: none"> ■ Government agency that is ultimately responsible for funding most voucher systems ■ Prefers to be kept in the loop initially; buy-in is not guaranteed ■ Voucher programs will require close MOH involvement during the transitional stage
UNICEF	<ul style="list-style-type: none"> ■ Established OBA program in eight clinics in '05; now operating in 20 clinics in NE Kenya ■ Current voucher funding flows from UNICEF → MOH → DMOH → Clinics; MOF expected to finance the vouchers after transition of program to MOH after 2008
NCAPD	<ul style="list-style-type: none"> ■ Established commissioned-based OBA system in H2:05; POP council (ops and QC) and PwC (financial structure and monitoring) manage the program ■ MOH on steering committee; will add full-time MOH employee to manage transition after 3-years of the program ■ Strong belief that re-investment spending should be decided by clinic itself
Pop Council	<ul style="list-style-type: none"> ■ Have implemented 2 types of voucher systems (including OBA program w/ NCAPD) and pre-pay installment plan system to address maternal health issues ■ Voucher programs must have strong management, support from KOL and clear messages rolled out immediately before implementing the pilots ■ Hurdles go well beyond cost of delivery; strongest hurdles likely distance and culture
PricewaterhouseCoopers	<ul style="list-style-type: none"> ■ Acts as 3rd party vendor for NCAPD program; only involved in program execution ■ Commission-based distribution structure created many problems causing team to switch to salaried employees to distribute vouchers

Interview – Summary

TBAs	<ul style="list-style-type: none"> ■ Mostly unskilled assistants, trusted by community but who perpetuate cultural beliefs ■ External parties and clinic workers believe TBAs create more harm than good ■ Some have been persuaded to participate in existing voucher systems with help of commission-based incentives
West Pokot Women	<ul style="list-style-type: none"> ■ Sense of heroism if deliver at home ■ Often isolated during pregnancy with lack of income; maintain long-standing relationship with TBAs
West Pokot Men	<ul style="list-style-type: none"> ■ Decision maker of whether or not to provide money to get wife to health facility ■ Culturally, husband is not supposed to be with wife during delivery
Health Facilities – Public	<ul style="list-style-type: none"> ■ Three categories (large → small): District Hospitals, Health Centers and Dispensaries ■ Gov-funded institutions that typically have limited equipment / supplies ■ Few number of facilities dispersed through West and North Pokot with minimal transportation resources ■ Budget reduction has led to unavailability of necessities such as cleaners
Health Facilities – Private	<ul style="list-style-type: none"> ■ Example: Ortum District Hospital ■ Small number of private and faith-based organizations funded by fee-for-service and private donors ■ Perceived as expensive; mothers will drive by to get to more affordable facilities farther away

Health Information System

Monthly Reporting Form

Name of Organisation	DOWUSA	Current Month	October
Name of District/Division	WEST POKOT	Current Year	2007

7.0 HIV/AIDS

7.1 Condom Distribution

Number of condoms distributed	
OPD / STI Clinic	
Family Planning Clinic	
Community Health	
Other	
Total	0

Condom Indicator	
Condom coverage rate	0.0

7.2 Voluntary Counselling and Testing (VCT)

Number of VCT clients	< 18		Total < 18	≥ 18		Total Crude	Others
	Male	Female		Male	Female		
Pre-test counselled			0			0	
Tested for HIV			0			0	
Tested positive for HIV			0			0	
Post-test counselled			0			0	

VCT Indicators	
VCT Uptake	
Prevalence of HIV (VCT)	

Health Information System

Monthly Reporting Form

Name of Organisation	DOWUSA	Current Month	October
Name of District/Division	WEST POKOT	Current Year	2007

Proportion who received post-test counselling and result	
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Proportional VCT service use by Nationals	
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Health Information System

Monthly Reporting Form

Name of Organisation	DOWUSA	Current Month	October
Name of District/Division	WEST POKOT	Current Year	2007

7.3 PMTCT (Antenatal)

Number of pregnant women	< 18	≥ 18	Total	P'tners	Others
Number of new antenatal visits this month	0	0	0	0	0
Pre-test counselled			0		
Tested for HIV			0		
Tested positive for HIV			0		
Post-test counselled			0		
Who accepted to take NVP at 28 weeks			0		

PMTCT Antenatal Indicators	
PMTCT Coverage	
PMTCT Uptake	
Prevalence of HIV (PMTCT)	
Proportion who received post-test counselling and result	
Prevalence of HIV among ANC partners	
Proportion of partners who received post-test counselling and result	
Proportional PMTCT service use by Nationals	

Health Information System

Monthly Reporting Form

Name of Organisation	DOWUSA	Current Month	October
Name of District/Division	WEST POKOT	Current Year	2007

7.4 PMTCT (Labour and Delivery)

HIV positive deliveries	< 18		Total < 18	≥ 18		Total Crude	O
	Home	Hlth Fac.		Home	Hlth Fac.		
Live births			0			0	
Still births			0			0	
Abortions			0			0	
During which mother swallowed Nevirapine			0			0	
After which newborn was given Nevirapine within 72 hours			0			0	
Number of mother-newborn pairs that received Nevirapine*			0			0	

PMTCT Delivery Indicators	
Proportion of mothers who swallowed Nevirapine during delivery	
Proportion of newborns who were given Nevirapine within 72 hours of birth	
Ratio of mother-newborn pairs that received Nevirapine*: HIV positive livebirths	
Proportion of HIV positive deliveries to Nationals	

* on time, according to national protocol

Health Information System

Monthly Reporting Form

Name of Organisation	DOWUSA	Current Month	October
Name of District/Division	WEST POKOT	Current Year	2007

7.5 PMTCT (Post natal)

Number of HIV positive women who:		< 18	≥ 18	Total	Others
Plan to exclusively breastfeed				0	
Plan to mix feed				0	
Plan to replacement feed				0	
Received at least one HBC visit*				0	
Accepted modern family planning				0	
Number of exits this month:	<i>discharge</i>			0	
	<i>death (neonatal)</i>			0	
	<i>death (< 1 year)</i>			0	
	<i>death (> 1 year)</i>			0	
	<i>default</i>			0	
	<i>transfer out</i>			0	
Infant HIV outcomes	HIV positive at 18 months				

* HBC = Home Based Care

PMTCT Postnatal Indicators	
Proportion of HIV positive women who plan to exclusively breastfeed	
Proportion of HIV positive mothers who received at least one HBC visit	
Proportion of HIV positive women who accepted modern family planning	

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Examination Couch			Screens			Delivery Bed		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
<i>KAPENGURIA</i>	Kapenguria Hospital	3	1	2	3	2	1	4	2	2
<i>SIGOR</i>	Ortum Hospital	3	0	3	3	1	2	4	2	2
<i>SIGOR</i>	Sigor H/Centre	3	3	0	3	1	2	2	1	1
<i>CHEPARERIA</i>	Chepareria H/Centre	3	1	2	3	0	3	2	1	1
<i>LELAN</i>	Kabichbich H/Centre	3	5	-2	3	1	2	2	1	1
<i>KACHELIBA</i>	Kacheliba H/Centre	3	1	2	3	1	2	2	1	1
<i>SIGOR</i>	Lomut Dispensary	1	3	-2	1	0	1	1	0	1
<i>KACHELIBA</i>	Serewo Dispensary	1	0	1	1	0	1	1	0	1
<i>KACHELIBA</i>	Konyao Dispensary	1	1	0	1	0	1	1	0	1
ITEMS TO BE BOUGHT PER CATEGORY		21	15	6	21	6	15	19	8	11

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Suction Machine			Delivery Kit/Tray			Resuscitation Kit/Tray		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
<i>KAPENGURIA</i>	Kapenguria Hospital	4	2	2	20	5	15	2	1	1
<i>SIGOR</i>	Ortum Hospital	4	1	3	20	3	17	2	2	0
<i>SIGOR</i>	Sigor H/Centre	2	0	2	10	4	6	1	0	1
<i>CHEPARERIA</i>	Chepareria H/Centre	2	0	2	10	3	7	1	0	1
<i>LELAN</i>	Kabichbich H/Centre	2	0	2	10	3	7	1	0	1
<i>KACHELIBA</i>	Kacheliba H/Centre	2	0	2	10	3	7	1	0	1
<i>SIGOR</i>	Lomut Dispensary	1	0	1	5	2	3	1	0	1
<i>KACHELIBA</i>	Serewo Dispensary	1	0	1	5	2	3	1	1	0
<i>KACHELIBA</i>	Konyao Dispensary	1	0	1	5	2	3	1	0	1
ITEMS TO BE BOUGHT PER CATEGORY		19	3	16	95	27	68	11	4	7

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Oxygen Set			Ultra-Sound			Functional Resuscitaire		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
KAPENGURIA	Kapenguria Hospital	4	4	0	1	0	1	2	0	2
SIGOR	Ortum Hospital	4	4	0	1	0	1	2	0	2
SIGOR	Sigor H/Centre	2	0	2				1	0	1
CHEPARERIA	Chepareria H/Centre	2	0	2				1	0	1
LELAN	Kabichbich H/Centre	2	0	2				1	0	1
KACHELIBA	Kacheliba H/Centre	2	0	2				1	0	1
SIGOR	Lomut Dispensary	1	0	1				1	0	1
KACHELIBA	Serewo Dispensary	1	0	1				1	0	1
KACHELIBA	Konyao Dispensary	1	0	1	1	0	1			
ITEMS TO BE BOUGHT PER CATEGORY		19	8	11	2	0	2	11	0	11

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Incubator			Sterilizers			Autoclave		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
KAPENGURIA	Kapenguria Hospital	6	1	5	0		0	3	1	2
SIGOR	Ortum Hospital	6	1	5	0		0	3	1	2
SIGOR	Sigor H/Centre	1	0	1	2	1	1			
CHEPARERIA	Chepareria H/Centre	1	0	1	2	1	1			
LELAN	Kabichbich H/Centre	1	0	1	2	1	1			
KACHELIBA	Kacheliba H/Centre	1	0	1	2	1	1			
SIGOR	Lomut Dispensary				1	1	0			
KACHELIBA	Serewo Dispensary				1	1	0			
KACHELIBA	Konyao Dispensary				1	1	0			
ITEMS TO BE BOUGHT PER CATEGORY		16	2	14	11	7	4	6	2	4

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Maternity Beds			MVA Kits			Caesarian Section Set		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
KAPENGURIA	Kapenguria Hospital	30	20	10	5	2	3	3	2	1
SIGOR	Ortum Hospital	30	27	3	5	0	5	3	2	1
SIGOR	Sigor H/Centre	5	4	1	2	0	2			
CHEPARERIA	Chepareria H/Centre	5	1	4	2	0	2			
LELAN	Kabichbich H/Centre	5	3	2	2	2	0			
KACHELIBA	Kacheliba H/Centre	5	0	5	2	0	2			
SIGOR	Lomut Dispensary	3	0	3						
KACHELIBA	Serewo Dispensary	3	0	3						
KACHELIBA	Konyao Dispensary	3	0	3						
ITEMS TO BE BOUGHT PER CATEGORY		89	55	34	18	4	14	6	4	2

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED								
EQUIPMENT		Mini lap Set			Stitching Tray			Ambulance		
SUPERVISION AREA	FACILITY	Desired	Available	# Missing	Desired	Available	# Missing	Desired	Available	# Missing
KAPENGURIA	Kapenguria Hospital	3	0	3	10	3	7	1	1	0
SIGOR	Ortum Hospital	3	0	3	10	3	7	1	0	1
SIGOR	Sigor H/Centre				5	2	3	1	1	0
CHEPARERIA	Chepareria H/Centre				5	3	2	1	1	0
LELAN	Kabichbich H/Centre				5	1	4	1	0	1
KACHELIBA	Kacheliba H/Centre				5	0	5	1	0	1
SIGOR	Lomut Dispensary				5	1	4			
KACHELIBA	Serewo Dispensary				5	1	4			
KACHELIBA	Konyao Dispensary				5	1	4			
ITEMS TO BE BOUGHT PER CATEGORY		6	0	6	55	15	40	6	3	3

ANNEX IV

INVENTORY OF MINIMUM EQUIPMENT REQUIRED FOR PROVISION OF REPRODUCTIVE HEALTH SERVICES

		EQUIPMENT REQUIRED			
EQUIPMENT		Telephone (Y/N)			Phone Contact
SUPERVISION AREA	FACILITY	Desired	Available	Missing	
<i>KAPENGURIA</i>	Kapenguria Hospital	Y	Y*	1	
<i>SIGOR</i>	Ortum Hospital	Y	Y*	1	0734425619
<i>SIGOR</i>	Sigor H/Centre	Y	Y*	1	0727792896
<i>CHEPARERIA</i>	Chepareria H/Centre	Y	Y*	1	
<i>LELAN</i>	Kabichbich H/Centre	Y	Y*	1	0721465909
<i>KACHELIBA</i>	Kacheliba H/Centre	Y	Y*	1	0729545884
<i>SIGOR</i>	Lomut Dispensary	Y	Y*	1	0727412287
<i>KACHELIBA</i>	Serewo Dispensary	Y	Y*	1	0734439856
<i>KACHELIBA</i>	Konyao Dispensary	Y	Y*	1	0736407216
ITEMS TO BE BOUGHT PER CATEGORY				9	

ANNEX V

West Pokot District Health Information Office

CHWs Data Collection Form						Month	
HOME VISITS							
No of home visits made		Average no of home visits per CHW		No of home visits for Maternal Health		No of maternal health referrals	
No of HH with ITNs		No of pregnant mothers using ITNS		No of U5 using ITNs			
TRAININGS							
Health education individual session		Health education group session		Total No of participants		No of Nutrition education attendees	
No of sanitation education attendees		No of breast feeding training attendees		No of Personal hygiene attendees		No of STD/AIDS prevention education attendees	
No trained on Malaria awareness		No of ORS training attendees		No of Child spacing/FP training attendees		No trained on mental health awareness	
REPRODUCTIVE HEALTH							
No of Pregnant women referred to health facility for ANC		No of Pregnant women referred to health facility for delivery		No of ANC defaulters followed up		Number of community deliveries registered	
No of maternal deaths registered		No of Neonatal deaths registered					
DISEASE SURVEILLANCE							
No of communicable diseases identified (specify)		Cases of eye infection treated		Bloody diarrhoea cases treated with ORS		Watery diarrhoea cases treated	
No of ITNs distributed		Amount of Vitamin A distributed		Referral to various clinics			
OTHER							
Number of Condoms distributed		No of Referrals for PMTCT		No of EPI defaulters followed		No of TB defaulters followed up	
FP CBD given		No of Referrals to FP		Amount of ORS distributed		Special Follow up	

ANNEX VI

SOCIAL AND BEHAVIOR CHANGE STRATEGY

1. Broad Behavior Change Goal: Improve maternal and neonatal health practices through promotion of positive behavior change at individual, household, and community levels.

2. Specific Behavioral Objectives: The behavior change objectives fall under overall project objective 2: Strengthen community awareness of and demand for quality maternal and neonatal care (MNC) services.

BC Objective 1: Pregnant women and through them, newborns, should utilize the recommended maternal and neonatal health services; community health workers, health system staff, and community members should assist pregnant women and newborns in seeking and receiving these services.

BC Objective 2: Mothers should take preventative measures to improve their health during and post-pregnancy, preserve their newborn's health and lower the risk of emergencies.

3. Summary of SBC Strategy: This project will improve maternal and neonatal health by increasing utilization of maternal and neonatal health services and practice of positive behaviors. Behavior Change Interventions (BCI) will address barriers in seeking and using MNC services in a timely manner, as well as preventive behaviors that promote maternal and newborn health and reduce the impact of HIV/AIDS and malaria. The project will also address behaviors at the facility level, helping providers identify and address non-resource barriers to providing quality MNC, HIV/AIDS, and malaria services.

The project will foster change in pregnant women's behavior by increasing knowledge and awareness about the benefits of key maternal and neonatal health services, such as attendance of at least four antenatal care visits and delivery at health facilities; and preventive behaviors, such as the use of insecticide treated nets (ITNs). Community knowledge and attitudes will be addressed through targeted education and behavior change messages delivered through a range of channels of communication including community education sessions (*barazas*), drama groups, community health workers, and radio stations. In addition to pregnant women, focused advocacy messages will target opinion leaders and men regarding the support of pregnant women, male involvement, and participation in community efforts addressing health issues. Health facility staff and other health system stakeholders will also be enlisted as channels of communication through training to improve counseling skills regarding, focused antenatal care (FANC), birth planning, skilled birth attendance and targeted post partum and neonatal care within 48 hours of giving birth. The behavior of health facility staff will also be targeted through skills training, to ensure that they are able and willing to provide quality maternal and neonatal health services.

4. Implementation of the SBC Strategy

Doctors of the World-USA (DOW) will play a facilitative role in this strategy, with the SBC Coordinator serving as a focal point. DOW's role will include:

- Offering guidance through out implementation
- Offering supportive supervision during implementation at all levels.
- Monitoring and evaluation

ANNEX VI

- Facilitating trainings of Community Health Extension Workers (CHEWs) and Community Health Workers (CHWs)
- Developing/adapting information, education, and communication (IEC) materials

Channels of Communication and Tools to be applied in this SBC strategy are described below, and in the BEHAVE framework. Channels and tools that specifically target the DHMT and health providers are not discussed at length below, as they are described in the DIP under Objectives 1 and 4, and will be discussed at length in the QI/QA strategy.

A. Channels of Communication:

a. Community Health Extension Workers (CHEWS) and CHWs

CHEWs

The National Community Strategy recently released by the MoH calls for DHMTs to appoint CHEWs whose main responsibility will be to train and supervise Community Health Workers (CHWs) who will serve as the community's public health foot soldiers, educating the community on key health issues and available services, as well as collecting basic health data. CHEWs will also serve as the DHMT's connection with the community, engaging with community leaders and supporting community based health activities. Since West Pokot and North Pokot are not among the districts selected for initial roll-out of the initiative, thus far no CHEWs have been appointed. DOW will work with the DHMT to implement the National Community Strategy in West Pokot. DOW will help the MOH identify community health extension workers (CHEWs) who by MoH guidelines must have prior experience as Public Health Technicians or Nurses. Each CHEW will offer supportive supervision to 25 CHWs working within the catchments area of the facility at which they are based. DOW will collaborate with the DHMT to train CHEWs in MNC knowledge and training skills. CHEWs will conduct monthly CHW meetings at the facility.

Community Health workers (CHW)

In collaboration with DHMT, DOW will facilitate selection of Community Health Workers (CHWs) through community public meetings where selection criteria will be developed through a participatory process, per MoH guidelines. The selection will be done at the sub-location level with each village selecting its CHWs. Men will be encouraged to become CHWs, thereby promoting male involvement by example. Each CHW will be responsible for 20 households. After selection CHWs will be trained in the knowledge and skills that will enable them to promote behavior change among the community in relation to MNC. DOW will also organize periodic refresher training for the CHWs, led by CHEWs. The major focus of CHW training will be:

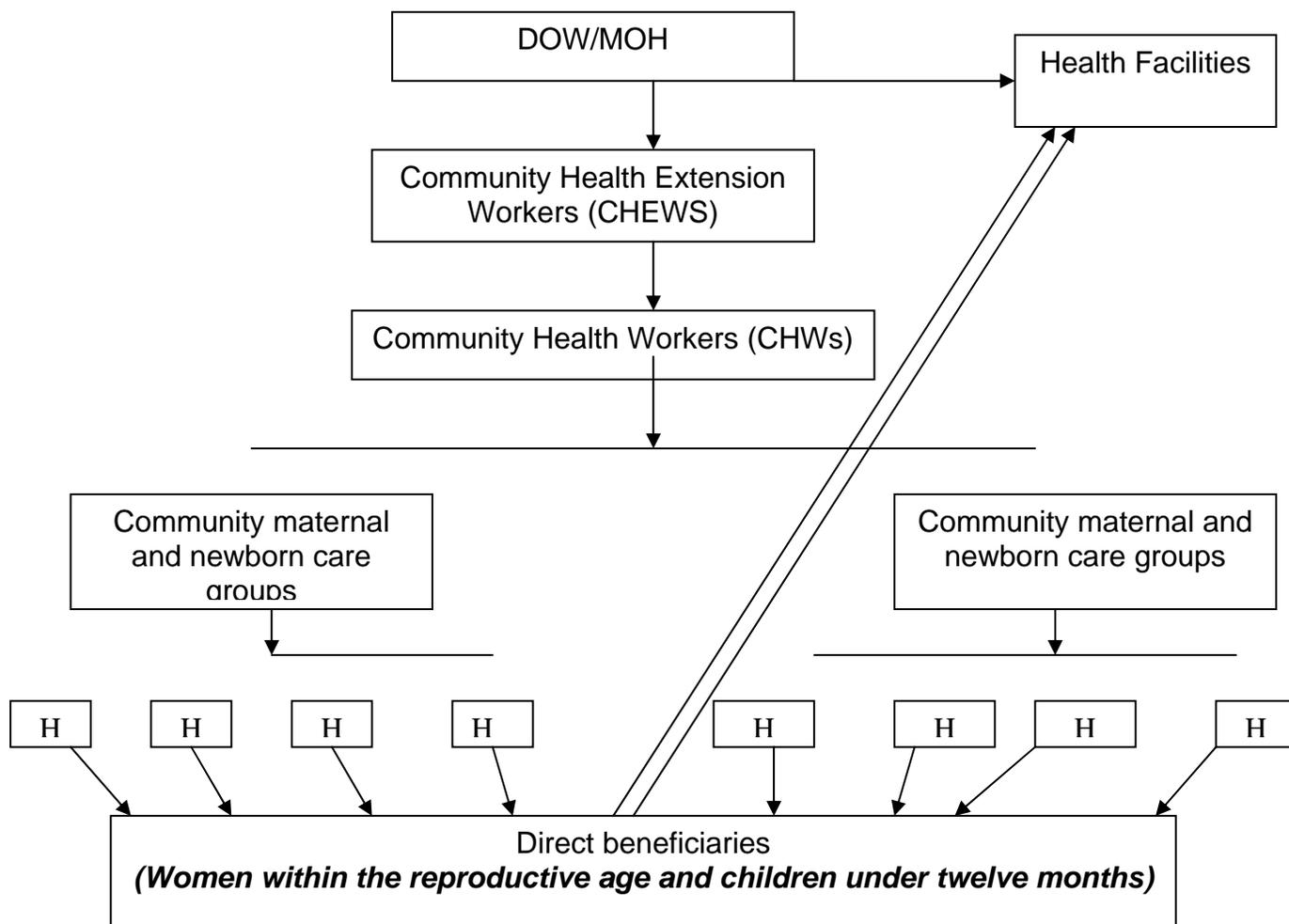
- Basic communication skills with mothers and families
- Healthy practices and care during pregnancy
- Care during delivery
- Healthy practices and care postpartum
- Recognition of danger signs and referral to appropriate facility

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CHWs will educate mothers and the individuals supporting them (spouses, parents, in-laws) through community MNC Groups, community *barazas*, MNC Health Days and any other forums allowing them to interact with community members.

In addition to educating the community, CHWs will be responsible for referring mothers and newborns for MNC services at appropriate times, follow up on defaulters (i.e. for ANC visits), promote and participate in MNC Health Day activities, and mobilize attendees to semi mobile clinics and other facility outreach services. CHWs will also serve a key role in the Community Based Health Information System (CBHIS) to be strengthened through this project, as they will be responsible for collecting basic MNC data and reporting it at the monthly meetings lead by CHEWs. Appendix V provides a draft of the CHW reporting form.

Per the National Community Strategy, CHWs will serve as volunteers. However, DOW is exploring several options for creating an incentive program. Leading among these is the option of giving CHWs the opportunity to sell items from a Health Kit. The Kit would contain various health and hygiene related items (i.e. bandages, antiseptic, etc.) and would be sold to CHWs at low cost. No matter what additional incentives are selected, CHWs will all receive identifying badges, IEC tools, and other materials and job aids that identify them as important members of the community.



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b. TBAs

TBAs will be eligible for becoming CHWs as long as they meet the criteria set by their community. Those who are not CHWs will still be engaged in SBC efforts, both as a target population whose awareness, knowledge and behaviors the project will seek to change, and as a communication channel to reach mothers and their household members to promote healthy MNC practices and refer mothers to facilities for delivery and pre and post services. TBAs will be recruited to participate in a series of trainings focusing on MNC practices, FGM, HIV/AIDS including benefits of PMTCT, and maternal malaria and prevention. TBAs will be asked to promote facility-based delivery especially when mothers display danger signs, HIV testing and counseling and ITN use during pregnancy. CHEWs will also hold regular follow-up meetings with TBAs.

c. Health Providers

Health providers will be trained to counsel mothers seeking care, integrating health visits with behavior change messages to encourage health care seeking behavior. Providers will counsel patients not only at the facilities but also through the outreach clinics. IEC materials will also be distributed through the clinics.

e. Health Facility Committees (HFCs)

The Health Facility Committees are the link between the facility and community, charged with providing feedback from the community to the facility and mobilizing the community's efforts to support the health facility (i.e. raising funds from the community for a new maternity ward). After training in key SBC topics and messages, CHCs will be asked to promote SBC events in the community and encourage participation. They will also be providing feedback to the facilities. The exact role of HFCs will be defined in the project's QI/QA strategy which is currently being finalized.

f. Local NGOs, CBOs and FBOs

Representatives from local organizations will be invited to participate in the community trainings. DOW will work closely with selected organizations to organize community events such as MNC Health Days and community meetings (*barazas*) focusing on health issues with the aim of having these organizations continue these activities independently after the project comes to a close. Where needed DOW will build the capacity of selected organizations so that they will be able to plan and implement such events effectively. DOW is also considering partnering with local organizations to implement other component of the project, such as administering the CHW incentive program (i.e. the procurement, sale and tracking of health commodity kits with items to be sold to the community by CHWs).

g. Local Administrators, Chiefs, Assistant Chiefs, and Elders

As leaders of the community, the Local Administrators, Chiefs, Assistant Chiefs, and Elders are regularly speaking at public events and serving as a source of advice to community members who go to them for support. Thus they are key informants in the community and play an important role in promoting behavior change. DOW will raise their awareness and knowledge on issues related to MNC, HIV/AIDS and malaria through trainings especially tailored for them.

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h. Radio

A radio campaign will be launched with carefully crafted messages regarding MNC, HIV/AIDS and malaria communicated through public service announcements, commercials and dramas/skits.

f. Poster Campaign

Tied to the radio campaign will be a poster campaign promoting the same messages through colorful posters heavily displayed throughout the project's target areas. Local organizations will be recruited to support the effort through volunteers. One may even be selected to oversee the implementation of the entire campaign.

B. Communication Tools

a. Community MNC Groups

Each CHW will be expected to form two MNC groups in their village. Each group will have at least 25 members (both male and female) who will be members of the households assigned to the CHW. The CHW will conduct meetings with each group once a month for about two hours.

After training and sensitization, MNC group members of the household will be expected to encourage the following key behaviors:

- Women seek/receive focused antenatal care (before 16 weeks, between 24 and 28 weeks, at 32 weeks, and at 36 weeks) from skilled provider.
- Women and men actively participate in household birth preparedness activities.
- Women and men initiate/participate in dialogue with family members about all aspects of advance planning for skilled attendance.
- Women seek/receive timely, appropriate obstetric care from skilled provider.
- Women seek/receive timely appropriate emergency obstetric care from skilled provider.
- Mothers seek/receive timely, appropriate early postpartum care (first 1-2 days after birth) from skilled provider.
- Mothers practice appropriate cord and thermal care for their newborn babies, and recognize newborn danger signs and seek timely care.
- Mothers to practice proper breastfeeding practices (infants are immediately breastfed in the first hour and exclusively breastfed for six months).

b. Community Barazas (public meetings)

DOW will advocate through local leaders (e.g., Administrators and Chiefs) that, during community public meetings, the CHWs and CHEWs be given a chance to sensitize the community on MNC. These meetings will also be opportunities for dramas to be performed on various topics related to target behaviors. A dialogue model of communication will be applied that will encourage participatory discussion, problem-solving, and decision-making regarding behaviors related to MNC.

c. IEC Materials

DOW will develop or adapt IEC materials in the local language that will communicate key messages on MNC; this may include bags, T-shirts, flyers, posters, and other items. These

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materials will be given to the CHEWs, CHWs and the local administrators, used at community-based education sessions, and also be put in public places such as health centers and market areas.

d. MNC Health Days

DOW and the MOH will periodically organize for health day in every sub-location where best practices on MNC will be demonstrated to the community. This will be through health talks, dramas on model mothers and fathers, posters, folk songs, etc.

e. Testimonies from Satisfied Clients

After delivering at the health facilities and receiving quality services mothers will be encouraged to give testimonies during public meetings or during MNC groups meetings or other public gatherings.

f. Outreach MNC Clinics

Dow will facilitate outreach MNC clinics at underserved areas where key messages on MNC and related services will be offered.

g. Skits/Dramas

DOW or, if possible, DOW's community partners chosen to lead this effort, will work with drama groups to create skits and or longer dramas promoting SBC messages, to be presented at community events such as Health Days and on the radio. One such skit was already presented at the project's launch event in on September 5, 2007.

h. Public Service Announcements/Commercials

DOW will air the key MNC messages using the popular radio stations in West Pokot. This will reinforce key messages in the three intervention areas of MNC, malaria, and HIV/AIDS. Further, the messages will include advertisement for the nine facilities that DOW is working with as well as the availability of outreach MNC clinics.

4. SBC Monitoring Plan

The outcomes of SBC activities will be measured through the process indicators described in the Monitoring Plan as well as the outcome indicators submitted with the DIP. However, the acceptability and effectiveness of SBC tools will be evaluated before they are rolled out across the program location. Tools will be developed and pilot-tested with small samples of the target groups, to ensure that they are clear, convey the intended information, and do not violate cultural norms or other community expectations. During mid-term and endline KPC and other evaluations, community members and other individuals will be surveyed about their exposure to any of the SBC tools and channels of communication, and will be asked about their retention of and response to the messages therein.

5. BEHAVE Framework

The project's BEHAVE Framework is presented below.

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Table: BEHAVE Framework

GROUPS		BEHAVIOR	KEY FACTORS	ACTIVITIES		
PRIORITY	SUPPORTING			Channels	Tools	Message/Content
All pregnant women	Husbands, in-laws, parents CHWs	Pregnant women plan for and deliver with a skilled provider.	<i>Note: All key factors have crosscutting impacts on all targeted groups</i> -Distance - Poor infrastructure (roads, phones) -Transport -Cost -Quality of care at the facility -Trust -Cultural practices – in the household - Cultural practices – not supported at facilities -Health information management systems – at community and in facility. -Linkages between the facility and the community -Staff work load -Equipment and supply gaps - Lack of MNC skills training - Lack of interpersonal	Potential channels include: <ul style="list-style-type: none"> • CHWs • TBAs (referral agents) • Health providers • Local organizations (CBOs, FBOs, etc.) • Local Administrators, Chiefs, Elders • Community Health Committee • Radio • Poster Campaign 	Potential tools / media include: <ul style="list-style-type: none"> • MNC Groups (group discussion) • Folk songs • Posters • Public Service Announcements/Commercials • Flip Charts • Provider Counselling • MNC Health Days • Demonstrations • Community Meetings • Drama / skits • Community Based Education sessions. • MNC Outreach Clinica • Testimonies 	<ul style="list-style-type: none"> • Birth planning (saving money, danger signs, where to get services and costs, transport options)
All pregnant women	Mother & Mother-in-law, husband, CHWS, Health facility staff	Pregnant women attend ANC at least four times				<ul style="list-style-type: none"> • Importance of IPT and daily 2 dose intake during pregnancy • Where to get IPT, ITN and costs.
All pregnant women	Mother & Mother-in-law, husband, CHWS, Health facility staff	Pregnant women sleep under insecticide treated nets. And receive IPT, and TT				<ul style="list-style-type: none"> • Dispel misperception about weight gain and baby size/delivery obstruction • Benefits of consuming sleeping under insecticide treated nets to pregnancy outcome and own health • Healthy.
Women in labour	Mother & Mother-in-law, husband, CHWS, Health facility staff	Moving to a health facility with a trained birth attendant.				<ul style="list-style-type: none"> • Organising for transport or a waiting home near the facility.
Postpartum women up to 28 days	CHWs, Health staff, husband, mother and mother in law	Go to postnatal clinic for postpartum and neonatal examination within 48 hours of giving birth.				<ul style="list-style-type: none"> • Importance of Vitamin A to build strength and resistance to diseases of the newborn • Frequency and where to get it
Postpartum women up to 28days	CHWs, Health staff, husband, mother and mother in law	Newborns are immediately breastfed within first hour of birth 40% to 60%				<ul style="list-style-type: none"> • Colostrum as first vaccination/ protective effect • Frequent breastfeeding early improves mothers milk production • Dispel common misperceptions.
Husband and mother-in-law	Mother	New born babies with rapid breathing or chest in-drawing receive care from a trained provider 45 % to 60%				<ul style="list-style-type: none"> • What is rapid breathing and chest in-drawing– key signs • Importance of seeing a trained provider, who they are and costs • Benefits of early recognition and treatment – lower costs, easier to treat, takes less time, and healthier child

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GROUPS		BEHAVIOR	KEY FACTORS	ACTIVITIES		
PRIORITY	SUPPORTING			Channels	Tools	Message/Content
Community Members	All community members, local administration, CHEWs and CHWs	-Advocate for improved MNC practices at community and facility level -Participate in management and implementation of MNC health interventions. -Support families to abandon harmful cultural practices such as FGM	communication training - Lack of MNC information and education - Women's status and decision-making power	See above	See above	<ul style="list-style-type: none"> • Importance of healthy mothers and babies • Effects of harmful traditional practices with greater focus on FGM
Health facility staff	CHEWs and CHWs, DHMT	-Provide quality delivery of services. - Provide information and education about MNC – services and preventive behaviors -Initiate timely referral of obstetric and neonatal complications - Provide mother/ baby friendly services	-	Specific to health facility staff and DHMT: DHMT PHMT DOW staff Training events Supportive supervision visits	Specific to health facility staff and DHMT: District stakeholders forum Training curricula IEC materials Patient education job aids QA/QI forms	<ul style="list-style-type: none"> • Importance of health education • Interpersonal communication and counselling • Planning, coordinating and implementing EOC and newborn care training for health facility staff • • Conducting/supportive supervision, including frequent visits to facilities. • Involving health facility staff in decision making. • Following-up on the application of MNC skills • Applying quality improvement and assessment
DHMT	CHEWs and CHWs, health facility staff	-Provide effective supportive supervision for MNC services in public facilities. - Improve stakeholders' partnerships and relationships				

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
OBJECTIVE 1: Strengthen the capacity of nine focus district health facilities to provide quality maternal and newborn care, in accordance with Ministry of Health policy			
Facility Quality Improvement Committees (QICs) oversee QI/QA Effort	# of facilities which have identified all members of their QIC	% of facility QIC's which held all monthly meetings in the last quarter FREQ: Quarterly SOURCE: Meeting minutes, staff interviews	
	% of QI Committee members who received training in QI/QA methods	% of facilities that completed more than 50% of items on the QI plan to be done that quarter FREQ: Quarterly SOURCE: Meeting minutes, staff interviews	
		% of staff aware of facility's QI process and how to contribute their ideas and concerns FREQ: Quarterly or if not possible Midterm & Final Eval SOURCE: Staff interviews	
Provider training on MNC services and integration of related malaria and HIV/AIDS services	% of providers who have received appropriate training	% of facilities scoring greater than 90% on last supervisory checklist FREQ: Quarterly or if not possible, biannual SOURCE: Completed Checklists	ASSUMPTION: Supervisory visit checklist covers all MNC services to be provided at the particular facility
		Patient satisfaction indicator/s for MNC services FREQ: Midterm and Final evaluation SOURCE: Patient interviews, MTE and Final Evaluation tools	
		To be monitored through outcome indicators (utilization rates) FREQ: Monthly SOURCE: Monthly DRH Forms	

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
Effective supply system in place – Facility’s Role	# meetings with DHMT # Facility QI/QA Committee meeting attended by DOW staff to provide technical support	% of facilities with any MNC supply outage FREQ: Quarterly or if not possible, biannual SOURCE: Supervisory Visit Checklist	ASSUMPTION: Based on list of key MNC supplies/meds that should always be in stock (including ITNs)
Renovation and installation of needed equipment for MNC services at health facilities	# of selected facilities with renovation completed. # of target facilities with equipment procured, installed and providers trained in use/maintenance	% of facilities scoring greater than 90% on MNC equipment and space check list FREQ: Biannual SOURCE: Completed checklists	
Fostering facilities’ relationship with community (especially TBAs, CHWs)	# of CHEWs facilitating monthly CHW meetings	% of expected CHW monthly meetings held in the last quarter FREQ: Quarterly SOURCE: CHEW log % of CHWs who attended 2 out of the 3 last CHW meetings FREQ: Quarterly SOURCE: CHEW log	NOTE: Should also segregate by clinic. NOTE: Section depends on Community QI strategy including facilities role in CBHIS. May be broken down into several inputs.
	# of CHEWs facilitating monthly TBA meetings	% of expected TBA monthly meetings held in the last quarter FREQ: Quarterly SOURCE: CHEW log	
		% of TBAs who attended 2 out of the 3 last CHW meetings FREQ: Quarterly SOURCE: CHEW log	
	# of facilities with Community Health Facility Committee (CHFC) established	% of quarterly CHFC meetings held per year FREQ: Annual SOURCE: Meeting minutes, CHFC	NOTE: This component depends on community QI strategy. CHFC refers to the existing group of community members and providers which meet to provide feedback to facility on quality of

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
		interviews	service issues,
		Indicator 2 TBD	NOTE: Should also segregate by clinic.
Timely and proper reporting of health conditions presented by patients and services provided	# of focus facilities with new/revised reporting forms in place # of facilities whose supervisory staff have received training on use of forms # of supervisory visits made to facility with immediate feedback provided	% of facilities which submitted all reports to DHMT on time for the last 3 months FREQ: Quarterly SOURCE: DHMT records % of facilities which completed >90% of the data forms submitted in the last three months correctly FREQ: Quarterly SOURCE: DHMT records	ASSUMPTION: Barring natural disaster or other condition out of facility staff's control NOTE: Should there be another indicator for completeness of data forms?
OBJECTIVE 2: Strengthen community awareness of and demand for quality MNC services.			
CHEWs mentor and supervise CHWs	# of CHEWs selected and trained to mentor and supervise CHWs	% of CHEW positions filled with a properly trained CHEW FREQ: Biannual SOURCE: CHEW contracts	
CHWs educate and support the community in utilizing MNC services	# of CHWs trained in MNC, HIV/AIDS, Malaria prevention # of CHWs in possession of and trained in using IEC materials/job aids # of CHWs with official badge, bag & other materials # of monthly CHW meetings held (proxy for supportive supervision provided by CHEWs)	% of CHWs speaking at or organizing at least two community meetings in the last quarter FREQ: Quarterly SOURCE: CHEW meeting minutes and records # of MNC Group meetings held in the last month FREQ: Quarterly SOURCE: CHEW meeting minutes and records Indicator on mother's satisfaction with Support Groups - TBD Indicator measuring community satisfaction	CONSIDER: Indicator on % of CHWs attending last month's meeting NOTE: Could be replaced with indicator measuring drop-out rate

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
		with CHWs - TBD FREQ: SOURCE: Indicator measuring CHWs referring patients to facility for deliver and accompanying them - TBD	
Training Chiefs, community leaders in MNC care seeking and HIV/AIDS and malaria prevention, harmful practices	% of Chiefs and Assistant Chiefs who received both trainings (MNC, HIV, Malaria and FGM Sensitization)	Process Indicator Not Needed (see outcome indicator)	
MNC Health Days held	# of meetings with local organizations, Health Facility Committees, CHWs, Chiefs and others involved in planning Health Days to provide planning and implementation support	% of sub-locations where an MNC Health Day was held in the last 6 months FREQ: Biannual SOURCE: CHEW records	
Poster Campaign Conducted	# of posters printed and distributed to the community	Process Indicator Not Needed (see outcome indicator)	
Radio Campaign Conducted	# of radio spots created # of radio stations spots broadcast on	Process Indicator Not Needed (see outcome indicator)	
Drama groups perform dramas with BCC messages	# of events where dramas performed	Process Indicator Not Needed (see outcome indicator)	
OBJECTIVE 3: Improve access for local communities in the district to quality MNC services			
Establishment of community outreach services	# of facilities with access to a vehicle for emergency transport	% of episodes when vehicle reached patient within ___ hours of time requested Process Indicator 2	NOTE: Indicator depends on process put in place for use of vehicle, change if not appropriate. Need determine exact point when time measure should start
	# of targeted facilities with staff, vehicle, and schedule assigned for outreach clinic	% of scheduled outreach clinic days held FREQ: SOURCE: Process Indicator 2	NOTE: Should also segregate by clinic.
	TBD	TBD	
To be completed upon decision on voucher system	TBD	TBD	
Objective 4: Strengthen the District Health Information System with Particular Attention to Maternal and Newborn Health			

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
Develop and implement improved monthly reporting forms for facilities	<p># of meetings to provide technical support and mentoring to DHRIO.</p> <p># of facilities with analysis of one year's existing forms completed.</p>	See Objective 1, Activity: Timely and Proper Reporting	
Develop District Health Information Reporting Tool to allow automatic compiling and configuration of key indicators	DHIRT developed and shared with DHRIO and DHMT.	<p># of months in which facility forms were aggregated in DHIRT.</p> <p>FREQ: Quarterly SOURCE: DHIRT records</p>	
Harmonize birth/death data received by District Civil Registry with DHMT data from facilities	# of meetings held with attendance by Civil Registry staff and DHMT staff.	<p>% of months in the last quarter where information from District Registry has arrived in DHMT in time for reporting to Provincial Health Office.</p> <p>FREQ: Quarterly SOURCE: DHMT records, DHRIO interviews</p>	
Increase use of HIS in decision making	# of meetings with DHMT to provide technical support in using data for decision making	TBD	
Develop and Implement Community Based HIS	<p>- # of Chiefs & Assistant Chiefs trained in data collection</p> <p>- # fo Chiefs receiving tools for data collection and reporting.</p>	<p>% of Chiefs providing reports that are at least 90% complete for the last three months</p> <p>FREQ: Quarterly SOURCE: Community HIS forms</p>	
Other DHMT Capacity Building			
Improve supervision system	# of meetings with DHMT to provide technical support for improving the supervision system or conducting supervision visits	TBD	

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ACTIVITY	INPUT INDICATORS	PROCESS INDICATORS	COMMENTS or ASSUMPTIONS
	with DHMT officials		

Child Survival and Health Grants Program Project Summary

Oct-30-2007

Doctors of the World-USA (Kenya)

General Project Information:

Cooperative Agreement Number: GHS-A-00-06-00011
Project Grant Cycle: 22
Project Dates: (10/1/2006 - 9/30/2010)
Project Type: Standard

DOW Headquarters Technical Backstop: Kavita Bali
Field Program Manager: Eunice Okoth
Midterm Evaluator:
Final Evaluator:
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Funding Information:

USAID Funding:(US \$): \$1,500,000 PVO match:(US \$) \$622,951

Project Information:

Description:

Project Goal: To contribute to the reduction of maternal and neonatal morbidity and mortality in five divisions of the West Pokot District of Kenya

Interventions:

- Maternal and newborn care
- HIV/AIDS
- Prevention and treatment of malaria

Strategies:

1. Strengthen the capacity of nine focus West Pokot District health facilities to provide quality maternal and newborn care, in accordance with Ministry of Health policy.
2. Strengthen community awareness of and demand for quality Maternal and Newborn Care (MNC) services.
3. Improve access for local communities in the district to quality MNC services
4. Strengthen the District Health Management Information System (DHMIS), with particular attention to maternal and newborn health

Location:

Chepareria, Kacheliba, Kapenguria, Lelan, and Sigor Divisions of the West Pokot District, Rift Valley Province, Kenya

Project Partners	Partner Type	Subgrant Amount
Ministry of Health-West Pokot District	Collaborating Partner	

General Strategies Planned:

(None Selected)

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Lot Quality Assurance Sampling
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
 Peer Communication
 Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	(None Selected)	(None Selected)	Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Malaria (15 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Training in Malaria CM
- Adequate Supply of Malarial Drug
- Access to providers and drugs
- Antenatal Prevention Treatment
- ITN (Bednets)
- Care Seeking, Recog., Compliance
- IPT

Maternal & Newborn Care (70 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Normal Delivery Care
- Birth Plans
- STI Treat. with Antenat. Visit
- Control of post-partum bleeding
- PMTCT of HIV
- Emergency Transport

HIV/AIDS (15 %)

(CHW Training)

(HF Training)

- Behavior Change Strategy
- PMTCT
- HIV Testing

Target Beneficiaries:

Infants < 12 months:	11,616
Children 12-23 months:	10,603
Children 24-59 months:	26,625
Children 0-59 Months	48,844
Women 15-49 years:	61,699

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	88	186	47.0%	7.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	74	186	39.0%	7.0
Percentage of children age 0-23 months whose births were attended by skilled personnel	32	186	17.0%	5.0
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child	20	186	10.0%	4.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	108	152	71.0%	7.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	14	33	42.0%	16.0
Percentage of children age 12-23 months who received a measles vaccination	5	12	41.0%	27.0
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	7	12	58.0%	27.0
Percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	6	12	50.0%	28.0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	8	22	36.0%	20.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	9	30	30.0%	16.0
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	17	65	26.0%	10.0
Percentage of households of				

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children age 0-23 months that treat water effectively.	51	186	27.0%	6.0
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	107	186	57.0%	7.0
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	80	186	43.0%	7.0
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	17	186	9.0%	4.0
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	17	33	51.0%	17.0

Comments for Rapid Catch Indicators

Indicator (6) Minimum of Appropriate Feeding Practices: Full instructions on calculating this indicator were not available at the time of the KPC design and implementation. Therefore, Doctors of the World does not have calculations for this indicator at this time. We do plan to report on this indicator at midterm and at the end of the project.

Due to sampling errors for indicators reflecting specific age categories, namely children 6-23 and 12-23 months, large confidence intervals rendered these indicators statistically not significant. The issue was fully discussed with USAID and CSTS+ and plans to account for these sampling issues in future surveys have been agreed upon.

