Management Sciences for Health /Health Commodities and Services Management Program (MSH/HCSM) Annual Report: 1st Oct 2012- 30th September 2013

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MSH/Health Commodities and Services Management

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About MSH/HCSM

The MSH/HCSM Program strives to build capacity within Kenya to effectively manage all aspects of health commodity management systems, including pharmaceutical and laboratory services. MSH/HCSM focuses on improving governance in the pharmaceutical and laboratory sector, strengthening pharmaceutical management systems and financing mechanisms, containing antimicrobial resistance, and enhancing access to and appropriate use of medicines and related supplies.

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Acronyms and Abbreviations

ADR	Adverse Drug Reaction
ADT	ART Dispensing Tool
AMU	Appropriate Medicine Use
AOP	Annual Operational Plan
APHIA	AIDS Population and Health Integrated Assistance (project)
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
CHAI	Clinton Health Access Initiative
CHS	Center for Health Solutions
CME	Continuous Medical Education
CPD	Continuous professional development
DANIDA	Danish International Development Agency
DASCO	District AIDS and STI Coordinator
DDPC	Department of Disease Prevention and Control
DHMT	District Health Management Team
DHIS	District Health Information System
DLTLD	Division of Leprosy, Tuberculosis and Lung Diseases
DOMC	Division of Malaria Control
DOP	Department of Pharmacy
DOD	Department of Defense
DRH	Division of Reproductive Health
DRHC	District Reproductive Health Coordinator
DTLC	District TB & Leprosy Coordinator
EMMS	Essential Medicines and Medical Supplies
FBO	Faith Based Organization
FP	Family planning
F&Q	Forecasting and Quantification
HCSM	Health Commodities and Services Management (program)
HSCC	Health Sector Coordinating Committee
ICAP	International Centre for AIDS Care and Treatment Programs
ICC	Inter Agency Coordinating Committee
ITT	Inventory Tracking Tool
KEML	Kenya Essential Medicines List
KEMSA	Kenya Medical Supplies Agency

KMTC	Kenya Medical Training College
KNPP	Kenya National Pharmaceutical Policy
LCM	Laboratory Commodity Management
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
MOH	Ministries of Health
MSH	Management Sciences for Health
MTC	Medicines and Therapeutics Committee
MTM	Medication Therapy Management
M&E	Monitoring and Evaluation
NAL	North Arid Land
NASCOP	National AIDS & STI Control Program
NEP	North Eastern province
NMTC	National Medicines and Therapeutics Committee
NPHLS	National Public Health Laboratory Services
PHMT	Provincial Health Management Team
PHC	Primary Health Care
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PPB	Pharmacy and Poisons Board
PSC-ICC	Procurement and Supply Chain Interagency Coordinating Committee
PV	Pharmacovigilance
RH	Reproductive Health
RDT	Rapid Diagnostic Test
RTK	Rapid Test Kit
SDP	Service Delivery Point
SOP	Standard Operating Procedure
SPS	Strengthening Pharmaceutical Systems (program)
STG	Standard Treatment Guidelines
SWAp	Sector wide approach
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group
USAID	U.S Agency for International Development

EXECUTIVE SUMMARY

The Health Commodities and Services Management (HCSM) program is designed to address gaps in commodity management, pharmaceutical policy and services, and laboratory systems with a goal of strengthening commodity management systems for improved health outcomes and greater impact. In line with the USAID/Kenya mission's implementation framework and the Ministry of Health national health strategic plans, MSH/HCSM program focuses on health systems strengthening in the pharmaceutical and laboratory sectors in three key technical areas: 1)Commodity Management Support for Ministry of Health and health facilities 2)Support to Pharmaceutical Policy and Service Delivery and 3) Support to Laboratory Governance, Commodity Security, and Service Delivery (implemented in collaboration with CDC-funded Strengthening Public Health Laboratory Systems (SPHLS)program).

This report covers the entire work plan II (1st October, 2012 – 30th September, 2013). This annual report is presented against the backdrop of four quarterly reports and a number of significant events and milestones across all four quarters. The highlights include having recruited the substantive program director; change in the financial director; changes in the portfolio of some senior technical team members; and in addition, the Government of Kenya underwent a bold devolution exercise that affected every institution and activity that works in Kenya and this affected some aspects of project relating to its work with government entities.

This being the midpoint of the project, MSH conducted and received feedback from a rigorous midterm review and an objective client satisfactory survey. The year also witnessed a flurry of consultative activities involving many key stakeholders—implementing partners at the periphery of the country and government departments including the new GOK structure-the Counties. The project focused on delivering a number of actions that were accomplished through local and international MSH efforts, such as making improvements in a number of technical areas that had been lagging behind, namely support for the development of a national Logistics Management Information System (LMIS), some aspects of commodity management for priority public health programs and effective support to forecasting and quantification. The project supported MoH departments and programs in ensuring that there was a sustained increase in reporting rates on commodity usage data. Other areas where notable achievement were realized include support to the Department of Reproductive Health (DRH) to finalize and disseminate quantification reports with the view to ensuring that the Government and donors are able to commit funds for the timely procurement of FP commodities.

Communication was identified as one area in which the project had not done very well in terms of keeping the donor updated on occurrences both at the national level and the periphery. This has been taken into account and since then the client is kept informed and while not yet optimal, there are good improvements in communication between the project and the client. The project also undertook to reexamine its support to the HIV/AIDS program area and especially the laboratory component with the view to informing USAID as to the best approach to improving this aspect of the project.
The indicator matrix was highlighted as an area for possible change and is currently being improved upon to ensure alignment between the project objectives and expected outputs and outcomes. The output of this will be a new PMP presented to the client for contract amendment. The geographical reach of the project has been addressed and a new modus operandi has been proposed, and contained in the new work plan. The project continued with its oversight on the project financial resources including tightening of reporting, management of the pipeline including an internal MSH assessment.

In terms of the program results matrix, the program report presents highlights in all three strategic objective areas. The results are presented in terms of the priority programs and according to cross-cutting areas.

Under HIV and AIDS, the project reports zero stock-out of ARVs at the central level during the year mainly as a result of accurate commodity requirements being developed through TA to NASCOP for quantification. Moreover, HCSM participated in the development of a new HIV/AIDS Global Fund Proposal for funding procurement and other related activities in this area. The Department of Pharmacy (DoP) was supported to develop guidelines for implementation of Pharmacy Information Systems (PIS); TA provided to the Pharmacy and Poisons Board to develop a content guide for summary reports on Pharmacovigilance; ART reporting rates have remained above 90% throughout period; and through support to decentralization efforts, the number of ARV ordering points increased from 287 in September 2012 to 310 in September 2013 representing a 8% increase. In addition, usage of the ARV Dispensing Tool (ADT) in these sites increased by 16% from 183 in Sept 2012 to 213 in Sept 2013. Overall ADT use increased by 19% from 306 sites in Sept 2012, to 364 in Sept 2013.

With regard to tuberculosis, no stock-outs of TB drugs were experienced at least at the central level; monthly stock status reports were generated and shared with all stakeholders and supply plans for TB MDR commodities developed with technical support from HCSM. At county level, 31 counties demonstrated a 73% submission of TB

reports to national level. Additionally the process of generation of stock status reports has been handed over to the division.

The malaria program maintained its traditional high performance levels. HCSM supported the finalization of the FY2013/14 quantification report that informs resource mobilization and procurement of the various commodities for control of malaria. The program also supported the DOMC to undertake a quantification and gap analysis for Global Fund Phase 2 proposal. There was a steady uninterrupted supply of anti-malarials at health facilities countrywide. To achieve this, HCSM supported the commodity security committee at DOMC to undertake pipeline monitoring with generation of stock status reports, preparation and dissemination of PPMRm reports to PMI for global planning and oversight of the malaria supply chain. HCSM provided TA to the DOMC commodity security committee to discuss redistribution of malaria RDTs, ACTs and Artesunate at the periphery. To monitor progress made including adherence to malaria treatment guidelines, HCSM in collaboration with KEMRI-Welcome Trust, supported the Quality of Care round six surveys by providing TA to data collection, data entry, analysis and report writing. The draft report is being finalized and will be disseminated in next quarter. The results are included in the key result areas presented in the details of this report. Generally, the results show that availability of malaria diagnostics at health facilities has improved from 65% (Sept 2012) to 90% currently, with that of RDTs improving from 16.9% (Sept 2012) to 70% currently. The consumption of ACTs is on a downward trend owing to the improved availability of diagnostics at health facilities.

The family planning program experienced zero stock-outs of key FP commodities at the central level, through the year ending September 2013. Stock summary reports were generated to monitor the FP commodity pipelines and appropriate interventions taken to correct pipeline gaps. Procurement Planning and Monitoring Report (PPMR) were also developed for Kenya and included in the global report by DELIVER for dissemination to all stakeholders. There were no funding gaps for FY2012/13. One stakeholder meeting was held where approximately $11 million worth of donor commitments were made to fill the supply plan for FY 2013/14 that had been developed with HCSM TA. County specific forecasts were generated for 2013/14 and aggregate national forecast for 2014/15. In collaboration with CHAI, HCSM supported the design and development of an online commodity dashboard for FP aimed at increasing access to FP commodity status and supply plan information by MoH and donors. The program also contributed to DRH operational research agenda by

providing inputs into the questionnaire for assessing Oxytocin availability at health facilities. This is still ongoing.

With the signs showing an upturn in the results reported by the project during the year under review, the priorities going forward in the new work plan will take into account all pieces of information gathered as a consequent of wide consultations with various stakeholders, MOH, APHIAs, FBOs, Private providers and USAID. The program will phase its approach into short and long term milestones. In the first quarter of the third HCSM work plan, the program will concentrate on immediate deliverables jointly identified with key stakeholders, such as concentrating on improving results in its two focus regions (Nyanza & Western), enhanced support for F&Q for all programmatic commodities, raising the bar in reporting rates and ensuring that quality of data comes through the system, ensuring commodity security and promoting sustainable best practices in commodity management. Phase two will see the project focus revert to capacity enhancement, improving coordination and ensuring data capture for evidence based decision making.

It is MSH/CHSM considered view that through its rigorous attention to technical details, through efficient MSH matrix consultative management style and employing frameworks to deliver results; this project is at the verge of turning the corner in terms of delivering on its mandate of facilitating health systems development that bring quality pharmaceuticals and services close to the family, which in turn improves the lives of people at the community level.

INTRODUCTION

The MSH Health Commodities and Services Management (MSH/HCSM) program goal is to build capacity within the Kenya health system for effective management of health commodities and delivery of quality pharmaceutical and laboratory services at all levels. Awarded in April 2011 and running through March 2016, the program is designed to contribute to strengthening health systems for the sustainable quality services component of the USAID Kenya implementation framework for the health sector. Overall, the program has adopted a systems strengthening model that seeks to improve local capacity to lead and manage service delivery and health commodity management. This is augmented by a systematic approach that emphasizes capacity building in the design and implementation of interventions for enhanced sustainability.

The program has the following three focus areas:

- Commodity management support for the Ministry of Health (MoH) and health facilities
- Support to pharmaceutical policy and service delivery
- Support to laboratory governance, commodity security, and service delivery (implemented in collaboration with the US Centers for Disease Control and Prevention [CDC]–funded Strengthening Public Health Laboratory Systems (SPHLS) program implemented through MSH)

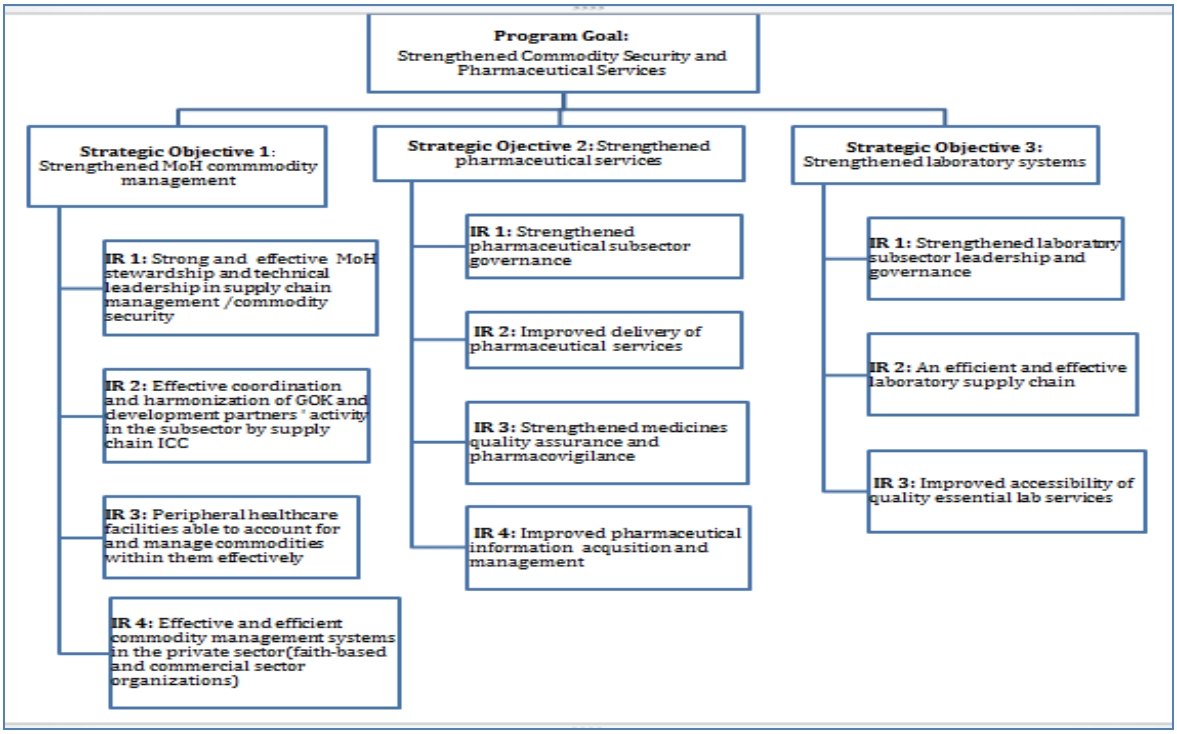


Figure 1: HCSM results framework

In implementing work plan 2, the program sought to build on the work done under work plan 1, through strengthen existing systems using the following core principles and approaches:

- Promoting country-led and country-owned initiatives
- Using of innovative approaches to and building local capacity for improved management of health commodities
- Adapting and implementing proven pharmaceutical and laboratory management approaches and tools and bringing them to scale
- Promoting integration of approaches and tools for pharmaceutical and laboratory subsectors across public health programs
- Engaging the private sector and professional bodies to strengthen both pharmaceutical and laboratory management systems in support of public health goals
- Promoting new concepts in pharmaceutical management and services (such as pharmaceutical care and pharmacovigilance) and laboratory management and services to complement commodity security and supply chain strengthening activities
- Facilitating the adoption of new health technologies and innovative strategies to support the scale-up and expansion of treatment services
- Building on existing as well as new collaboration and linkages with stakeholders, donors, and implementing partners to scale up interventions; developing strategic partnerships that promote harmonization of technical strategies and coordination of donor inputs
- Focusing on health sector–wide systems strengthening for commodity management and services to include both faith-based organizations (FBOs) and the private sector

Section I: Commodity management support and security

During this period, the HCSM program focused on improving commodity management and accountability at the peripheral level as well as strengthening oversight and planning at central level. The main goal for this was to ensure uninterrupted access to health commodities at the health facilities. The technical support provided was focused at the key priority public health program divisions of the Ministry of Health (NASCOP, DOMC, DRH and DLTLD).
Of importance for the program was to ensure that stock out incidences were minimized through improved planning and continuous monitoring of the commodity pipelines for the priority MOH programs. At the peripheral level, the main aim was to ensure that facilities were able to improve their inventory management practices as well as account for their commodities through submission of their usage and resupply requests to the central level. Peripheral level County focal teams were therefore supported to follow up on their facility reports and utilize the data available in the regions to inform their commodity management interventions.

a) CENTRAL-LEVEL COMMODITY MANAGEMENT AND SECURITY

HCSM continued to support the MOH in playing a greater and more effective leadership role in supply chain management and commodity security. In implementing its activities, HCSM adopted a mix of approaches, including providing technical assistance and active participation in high-level stakeholder meetings, technical working groups, and targeted training workshops, and also provided active support to specific initiatives. These interventions ensured that stock-outs of health commodities for priority health programs—HIV/AIDS, malaria, TB, and reproductive health—were largely avoided at the national level. Major collaborators in these activities included both ministries of health, priority health programs (National AIDS & STI Control Program [NASCOP], Division of Malaria Control [DOMC], Division of Reproductive Health [DRH], Division of Leprosy, Tuberculosis and Lung Diseases [DLTLD]), Kenya Medical Supplies Agency (KEMSA), US Government (USG) partners (e.g., Kenya Pharma, the Supply Chain Management System [SCMS], KEMSA's technical assistance partner), and other donor agencies (Danish International Development Agency, German International Development Agency, and the Clinton Health Access Initiative).

Other key national-level activities and achievements in commodity security over the reporting period include capacity building and skills transfer for quantification and pipeline monitoring; supporting the generation of monthly stock-status reports; supporting national quantifications; supporting a malaria Quality of Care Survey; and participating in national policy reform activities. Table 1 below presents a summary of progress made by the end of this reporting period:

Table 1: Summary of highlights on commodity management activities

<table>
<tr><th>Key area</th><th>Progress Made</th><th>Comment</th></tr>
<tr><td>Improving Reporting rates for health commodities</td><td>
<table>
<tr><th>Program Area</th><th colspan="2">National average Reporting Rate (RR)</th></tr>
<tr><th></th><th>No of sites</th><th>RR</th></tr>
<tr><td>Malaria</td><td>4030</td><td>72%</td></tr>
<tr><td>FP</td><td>4107</td><td>40%</td></tr>
<tr><td>ARVs</td><td>310</td><td>94%</td></tr>
<tr><td>TB</td><td>210</td><td>45%</td></tr>
<tr><td>RTKs</td><td>4739</td><td>58%</td></tr>
<tr><td>CD4</td><td>157</td><td>68%</td></tr>
</table>
</td><td>Reporting rates have been fluctuating. During quarter 4, the program supported an initiative at the peripheral level aimed at improving reporting rates. From this initiative 2 recommendations were made;
Higher RR can be obtained with enhanced support to counties for follow-up and monitoring of reporting rates
Establishing a system (e.g. DHIS2 or other platform) where facilities /counties can submit reports directly to national level should optimize reporting</td></tr>
<tr><td>Support to quantification and Stock status monitoring</td><td>– 100%- All priority programs (HIV & AIDS, TB, malaria, FP) supported to generate monthly stock status reports
– 100%-all programs (HIV & AIDS, TB, malaria, FP) have been supported this year to conduct quantification activities.</td><td>These reports have been used to inform decision making and lobby for funds, for example, for FP Donors have committed to fill the $11million supply plan requirements and hence there is currently no gap for 2013/14.</td></tr>
<tr><td>Strengthened capacity of MoH for commodity oversight at peripheral levels</td><td>– Cumulatively 107 functional District Health Commodity Security TWGs have been formed
– Commodity data and reporting rate review meetings were held in 25 of the 47 counties.
– Consultative introductory engagement meetings held with 18 of the 47 counties (since July 2013).
– Sensitization of health county coordinators on the Malaria program drawn from all the 47 counties
– TA provided to Kiambu County to undertake selection and F&Q for pharmaceuticals in the region
– Through support to decentralization efforts, the number of ARV ordering points increased from 287 in September 2012 to 310 in September 2013 representing an 8% increase in ARV ordering points.
– Overall ARV Dispensing Tool (ADT) use increased by 19% from 306 sites in Sept 2012 to 364 in Sept 2013.
– 81% of all patients treated with ARVs have their medicines dispensed through the ADT, allowing greater accountability and reporting</td><td></td></tr>
</table>

Key Highlights by disease program area

HIV/AIDS

- There have been zero stock-outs of ARVs at the central level resulting from HCSM's technical assistance to the National AIDS and STI Control Program (NASCOP) on monthly commodity stock status and pipeline monitoring and support to the central level coordination by the HIV commodity security committee. The monthly stock status reports have been shared with all key stakeholders.
- Key HIV program commodity data requirements for LMIS rollout were developed with HCSM TA to the HIV Nutrition team. Rollout of the nutrition LMIS is ongoing.
- Estimates of national HIV and AIDS commodity requirements were developed through TA to NASCOP for quantification. Draft forecasts for 2013/14 and 2014/15 were generated for all HIV & AIDS commodities (ARVs, OI medicines, nutrition, condoms, lab commodities, basic care kits). These will inform commodity procurements and resource mobilization to fill the gaps.
- NASCOP proposal to GF-SSF Phase 2 HIV application was presented to HIV ICC and approved for forwarding to the Kenya Coordination Mechanism. HCSM provided technical inputs into the commodity quantification and commodity management activities of the GF proposal.
- Draft standards and guidelines for Pharmaceutical Information Systems (PIS) have been developed with HCSM TA to the Department of Pharmacy in collaboration with I-TECH.
- Content guide and template for Pharmacovigilance summary reports has been developed in collaboration with Pharmacy and Poisons Board. This will guide the generation of routine reports (two-pagers) on HIV Pharmacovigilance activities.
- ART reporting rates have remained consistently high at above 90% throughout the quarter. HCSM supported the monthly follow up of non-reporting sites centrally through the HIV commodity security committee and peripherally through MoH counterparts and regional implementing partners.
- The ARV Dispensing Tool (ADT) has been implemented in 364 sites by end September 2013 (213 ordering points and 151 satellite sites). HCSM also provided backup maintenance support to these sites through the implementation of Helpdesk and use of Remote Support. These interventions have reduced the response time for facility ADT problem resolution for ADT from about 1- 2 weeks (depending on site location and logistics) to about 1 – 2 days for sites with internet access. HCSM also continued to undertake rapid orientation sessions on the tool to facility staff in collaboration with regional partners, with 16 target staff being reached during the quarter. By September 2013, about 81% of patients are being served at health facilities using the ADT. Discussions are at an advanced stage to mainstream the remote support and Helpdesk into NASCOP for facility based electronic tools support.

Success story: Using the Antiretroviral dispensing tool (ADT) to ensure access to medication

"I have encouraged four of my friends to get tested and they agreed. They are now living happily with full knowledge of their HIV status and faithfully getting Anti-retroviral treatment,' says Mzee Ahmed who has brought his six year old son to Port Reitz Hospital to collect his Antiretroviral drugs.

His son is the fourth born in a family of five children. Mzee Ahmed, his wife and his son Juma are HIV positive while Juma's younger brother was born HIV negative. "My wife was the first to discover her status. After giving birth, my wife started feeling unwell and when she came to hospital she was admitted. She received some counselling and was tested and the results were positive for HIV. Juma was also tested and found to be positive", says Ahmed.

"After learning my wife's status, it took me a while to get tested but I eventually got the courage to get tested. The test was positive and I was also put on Antiretroviral treatment," explains Mzee Ahmed

This was six years ago. Mzee Ahmed says that by the time he learnt of his wife's status, there was still a lot of stigma and fear of HIV. Though his wife and son get their medication in Port Rietz hospital, Mzee Ahmed gets his medication from Bomu Medical Centre, in the Mkomani area which is 3 km from Port Reitz. The good news is that they always get their ARVs whether in Port Rietz or Mkomani.

Antiretroviral drugs (ARVs) work to boost the immunity of HIV patients and reduce the risk of opportunistic infections – it's a complex, life-long treatment that must be strictly adhered to. Missing a routine doctor`s appointment, or failure to adhere to the treatment plan can impact both the individual and the community. Incorrect dosing or missing as little as one dose puts a patient at risk of developing drug resistance, which means the virus becomes resistant to certain antiretroviral drugs.

NASCOP has been working with the USAID-funded HCSM program using an electronic antiretroviral medicine dispensing tool to ensure that close to 600,000 patients receive their ARVs on time. Dr. Dominic Miruka Nyamwega, pharmacist at Port Rietz credits the availability of drugs at his facility to the use of the tool – an easy-to-use electronic pharmacy management software, which has helped him to effectively manage HIV medications.

The dispensing tool allows pharmacy staff to keep track of patient information and records on antiretroviral drugs prescribed and dispensed. Keeping track of medication consumption allows staff to accurately forecast the amount of medicines needed. In order to effectively combat the disease, health providers must maintain an uninterrupted supply of antiretroviral drugs and medicines to treat related opportunistic infections

As at end of June 2013, 619, 669 patients were on ART. The total number of adults on ART was 561, 774 and that of children was 57,895. Mzee Ahmed and his son are just two of the over 600,000 patients who present their card and prescription at the pharmacy. The healthcare workers then confirm the patient's biographical information and match the drugs on the prescription, with the drug history stored in the dispensing software. A patient's next appointment is then entered and the pharmacy staff then input the drug name and batch number dispensed. This exercise is replicated in over 320 sites that have the antiretroviral therapy dispensing tool.

Tuberculosis

- There have been zero stock-outs at central level for TB commodities. This has been achieved through the support provided by HCSM to the TB commodity security committee on monthly pipeline monitoring. Monthly stock status reports have been prepared and shared with all stakeholders.
- Estimates of national TB commodity requirements were developed through quantification TA to DLTLD. Draft forecasts for 2013/14 and 2014/15 were generated and these have informed the procurements as well as resource mobilization to fill the gaps.
- LMU – compiled national facility reporting rates for TB commodities have remained low, going below 30% as at September 2013. However, a follow up at county level in 31 counties demonstrated that on average, about 73% of facilities had submitted their reports, implying that information compiled at national level was incomplete with reports either not reaching this level or not being captured. With the uploading of all program commodity tools onto the DHIS2 platform, this should be addressed
- There are ongoing initiatives to address this through the use of DHIS2 for commodity reporting.

Malaria

- DOMC undertook quantification for FY2013/14 with HCSM technical assistance. This informed resource mobilization and procurement of the various commodities for malaria control. The program also supported the DOMC to undertake a quantification and gap analysis for Global Fund Phase 2 proposal.
- There were no stock-outs of key antimalarial medicines over the past one year. This was achieved through the continuous pipeline monitoring undertaken by the DOMC commodity security committee with HCSM technical assistance. The stock status reports generated by this committee have been shared with all key stakeholders. Further, the DOMC commodity security committee has been able to address issues on redistribution of malaria RDTs, ACTs and Artesunate at the peripheral level.
- To monitor progress made including adherence to malaria treatment guidelines, HCSM in collaboration with KEMRI-Welcome Trust supported the Quality of Care round five and round six surveys by providing TA for data collection, data entry, analysis and report writing. Preliminary results after round six show the following:
    a. Availability of RDTs improved to 70% of all the facilities (75% in level 2 and 3 facilities) from 31% in the previous survey and 8% at baseline in 2010. The proportion of facilities with any form of functional diagnostics increased to 90%, up from 76% in previous survey and 55% at baseline. This is directly attributed to the RDTs roll out.
    b. Supervision on RDTs use is still low at 20% of the facilities sampled.
    c. 96.5% of facilities sampled could treat malaria on the day of the survey. Compared to the previous rounds, the retrospective stock outs of ACTs has gone down significantly, with only 7% of facilities reporting having a stock out of all AL weight bands in the previous three months.

d. In-service training on malaria case management has gone up to 50% of all health workers interviewed on survey day. This is a result of the case management training conducted by DOMC in April and May. PMI supported, through HCSM, the development and review of the training curriculum.
e. Adherence to treatment guidelines (Criteria – suspected malaria cases tested, and if positive, treated with an ACT and if negative, not treated with any antimalarial) improved to 50% in all facilities compared to only 15.7% in 2010. When evaluated at those facilities that had both ACTs and Diagnostics, this goes up to 55%, up from 28% at baseline. In addition, teh survey found that of the patients who test negative for malaria, 17% are treated with an antimalarial, down from 53% recorded in 2010.

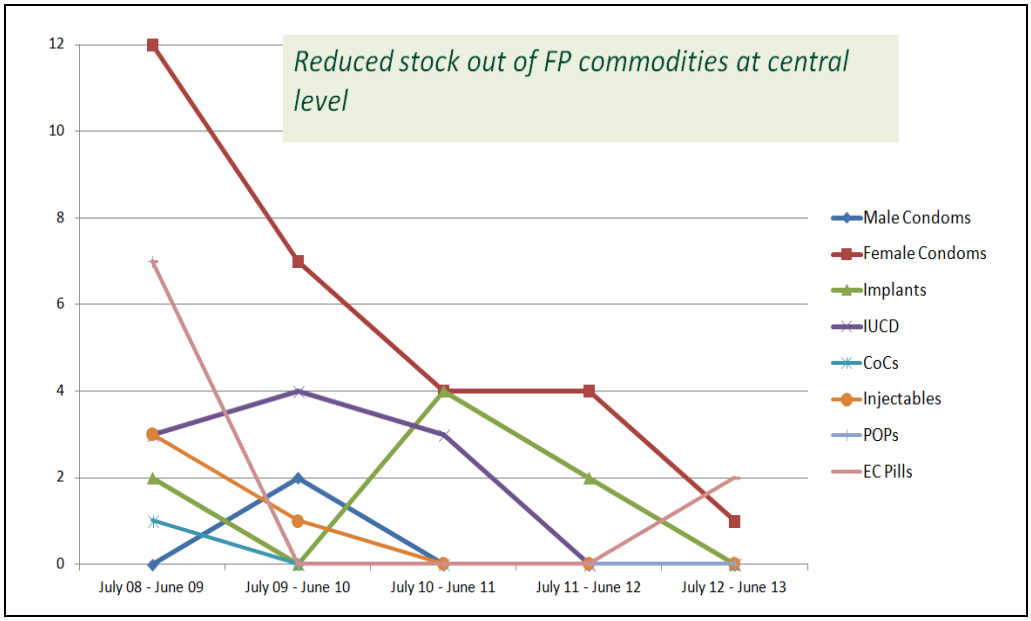
The results show that availability of malaria diagnostics at health facilities has improved from 55% to 90%, with that of RDTs improving from 8% in 2010 to 90% in June 2013. The consumption of ACTs is on a downward trend owing to the improved availability of diagnostics at health facilities.

Vivian Akinyi a data collector interviews 23 year old Zuleka Hamisi and her 9 year old sister Mwanahamisi after receiving treatment at Mswambweni District Hospital. Vivian Akinyi was one of the data collectors for the Malaria Quality of Care survey round 6 undertaken in June 2013. The survey is part of a monitoring process aimed assessing national trends in the availability of anti-malarials, malaria diagnosis and other malaria related health systems support activities in public health facilities. USAID through the Health Commodities and Services Management program has been providing support to the Division of Malaria Control (DOMC) in conducting these surveys

Family Planning

- At the central level, there have been reduced stock-outs of key family planning commodities compared to the previous years (see figure 2 below). This reduced stock-out at central level has been attributed to the close monitoring of the FP commodity pipeline by the DRH/FP commodity security committee with HCSM technical assistance. Monthly stock status reports are usually generated monthly showing the FP commodity pipelines and relevant interventions needed to correct pipeline gaps.

Figure 2: Stock out of Family Planning commodities at central level



- There are no funding gaps for FY2013/14 for FP commodities. Stakeholder meetings were held where approximately $11 million worth of donor commitments were made to fill supply plan for FY 2013/14 that had been developed with HCSM TA. County specific forecasts were also generated for 2013/14 and aggregate national forecast for 2014/15.
- The program in collaboration with CHAI supported the design and development of an online commodity dashboard for FP aimed at increasing access to FP commodity status and supply plan information for MoH and donors. Tool development is being done by CHAI with implementation planned for late 2013 to early 2014.

Other cross cutting programmatic areas

LMIS

- The program developed and disseminated a concept paper aimed at providing guidance for the implementation of a national LMIS. The concept paper has been used in discussions

spearheaded by the Cabinet Secretary for Health on the implementation of a suitable system. A high level technical working group has been constituted for this purpose and is already conducting meetings with HCSM playing an advisory role on how MOH will move forward.

- Consensus has been reached with NASCOP, DLTLD and DRH for the incorporation of commodity reporting using the DHIS2 platform. DOMC is already using the DHIS2 for commodity reporting. By end September 2013, the commodity tools for HIV, TB and FP were being incorporated into the system with national rollout expected to be initiated by late 2013 and early 2014. This is a short term and interim measure to address reporting challenges as the long term solutions are developed.

b) STRENGTHENED MOH COMMODITY MANAGEMENT- PERIPHERAL LEVEL

During the year under review, the program worked to build on the successes achieved in the previous year specifically with regard to providing support for commodity management and security at peripheral level. The key interventions at this level were targeted at the following key results:

- Strengthening oversight for commodity management at provincial and district levels through support for provincial/district health commodity security committees or TWGs
- Improving commodity management and accountability at facility level
- Improving commodity usage reporting for all priority program commodities- HIV/AIDS, Malaria, Family Planning, Tuberculosis and other Essential Medicines and Medical Supplies
- Reducing stock-outs of the above commodities

To achieve these results, the program scaled-up the district intervention package to additional districts. Moreover, recognizing the important role Faith-Based Facilities play in supplementing services provided by public health facilities and in line with the whole-market approach, the program actively engaged and provided support to FBO facilities through the umbrella organizations- KCCB and CHAK.

The following achievements were realized during the year.

Commodity management support- Oversight at regional level

The program successfully scaled up support for commodity management from the 52 districts covered in Work plan I to a total of 112 priority districts. Utilizing a defined package of interventions, the program sought to build the capacity of health management teams at district level for provision of oversight for commodity management and in collaboration with these

teams and other implementing partners support facility level staff in improving commodity management at that level.

Cumulatively, by the end of the year, the program had supported the formation of a total of 107 functional District Health Commodity Security TWGs through which support for commodity management at lower levels was channeled. In addition, cumulatively a total of 112 DHMTs had been orientated on commodity management.

In rolling out interventions, the program relies on commodity champions or mentors drawn from various facilities in the districts. It is these champions who mentor and provide OJT on commodity management to staff at facility level. They are a key resource in rolling out interventions and supporting facility level commodity management activities. By the end of the year, champions from a total of 109 priority districts had been oriented on commodity management and therefore provided with the required knowledge and skills to support lower level facilities.

Commodity management support- facility level

Peter Nguhiu of HCSM and partners providing OJT at the Sololo Mission Hospital Comprehensive Care Clinic

To support commodity management at facility level, the program provided TA for the orientation on commodity management for facility level staff from 79 priority districts. This was supplemented by the provision of practical OJT and mentorship through commodity champions/mentors in a total of 53 priority districts. In addition, the program provided support to 54 DHMTs to conduct follow-up support supervision in facilities under their jurisdiction. The target for all the facility level support was the improvement of inventory management, commodity usage reporting and reduction in expires and wastage of health commodities. The program also supported 31 model sites earmarked to serve as learning sites/ centres of excellence for commodity management

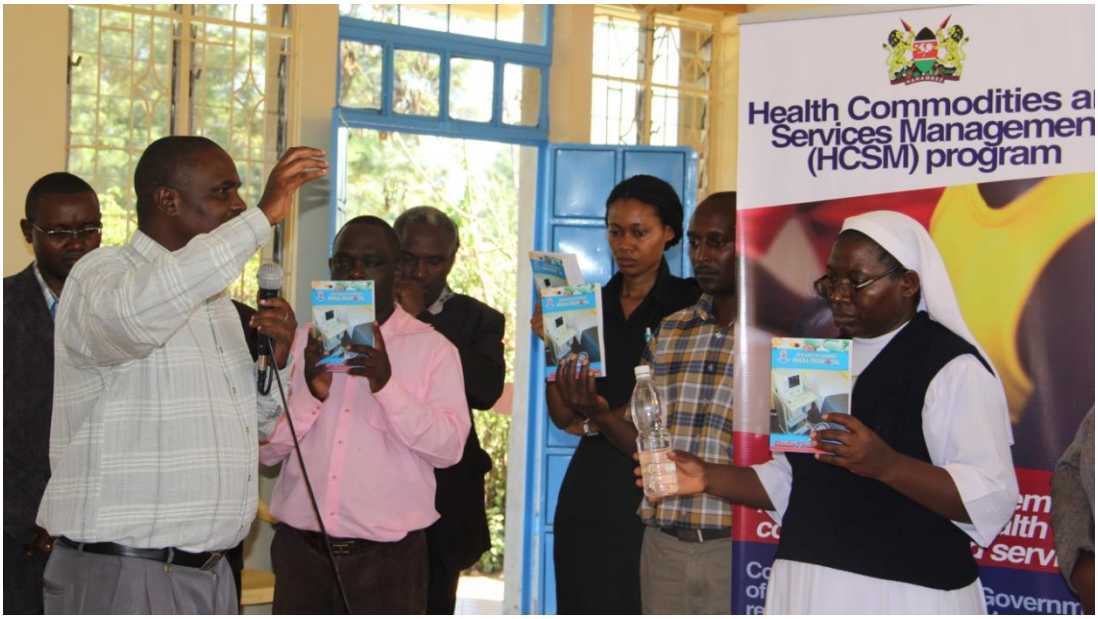
Support to FBO facilities

During the year, significant progress was made in the support to the FBO sector facilities on commodity management support. The scope of support included the following:

- Commodity management capacity building/orientation for facility in-charges and staff

- Dissemination of commodity management tools.
- Provision of TA for OJT and support supervision.

Specifically, the program provided support to Kenya Conference of Catholic Bishops (KCCB) facilities to build capacity of staff from their various dioceses. In total 202 staff were orientated on inventory management, appropriate medicine use and pharmacovigilance. Moreover, TA was provided to 2 dioceses - Nakuru and Eldoret to conduct support supervision for facilities in their areas. Overall, support by the program to FBO sector facilities has greatly enhanced their ability to manage health commodities filling a TA gap that has existed for a very long period of time.

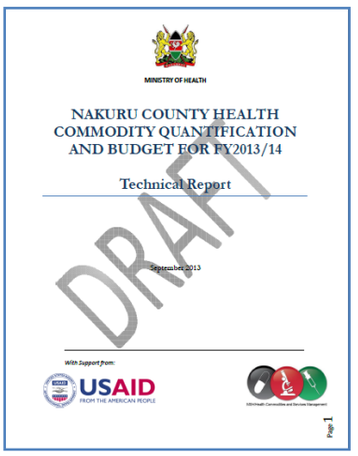


HCSM provided technical support to Our Lady of Lourdes Mission Hospital's Medicines & Therapeutics Committee (MTC) in the development of the Institutional Standard Treatment Guidelines (STGs) which were officially launched on the 24th of May 2013. Speaking during the launch, Sister Josephine Ndege , the Chief executive Officer of the Hospital said that the launch of the guidelines marked a great step in inspiring service delivery for the community

'The regular and consistent use of these guidelines by the clinicians in Our Lady of Lourdes Mission Hospital in Mwea is expected to improve rational use of available drugs and contribute to the realization of vision 2030; that is creating an enabling environment for the provision of sustainable quality health care that is cost effective and accessible to all Kenyans.' She said.

Support to counties

Decentralization and the set-up of independent county health management structures from March 2013 led to the reconfiguration of the program's support for commodity management at peripheral level. With new responsibilities, the demand for TA for various aspects for commodity management by the various counties continued to grow. Specifically with most counties preparing to take up the procurement function for health commodities, support for F&Q was a general demand across all regions. For instance TA for selection and quantification of all health commodities was provided to Kiambu and Nakuru Counties. In Kakamega County, the program provided support to the county commodity working group on the establishment of systems and practices to enhance accountability of health system. Across all counties, the program provided support for acquisition and reporting of commodity usage data. Comparison of the dat gathered in quarter 4 and what is available central level indicate that most facilities are reporting their commodity usage data but this fails to reach the central level or is not uploaded for collation, resulting in apparently low national reporting rates. Table below summarizes the findings from this exercise.


MINISTRY OF HEALTH

NAKURU COUNTY HEALTH COMMODITY QUANTIFICATION AND BUDGET FOR FY2013/14

Technical Report

DRAFT

September 2013

With Support from:

USAID FROM THE AMERICAN PEOPLE

Table 2: Summary of results from county level reporting rate monitoring

Program Area	Average RR for May to Aug 2013 Period				Comment
	Counties' RR		National Level RR		
	No. of Counties	*RR*	*No of sites*	*RR*	
Malaria	37	77%	4030	71%	Although the County RR was slightly higher than the national RR the trend over the four months showed close correlation in the rates
FP	37	78%	4107	39%	County RR consistently and significantly higher than National RR (from the LMU)
ARVs	24	94%	310	94%	Comparable County and National RR with close correlation
TB	31	73%	2818	26%	County RR consistently and significantly higher than National RR from the LMU
RTKs	34	76%	4739	58%	County RR consistently and significantly higher than National RR from the LMU
CD4	17	96%	157	68%	County RR consistently and significantly higher than National RR from the LMU

Overall, the following observations can be made:

- RR for commodities where there is a system for data transmission from facility/county level to national level- Malaria & ART are similar for both county and national level
- RR for commodities where there is no defined system for transmission from facility/county level to national level are significantly different with County RR consistently and considerably higher

Based on this follow up, the following conclusions can be made:

- Reports are getting to district/county level but a significant proportion not being transmitted to national level or are not being captured as submitted at this level
- Establishing a system (e.g. DHIS or other platform) where facilities /counties can submit reports directly to national level should optimize reporting

Table 3: Summary of the peripheral level support

Indicator	Achievement
DHMTs oriented Commodity management (against target of 120)	112
Number of districts with Commodity security TWGs	107
Number of districts oriented health facility staff on Commodity management	79
Districts undertaken follow-up Support Supervision	54
Facilities supported to establish Medicine & Therapeutics Committees	54
Provision of OJT & Mentorship on commodity management	53
Number of health workers trained on commodity management and data for decision making	96
Health facility staff trained on commodity and Inventory management	863
Graduating KMTC pharmacy students trained on commodity management (Nairobi, Nyeri, Machakos and Mombasa campuses)	273
Graduating University of Nairobi Pharmacy students trained on commodity management	82
Health facility staff trained on use of Laboratory LMIS tools	206
Number trained on use of Malaria RDTs	3,002
Number of TOTs trained on Lab commodity Management	45

Section II: Strengthened Pharmaceutical Policy and Service Delivery

This technical area focuses on interventions aimed at improving and strengthening governance and service delivery in the pharmaceutical sector to promote access to quality, efficacious and safe medicines and health commodities in the public, private and faith-based sectors across all tiers of care. Under this area, the HCSM program works with the Pharmaceutical Services Unit, the regulatory body – Pharmacy and Poisons Board (PPB), National Quality Control Laboratory, professional organizations, training institutions, priority health programs, the county health system and other stakeholders.

In the last fiscal year, the HCSM program continued to use a health systems approach to strengthen pharmaceutical policy implementation and service delivery at the national and county levels. At the national level, HCSM collaborated with the Ministry of Health, Department of Pharmacy (DOP) and other stakeholders in the development of relevant policy, legislative and regulatory frameworks. The main focus was development of pharmaceutical services package and review of the health products technologies laws (HPT).

The HCSM program collaborated with the Pharmacy and Poisons Board (PPB) and priority health programs to promote medicine quality assurance and patient safety through enhanced monitoring, management, documentation and reporting for suspected adverse drug reactions (ADRs) and poor quality medicinal products.

The HCSM program also collaborated with the department of pharmacy of the Kenya Medical Training College (KMTC) and the University of Nairobi to introduce health commodity management and pharmacovigilance for the undergraduate pharmacy diploma students and post-graduate Masters of Pharmacy (MPharm) students respectively.

At the county level, HCSM focused on strengthening the oversight structures for improving access to and rational use of quality and safe medicines. The program worked with county health teams, selected institutional medicines and therapeutics committees (MTCs) and regional partners to promote appropriate medicine use practices and disseminate relevant materials such as standard clinical guidelines, pharmaceutical standard operating procedures (SOPs) and services charter.

To support operations research for evidence-based decision making for Malaria program planning, implementation, monitoring and evaluation (M&E); HCSM provided technical assistance to Malaria control unit in conducting round 5 and round 6 quality of care survey whose findings have shown great improvements in malaria case management.

Achievements highlights

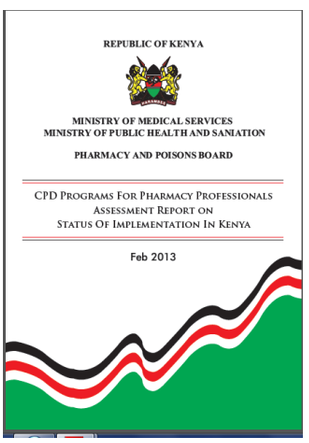
- To promote use of quality and safe medicines, HCSM in collaboration with priority health programs and other stakeholders continued to support the Pharmacy and Poisons Board in implementing the national Pharmacovigilance system. Cumulatively, adverse drug reactions (ADRs) received at PPB increased from 5000 (October 2012) to over 7690 by the end of September 2013 representing a 54% increase in reports. Over 90% of these ADR reports are related to ARVs. This information has led to increased vigilance in monitoring ART related ADRs.

- The HCSM Program supported the development and launch of the pharmacovigilance electronic reporting system (PVERS) for online reporting of ADRs and poor quality medicines. Over 1000 ADRs and 60 poor quality of medicines reports have been reported through this e-reporting system

- Cumulatively, Poor Quality Medicinal Product reports received at PPB have increased from 250 in October 2012 to 489 by the end of September 2013, representing a 96% increase in reports. This information has led to several regulatory actions being taken by PPB, including product recalls and withdrawal of market authorization.

- HCSM supported the finalization, printing and dissemination of Post Market Surveillance (PMS) reports for anti-retroviral, anti-TB and anti-malarial medicines. A presentation on PMS for anti-TB medicines was presented by DLTLD at the 2nd Africa TB conference in Zanzibar.
- Supported the TB program to develop the MDR-TB curriculum and incorporated commodity management and pharmacovigilance in the content. Additionally HCSM program supported training of 257 health care providers from MDR-TB and comprehensive care clinics in the 47 counties under the coordination of the former provincial and district TB and Leprosy coordinators.
- Collaborated with NASCOP and PPB to undertake supportive supervision visits to the 12 HIV-ADR sentinel sites with a goal of boosting their capacity to monitor, manage and report ADRs. To boost active surveillance, HCSM program, NASCOP and PPB developed the protocol for cohort event monitoring (CEM) of ARVs.
- HCSM program collaborated with several regional partners to orient over 400 healthcare providers on Pharmacovigilance and to disseminate related guidelines, job aids and newsletters. Additionally the program collaborated with MEDS-CHAK AIDS Program (MEDS/ CHAP), NASCOP and PPB to train 15 technical officers from CHAP who will spearhead roll-out of pharmacovigilance activities within the faith based sector.
- Jointly with International Network for Rational Drug Use (INRUD)- Kenya chapter and Getrude's hospital, the HCSM program supported a 5 –day training on MTCs and sponsored 15 health care providers from selected model sites.
- To promote appropriate medicine use and provision of quality patient care, HCSM supported the Kenyatta National Hospital (KNH) Medicines and Therapeutics Committee (MTC) to finalize and launch the institutional formulary, the first comprehensive hospital formulary in Kenya. This will be adopted by the National Medicines and Therapeutics Committee (NMTC) to be used as a reference and template to guide the development of a national formulary for use in all health facilities in the country. 500 copies of the formulary have been disseminated to hospital staff and clinical departments.
- To promote appropriate medicines use in the faith based sector, HCSM program supported the KCCB (formerly KEC and Mwea Mission Hospital to develop and launch the hospital STGs.
- HCSM program supported the Pharmaceutical Services Unit to disseminate pharmaceutical SOPs and services charter to 183 senior pharmacists in 7 provinces to promote clinical governance
- HCSM program supported training of 82 Bachelor of Pharmacy students in health commodity management and Pharmacovigilance. Additionally the program supported the school of pharmacy to review the UON pharmacy preceptorship program and log-books to incorporate commodity management and pharmaceutical care topics. Fourty five (45) preceptors drawn from pharmaceutical industry, hospital and retail pharmacies were trained on the preceptorship program.
- The HCSM program supported the faculty of Pharmacy at the Kenya Medical Training College (KMTC) to implement commodity management training for final year Pharmacy students in their 4 campuses. A total of 273 students were trained. The breakdown is as follows: Nairobi (113), Nyeri (59), Mombasa (45) and Machakos (56).
- Supported the MOH, Department of Pharmacy to review the integrated in-service training materials on commodity management for all health commodities. These materials will be used by Funzo Kenya for roll-out of integrated commodity management trainings.
- HCSM collaborated with the University of Nairobi (UON), the global USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) program; and University of Washington to conduct a 4-day training of trainers' (ToT) workshop on the application of Pharmacoeconomics (PE) principles and Health Technology Assessments (HTA) to essential medicines selection. This is aimed at building sustainable in-country skills and capacity for PE and HTA to support evidence based management of formulary systems. 23 participants from the Universities, MOH, Counties, KNH, MTRH, KEMSA, NQCL and PPB were trained.

- The HCSM program supported dissemination of pharmaceutical guidelines, SOPs and and tools. Availability of the essential medicines list and pharmaceutical service charters at facilities increased from 16% and 15% at baseline in 2011 to 53.5% and 29% respectively in November 2012 and to 65.0% and 35.7% in June 2013. These resources guide clinical practice and service delivery at the facility and district level ensuring rational use of medication.
- To promote quality pharmaceutical services at county level, the HCSM program supported a forum for the Pharmaceutical services unit staff and county pharmacists where pharmaceutical services under devolved structure were discussed. 55 participants drawn from 37 counties and the national level participated.
- The HCSM program collaborated with the Pharmaceutical Society of Kenya (PSK) and the Kenya Pharmaceutical Association (KPA) to review their strategic plans and develop appropriate operational plans.



- To promote pharmacy practice and continuous professional development (CPD), the HCSM program supported the PPB to finalize the CPD guidelines for pharmaceutical services as informed by the CPD assessment undertaken in Year 1.
- In collaboration with DOMC and KEMRI-Welcome Trust, the HCSM program supported data collection, data entry, analysis and report writing for the round 5 and round 6 quality of care malaria surveys. The findings indicate an increased availability of malaria diagnostics in health facilities up from 65% (Sept 2012) to 90% (June 2013) and RDTs from 16.9% (Sept 2012) to 70% in June 2013.

Table 3: Summary - Indicator Progress

Broad Result area	Indicator	Progress	Comment
Improved reporting of pharmacovigilance activities	Number of ADR reports received at central level	54% increase in cumulative number of reports for adverse drug reactions (ADRs) to PPB from 5000 (Oct 2012) to over 7690 (Sept 2013).	Over 90% of the ADRs reports are related to ARVs and this information has led to increased vigilance for monitoring ART related ADRs
	Number of poor quality medicinal products reports received at central level.	96% increase in cumulative number of poor quality medicine reports received at PPB from 250 (Oct 2012) to 489 (Sept 2013).	Poor quality received medicine reports have led to several regulatory actions being undertaken by the PPB like recalls (e.g. paracetamol, metronidazole), quarantine of Oxytocin and withdrawal of market authorization.

Section III: Support to Laboratory Governance, Commodity Security, and Services

Laboratory commodity management and security have continued to be a key focus area for the program. Specifically, HCSM continued to focus on strengthening the laboratory supply chain. However, the other two focal areas of governance and quality of laboratory services are critical and have been supported through the CDC-funded Strengthening Public Health Laboratory Services (SPHLS) project implemented by MSH.

Towards the end of this implementation period, the former Ministries of Health have been merged into one unit with peripheral structures being put in place and starting to function. The program's intervention targeted at improving commodity management and security at both the central and peripheral level. At the both levels, the program worked with a number of stakeholders including the various MoH departments (NPHLS, DDFS, National HIV Reference Laboratory, and National Blood Transfusion Services), donor agencies (e.g. USG, JICA), supply chain agencies (KEMSA, SCMS), regional implementing partners and facility staff. These stakeholders have also been engaged during implementation at the peripheral level with a focus on leveraging resources, and collaboration to maximize the impact of the desired interventions. Due to the use of multidisciplinary teams at the peripheral level, a lot of the laboratories strengthening interventions were also undertaken together with the other commodity management activities (see section 1 under peripheral level achievements). Table 4 below summarizes some of the key achievements.

Table 4: Progress on key areas

Key area	Indicator	Progress made	Comment
Improving Reporting rates for lab and health commodities	Proportion of health facilities submitting commodity usage reports to the central level for priority program commodities [Malaria, ART, TB, RTKs and CD4]	**National average Reporting Rates (RR) based on most recent quarter** **Type of commodity** / ***No of sites*** / ***RR*** **RTKs**: 4739 / 58% **CD4**: 157 / 68%	As indicated under section 1
Support to F&Q and Stock status monitoring	Programs and key MoH departments able to quantify and generate monthly commodity stock status reports	– **100% -** Laboratory commodities have been incorporated into quantifications done by the key priority MOH divisions (NASCOP, DLTLD and DOMC). Annual quantifications have been done for these commodities – **HIV** program has continued to undertake monthly pipeline monitoring for their laboratory commodities. Stock status reports have been generated and shared with all stakeholders.	These reports have been used to inform decision making and lobby for funds
Strengthened capacity of MoH for commodity oversight at peripheral levels	Functional regional commodity security committees established	– Consultative introductory & engagements meetings held with **18** of the **47** counties – Commodity data review meetings held in **25** of the **47** counties to address low reporting rates. – Sensitization done of health county coordinators on the Malaria program drawn from all the 47 counties	
RDT roll out	Facilities able to conduct malaria testing (Microscopy and/or RDTs)	– Improved availability of malaria diagnostics in health facilities from **65% (Sept 2012)** to 90% at end September 2013. – Improved availability of RDT from 16.9% (Sept 2012) to **70%** in September 2013.	Analysis conducted in June 2013 has shown that consumption of ACTs is on a downward trend

Key highlights from the period

- The country has continued to experience minimal stock-outs of HIV lab commodities at the central level. This was due to the program's support for routine pipeline monitoring of HIV lab

commodities and malaria RDTs to ensure minimal stockouts especially at central level. However, towards the end of the workplan year, some incidences of stock out were experienced at central level due to introduction of Railway Development Levy occasioning delays in port clearance of incoming commodities.

Despite this situation at central level, peripheral level facilities within the regions have still continued to report stock out incidences due to a variety of system related issues. These have been identified and will continue to be addressed through the next workplan period.

- The quantifications of laboratory commodities have been incorporated into the overall commodity quantifications undertaken by the MOH divisions (NASCOP, DOMC and DLTLD). During the past year, all these MOH divisions have done their quantifications for 2013/14 and 2014/15 that informed the resource mobilization efforts to fill the commodity gaps, as well as the procurements that have been done. HCSM provided technical assistance to these programs to undertake the quantification as well as the update to the supply plans to avoid supply gaps.

Edward Beja, Kaloleni Lab Sub County Coordinator displays some of the job aids issued to participants during lab commodity trainings

- The program has continued to address the challenges in commodity data transmission by facilities to the central level. Targeted support has been provided to MOH to follow up and monitor HIV laboratory commodity reporting, and support for regional data review meetings. Despite these interventions, the national reporting rate has stagnated with CD4 reagents reporting rate maintained at 63% and RTKs reporting rate at 58% as at end August 2013. However, on further follow up at county level, it was noted that the reporting rates were much higher and a lot of the reports were not reflected in the national level. These and other issues have been prioritized for the next work plan year.
- Supported NASCOP to clean and harmonize the list of HIV Testing and Counseling sites to inform distribution of HIV laboratory commodities, tracking and accountability of the same.
- Supported the Quality of Care round 6 survey to monitor progress of malaria RDTs use at facilities. Results show that availability of malaria diagnostics at health facilities has improved from 55% to 90%, with that of RDTs improving from 8% in 2010 to 90% in June 2013. The analysis has further shown that consumption of ACTs is on a downward trend owing to the improved availability of diagnostics at health facilities curtailing the random and inappropriate prescription and use of this medicine.
- Improved inventory management at the facility level through provision of various commodity management tools and job aids. HCSM assisted MOH to distribute and disseminate a number of commodity management materials to health facilities (table 4 below). The program also collaborated with other partners to implement the commodity management curricular. Through collaboration with University of Maryland, the electronic Inventory Tracking Tool was implemented in seven facilities in Nairobi.

  Other approaches used by the program to address commodity management include supporting one-day orientation sessions on the use of laboratory inventory and LMIS tools; provision of OJT on good inventory management; supportive supervision on data quality and continuing medical education sessions on laboratory commodity management.

Table 4: Tools and Other Material Disseminated by HCSM to SDPs

Description
• Job aids (Quantification, Good storage practices, Inventory management) • Laboratory stock cards • Commodity top-up forms • Daily activity register (MOH 642) • Facility consumption request and reporting forms (MOH 643) • Expiry tracking charts • Temperature monitoring charts

- Recognizing the need for improving flow of information, HCSM assisted the MOH to upload the commodity tools onto the DHIS2 platform. Once implemented, it's expected to address a lot of the reporting challenges by facilities as identified above.
- In collaboration with CHAI, the program supported NASCOP to develop data requirements for online lab reporting for CD4 reagents and RTKs to guide in the planned development of a web based reporting tool. Once developed, the tool will be piloted in selected facilities in the next quarter.

In as much as HCSM works to improve laboratory supply chain systems, achievement of sustainable results is dependent upon the existence of strong governance structures and a conducive policy environment. Likewise, optimal delivery of laboratory services is dependent upon an uninterrupted supply of laboratory commodities at the point of use. Both HCSM and SPHLS recognize the interdependent and symbiotic nature of their work and continue working together for the overall strengthening of the lab sub sector. The table below summarizes the laboratory activities that SPHLS has been supporting.

Table 5: Ongoing SPHLS activities

Result Area	SPHLS Activities
Strengthened laboratory subsector leadership and governance	• Support to the activities of the Laboratory Interagency Coordinating Committee (Lab ICC). • Supported and coordinated an Orientation and consultative forum for all 47 county laboratory coordinators and national program laboratory staff for establishing working relationships, linkages, and sharing policies and tools • Development of National laboratory policy 2012 (in progress) and National laboratory strategic plan 2012-2016 (in progress) • Development of Strategic Plan 2012-2017 for Kenya Medical laboratory Technicians & Technologists (KMLTTB)- officially launched and in use. • Development of laboratory infrastructure guidelines (complete) • Development of Laboratory equipment Management Guidelines (complete) • Development of specimen referral guidelines- (complete)
Improved accessibility of quality Essential laboratory services	• Contribution to Quality management systems (QMS) • In collaboration with AMREF, support provision on of an external quality assurance program in 61 facilities in CCN and selected hard to reach districts/ counties. • Contribution to infection prevention through capacity strengthening of staff to improve biosafety and safe phlebotomy practices of all health care workers.

Section IV: HCSM Program Challenges

The fiscal year 2012/2013 has been an eventful year in the implementation of the HCSM program. HCSM was set up in 2011 in support of GOK to improve health systems and capabilities for managing health commodities and related services. It has been a year of many activities in the life of the Kenyan health sector, the Kenyan population and most certainly the USAID support to the Kenyan people. There were many achievements recorded and the project had a number of highs in terms of delivery of contractual obligations. However, the year FY12/13 will mostly be remembered for the challenges that were faced by all parties associated with the implementation of the project. Chief among the constraints were: 1) delayed development and deployment of a functional national LMIS system, 2) poor quality of data for commodity forecasting and pipeline monitoring; 3) laboratory commodity tracking and lack of leadership the first half of the fiscal year.

During the first quarter of the year, the project had to initiate some restructuring in order to match the expanding geographical coverage of the project and the need to better deliver results. The project counterparts in the public health sector in many instances were preoccupied with trying to figure out the implications and consequences of the changes and hence were unwilling to commit to implement some activities. Moreover, some competing priorities resulting from the need to prepare for devolution as stipulated by the new constitution at both the central and peripheral levels resulted in the postponement or delay in the implementation of some planned activities. The holding of the national elections also affected the performance of the project by adversely impacting the quality and quantity of work undertaken.

In addition, weak administrative structures in some of the new set ups, contributed significantly to low reporting rates because of poor coordination and oversight from the DHMT level. The required restructuring and re-organization occasioned by the new constitution are largely unclear and have pre-occupied the time of key MOH counterparts. Moreover, some competing priorities at both the central and peripheral levels resulted in deferment, postponement or delay in the implementation of some planned activities. The program was faced by delays in transitioning some of the pre-planned activities because of reluctance by MOH counterparts to be handed over activities. There has also been inconsistent understanding of the HCSM's mandate by some partners, staff and counterparts resulting in highs demands, delayed transitioning of activities and reluctance by some partners to scale up collaborative activities for various reasons. The project was still running without a substantive head, which created additional obstacles, especially in relation to managing relationships with partners, team morale and momentum.

The third quarter was still constrained by government restructuring which resulted into the postponement or delay in the implementation of many planned activities. The program was faced by delays in transitioning some of the pre-planned activities because of reluctance by MOH counterparts to be handed over activities, especially the area of LMIS, laboratory commodity tracking and stewardship and ensuring skills transfer and transitioning to MOH. The skills in forecasting and quantification were still not up to scratch, forcing the project to carry out the lion's share of quantification on behalf the government and other counterparts. It also became clear that engagement of higher level MOH management was critical for the project efforts to impact MOH policy or strategy formulation. Management of communication with the client was also recognized as another area of concern in the project.

A final quarter SWOT analysis by the team showed that there was still Limited coordination and linkages among national MOH officers, priority programs and between the central and peripheral levels, resulting in unsustainable short term gains in most areas. The quality of data from facilities on commodity consumption remained low in spite of the increase in reporting rates. There was still

limited immediate results due to the program's adoption of the system's strengthening approach, targeting system-wide improvements leading to long drawn-out and not immediately visible results, which continued to dog the project in the quarter under review. During the quarter, there were hitches in commodity supply at central level occasioned by the new Railway Development Levy for all commodities being brought into the country. This impacted on stock availability for some programs especially distribution of HIV test kits to health facilities. This appears to be headed towards resolution and hopefully the situation should normalize in the near future. The project continued to struggle during this quarter to increase physical data reporting rated from the peripheral to the central level and vice versa. This was compounded further by on-going devolution which continued to result into limited authority over staff at different levels to enable them exercise their reporting functions, without requiring "incentives". Ongoing devolution by GOK affected the implementation of programs in terms of authority lines between the center and county. This is an ongoing challenge which will prove advantageous after completion of the process. Lastly, it appears that clarity of understanding of what the project mandate by most stake holders remained an issue, leading to misplaced expectations.

Section V: PRIORITIES FOR THE NEXT YEAR

The program will continue to utilize a systems strengthening approach across the three technical areas for achievement of sustainable results while paying attention to achievement of the relevant results in the priority health programs such as HIV, Malaria, Tuberculosis and Reproductive Health/Family Planning. Specifically, the HCSM program will focus on skills transfer, handover and integration of implementation approaches where possible. At the county level, the HCSM program will collaborate with CHMT and other partners to strengthen health commodity management practices in public, private and faith-based sectors. The program in collaboration with MOH and other stakeholders has identified the following priorities for the next fiscal year (October 2013 – September 2014):

1. **Commodity Management, Quantification, pipeline monitoring**

Central level

- Skills transfer in commodity security and supply chain oversight
- Development and dissemination of National and County level guidelines and training materials on quantification and pipeline monitoring

County level

- Support to the establishment of county level commodity security governance structures in collaboration with CHMTs in Nyanza, Western and Coast
- Technical assistance to CHMTs on quantification and pipeline monitoring in Nyanza Western and Coast regions
- Support to county-level commodity usage reporting and use of commodity information for decision making in Nyanza, Western and Coast.

2. **Logistics Management Information System**

Central level

- Support incorporation of existing commodity tools into the DHIS2 platform
- Engage with high level policy makers and other stakeholders to obtain buy-in for LMIS
- Support to MOH technical working group to drive the national LMIS agenda
- Upgrade ADT to web-based and expand its scope to other medicines

County level

- Support development of county level commodity related information requirements and deploy relevant data collection and reporting tools
- Capacity building and skills transfer on facility-based tools to county health teams & partners
- Undertake data quality assessment for selected sites and provide support to scale up of ADT and other electronic tools

3. **Laboratory Supply Chain**

Central level

- Capacity building of MOH staff on quantification and pipeline monitoring, with a focus on handover of roles to government counterparts. This will include pipeline monitoring through use of dashboards
- Advocate to senior level MoH for commitment to strengthen laboratory commodity management coordination through the national coordination mechanism/TWG
- Support to finalization and disseminate the Essential Laboratory Commodities List

- Facilitate MOH to undertake comprehensive review of Lab commodity supply chain structures

County level

- Provide TA to County HMTs to identify and address laboratory commodity management gaps in targeted counties (Nyanza and Western regions), including dissemination of commodity management curricula, tools and job aids
- Support focal persons within targeted county health management teams to undertake data analysis and follow up on reporting by health facilities, including the use of end-use verification for accountability and tracking
- Undertake facility and supply chain mapping to identify supply chain gaps (Nyanza, Western)

4. Priority Health Programs activities

NASCOP- HIV Program

- On-going support to the NASCOP for commodity security activities, including quantification, pipeline monitoring, with a focus on capacity building and handover of roles to government counterparts
- Strengthen the LMIS for HIV commodities including use of the DHIS2 for reporting on commodity use
- Technical support to targeted HIV-Pharmacovigilance activities including use of data for decision making on ADRs and poor quality medicinal products.

Reproductive Health/ Family Planning

- On-going support to RH/FP commodity security committee for commodity security with a focus on handover of roles to DRH on quantification and routine pipeline monitoring
- Improve visibility of commodity information at central level as well as the use of facility level data for planning and oversight. This will include use of dashboards for commodity tracking
- Support the transition of FP commodity reporting to DHIS-2

Division of Malaria Control- Malaria Program

- Support to data collection, report writing and dissemination of reports for Malaria Quality of Care Surveys
- Development of an implementation plan for QA/QC for malaria diagnostics and support for implementation of the same
- Support to improving upstream data capture for malaria commodity (ACTs and RDTs) usage data in selected facilities

Division of Leprosy TB and Lung Diseases (DLTLD)/ TB Program

- Support to DLTLD on quantification capacity building and pipeline monitoring

Section VII: PERFORMANCE OF SELECTED INDICATORS

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
SO 1: Strengthened MoH commodity management				
IR 1.1 Strong and effective MoH stewardship and technical leadership in supply chain management/commodity security				
Indicator 1: Functional MOMS/ MOPHS supply chain oversight committee (SCOC) at national level	SCOC non functional	TORs reviewed and adopted Work plan developed Supply chain audit toolkit reviewed Two Level-4 hospital audits conducted	Draft TOR developed by not adapted Not done Supply chain audit toolkit reviewed Supply chain audits conducted in 4 sites in Nyanza province (New Nyanza PGH, Kisii level 5 DH, Siaya DH and Bondo DH). [HCSM progress reports]	The Health sector's coordinating mechanism is being re-structured to be aligned to the Comprehensive Health Sector Framework 2012 – 2030. Finalization of this process will guide the direction going forward
Indicator 2: Proportion of priority programs and key MoH departments [including NASCOP, DLTLD, DOMC, DRH, NPHLS] able to independently generate monthly commodity stock status reports	None	DOMC, DRH, DLTLD and NPHLS able to generate monthly commodity stock status reports	100% (5/5) of the priority program have staff who have been capacitated and are able to generate stock status reports as follows: NASCOP: 2 DRH: 1 staff DLTD : DOMC : 2 NPHLS:	All priority programs routinely generated stock status reports. Priority programs are actively involved in generation of monthly stock status report. Additionally HCSM has working toward automation of stock generation process. Progress made so far includes; – **NASCOP:** Stock status monitoring report generation tool for ARVs was updated to cater for changes in the key regimens tracked. – **DRH:** Automated package for generation of stock status reports (and user guidelines) for FP commodities has been developed. The hand-over of the stock status monitoring process has not been finalized – **DLTD:** Automation of 2 pager report for TB commodities is complete and the process handed over to the division – **DOMC:** Automation of the 2 pager for malaria report is complete. – NPHLS:
Indicator 3: Proportion of priority	NASCOP's ART program (1	Key officers from	100% (5/5) of the priority program have staff	This support to program in F&Q, stock status and

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
programs [including NASCOP, DLTLD, DOMC, DRH, NPHLS] and key MoH departments mentored by HCSM that are able to independently undertake commodity quantification	staff), and DRH/FP (1 staff) able to independently undertake commodity quantification	DOMC (2), DRH (2), DLTLD (1), NASCOP ART (1) and NPHLS (1)	that have been capacitated and are able to do forecasting and quantification as follows. NASCOP: 3 DRH: 1 staff DLTD : DOMC : 2 NPHLS: Additionally in the previous work plan – 23 key officers from priority MoH programs, DoP, NPHLS and MEDS officers were trained in quantification – 6 senior DRH staffs were trained in quantification and pipeline monitoring concepts and tools (Reality-FP, Pipeline®).	pipeline monitoring had positive results, for example, there has not been reported stock-out of ARVs, anti-TB drugs, DMPA and anti-malarial at central level.
Indicator 4: Percent difference between forecasted consumption and actual consumption for ARVs	-	<25%	The difference for all the 4 key adult first-line regimens was within the target as follows: TDF+3TC+EFV: 3% TDF+3TC+NVP: 23% AZT+3TC+EFV: 22% AZT+3TC+NVP: 12	Increased accuracy noted, for example, the difference between the forecast and consumption for FY 2012/13, for 4 key adult first-line regimens: TDF+3TC+EFV, TDF+3TC+NVP, AZT+3TC+EFV and AZT+3TC+NVP medicines fell within the program target of less than 25% unlike for FY 2011/12 where the difference for TDF+3TC+NVP and AZT+3TC+NVP exceeded the <25% difference target
IR 1.2: Effective coordination and harmonization of GoK and development partners' activity in the sub-sector by supply chain ICC *(or similar coordinating mechanism)*				
Indicator 1: Functional and expanded Procurement and Supply Chain Inter-agency Coordinating Committee (PSC-ICC)	PSC-ICC partially functional. Non-xistent harmonized (a) Procurement planning and F&Q guidelines, (b) Procurement Plan	TORs reviewed and adopted	None	The Health sector's coordinating mechanism under the SWAp secretariat is being re-structured to be aligned to the Comprehensive Health Sector Framework 2012 – 2030. Finalization of this process guide formation of this committee.
IR 1.3 Peripheral healthcare facilities able to account for and manage commodities effectively				

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
Indicator 1: Proportion of health facilities submitting commodity usage reports to the central level for priority program commodities [ART, Malaria, TB, FP]	ART: 84% ordering points] Malaria: 62% [SDPs] TB: 49% [ordering points] FP: 51% [stores]	ART: 90% [ordering points] Malaria: 75% [SDPs] TB: 75% [ordering points] FP: 75% [stores]	ART: 91% [LMU report] Malaria: 62% (Annual average 51%). [DHIS II] report] TB: 56 % (Annual average 56%) [LMU report] FP: 42% (Annual average 51%) [LMU report]	Reporting rates have been fluctuating. The program embarked in an exercise geared toward improving reporting rate in the county. During this exercise the program worked with county team to obtain reporting rates data from peripheral levels. A Comparison of the county data and National data revealed; 1. Minimal variation in Malaria and ARTs reports. These two enjoy good system support (DHIS II for Malaria and fully pull system for ARTs) 2. Huge variation with other program areas that do not enjoy similar support 3. Reports are getting to district/county level but a significant proportion not being transmitted to national level or are not being captured as submitted at this level From above the program has made 2 recommendation 1. Higher RR can be obtained with enhanced support to counties for follow-up and monitoring of reporting rates 2. Establishing a system (e.g. DHIS or other platform) where facilities /counties can submit reports directly to national level should optimize reporting
Indicator 2: Total number of health workers trained in commodity management. (desegregated by cadre and ownership (FBO or Public))	-	Cumulatively capacitate regional and facility staff in commodity management in 120 districts	Cumulatively the program has trained over 4,000 health care workers have trained from 109 districts. [Program report]	Training of the health care staff in commodity management was a part of intensive roll out of HCSM Commodity and Services Management Package at the peripheral level. The program has since scaled down on trainings and it is providing targeted capacity building.
Indicator 3: Proportion of facilities reporting stock-out for a set of tracer health commodities on the day of the assessment.	AL all sizes (Malaria): 25% AZT/3TC/NVP 300/150/200 tab (ART): 4.8%	AL all sizes (Malaria): 12% AZT/3TC/NVP 300/150/200 tab (ART): 3.0%	AL all sizes (Malaria): 7.0% [QoC round 6] - Others: Oxy 16.6% and Penta 3.7% [QoC R 5]	The program leverage on the QoC survey to collect data on this indicator among others. A declining trend in all stock-out indicators was observed.

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
Indicator 4: Proportion of health facilities having expiries of at least one commodity from the tracer commodities list	36%	<20	One expired AL pack has ranged 2.9% to 16.30% in all QoC AZT/3TC/NVP 300mg/150mg/200mg FDC tabs: 5.7% [QoC R 5] Oxytocin Inj: 7.6% [QoC R 5] Pentavalent vaccine: 1.3% [QoC R 5] HIV rapid test kits : 2.5% [QoC R 5]	In QoC surveys existence of expired antimalarial drugs were uncommon, however compared to the baseline results, the findings of the last survey have shown an increase from 2.9% to 16.3% of facilities stocking at least one expired AL pack..
Indicator 5: Proportion of health facilities receiving integrated supportive supervision visits in the last 3 months	78% reported, but no supporting documentation [Actual estimated to be <40%]	At least 50% by 2013	69.2% [QoC round 6]	There was a significant increase from 41.5% in QoC 5 to 69.2% in QoC 6 of health workers receiving at least one supervisory visit in malaria commodity management. This is a proxy indicator for facilities receiving integrated supportive supervision visits however over 60 districts have been supported by HCSM to conduct commodity management supportive supervision.
Indicator 6: Number of functional regional commodity security committees established (disaggregated by administration units)	Non-existent	Functional (8 Provincial and 120 district level) commodity security committees set up in all the regions with TORS and minutes of quarterly meetings;	8 Provincial health commodity committees formed but 7 are active. Over 107 District health commodity committees have been formed [HCSM progress reports]	The program supported formation of provincial and district level health commodity management committees. The committees were chaired by MoH staff and members comprised of provincial and district health management teams (P/DHMTs) and representative of key stakeholders e.g. KEMSA, Kenya Pharma, APHIAplus, CDC partners etc. In support to devolution the program will utilize the lesson learned in formation and support to these committees to assist county governments incorporate commodity management agenda in CHMT agendas
SO 2: Strengthened Pharmaceutical Services				
IR 2.1: Strengthened Pharmaceutical sub-sector governance				
Indicator 1: Updated National	Draft revised KNPP	Draft KNPP	The KNPP was adapted by the cabinet. The KNPP	The HCSM program supported the DOP to unpack the

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
Pharmaceutical Policy approved by the government including corresponding implementation and M&E plans	available and awaiting cabinet approval	Implementation plan (KNPP IP) and M&E plan	sessional paper #4 is awaiting parliamentary approval before development of the implementation plan.	KNPP to determine Implementation requirements
Indicator 2: Updated strategic plans for KPA and PSK	KPA: 2009-2012 strategic plan PSK: Strategic plan exists (2009-2014); No implementation plans	KPA Strategic plan revised and implementation plan developed PSK implementation plan developed	KPA Strategic plan revised and implementation plan developed and disseminated. [KPA] Development of PSK implementation plan has been done, launched and disseminated [PSK]	
IR 2.2: Improved delivery of pharmaceutical services				
Indicator 1: Percentage of health facilities with the most current edition of Kenya National STGs and Essential Medicines List	47.1% **5.7% new malaria guidelines**	75% for all guidelines	**65.0%** for EML **58.1% for new malaria guidelines** [QoC round 6] Over 80% for Current edition of Kenya National STGs [HCSM program reports]	Coverage of health facilities with new malaria guidelines increased from 5.7% at the first follow-up survey to 58.1%.
Indicator 2: Percentage of tracer conditions treated according to treatment guidelines at health facilities	Diarrhoea 6.9% Malaria 22%	Diarrhoea 30% Malaria 50%	No data available 54.5% Malaria case management at facilities with diagnostics and AL in stock [QoC round 6]	From QoC findings the performance of the composite case-management indicator has improved to 54.5% while testing rates improved from 42.5% to 63.2% (20.7% increases). Update period specific to Nov 2012 and June 2013)
IR 2.3: Strengthened medicines quality assurance and pharmacovigilance				
Indicator 1: Availability of pharmacovigilance guidelines at facilities	28.8%	50%	62.4% [HCSM progress reports]	The program has supported dissemination of pharmacovigilance guidelines to health facilities.
Indicator 2: Availability of suspected ADR and Poor quality medicinal products reporting forms at facilities	ADR forms: 57.6% Poor Quality Medicine Forms: 53.4%	80% for both	ADR forms: 65.3% Poor Quality Medicine Forms: 65.3%	PV E-reporting system was launched and orientation conducted targeting PPB and ART ADR sentinel sites staff.

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
			[HCSM progress reports]	
Indicator 3: Number of ADR reports received at central level	1400 (Sept 2011)	6000	**54%** increase in reporting for adverse drug reactions (ADRs) to PPB from 5000 (Oct 2012) to over 7690 (Sept 2013). [PPB]	
Indicator 4: Number of poor quality medicinal products reports received at central level.	175 (Sept 2011)	280	**96%** increase in reporting for poor quality medicines received at PPB from 250 (Oct 2012) to 489 (Sept 2013). [PPB]	
Indicator 5: Number of regulatory actions taken during the reporting period consequent on pharmacovigilance activities	No data available	At least one	Over 5 actions taken	Over 90% of the ADRs reports are related to ARVs and this information has led to increased vigilance for monitoring ART related ADRs Poor quality received medicine reports have led to several regulatory actions being undertaken by the PPB like recalls (e.g. paracetamol, metronidazole, diclofenac, cotrimoxazole), quarantine of Oxytocin and withdrawal of market authorization.
IR 2.4: Improved Pharmaceutical Information Acquisition and Management				
Indicator 1: PMIS framework developed	None	Assessment done Results disseminated	Not done	This activity was deferred to FY 14 (Year 3)
Strategic Objective 3: Support to laboratory governance, commodity security, and service delivery				
IR 3.2: An Efficient and Effective Laboratory Supply Chain				
Indicator 1: Proportion of health facilities submitting monthly commodity usage reports to the central level for priority programs [HIV, Malaria)	HIV Test Kits 50% CD4-	HIV Test Kits 75% CD4:75%	Annual average of 58% for HIV Test Kits [LMU report] Annual average of 68% for CD4 [LMU report]	There was a noted improvement in reporting rates however the quality of reports is poor. As highlighted earlier in this matrix the program has made some recommendation on how to improve reporting.
Indicator 2: Number of functional regional commodity security committees established (disaggregated by administration units)	Non-existent	Functional (8 Provincial and 120 district level) commodity security committees set up in all the regions with TORS and minutes of quarterly meetings;	8 Provincial health commodity committees formed but 7 are active. Over 107 District health commodity committees have been formed	The program supported integration of lab commodity agenda in provincial and district commodity management committees. These committees have since became defunct and hence in support to to devolution the program will utilize the lesson learned in formation and support to these committees to assist county governments incorporate lab commodity management agenda in CHMT agendas

Indicator	Baseline	Target (Sep 2013)	Current Status [Data Source]	Comment
			[HCSM progress reports]	
IR 3.3: Improved accessibility of quality essential lab services				
Indicator 1: Percentage of facilities able to conduct malaria testing (Microscopy and/or RDTs)	45%	75%	90.7% [QoC round 6]	Analysis conducted in June 2013 has shown that consumption of ACTs is on a downward trend. This has been attributed to: – Improved availability of malaria diagnostics in health facilities from **65% (Sept 2012)** to 90% currently. – Improved availability of RDT from 16.9% (Sept 2012) to **70%** currently.

ENVIRONMENTAL MITIGATION AND MONITORING REPORT

In compliance with USAID's environmental procedures—22 CFR 216 ("Reg 216")—HCSM completed and submitted an Environmental Mitigation and Monitoring Report (EMMR) to USAID/Kenya Mission.

The program activities as captured in the report were considered to be low risk to the environment as summarized in table 6.

Table 6. Environmental Assessment of Program Activities

Program activities	Screening Result		
	Very low risk	High risk	Moderate or unknown risk
1. Strengthen MOMS/MOPHS stewardship and technical leadership in supply chain management/commodity security	√		
2. Support effective coordination and harmonization of government and development partners' activity in the subsector	√		
3. Strengthen peripheral health care facilities to able to account for and manage commodities effectively	√		
4. Support effective and efficient commodity management systems in the private sector (faith-based and commercial-sector organizations).	√		
5. Strengthen pharmaceutical sector governance	√		
6. Improve delivery of pharmaceutical services	√		
7. Strengthen medicines quality assurance and pharmacovigilance	√		
8. Improve pharmaceutical information acquisition and management	√		
9. Strengthen laboratory sector leadership and governance	√		
10. Support an efficient and effective laboratory supply chain	√		
11. Improve accessibility of quality essential laboratory services	√		

SUMMARY OF FINANCE REPORT

FEDERAL FINANCIAL REPORT
(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)	Page	of
USAID/OFM	AID-623-LA-11-000008	1	pages

3. Recipient Organization (Name and complete address including Zip code)
Management Sciences for Health, Inc.
784 Memorial Drive, Cambridge, MA 02139

4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type	7. Basis of Accounting
071713085	04-2482188	FRLC 72 00 1329	X Quarterly □ Semi-Annual	X Cash □ Accrual

8. Project/Grant Period From: (Month, Day, Year)	To: (Month, Day, Year)	9. Reporting Period End Date (Month, Day, Year)
04/01/2011	03/31/2016	09/30/2013

10. Transactions	Cumulative
(Use lines a-c for single or multiple grant reporting)	
Federal Cash (To report multiple grants, also use FFR Attachment):	
a. Cash Receipts	$12,026,250.00
b. Cash Disbursements	$12,103,343.10
c. Cash on Hand (line a minus b)	($77,093.10)
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$13,886,574.00
e. Federal share of expenditures	$12,103,343.10
f. Federal share of unliquidated obligations	$0.00
g. Total Federal share (sum of lines e and f)	$12,103,343.10
h. Unobligated balance of Federal funds (line d minus g)	$1,783,230.90
Recipient Share:	
i. Total recipient share required	$1,249,845.00
j. Recipient share of expenditures	$41,775.23
k. Remaining recipient share to be provided (line i minus j)	$1,208,069.77
Program Income:	
l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
11a. Indirect Expense	Salaries	81%	07/01/2013	09/30/2013	58,722.99	47,565.62	100%
	Local Proff	40%	07/01/2013	09/30/2013	332,813.36	133,125.34	100%
	Consultants	40%	07/01/2013	09/30/2013	3,439.62	1,375.85	100%
				g. Totals:	$ 577,042.78		

12. *Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:*

13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official
Patricia Barros-Smith, Manager Corporate Accounting

b. Signature of Authorized Certifying Official
P Barros-Smith

c. Telephone (Area code, number and extension)
617-250-9214

d. Email address
pbarrossmith@msh.org

e. Date Report Submitted (Month, Day, Year)
10/23/2013

14. Agency use only:

Standard Form 425
OMB Approval Number: 0348-0061
Expiration Date: 10/31/2011

Paperwork Burden Statement
According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0061. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the