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

Greater Pokot District - Kenya
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ANNUAL REPORT

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LIST OF ACRONYMS:

AMTSL – Active Management of Third Stage of Labor

ANC – Antenatal Care

AOP – Annual Operations Plan

APHIA II – AIDS, Population & Health Integrated Assistance Program II

ART – Anti Retroviral Therapy

CATCH – Community Access to Child Health

CBC – Community Based Coordinator

CBHIS – Community Based Health Information System

CBO – Community Based Organization

CHC – Community Health Committee

CHEW – Community Health Extension Worker

CHW – Community Health Worker

CM – Community Mobilizer

CME – Continuing Medical Education

CSHGP – Child Survival and Health Grants Program

DASCO – District AIDS and STI (Sexually Transmitted Infections) Coordinator

DHMT – District Health Management Team

DHRIO – District Health Records and Information Officer

DHIS – District Health Information System

DIP – Detailed Implementation Plan

DPHN – District Public Health Nurse

DRHTST – District Reproductive Health Training and Supervision Team

ELCK - Evangelical Lutheran Church of Kenya

EmONC – Emergency Obstetric and Newborn Care

FANC+ – Focused Ante-Natal Care

FBO – Faith Based Organization

FGM – Female Genital Mutilation

FHI – Family Health International

HENNET – Health NGO Network

HF – Health Facility

HFA – Health Facility Assessment

HFMC – Health Facility Management Committee

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HR – Human Resources

IEC – Information, Education and Communication

IPT – Intermittent Preventative Treatment (against malaria)

ITN – Insecticide Treated Nets

KEMSA – Kenyan Essential Medical Supply Agency

KPC – Knowledge, Practice and Coverage

LLITN – Long Lasting Insecticide Treated Net

M&E – Monitoring and Evaluation

MNC – Maternal and Newborn Care

MOH – Ministry of Health

MOU – Memorandum of Understanding

MTE – Mid Term Evaluation

MVA – Manual Vacuum Aspirator

NGO – Non Government Organization

NHIF – National Health Insurance Fund

OJT – On-the-Job Training

PAC – Post-Abortion Care

PHMT – Provincial Health Management Team

PMNH – Partnership for Maternal and Neonatal Health

PMO – Provincial Medical Officer

PMTCT – Prevention of Mother-to-Child Transmission

PNC – Post Natal Care

PSI – Population Services International

QIC – Quality Improvement Committee

QI/QA – Quality Improvement/Quality Assurance

SBC –Social and Behavior Change

SF – Sustainability Framework

USAID – US Agency for International Development

TAG – Technical Advisory Group

TBA – Traditional Birth Attendant

TRM – Technical Reference Material

TT – Tetnus Toxoid

A. MAIN ACCOMPLISHMENTS (See ME plan in Annex I for details.)

1. General:

Improved Coordination:

Since the MTE, the PMNH has dramatically improved the project's coordination with all stakeholders. In addition to re-establishing quarterly stakeholder meetings at the district level, the PMNH project has been the impetus for organizing smaller divisional partner meetings as a means of coordinating the activities of the CHWs in their areas. In this way, HealthRight Community Mobilizers (CM) have had the opportunity to meet at a more local level to discuss CHW priorities, progress and challenges.

In addition, HealthRight was an active participant in the development of the district and provincial level Annual Operations Plans (AOP). With the District Health Management Team (DHMT), the plan outlines the priority health activities each year and is the basis upon which the district health budget is developed. The PMNH priority activities have been included as a part of the MOH 2010 plan, in order to ensure on-going partnership and coordination of activities.

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

Quality Assurance Systems Implemented at Health Facilities: During the MTE, HealthRight's work to establish QA Committees in each of the health facilities was heralded as an area of great success. However, the sustainability of those efforts required intense support in Y3. As such, the HealthRight team has been attending QA Committee meetings at the facilities and promoting the implementation of QA action plans. The Kabichbich QA Committee successful fundraised for a medical waste pit and plans to construct a medical waste incinerator. At Kapenguria District Hospital, the QA committee chose to address high neonatal death rates by organizing Advanced Life Skills Training for staff. The PMNH organized a refresher QA/QI Training of Trainers for the DHMT to compensate for recent staff turn-over and will establish a District-level QA committee in Y4.

Capacity Building of Health Facility Staff Continues:

- ***Formal trainings***: In January, the PMNH organized another MNC clinical training which included normal delivery, obstetric complications, infection prevention, and mother/newborn care. A total of 30 MOH staff received this 2-week clinical training for the first time in Y3. The PMNH will organize refreshers of this clinical training in Y4 to compensate for staff turnover and to provide clinical updates. Also in Y3, PMNH worked with the DRHTST to conduct a round of refresher training on FANC+ to 80 staff in Y3 including the topics of malaria in pregnancy and PMTCT. Finally, the project completed Post-Abortion Care training for 28 MOH staff. The project donated MVA kits to each facility to allow staff to offer these services; these kits were purchased with cost-share resources.
- ***Continuing Medical Education (CME) Systems***: All participants in the PMNH-organized trainings received CME credits for their participation. The PMNH team has been working with HFMCs to provide on-going support to the national CME system. Facility management identifies the most pressing CME needs and PMNH facilitates those related to the project objectives. At Kapenguria District Hospital, the management team chose to expand the clinical training done by the PMNH to additional hospital staff. The PMNH supported this effort.

- ***On the job training***: Through the MTE, the PMNH team committed to making the training strategy more efficient and sustainable through the use of on-the-job training (OJT) in the facilities. Participants in all PMNH trainings commit to cascading the training to at least two colleagues through OJT in their facility. Since the Post-Abortion Care (PAC) conducted in Y3, six additional facility staff began receiving OJT on PAC services with expectation that they will receive CME credits for their new skills after achieving competency.

Training Follow Up to Ensure Impact at Facilities: The PMNH team with the DRHTST established guidelines for follow up of all trainings as a means of monitoring their impact in the facilities. In Y3, the DRHTST completed two monitoring visits for the FANC+ and PAC trainings, as planned. In Y3, the team conducted brief meetings before and after supervision visits allowing time to discuss findings in a supportive way and making the visits more useful. As with the MTE, the supervisors highlighted simple hand-washing as an area of on-going concern in these facilities, despite several trainings on infection prevention.

Ensuring a Steady Medical Supply Chain System: This year, the national MOH rolled out a new medical supply chain system that operates based on needs at each facility. Although training has now been provided at all of the PMNH facilities, this new "pull" system has been slow to function, leaving many of the partner health facilities without essential medical supplies, including sutures, gloves and needles, for over six months. The PMNH worked to fill gaps where possible with donations. Furthermore, the project established a partnership with Project CURE to conduct a needs assessment in the Pokot districts and provide donated medical supplies to Kapenguria in Y4. A description of ProjectCURE's work is found in Annex VI. PMNH will continue to support the MOH supply chain system upgrade at the district and facility levels.

LLITN Distributions: HealthRight partnered with PSI to distribute over 34,000 LLITNs to all facilities in the Greater Pokot Districts. The distribution was completed in just two weeks in March, prior to the onset of the high malaria season. Nets are provided free to pregnant women and children <5yrs by the facility staff and were distributed before the high-malaria season. Nets were donated by PSI, and no charges for purchase were incurred by the PMNH.

Increased HIV testing and referrals: Through it's HIV project, HealthRight staff works in all health facilities in the three Pokot districts to increase the rates of HIV testing as an integrated activity during in-patient and out-patient services. In 2009, HIV testing in Pokot facilities has increased by 356%, identifying 389 positives and enrolling 428 new patients into care.

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

Low-literacy IEC Materials Developed: This year, HealthRight has established a partnership with FilmAid International to develop three 20-minute entertaining and educational videos in Pokot language which feature the project's four priority MNC messages. HealthRight and the

4 PMNH Priority MNC Messages

1. The importance of birth-planning
2. The importance of delivering in a health facility with a skilled health provider
3. The importance of 4 ANC visits
4. The importance of PNC within 2 hrs of delivery

communities worked on the development of the video scripts while a local youth drama group provided actors for the series. First drafts of all three videos have been completed and FilmAid has entered the post-production work at the end of this reporting period. These videos will be used by the CMs, CHWs and community partners in Y4.

Another method of educating non-literate communities is to use traditional song. HealthRight has worked with a local singer/songwriter named Loketo to produce 12 songs in Pokot language, addressing important MNC topics including malaria, HIV, healthy deliveries, ANC etc. the project recorded and began distribution of the tapes in Y3. The tapes will be played at community events and will also be used in radio spots and during mobile outreach clinics.

This year, HealthRight's CMs organized monthly community events which delivered messages to 31,338 people. Some of these events included theatre and song on market days, community dialogues and health talks during meetings (*barazas)* organized by community chiefs. Pokot language is used at all community events.

Support to the National Community Strategy

The MTE raised concerns that the CHW training provided in Y2 wasn't at the appropriate skill level for CHWs in the Pokot Districts. Based on these recommendations, HealthRight committed to additional capacity building for the 253 CHWs in Y3. For the entire year, CHWs received a half-day of training each month as a part of their regular coordination meetings. In addition, HealthRight offered a two-day HIV basics training in September. These CHWs conducted 15,288 home visits in the past year.

The project continues to work with the CHWs to monitor the use of the health kits that were provided in Y2 as incentives. Many of the most active CHWs sold their supplies within the first two months of their work. The PMNH is finalizing a system that will ensure the kits are replenished effectively after the grant end. In addition, PMNH has secured partnerships with PSI to provide LLITNs and Intuitive Motion to provide sanitary pads at low cost for CHWs to sell.

The PMNH has been working to build capacity of the CHCs in each of the five units. These committees monitor and support the CHWs in their communities. A five-day orientation session on the community strategy was conducted in Y3 for all 45 CHC members. On-going capacity building is organized during each of the monthly CHC coordination meetings.

4. Objective 3: Improve access for local communities to quality MNC services.

Maternity Waiting Homes Constructed in Three Facilities: See Annex V, Results Highlight.

On-going Support for Mobile Outreach Clinics: In 2009, HealthRight continued to support partner health facilities to conduct 12 monthly outreach clinics. These clinics served an average of 1,560 women and children each month. In total, this year 18,835 people received services through the outreach clinics (may be duplicated if a woman attended more than one mobile clinic). Two additional outreach clinics were conducted each month through support to ELCK which employs a clinical team for the visits.

Emergency Transportation Planning with Communities: The PMNH is working through the

CHCs to identify emergency transport options for women in their communities. Two committees are working to raise funds for a motorbike that could serve as both income generation and as an effective means of transporting a pregnant woman to the hospital during labor. Efforts to find sustainable solutions in all sites will continue in Y4.

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

Intense Support to the Health Information and Records Officers (DHRIO): Due to the division of West Pokot district into 3 distinct districts, the PMNH has committed to supporting the newly identified DHRIOs in North and Central Pokot. The PMNH M&E Officer assisted with monthly data collection, compilation and reporting at all sites. In addition, the PMNH staff ensures that data is reviewed and discussed at each DHMT monthly coordination meeting. The HealthRight HIV project complements this work by reviewing and doing quality checks for all HIV data in the health facilities each month.

Community-Based Health Information Systems Established: With the establishment of CHCs, the PMNH is working to facilitate the collection of important health data, including home births, from each community. Chalkboards have been installed in each community unit for this purpose. CMs also support the CHCs to review the data and discuss it with community members in order to strengthen community involvement.

Contributing Factors: In Y3, there were a number of changes in national health policy that have contributed to PMNH progress. First, MOH policy has begun allowing lower-level health facility staff to perform assisted vaginal deliveries, a service that previously could only be performed by doctors. This year, the policy also allows nurses to perform assisted vaginal deliveries and the PMNH project has been building their capacity to do so through the clinical skills training. This is expected to reduce neonatal mortality and morbidity. A second policy contributing to PMNH progress this year has been the policy requiring health facilities to have functioning QA systems in order to qualify for reimbursements through the national health insurance fund. This has renewed interests and efforts in the PMNH-supported QA Committees. Finally, the expansion of APHIA II into the Pokot districts has contributed to greater HIV testing and treatment and assisted in providing HIV training to the CHWs.

B. ACTIVITY STATUS TABLE: This table reflects the activities noted in the DIP. Activities added since the MTE shaded in green. A complete revised work plan for Y4 is found in Annex II. Activities that were successfully completed by Y2, have been excluded from the table.

Objectives/Activities	Met	Activity Status
Objective 1: Strengthen the capacity of nine focus Greater Pokot District health facilities to provide quality maternal and newborn care		
EmONC Training, including FGM-related Complications and Appropriate Referral Mechanisms	Partial	Trained 78 in EmONC No training in FGM-related complications
Post Abortion Care (PAC) Training	Yes	Trained 28 in Y3; deemed as sufficient in these districts

Objectives/Activities	Met	Activity Status
Facility Infection Prevention training	Yes	Infection prevention incorporated into all clinical training; additional training organized through APHIA II; progress monitored through facilitative supervision
On-site QA/QI Training with a focus on COPE	Yes	Training provided and action plans developed in Y2; on-going monitoring and facilitation in Y3;
QA/QI refresher training for DHMTs	Yes	Completed in Y3
Refresher training FANC+, Delivery , EmONC/FGM, PPC, PAC, Infection Control, COPE, Supply Chain, HMIS Training	Yes	Refreshers completed in FANC+, Infection prevention, PAC in Y3; Delivery, EmONC and PPC in Y4; HMIS refresher in Y4; supply chain in Y4
Training follow up visits by DRHTST and PMNH	Yes	2 monitoring visits conducted to all participant for each clinical training in Y3
Quarterly PMNH-West Pokot Partner Meetings	Yes	Quarterly district meetings held in 2009, several partner meetings also held at the lower divisional level
Renovate and equip four health centers for improved MNC, delivery and EOC services	Yes	Completed in Y2; monitoring of donated equipment at facilities done in Y3
Quarterly QA/QI monitoring visits DHMT	Yes	Monitoring visits conducted to all nine partner facilities each quarter in Y3
Quarterly coordination meetings of DHMT and District Civil Registry Monitoring Committee	Yes	Civil registrar participates in monthly DHMT meetings
Assess gaps in procurement chain for MNC supplies and medications	Yes	The district pharmacist conducted assessments of the facilities for the roll out of the new MOH supply chain system.
MNC Supply Chain Training	Yes	MOH training done for all sites;
Implement sustainable solutions to supply gaps at health facilities	Yes	National re-orientation of the medical supply system; MOH training done at all partner facilities; PMNH assisting with implementation and on-going monitoring
Develop and implement plan with HFs, AMPATH, and DOW HIV/AIDS clinic to enroll MNC clients in full ART through referral and mobile management teams	Partial	System currently in place using HealthRight PMNH and HIV staff; handover of responsibilities will be ongoing in Y4
Partner with international organizations to provide medical supply needs	Partial	Partnership formed with Project CURE in Y3
Nurses conduct monthly TBA monitoring visits at 8 MOH sites	No	Work with TBAs to happen in Y4
Provide vehicles to health centers for patient transfers	No	

Objectives/Activities	Met	Activity Status
Objective 2: Strengthen community awareness of and demand for quality maternal and newborn care		
Kenya National Community Strategy Training	Yes	5 units established and trained; on-going CHW capacity building provided each month; training of CHC also ongoing
Training on Behavior Change Advocacy Messaging for HFMC and Community Partners	Partial	SBC training provided to ELCK and HealthRight Community Mobilizers; Roll out to CHWs and Chiefs in Y4
Training on General MNH, HIV/AIDS, and Malaria Prevention for Community Partners, Chiefs/Asst. Chiefs, CHWs	Yes	4 Day training completed for all 253 CHWs. Ongoing capacity building provided each month. Training for CHCs also ongoing; training for chiefs in Y4.
Refresher training on MNC, HIV/AIDS, Malaria Training for Community Partners, Chiefs/ Assistant Chiefs, CHWs	Partial	CHW refresher training ongoing on a monthly basis; All other community groups will receive refresher training in Y4
Birth planning & FANC+ training including Malaria in Pregnancy and PMTCT for community partners	Yes	4-Day training completed for all five units completed in Y2 and 3; ongoing capacity building done monthly
FGM Sensitization for Community Partners, Chiefs/ Assistant Chiefs, CHWs	Partial	FGM sensitization for community leaders conducted in Y1; FGM sensitization for CHWs and CHEWs in Y4
Establish sustainable CHW health kit supply chain	Partial	Discussions with CHC and CHWs in Y3; roll out of supply chain system in Y4
CHWs conduct barazas on HIV/AIDS and malaria	Partial	CHWs trained on HIV and malaria basics; refresher malaria training in Y4 through PMI funding; CHWs are not yet conducting barazas independently
Conduct training of HFMCs and health centers in monitoring CHWs	Partial	Curriculum developed, and training scheduled on topics of community strategy, data use, MNC topics; training begins in October 2009
HFMCs conduct monthly monitoring meetings with CHWs	No	To happen in Y4 after HFMC training
Objective 3: Improve access for local communities to quality MNC services.		
Develop, implement and monitor MNC transportation system	Partial	Working with CHCs in all five communities to develop transport plans; facility transport plans in Y4
Implement community MNC services with mobile outreach teams	Yes	12 mobile clinics each month conducted providing ANC, PNC and infant/child care
Assist facilities in purchasing LLITNs through provision of seed money and supervision	Yes	Facilities are linked with PSI and beginning new program for free net distribution. CHWs have LLITNs in CHW Kits
Construction of five maternal waiting homes to improve access to delivery services	Partial	3 of 5 maternal waiting homes started in Y3

Objectives/Activities	Met	Activity Status
Objective 4: Strengthen the District Health Information System with particular attention to maternal and newborn health.		
Data Collection and Use Training : CBIS for Community Partners, Chiefs/Asst Chiefs, CHEWs, CHWs	Yes	CBHIS training done for 19 chiefs, 253 CHWs, 5 CHEWs, and 44 CHC members
Refresher Data collection and use: for Chiefs/ Assistant Chiefs, CHEWs and CHWs	No	In Y4
Data collection of MNH activities and use of HMIS	Yes	Monthly utilization data collected, over 85% of health facilities reporting on time all year, both DHMTs reported on time each month to the province
With HFMCs, create data forms for CHW activities	Partial	Data forms based on MOH Community Strategy model, rolled out to CHWs in Y3 and Y4
DHMT to incorporate data collected from CHWs	Partial	Chalkboards installed in all five units, registrar meeting monthly with DHRIOs; system strengthening in Y4
Conduct quarterly NGOs/FBO meetings to collect data from PMNH-supported activities	Yes	Data from ELCK outreach activities collected monthly rather than quarterly

C. CONTEXTUAL FACTORS IMPEDING PROGRESS

1. Redistricting of Project Location: When HealthRight wrote the DIP for the PMNH, West Pokot was one district which has since been divided into three – North, Central and West Pokot. This re-districting has created three DHMTs with which to partner and plan activities, although Central Pokot is not yet functioning. This has led to additional training and support needs. Also, the health centers in Kacheliba and Sigor will become District Hospitals despite the fact that they didn't receive all the necessary resources for the upgrade. PMNH continues to consider those sites as health centers but assists to upgrade them when possible.

2. National Community Strategy: The national community strategy is still in the early phases of development. The PMNH has been ahead of the national MOH in the development and training of the CHCs. Therefore, the PMNH is working to develop an appropriate curriculum based on the strategy guildelines. In addition, the initial MOH plan was for the training of volunteer CHWs. As the strategy has rolled out across the country, several agencies have begun to offer monthly stipends to the CHWs as motivation for their work. The PMNH budget does not include funds to support the 250 trained CHWs whereas other USAID-funded projects in neighboring areas are able to do so. This has led to difficulties in coordination and may increase CHW attrition rates in the PMNH areas. However, in the long-term, sustainability will be compromised in other districts if CHW stipends are not maintained.

3. Weak National Medical Supply System: The Kenya Essential Medical Supply Agency (KEMSA) was defunct for about eight months in 2009 during which time the organization was restructured to allow for establishment of a pull-system. During those months, no medical supplies were delivered and the hospital was depleted of all supplies including gloves, sutures and needles. PMNH was able to fill a few of these essential gaps with donations of medical

supplies. However, these stock-outs drastically decreased the facilities' ability to prevent maternal and neonatal mortality.

4. Decreases in National Health Funding: In January 2009, the MOH announced a decrease in national health funding from 15% to 6% of the national budget. This will undoubtedly decrease the resources available for the Pokot Districts, which are already neglected, and further diminish the staffing levels in PMNH partner facilities.

D. AREAS REQUIRING TECHNICAL ASSISTANCE: The PMNH has been establishing strategic partnerships to address the most pressing areas requiring technical assistance. These include: working with FilmAid to produce high-quality health videos, integrating activities with the HealthRight HIV projects, collaborating with Project CURE to conduct supply chain assessments and offer donated medical supplies, identifying an external researcher to document the effectiveness of the maternal waiting homes, and contracting external consultants to conduct the project end evaluation.

E. CHANGES FROM DIP

New Project Targets: After the 2008 KPC survey, HealthRight worked with the project team to review the CATCH indicators and revise the project targets appropriately. The mid-term KPC consultant re-analyzed the data from the baseline KPC to focus on the cohorts of women with children 0-5mos and 0-11mos, because these are the priority groups that our program attempts to reach. In two cases, the team revised targets due to a substantial difference between the old and revised baseline values. For seven of the indicators, the project had already achieved the established target by the mid-term; therefore, the team agreed to raise the target in hopes of promoting and achieving even greater progress. In seven other cases, however, a target needed to be revised down because it had become an unrealistic goal based on progress to the mid-term. These revised targets can be found in Annex I: ME Table.

Work plan activities: Annex II contains the quarterly work plan which has some revisions in specific activities based on the MTE or to reflect changing realities on the ground. New activities have been shaded while outdated activities have been deleted.

Organizational Development Training for CHCs: PMNH did not intend to provide organizational development for the CHCs when the DIP was developed. However, because the PMNH has been leading the roll out of the community strategy in the Pokot Districts, the CHCs have not yet received the orientation or training that they need to perform their duties. Therefore, the project has offered an orientation to all five committees and will provide intensive support and capacity building through Y4.

F. SUSTAINABILITY PLAN: The PMNH has strived to address sustainability from the design stage by focusing interventions on strengthening existing DHMT processes or supporting the implementation of MOH systems and policies. The following is an update on a selection of primary strategies to improve sustainability of program outcomes as outlined in the MTE Report.

Collaboration with the DRHTST: All PMNH clinical training has been organized in coordination with the DRHTST in West Pokot and the new North Pokot Districts. Central Pokot, one of these new districts, does not yet have a functioning DHMT or a Reproductive Health Coordinator and is managed through the West Pokot team. Members of the DRHTST have led 100% of post-

training follow up visits. HealthRight supports facilitation fees for DRHTST members according to MOH guidelines.
Supporting the implementation of the National Community Strategy: All structures of the Community Strategy have been established in the five units that HealthRight committed to support. Intensive capacity building for CHWs, CHCs and HFMCs is currently underway. This is one of the first areas to be piloting the new Strategy in line with MOH guidance and policy.
Implementation of a QA/QI System at target hospitals and health centers: As mentioned above, PMNH offered intensive technical support to QA/QI committees at PMNH target facilities to institutionalize QA/QI systems within the facilities. As of Y3, a new national policy requires facilities to maintain QA systems as a pre-requisite to receiving NHIF reimbursements. Therefore, the PMNH strategy is both timely and effective.
Development of an Excel-based database for the HMIS: In addition to West Pokot District, the Excel tool is now being used by the new North Pokot District. HealthRight provided a laptop to the new district and has worked with the DHRIO in the District Hospital to build capacity to report to the province as well as back to the facilities.

The following sustainability-focused initiatives were initiated since the MTE:
Establishment of Maternal Waiting Homes: To create ownership of these homes, each HFMC submitted proposals to HealthRight outlining their contribution and maintenance plans. Construction is underway in 3 of 5 facilities with the close involvement of the facility HFMC.
Sustainable Strategies for Capacity Building: The MTE recommended the establishment of CME and OJT programs to combat one of most common sustainability dilemmas, ensuring providers' clinical skills remain up to date. As mentioned in the Progress section, both of these strategies are underway.

Some activities continue to present a challenge to sustainability including:
Mobile Outreach Clinics: Although facility staff now have the capacity and motivation to conduct mobile outreaches on their own; however, the cost of fuel and lack of MOH vehicles continue to be a challenge to continuing this service once the project is terminated. However, the mobile clinics also serve to build trust between health facility staff and the communities and to offer referrals to the facilities for services.
Supply system for CHW Kits: Although a centralized process for procurement of the materials for these kits is envisioned in the Kenya Community Strategy, the MOH has yet to create such a system and instead is relying on partners to take on the cost and implementation. Currently, HealthRight is supporting the purchase and distribution of kit supplies with the hope that a sustainable system of maintaining them can be developed through the CHCs or HFMCs.

HealthRight is utilizing the Sustainability Framework (SF) model. In Y4, PMNH aims to establish the scoring system for indicators in each of the framework categories so that a final score can be achieved prior to the grant end.

Phase out expectations: Apart from the challenges noted in the sections above, as it enters its fourth and final year, the PMNH will be handing over most of the project implementation duties to the DHMT and health facilities. This will be facilitated by HealthRight's involvement in the annual AOP planning process, which will ensure that funding is included in the district health budget to cover the costs for on-going project activities and/or staff. At the end of the grant

cycle, the PMNH intends to apply for continued funding to serve in a supportive and monitoring role with the current partner facilities in Pokot to assure and assess the project's long-term impact. In addition, with continued funding, HealthRight hopes to expand the project approaches into three additional North Rift Valley districts in which HealthRight's HIV/AIDS testing, treatment and support project is already active.

G. INFORMATION REQUESTED IN MID-TERM EVALUATION REPORT
As promised in the MTE, the updated project work plan can be found in Annex II.

H. PHASE OUT EXPECTATIONS - (See Sustainability Section above)

I. PROJECT MANAGEMENT SYSTEM
Financial Management System: HealthRight has established a line of credit with USAID which has improved the cash flow for the PMNH, a challenge identified during the MTE. Since the MTE, the project has experienced no financial shortages or difficulties.
Human Resources: HealthRight strengthened its team in Y3 to include an HR officer and a logistician which has greatly improved the operations of all the projects including a more efficient vehicle schedule. Also in Y3, HealthRight eliminated the expatriate HIV Project Director position, at least temporarily. For most of 2009, the HIV Deputy Director has led the project working with the PMNH Director to integrate the project activities. Finally, in Y3, the PMNH recruited a new Capacity Building Coordinator (CBC) who works closely with the DRHTST to organize all formal training activities as well as the follow up supervision at the health facilities.
PVO coordination/collaboration in country: The PMNH and the CSHGP project in Busia have been sharing tools and resources in the implementation of the national community strategy.
Other relevant management systems: HealthRight moved into a new office to house all project staff in one location, which improved project integration and fostered more efficient use of resources. The Project Support Team, including all admin/finance staff and the Project Directors, meets bi-weekly to discuss relevant operations and project highlights.

J. LOCAL PARTNER CAPACITY BUILDING: In addition to building capacity of the primary partner, the MOH, the PMNH has emphasized capacity building of local CHCs and to its on-going partnership with the Evangelical Lutheran Church of Kenya.

K. MISSION COLLABORATION: The PMNH has been an active participant in all USAID mission collaboration meetings, including offering a presentation in June about efforts to roll out of the community strategy. The PMNH staff assisted the Kenya mission to coordinate a field visit from the CTO in July. Quarterly debriefs are held between PMNH staff and the mission. HealthRight is a sub-grantee of the mission's APHIA II project to implement HIV testing and treatment activities in the North Rift Valley. In addition, the PMNH has been collaborating with APHIA II to coordinate RH activities in the project areas to ensure that activities are complementary rather than duplicative. This was done through DHMT Stakeholders' meetings, participation in the MTE discussion, and other local networking opportunities.

L. MONITORING AND EVALUATION UPDATE: See Annex VIII.

ANNEXES

I. M&E TABLES (Showing baseline, midterm and most recent data points)
N/A = Activity not yet started or data not available.

Obj. 1: Improved quality of MNC services provided at HFs

				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
1	PROCESS	Qtr	Fraction of HFs providing BEmONC	0	9	**0/9**	0	9	**0/9**	2	9	**2/9**
2	PROCESS	Qtr	Fraction of HFs providing CEmONC	0	2	**0/2**	0	2	**0/2**	2	2	**2/2**
3	PROCESS	Qtr	Fraction of HFs providing ANC services according to MOH standards	9	9	**9/9**	9	9	**9/9**	9	9	**9/9**
4	PROCESS	Qtr	Fraction of HFs providing delivery and immediate post-partum services according to MOH standards	6	9	**6/9**	6	9	**6/9**	7	9	**7/9**
5	PROCESS	Qtr	Fraction of HFs providing postpartum services according to MOH standards	6	9	**6/9**	6	9	**6/9**	9	9	**9/9**
6	PROCESS	Qtr	Fraction of HFs providing neonatal services according to MOH standards	6	9	**6/9**	6	9	**6/9**	9	9	**9/9**
7	INPUT	Bi-Annl	% of targeted health providers trained in MNC by HEALTH**RIGHT**			**0**	140	150	**93.33%**	326	350	**93.14%**
8	PROCESS	Qtr	Fraction of post-training supervision visits completed			**0**			**NA**	3	7	**3/7**
9	PROCESS	Qtr	Fraction of targeted HFs that received supportive supervision visits by DHMT			**N/A**	0	9	**0/9**	9	9	**9/9**
10	INPUT	Bi-Annl	% of QI Committee members who received orientation or training in QI/QA methods			**N/A**	142	160	**88.75%**	68	99	**68.69%**
11	PROCESS	Mon	Fraction of QI/QA committees that held meetings last month			**NA**	4	6	**4/6**	5	6	**5/6**

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				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
12	PROCESS	Mon	% of QI/QA committee members who attended last meeting			**NA**	42	73	**57.53%**	46	73	**63.01%**
13	PROCESS	Mon	Fraction of QI/QA committees that achieved 80% of their action plan for the quarter *(achieved defined as took some action towards listed action point)*			**NA**	2	6	**2/6**	3	6	**3/6**
14	PROCESS	Eval	% of staff aware of facility's QI process and how to contribute their ideas and concerns			**NA**			**NA**			**NA**
15	PROCESS	Qtr	Fraction of HFMCs that held at least one meeting last quarter			**NA**			**NA**	3	9	**3/9**
16	PROCESS	Qtr	% of HFMC members who attended last meeting			**NA**			**NA**			**NA**
17	PROCESS	Qtr	Fraction of HFMC committees that achieved 80% of their action plan for the quarter			**NA**			**NA**			**NA**
18	PROCESS	Qtr	% of HFMCs that raised funds last quarter			**NA**	9	9	**100.00%**	2	9	**22.22%**
19	PROCESS	bi-annual	Fraction of target HFs with functional MNC equipment per MOH standards	6	9	**6/9**	6	9	**6/9**	9	9	**9/9**
20	PROCESS	Qtr	Fraction of target HFs meeting minimum standards set by the MOH for infrastructure	6	9	**6/9**	6	9	**6/9**	6	9	**6/9**
21	PROCESS	Qtr	Fraction of target HFs experiencing no stock-outs of essential medicines and supplies for MNC in the last quarter			**NA**			**NA**	9	9	**9/9**
22	INPUT	Qtr	Fraction of target HFs with proposed renovations completed according to plan	0	3	**0/3**	3	3	**0/3**	3	3	**3/3**
23	INPUT	Qtr	Fraction of selected HFs with proposed renovations for kirors completed according to plan	0	6	**0/6**	0	6	**0/6**	0	6	**0/6**

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				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
24	INPUT	Annl	Fraction of districts DHMTs that conducted supply chain analysis in the last year	0	3	**0/3**	0	2	**0/2**	2	2	**2/2**
25	INPUT	Annl	Fraction of target HFs that conducted supply chain analysis in the last year	0	9	**0/9**	0	9	**0/9**	2	9	**2/9**

Obj. 2: Increased knowledge and positive MNC practices among women (and their households)

				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
26	OUTCOME	Eval	All KPC indicators on health practices not directly related to utilization									
27	INPUT	Mon	# of people receiving health talks			**0**			**8281 (annl)**			**2909**
28	INPUT	Mon	# of people attending video shows			**N/A**			**N/A**			**NA**
29	INPUT	Mon	# of IEC materials distributed			**0**			**1200 (annl)**			**0**
30	PROCESS	Qtr	% of CHW assigned households visited by CHWs last quarter			**N/A**			**N/A**	3762	5000	**75.24%**
31	PROCESS	Qtr	% of trained CHWs that were active (attended monthly meeting and turned in a report) in all of the last 3 months			**N/A**			**N/A**	205	253	**81.03%**
32	INPUT	Annl	% of CHEW positions filled with a qualified candidate	**0**	**5**	**0%**	2	5	**40%**	4	5	**80.00%**
33	INPUT	Qtr	# of CHWs trained in 1 week MNC course			**N/A**			**89**			**253**
34	PROCESS	Mon	Fraction of monthly CHW meetings held			**N/A**	2	2	**2/2**	5	5	**5/5**
35	PROCESS	Mon	% of CHWs who attended the last monthly meeting			**N/A**	85	89	**96%**	171	253	**67.59%**

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				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
36	PROCESS	Mon	% of CHWs who turned in their monthly report last month			**N/A**			**N/A**	171	253	**67.59%**
37	PROCESS	Mon	% of CHWs participating at barazas or other community events (including mobile clinics)			**N/A**			**N/A**	66	253	26.09%
38	INPUT	Qtr	# of health kits given to CHWs (cumulative)			**N/A**			**89**			**253**
39	PROCESS	Qtr	Amount of money given to CHC or CHEW to replenish kit items			**N/A**			**N/A**			**6,409 KES**
40	PROCESS	Qtr	Fraction of CHCs that achieved 80% of their action plan for the quarter *(achieved defined as took some action towards listed action point)*			**N/A**			**N/A**	1	5	**1/5**
41	PROCESS	Qtr	Fraction of CHCs that have raised funds/resources for community activities in the last quarter			**N/A**			**N/A**	1	5	**1/5**
42	INPUT	Qtr	Fraction of CHCs for the 5 community strategy units rolled out with HEALTH**RIGHT** support			**N/A**	3	5	**3/5**	5	5	**5/5**
43	INPUT	Qtr	# of CHC members trained in MNC topics, role of CHC and CHC management			**N/A**			**0**			**45**
44	INPUT	Mon	# of village leaders trained in MNC topics						**86**			**95**
45	PROCESS	Mon	Fraction of monthly CHC meetings held			**N/A**	2	5	**40%**	5	5	**5/5**
46	PROCESS	Mon	% of CHC members who attended last meeting			**N/A**			**N/A**	35	45	**77.78%**
47	PROCESS	Mon	Fraction of CHCs who discussed CBHIS information in their monthly meeting			**N/A**			**N/A**	2	5	**2/5**
48	PROCESS	Mon	# of community education events held by partner MOH, NGOs, CBOs & FBOs			**0**			**6**			**2**

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				Baseline			Midterm			September 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
			where MNC messages shared									
49	INPUT	Qtr	# of organizations partnering with HEALTH**RIGHT** to conduct joint events or disseminate MNC messages through own events			**0**			**5**			**5**
50	INPUT	Annl	# of partner NGOs that received training on MNC topics			**0**			**5**			**5**

Obj. 3: Reduced barriers to access of quality MNC services

				Baseline			Midterm			SEPTEMBER 2009		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**
51	PROCESS	Mon	% of HEALTH**RIGHT** supported outreach clinics providing routine ANC services according to MOH standards			**N/A**	12	12	**100%**	11	12	**91.67%**
52	PROCESS	Mon	% of HEALTH**RIGHT** supported outreach clinics providing postpartum services (except PMTCT) according to MOH standards			**N/A**	12	12	**100%**	11	12	**91.67%**
53	PROCESS	Mon	% of HEALTH**RIGHT** supported outreach clinics providing neonatal services according to MOH standards (except vaccinations)			**N/A**	11	12	**92%**	11	12	**91.67%**
54	PROCESS	Mon	% of HEALTH**RIGHT** supported outreach clinics providing PMTCT services according to MOH standards			**N/A**	12	12	**100%**	8	12	**66.67%**
56	PROCESS	Mon	% of HEALTH**RIGHT** supported outreach clinics providing vaccination services according to MOH standards			**N/A**	12	12	**100%**	12	12	**100.00%**

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57	PROCESS	Annl	% of villages with MNC services available within 12 km (outreach and HF)			**N/A**				79	148	**53.38%**
58	PROCESS	Eval	Utilization related KPC indicators									
59	PROCESS	Mon	# of first time ANC visits at health facilities			**N/A**			**3035**			**406**
60	PROCESS	Mon	# of repeat ANC visits at health facilities			**N/A**			**2782**			**445**
61	PROCESS	Mon	# PPC visits at health facilities			**N/A**			**464**			**177**
62	PROCESS	Mon	# of neonatal clinic visits before the baby reaches 28 days of age at health facilities			**N/A**			**464**			**614**
63	PROCESS	Mon	# of ITNs distributed at health facilities to expecting mothers and children			**N/A**			**3612**			**517**
64	PROCESS	Mon	# of deliveries conducted at health facilities (see utilization tab for breakdown)			**N/A**			**688**			**285**
65	INPUT	Mon	Fraction of scheduled mobile clinics conducted			**N/A**	12	14	**6/7**	12	14	**12/14**
68		Eval	% of KPC indicators that have met target			**N/A**			**62%**			**NA**
69	PROCESS	Mon	% of target facility referrals who were referred by CHWs			**N/A**			**51%**			**NA**
70		Qtr	Fraction of community units with emergency transport plan			**N/A**	0	5	**0**	1	5	**1/5**
71		Qtr	Fraction of HF with functioning emergency transport service (defined as able to provide emergency transport to the District Hospital 24 hrs a day, 7 days a week)			**N/A**			**N/A**	4	9	**4/9**

Obj. 4: Improved HF, community and DHMT mechanisms for data collection, reporting and utilization for decision making.

				Baseline			**Midterm**			**September 2009**		
Indicator #	**Type of Indicator**	**Freq**	**Indicator**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**	**Num**	**Den**	**Indicator Value**

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73		Mon	% of HFs that submitted monthly report on time						**76%**	**39**	**45**	**86.67%**
74		Mon	% of health facility monthly reports with all required sections completed							**44**	**45**	**97.78%**
75		Mon	Fraction of DHMT monthly reports submitted on time to Province				1	1	**1/1**	**2**	**2**	**2/2**
76		Mon	Fraction of DHMTs that reviewed monthly data							**2**	**2**	**2/2**
77		Mon	Fraction of DHMTs that developed specific actions based on review of monthly data							**2**	**2**	**2/2**
78		Qtr	% of HFs that have received supervision to verify the quality of data in the last quarter							9	9	**100.00%**
79		Qtr	% of HFs with updated catchment population and graphic displays of key indicators posted						**40%**	6	9	**66.67%**
80		Mon	Fraction of sublocations with chalkboards updated (*Denominator: those who have received chalkboards*)							5	5	**5/5**
81		bi-annual	Fraction of key DHMT staff trained on HMIS and utilization of data	0	20	**0**	18	20	**18/20**	10	16	**10/16**
82		bi-annual	% of key HF staff trained on data reporting and utlization of data				44	76	**58%**	30	76	**39.47%**
83		bi-annual	Fraction of CHC members trained in key MNC indicators and maintenance of chalkboards							44	45	**44/45**
84		bi-annual	% of HFMC members trained on HMIS and utilization of data							0	81	**0/81**
85		bi-annual	% of CHEWs and CHWs trained in data collection, compilation, validation and posting on chalkboards							240	253	**94.86%**

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86		bi-annual	Fraction chiefs/subchiefs (project *community strategy areas ONLY)* trained in data collection and reporting							19	TBD	**19**
87		Qtr	Fraction of target HFs with updated utilization data posted.							9	9	**9/9**
88			HFs/HFMCs utilizing data									**N/A**
89		Mon	% of reports HFs submitted on official MoH forms							9	9	**100.00%**
90		Mon	Fraction of DHMT monthly reports that include CBIS information (*for communities with community strategy rolled out*) and info from vital statistics department							2	2	**2/2**
91		Mon	Fraction of CHEWs reporting community data to HFs							3	10	**3/10**
92		Mon	% of all Chiefs who submitted reports to appropriate authorities									**100%**
93		Qtr	% of health facilities receiving feedback and comparison data from DHMT in the last quarter						**76%**	9	9	**9/9**

CATCH Indicators:

Indicators	**Baseline, March 2007**			**Midterm, August 2008**			**Old Target**	**Revised Target**
	(DIP) MTE	*LCL (%)*	*UCL (%)*	**%**	*LCL (%)*	*UCL (%)*	%	%
Maternal and Newborn Care								
Percent of mothers of children 0-11 months who attended ANC at least four times during most recent pregnancy	**(30.5) 28%**	21%	34%	**26%**	20%	32%	80%	40%
Percent of mothers with children age 0–11 months who received two tetanus toxoid injections before the birth of their youngest child.	**(68.4) 30%**	23%	37%	**24%**	18%	30%	60%	

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Indicators	Baseline, March 2007			Midterm, August 2008			Old Target	Revised Target
	(DIP) MTE	*LCL (%)*	*UCL (%)*	%	*LCL (%)*	*UCL (%)*	%	%
Percent of children age 0–11 months whose births were attended by skilled health personnel	**(26.3) 28%**	21%	35%	**28%**	22%	35%	70%	40%
Percent of mothers of children age 0-11 months who had at least one postpartum check-up	**(48.4) 49%**	42%	57%	**26%***	20%	33%	80%	52%
Percent of mothers of children age 0-11 months who received child spacing information during a postpartum check-up	**(9.5) 8%**	2%	14%	**34%***	21%	47%	40%	72%
Percent of mothers of infants 0-5 months who received neonatal care within two days of delivery.	**(37.4) 16%**	10%	22%	**22%**	14%	30%	80%	50%
Percent of mothers of children age 0-11 months who know at least 2 maternal danger signs during the antenatal period	**(48.2) 19%**	13%	25%	**45%***	38%	52%	40%	65%
Percent of mothers of children age 0-11 months able to report at least two known neonatal danger signs.	**(72.6) 70%**	63%	77%	**74%**	67%	80%	50%	90%
Percent of mothers of children 0-11 months able to report at least two known maternal danger signs during the postpartum period.	**41%**	34%	49%	**69%***	62%	76%	50%	85%
Percent of mothers of children age 0-11 months with a maternal health card (interviewer -confirmed).	**17%**	11%	22%	**10%**	6%	14%	60%	35%
Percent of mothers of children 0-11 months who received IPT at least twice during ANC.	**4%**	1%	7%	**4%**	1%	7%	40%	
Breastfeeding								
Percent of children aged 0-5 months who were exclusively breastfed in the last 24 hours.	**(19.8) 14%**	8%	19%	**27%***	18%	36%	90%	43%
Percent of children aged 0-5 months who were exclusively breastfed within the first hour after birth (initiation of Breast feeding).	**(12.1) 20%**	14%	27%	**68%***	59%	78%	40%	90%
Malaria-ITN Use								
Percent of household with at least one ITN.	**29%**	23%	36%	**46%***	39%	53%	70%	
Percent of mothers of children 0-11 months who slept under ITNs the previous night	**(5.3) 11%**	7%	16%	**1%**	-1%	2%	50%	15%
Percent of children 0-11 months who slept under ITNs the previous night.	**(41.1) 21%**	15%	27%	**42%***	35%	49%	60%	
HIV & AIDS								

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Indicators	Baseline, March 2007			Midterm, August 2008			Old Target	Revised Target
	(DIP) MTE	*LCL (%)*	*UCL (%)*	%	*LCL (%)*	*UCL (%)*	%	%
Percent of women with children 0-11 months who received HIV counseling and testing services during pregnancy.	**(26.3) 28%**	21%	34%	**42%***	35%	49%	60%	
Percentage of mothers with children age 0–11 months who cite at least two known ways of reducing the risk of HIV infection.	**(30.5) 28%**	21%	35%	**42%***	35%	49%	40%	65%
Percent of mothers of children age 0-11 months who know where to go for HIV testing and counseling.	**61%**	54%	69%	**95%***	92%	98%	40%	98%
Percent of mothers with children 0-11 months who know that the risk of MTCT can be reduced by ART.	**20%**	14%	25%	**17%**	12%	22%	50%	34%
Percentage of women who know about the risks of spreading HIV through breast milk.	**(37.9) 39%**	31%	46%	**82%***	76%	87%	60%	90%

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II. PROJECT WORK PLAN: By objective. Activities that are bolded have been added or revised since the MTE.

Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
START UP																
Prepare job descriptions and plan for hiring																
Initial meetings with CSH partners																
Hire staff required for startup																
Locate appropriate office space																
DIP planning meeting with key partners to confirm program sites and priority communities																
Draft research action plan for baseline assessment																
Develop survey for NGOs, health service sites, etc.																
Identify and train enumerators and interviewers to perform baseline assessments.																
Conduct health facility assessment																
Review Health Facility monthly reports to DHMT to identify gaps, data quality, etc																
Enter and analyze baseline assessment data																
Draft DIP and send out for review																
Complete and submit DIP																
Revise, defend and approve DIP																
Hold Community Meetings to develop BCC Strategy; Complete BEHAVE Framework and Narrative																
With DHMT, conduct MNC equipment review at facilities																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Conduct renovation needs assessment and develop renovation plan																
Develop QI/QA Strategy																
REGULARLY HELD EXTERNAL MEETINGS																
Annual Planning Meeting with DHMT																
Quarterly NGO Coordination Meeting (called by DHMT)																
Annual Kenya CSHGP Grantees Meeting																
Annual PVO Field Visits																
Annual District Operations Planning (AOP)																
Annual Provincial Health Planning Meeting (AOP)																
TRAINING – ALL LEVELS																
Curriculum Development and Preparation																
Identify training topics based on baseline assessment results																
Develop or adapt curricula for trainings																
OBJECTIVE 1: Improved Quality of Maternal & Neonatal Care – Health Facility and DHMT																
Trainings																
CLINICAL SKILLS																
Malaria Prevention and Control																
General HIV/AIDS Training at facilities (provided by HIV team)																
Focused Antenatal Care (FANC) including Malaria in Pregnancy (MIP) and Prevention of Maternal to Child Transmission (PMTCT) of HIV																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Normal Delivery, including Use of Partographs, Assisted Vaginal Delivery (AVD), and Active Management of Third Stage of Labor (AMSTL)																
Emergency Obstetric and Neonatal Care (EmONC),																
Female Genital Mutilation (FGM)-related Complications and Appropriate Referral Mechanisms (separated from EmOC training above)																
Postpartum and Newborn Care																
Post Abortion Care (PAC) (MVA techniques)																
MANAGEMENT SKILLS																
On-site QA/QI using COPE methodology (HFs)																
HFMC trainings (exact topics include HFMC orientation, community strategy, use of data, MNC topics)																
Supply Chain Management – DHMT (done by MOH)																
Supply Chain Management – Facility Staff (done by MOH)																
Trainings: DHMT Level																
QA/QI Facilitator Training (DHMT)																
QA/QI Action Planning – DHMT and KDH Senior Management																
QA/QI Facilitator Training Refresher (including facilitative supervision) – DHMT																
OBJECTIVES																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Establish QA/QI committee and rules of operation at DHMT																
Establish QA/QI committees and rules of operation at health facilities (part of QA training above)																
Provide intensive support to QA/QI committees to ensure progress on action plans																
Continuous monitoring of QA/QI system to ensure institutionalization																
Work with the DHMT to conduct quarterly facilitative supervision in their districts																
Work with the PHMT to conduct annual facilitative supervision to the Pokot districts																
Conduct assessment of ITN supply system with PSI																
Develop and implement ITN procurement, distribution and supervision plan with PSI, DHMT and Health Facilities																
Renovate health facilities for improved MNC services																
Provide medical equipment and supplies for provision of MNC services																
Conduct post-training Supervision (2x per training) with District RH Training Team																
Continuous monitoring and technical support to DHMT to improve general supervision system																
Conduct job aid assessment at facilities (facilities have necessary MNC related job aids properly displayed) - part of supervision																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Establish Resource Centers at health facilities (QA committee activity)																
Establish and support CME System at Health Facilities																
Continuous monitoring and support at DHMT level of CME system																
Conduct independent inventory check of HealthRight donated inventory at health facilities (HealthRight Logistician) bi-annually																
Mentor DHMT to improve planning capacity																
Support DHMT to improve district equipment inventory, maintenance and repair system																
Conduct informal supply chain assessment to present problem for investigation by QI committees																
Conduct informal HFMC capacity assessment to determine training needs																
Support facility QACs to conduct supply chain analysis and implement improvements																
Support DHMT to conduct supply chain analysis and implement improvements																
Assist the DHMT and the facilities to implement Kenya's new "pull" supply system																
Continuous monitoring and technical support to facilities to sustain interventions in: facilitative supervision, supply chain management, equipment inventory and preventive maintenance, data reporting and use, well functioning HFMC, functioning emergency transport system																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
OBJECTIVE 2: Adoption of Positive MNC Practices in the Community																
Trainings																
COMMUNITY STRATEGY ROLL OUT																
Community Strategy Orientation for CHEWs & CHWS																
Community Strategy Orientation – Chiefs and Community Leaders																
CHW Induction Training – MNH, Malaria and FGM topics, Roles & Responsibilities																
CHC Capacity Building Training (team building, data use, MNC, financial management, community strategy, FGM and Malaria Prevention)																
Community MNC TOT Training for CHEWs and Community Mobilizers (CMs)																
Community Strategy Re-Orientation HFMC members																
Distribute copy of MoH Community Strategy document to key DHMT officials																
Support DHMT to further define roles and responsibilities of HFMCs, CHCs and CHEWs. DHMT to inform all stakeholders of the decisions made.																
HIV/AIDS training for CHWs																
CHW on-going capacity building (MNC, Malaria, HIV)																
HEALTH EDUCATION																
General MNH, FGM and Malaria Prevention for Community Partners **and refresher training**																

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Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
General MNH, FGM, and Malaria Prevention for Chiefs/Asst. Chiefs **and refresher training**																
General MNH, FGM, and Malaria Prevention for TBAs																
OBJECTIVES																
COMMUNITY STRATEGY IMPLEMENTATION																
Support DHMT and CHEWs to conduct CHW and CHC selection per community strategy criteria in five sublocations, to create five community strategy units																
Implement CHW Supply Kits																
Implement supply system for CHW supply kits																
Develop job aids for CHEWs, CMs and CHWs (adapted for low literacy)																
CHEWs, CHWs conduct talks and dialogue sessions at community events, mobile clinics, etc. spreading key MNC messages																
Develop list of topics/curriculum to be taught to CHWs during monthly meetings (continuous training)																
Monitor monthly CHC/CHW meetings and trainings.																
Continued monitoring and capacity building of CHCs through trainings at monthly meetings																
OTHER SBC ACTIVITIES																
CMs conducting talks and dialogue sessions at community events, mobile clinics etc. in non-community strategy areas and collecting community feedback.																

ANNEXES

Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assess capacity of additional CBOs for partnership (Kiletat, PADO)																
Sign MOUs with CBO/FBO partners																
Regular meetings with CBOs/FBO partners to collect data on community education activities they conduct with HealthRight support.																
Define and document strategy for targeting men																
Define and document strategy for continuing monitoring and engagement of TBAs post MNC training																
Adapt existing IEC materials for Pokot context and for low literacy levels																
With DHMT and other stakeholders develop a birth planning for low-literacy populations																
Distribute IEC materials and new birth planning cards through various channels																
Develop video series depicting MNC messages																
OBJECTIVE 3: Increase Access and Utilization of MNC Services																
Support facility staff to conduct MNC mobile clinics in remote communities with minimal access to health facilities																
Create/renovate *kirors* (waiting dorms for mothers close to delivery) at selected health facilities																
Monitor *kirors* and measure their utilization																
Work with facilities and CHWs to ensure effective referral systems																

ANNEXES

Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop and implement plan with facilities, APHIA II, and HealthRight HIV/AIDS clinic to enroll HIV+ MNC clients in full ART through referral and mobile HIV management teams																
Develop emergency transportation plans at community level through CHCs																
Support health facilities to establish functioning emergency transport system																
OBJECTIVE 4: Strengthened District Health Management Information System (HMIS)																
Trainings																
MANAGEMENT SKILLS: Facility Level																
Data reporting and Use Training (HMIS)- providers																
Data reporting and Use Training (HMIS)- HFMC																
DHMT Level																
Data reporting and Use Training (HMIS) - DHMT																
Data reporting and Use Training (HMIS) – District Records Team																
COMMUNITY STRATEGY ROLL OUT																
Data Collection, Reporting and Use (CBIS) for CHEWs, CHWs and CHCs																
Data Collection, Reporting and Use (CBIS) for Chiefs and Assistant Chiefs																
OBJECTIVES																
Review health facility data collection tools																
Revise/develop health facility data collection tools																

ANNEXES

Work Plan – By Quarter	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop/implement District Health Information Reporting Tool																
Facilitate quarterly coordination meetings of DHMT and District Civil Registry Monitoring Committee																
Monitor/encourage monthly DHMT data reviews (part of monthly DHMT general meeting)																
Continuous monitoring and support to DHMT, HFMC, and health facilities for proper reporting and utilization of data																
Support DHMT to establish pool of funds for producing reporting forms to which each facility must contribute																
Support DHRIO to establish checklist to track monthly HF reports that do/do not include community CBIS information																
PROJECT MANAGEMENT, MONITORING, and EVALUATION																
Updated monitoring matrix sent to HQ monthly																
Review of project ME plan data monthly, quarterly and annually, as required																
Midterm and End line Evaluation																
Presentation of evaluation results to all stakeholders																
Review and use of facility utilization data by PMNH staff																

The Partnership for Maternal and Neonatal Health (PMNH) –

Reducing Maternal Mortality in Hard-To-Reach Areas

HealthRight - Mission

HealthRight (formerly Doctors of the World-USA) works with local partners to build lasting access to health for excluded communities.





HEALTHRIGHT INTERNATIONAL

Project Goals and Objectives

To contribute to a reduction in maternal and neonatal morbidity and mortality in West Pokot, Kenya

- Strengthened capacity of 9 HFs and the DHMT to provide quality MNC, in accordance with MOH policy;
- Adoption of positive MNC, malaria and HIV/AIDS practices in the community;
- Increased access to, and utilization of, quality MNC services for communities in the target area;
- Strengthened District Health Management Information System (DHMIS);

HEALTHRIGHT INTERNATIONAL

EUNICE TO ADD

- Add a few points on the context (i.e. examples of why the project area is a difficult place) OR
- Just a picture or two demonstrating the difficulties!

Health S¸stems Stren¸thenin¸

- Staff Training: FANC+, PNC, PAC, Normal delivery, EmOC, HIV/AIDS
- DHMT Capacity Building: facilitative supervision, supply chain mgmt, improved planning, (participation in AOP 4&5)
- QA/QI system implementation & mentoring
- Maternal mortality reviews at KDH
- Facility Upgrades & Equipment
- Reviving the Continuing Medical Education system

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Improving Health Information Systems

- Extensive training and mentorship for DHRIO and facility HIS staff;
- Doubled the monthly reporting rates from health facilities to the DHMT;
- Computerized database at district level computes 153 standard indicators;
- Roll Out of CBHIS

HEALTHRIGHT INTERNATIONAL

Community Capacity Building

- Role out of Community Strategy in 5 units (training 250 CHWs)
- CHC development and training
- Community Behavior Change Campaign:
  - Barazas. market theatres and songs
  - Community dialogues
  - Radio programs and films
- Males ke_ tar_et in su_ _ ort role

Improving Access to Services

- Mobile outreach clinics in 10 villages offering hundreds of ANC, PNC services at each clinic every month
- Health education sessions ın partnership with CHWs at mobile clinics
- Referrals to the health facility – building bridges
- Maternal waiting homes to be built at target facilities with community collaboration – 2009
- Promotion of community emergency plans - 2009

HEALTHRIGHT INTERNATIONAL

EUNICE TO INCLUDE

- CHALLENGES, should we include?
  - Jen thought you might not want to because no one else does and it may seem we're the only ones with challenges. Roz supports including. Up to you.
  - Suggestions:
    - Division of district into 3 and Division of MoH into 2 and impact of this
    - Low staffing
    - Community Strategy role out – Some NGOs not properly coordinating, paying stipends when those before not

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Project Impact by Mid-Term

Indicator:	Baseline	Midterm
Percentage of mothers of children 0-23 months who received child spacing information during postpartum check-up	8%	34%
Percent of mothers of children 0 23 months able to report ≥2 maternal danger signs during antenatal period	19%	45%
Percent of mothers of children 0-23 months able to report ≥2 known maternal danger signs during postpartum period.	41%	69%
Percent of children aged 0-5 months who were exclusively breastfed within the first hour after birth.	20%	68%
Percent of women with children 0-23 months who received HIV counseling and testing services during pregnancy.	28%	42%
Percentage of women who know about the risks of spreading HIV through breast milk.	39%	82%
Percentage of mothers of children 0-23 months who know where to go for HIV testing and counseling	61%	95%
Percent of children 0-23 months who slept under ITNs the previous night.	21%	41%
Percent of households with at least one ITN	29%	46%
Percent of mothers of children 0-23 months with a maternal health card	17%	5%
Percent of mothers of children age 0-23 months who had at least one postpartum check-up (PPC)	49%	26%

HEALTHRIGHT INTERNATIONAL

E ˙uit˙ of Pro˙ect Impact

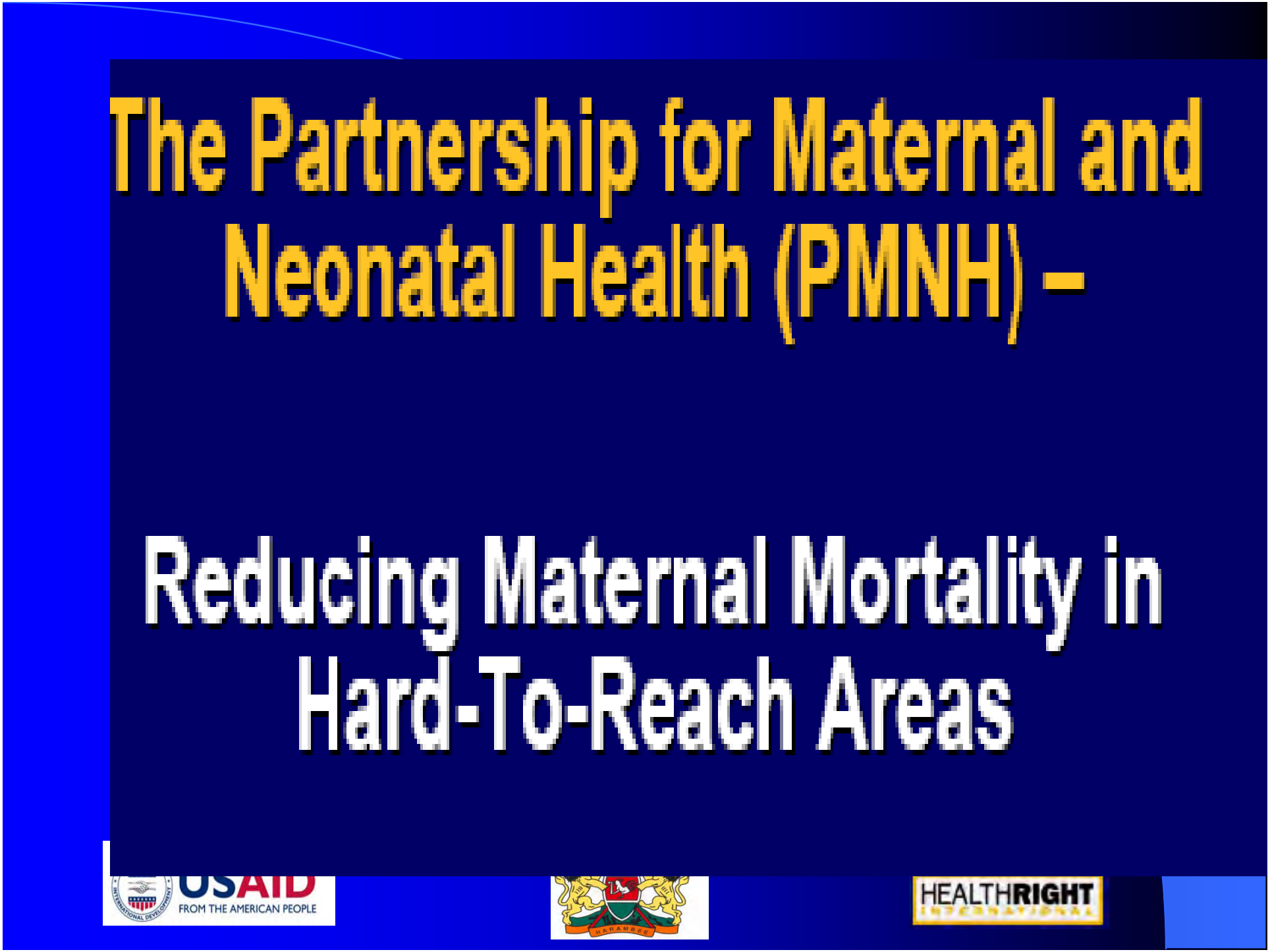
- Levels of knowled˙e indicators and HIV˙ AIDS indicators were equal across all socio-economic groups;
- Big differences across socio-economic groups in utilization of MNC services:
  - ≥ 4 ANC visits during last pregnancy (21% in poorest group vs. 45% in richest)
  - Delivery in facility during last pregnancy (8% in poorest group vs. 63% in richest)

HEALTHRIGHT INTERNATIONAL

Questions?

Eunice Auma Okoth
Project Director

www.healthright.org


The Partnership for Maternal and Neonatal Health (PMNH) –
Reducing Maternal Mortality in Hard-To-Reach Areas
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HealthRight - Mission

HealthRight (formerly Doctors of the World-USA) works with local partners to build lasting access to health for excluded communities.





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Where Are We In Kenya.

- Greater West Pokot- Kapenguria and Lelan
- North Pokot- Kacheliba.
- Central Pokot- Sigor

WHY HARD TO REACH !

- Difficult Terrain.
- Poor Road network.
- Security Threats.
- Low levels of Literacy.
- Semi-Nomadic life style

Project Goals and Objectives

To contribute to a reduction in maternal and neonatal morbidity and mortality in West Pokot, Kenya

- Strengthened capacity of 9 HFs and the DHMT to provide quality MNC, in accordance with MOH policy;
- Adoption of positive MNC, malaria and HIV/AIDS practices in the community;
- Increased access to, and utilization of, quality MNC services for communities in the target area;
- Strengthened District Health Management Information System (DHMIS);

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HEALTHRIGHT INTERNATIONAL

Health Systems Strengthening

- Staff Training: FANC+, PNC, PAC, Normal delivery, EmOC, HIV/AIDS
- DHMT Support: facilitative supervision, AOP4&5
- Support for QA/QI systems
- Facility Upgrades & Equipment
- Maternal mortality reviews at KDH
- Supply Chain – 2009 focus

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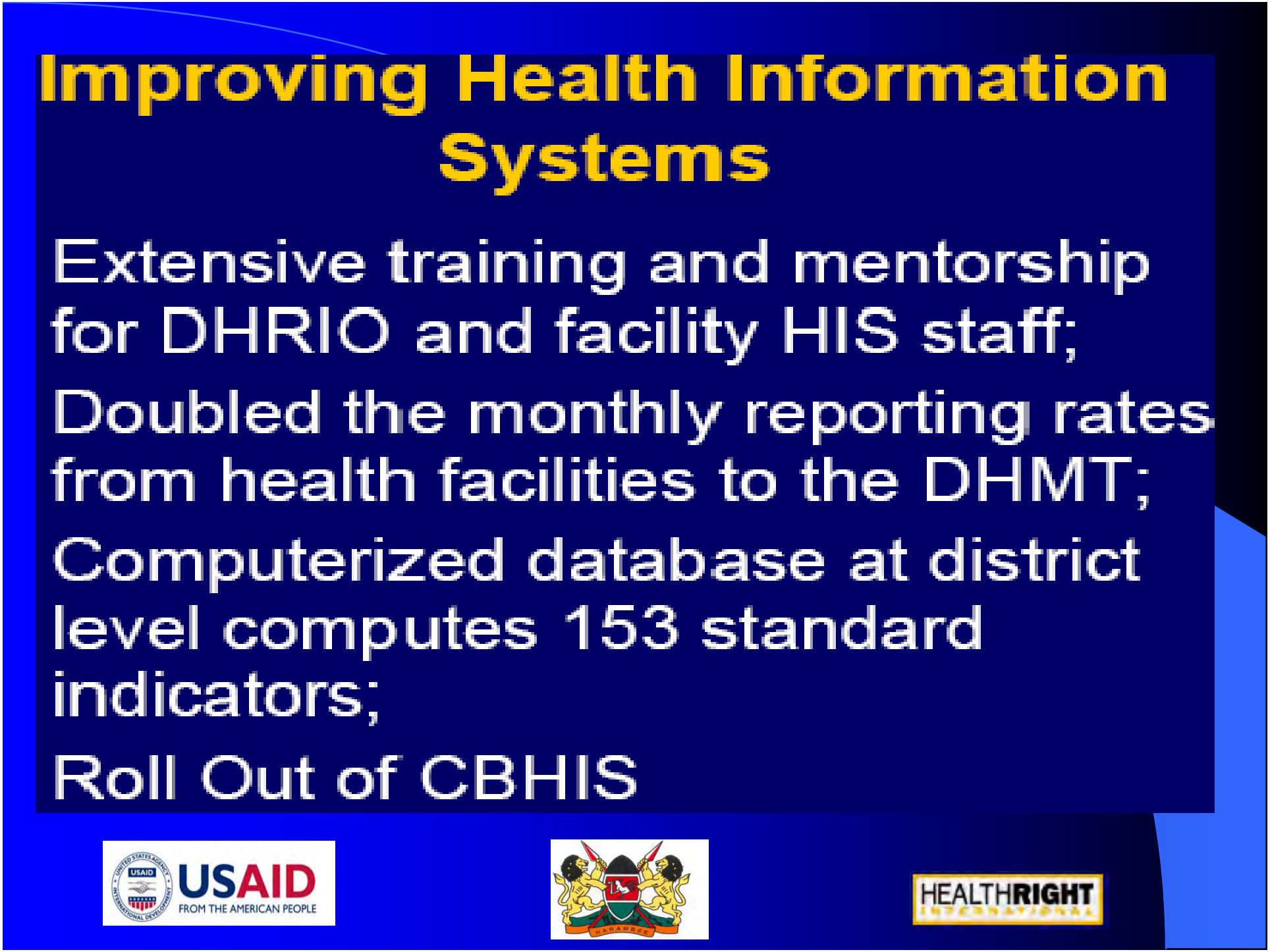
Facilities renovation


Improving Health Information Systems
Extensive training and mentorship for DHRIO and facility HIS staff;
Doubled the monthly reporting rates from health facilities to the DHMT;
Computerized database at district level computes 153 standard indicators;
Roll Out of CBHIS
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Community Capacity Building

- 250 Community Health Workers with health kits visit pregnant women monthly
- CHC development and training
- Community awareness raising:
  - Barazas. market theatres and songs
  - Community dialogues
  - Films – 2009
- Project works with males to change attitudes

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Improving Access to Services

- Mobile outreach clinics in 10 villages offering hundreds of ANC, PNC services at each clinic every month;
- Health education sessions in partnership with CHWs;
- Referrals to the health facility – building bridges;
- Maternal dormitories - 2009

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HEALTHRIGHT INTERNATIONAL

Mobile MNC clinics

Questions?

Eunice Auma Okoth
Project Director

www.healthright.org

ANNEXES

V. RESULTS HIGHLIGHT

Maternity Waiting Homes (MWH) As a Strategy to Reduce Maternal and Neonatal Mortality:
Maternal Waiting Homes are residential facilities located within easy reach of a hospital or health center. The purpose of a MWH is to house women near an essential obstetric facility during the final weeks of pregnancy. By using this strategy, PMNH aims to improve access to skilled delivery in partner facilities for women living in distant villages and to improve maternal and neonatal outcomes by averting care-seeking delays.

MWHs are a promising practice because, while they have often been used as a strategy to reduce maternal mortality, there is insufficient research documenting their efficacy in all settings. Utilization rates and user satisfaction are also insufficiently documented. In Y3, the PMNH committed to establishing five MWHs in the partner facilities in the Pokot Districts. All interested HFMCs were encouraged to submit proposals to PMNH outlining the designs for the MWH as well as their intended contributions to the construction and the long-term maintenance. Three of the project sites have already been selected and provided with the initial funding. All of the selected sites must agree to collect careful data through partographs, registers, patient files and client satisfaction surveys. The PMNH intends to use this information to monitor use and effectiveness as well as for improving the MWH strategy based on feedback from the clients.

HealthRight intends to conduct assessments at three levels - the community, the MHW and the health facility. Community knowledge and attitudes will be evaluated at baseline and at 4 months, using convenience sampling to identify community respondents. At MHWs, demographic profiles of clients and their satisfaction will be compiled through a short questionnaire administered to every patient. Functioning of MHWs will be assessed monthly through indicators such as the number of beds occupied, ratio of beds to population in catchments' area, drop out rate, mean duration of stay, availability of staff and operating costs and staff satisfaction. At the health facility, indicators of maternal and neonatal outcomes are collected monthly. In addition, qualitative information will be collected to supplement and support findings. Focus group discussions will be conducted with community members to understand their views and to evaluate suggestions that emerge from satisfaction surveys. In-depth interviews will be conducted with key health facility staff.

ANNEXES

VI. PROJECT C.U.R.E. PARTNERSHIP DESCRIPTION

Project C.U.R.E. (www.projectcure.org) is a Colorado-based, internationally-focused, nonprofit humanitarian relief organization that improves health outcomes by augmenting health care infrastructure in developing nations through providing medical supplies, equipment, and program services to disaster relief personnel and medical professionals and the patients under their care. In 2008, Project C.U.R.E. delivered nearly $40 million in customized, medical relief to more than 100 health care facilities in the developing world. Since its inception in 1987, Project C.U.R.E. has impacted lives of 20 million people in more than 125 developing countries.

Organizational Information

Founded in 1987 to help meet the endless need for medical supplies and services in developing countries, PROJECT C.U.R.E.'s mission is to identify, solicit, collect, sort and deliver medical supplies and services according to the imperative needs of the world. Project C.U.R.E. is the world's largest distributor of donated medical supplies and equipment to developing nations, working with reputable organizations in 123 countries worldwide.

Project C.U.R.E. began with the compassion of one man, Dr. James Jackson. While traveling as an economic consultant to Brazil in 1987, a friend took him to see the conditions of healthcare in Brazil at a local health care clinic. He observed long lines of sick people waiting under the hot sun to enter a small clinic that had a few rolls of dirty bandages and nothing else. Once inside, he learned that children, parents and grandparents were often turned away due to the lack of basic medical supplies and equipment. Jackson was moved to action. He made a promise to the doctor of that small clinic that he would use the tools of commerce and trade to help provide relief to those people.

Returning to his home in Evergreen, Colorado, Dr. Jackson collected approximately $250,000 worth of donated, surplus medical supplies in one month's time. Paying for shipping costs out of his own pocket, Jackson was able to send an ocean-going cargo container to Brazil. Since that first shipment in 1987, Project C.U.R.E. has grown from a one-man, garage operation, into the largest, singly-focused distributor of donated medical supplies and equipment.

Headquartered in Denver, Colorado, project C.U.R.E has presence in 14 major cities nationwide and has approximately 550,000 square feet of warehouse to process and distribute donated medical supplies and equipment. Distribution centers are located at headquarters in Denver, Colo. as well as in Phoenix, Ariz.; Nashville, Tenn.; and Houston, Texas. Collection centers are located in Albuquerque, N.M.; Austin, Texas; Des Moines, Iowa; Lexington, Ky.; New York, NY, Harrisburg, Pa.; and Sarasota, Fla. PROJECT C.U.R.E. plans to expand to 25 U.S.-based, large distribution centers in order to process and distribute 1,250 international shipping containers to 125 developing nations annually.

Project C.U.R.E.'s focus is on building sustainable healthcare infrastructure in the form of desperately needed medical supplies and equipment, providing the necessary tools for medical personnel to deliver healthcare.

The project receives donated medical materials from more than 3,000 hospitals, health care clinics, manufacturers and wholesale suppliers, processes 26,000 types (SKUs) of medical

supplies and equipment; and annually hosts more than 12,000 volunteers to sort, inventory, and hand-pack supplies for worldwide delivery.

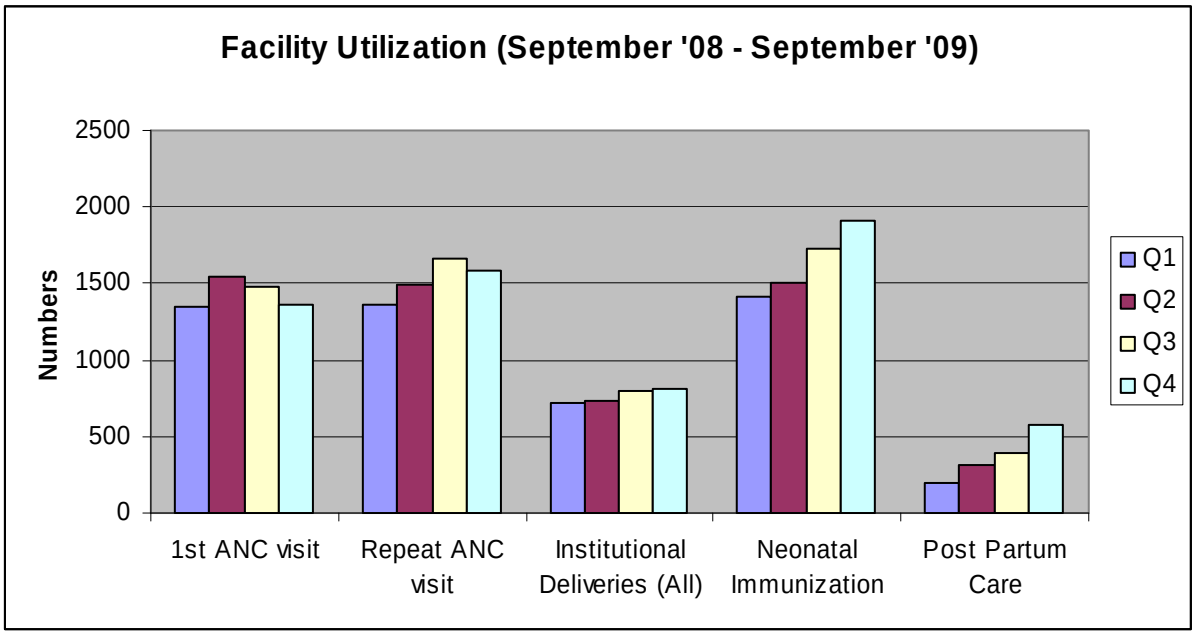
Donations are only made after assessing the needs of an individual clinic or hospital. A trained Project C.U.R.E. representative conducts an extensive "on-site" appraisal of the capacity of the facility, the character of the recipient and the ability to work through customs. This process ensures that the medical personnel receive the supplies appropriate to the need.

As confirmed by an annual audit, less than two percent of Project C.U.R.E. funding goes to administrative and fundraising overhead costs. That means more than 98 percent of funds directly support Project C.U.R.E.'s mission to deliver health and hope to the world through donated medical supplies.

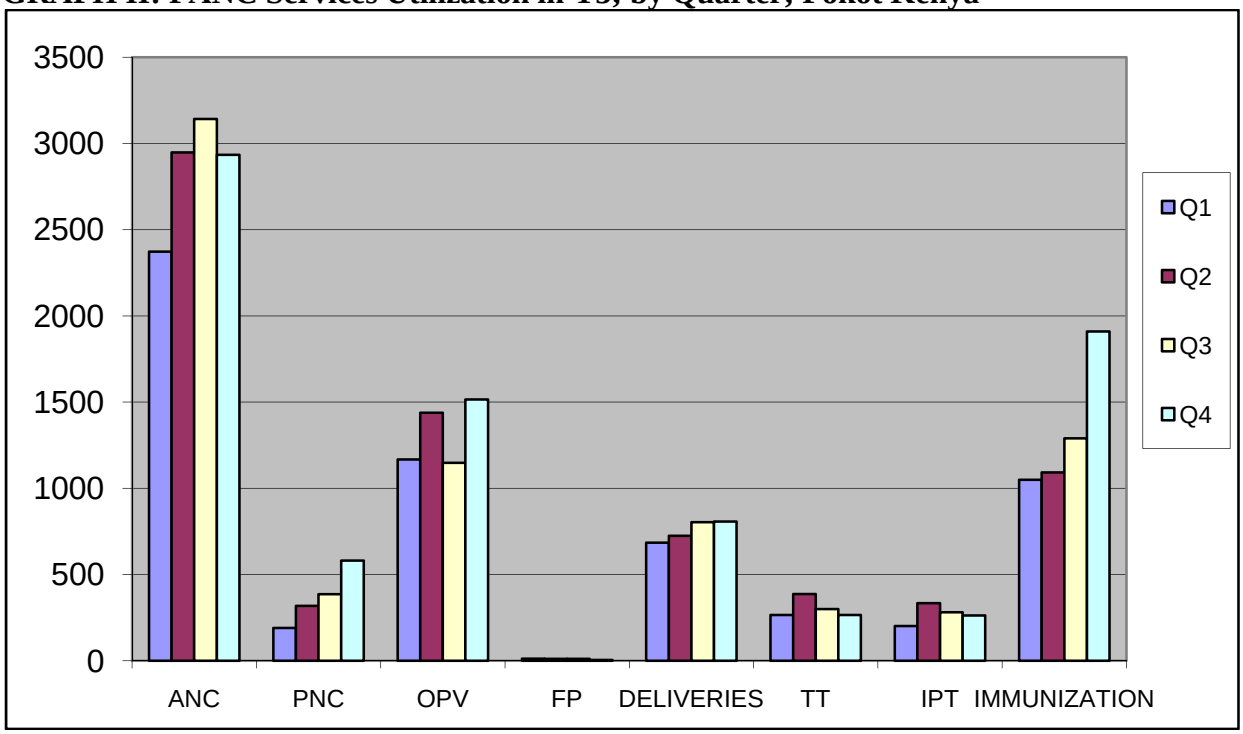
ANNEXES

VII. FACILITY DATA:

GRAPH I: Facility Utilization in Y3; by quarter; Pokot Kenya



GRAPH II: FANC Services Utilization in Y3; by Quarter; Pokot Kenya



ANNEXES

VIII. MONITORING & EVALUATION UPDATE

a. Monitoring Plan: Annex I presents the project's monitoring plan, listing the input and process indicators which will be used to track progress on all major activities. The outcome indicators remain the same as those presented in the DIP and MTE.

b. Key Monitoring Activities: Bi-weekly narrative reports and monthly data reports allow management to monitor closely the progress on all proposed activities and on the project indicators overall. Weekly HQ phone calls and quarterly field visits allow for strategic planning and technical support. Data is reviewed by the field and HQ and discussed during the phone calls. Project data is also discussed with strategic partners at various venues including the MTE presentation in November, monthly DHMT coordination meetings and quarterly USAID Partner Meetings.

Information from the communities is gathered monthly in all five divisions through informal focus group discussions organized by the CMs. These dialogues are documented and discussed at the bi-weekly PMNH staff meetings to allow for strategic responses to the information.

Tracking Service Utilization Rates: Utilization data is included in the PMNH M&E plan and it is reviewed by project and facility staff regularly. PMNH works to ensure that facility data is discussed at all DHMT meetings. Data is utilized by HFMCs and CHCs, where appropriate.
Facilitative Supervision: PMNH facilitates quarterly supervision by the DHMTs in each district. Using quality checklists, the DHMT members review each facility and foster supportive capacity building.
Training Follow-up Visits: After provider trainings, the PMNH, along with members of the DRHTST, make two visits to facilities to ensure trainees have been able to apply their new skills and to provide additional coaching. Any difficulties encountered at the facilities are recorded and used in planning refresher trainings on that topic.