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

West Pokot District - Kenya
October 1, 2006 – September 30, 2010
Cooperative Agreement No. GHS-A-00-06-00011-00

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Annexes:

List of Acronyms:

AIDS	**Acquired Immune Deficiency Syndrome**
AMPATH	**Academic Model for the Prevention and Treatment of HIV/AIDS**
AMREF	**The African Medical and Research Foundation**
ANC	**Antenatal care**
ART	**Anti-retroviral treatment**
ARV	**Anti-retroviral**
BC	**Behavior Change**
BCC	**Behavior Change Communication**
BCI	**Behavior Change Intervention**
BEmONC	**Basic Emergency Obstetric and Newborn Care**
CATCH	**Core Assessment Tool on Child Health**
CDC	**Centers for Disease Control and Prevention**
CEmONC	**Comprehensive Emergency Obstetric and Newborn Care**
CHW	**Community Health Worker**
CORP	**Community's Own Resource Person**
CPD	**Cephalopelvic Disproportion**
CPI	**Client-Provider Interaction**
CS	**Child survival**
CSH	**Child survival and health**
CSHGP	**Child Survival and Health Grants Program**
CSSA	**Child Survival Sustainability Assessment**
CWC	**Child Welfare Clinic**
DASCO	**District AIDS and STD Control Officer**
DHMT	**District Health Management Team**
DHRIO	**District Health Records and Information Officer**
DIP	**Detailed Implementation Plan**
DMC	**Division of Malaria Control**
DMO	**District Medical Officer**
DOW	**Doctors of the World-USA**
DRH	**Division of Reproductive Health**
DTC	**Direct testing and counseling**
ELCK	**Evangelical Lutheran Church in Kapenguria**
EmOC	**Emergency Obstetric Care**
EmONC	**Emergency Obstetric and Newborn Care**
FBO	**Faith-based Organization**
FGM	**Female genital mutilation**
FP	**Family planning**
FSB	**Fresh stillbirth**
GAVI	**Global Alliance for Vaccines and Immunization**
HFA	**Health Facility Assessment**
HFC	**Health Facility Committee**
HIV	**Human Immunodeficiency Virus**
HIV+	**HIV-positive**
HMIS	**Health Management Information System**

HQ	**Headquarters**
IEC	**Information, education, communication**
IMCI	**Integrated Management of Childhood Illness**
IMR	**Infant Mortality Rate**
IPT	**Intermittent Preventive Treatment for malaria**
IR	**Intermediate Result**
ITN	**Insecticide-treated mosquito net**
KDH	**Kapenguria District Hospital**
KDHS	**Kenya Demographic and Health Survey**
KEPH	**Kenya Essential Packages of Health**
KPC	**Knowledge, Practices, and Capacities**
LOE	**Level of Effort**
M&E	**Monitoring and evaluation**
MBA	**Masters in Business Administration**
MCH	**Maternal and child health**
MD	**Doctor of Medicine**
MDM	**Médecins du Monde**
MHRA	**Medical Health Research Association**
MMR	**Maternal mortality rate**
MNC	**Maternal and Newborn Care**
MNH	**Maternal and Neonatal Health**
MNHP	**Maternal and Newborn Health Program**
MO	**Medical Officer**
MOH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MPH	**Masters in Public Health**
MSB	**Macerated stillbirth**
NASCOP	**National AIDS and STD Control Program**
NGO	**Non-governmental organization**
NMS	**National Malaria Strategy**
NND	**Neonatal death**
NTP	**National TB Control Program**
OB/GYN	**Obstetrician and Gynecologist**
OR	**Operations Research**
OVC	**Orphans and vulnerable children**
PAC	**Post-abortion care**
PADO	**Pastoralist Area Development Organization**
PEPFAR	**President's Emergency Plan for AIDS Relief**
PHO	**Public Health Officer**
PLWHA	**People living with HIV/AIDS**
PMTCT	**Prevention of mother-to-child transmission of HIV/AIDS**
PNC	**Postnatal care**
PSI	**Population Services International**
PVO	**Private Voluntary Organization**
QA	**Quality Assurance**
QI	**Quality Improvement**
RBM	**Roll Back Malaria**
RH	**Reproductive Health**
STI	**Sexually transmitted infection**
TADSA	**TB Alliance DOTS Support Association**
TB	**Tuberculosis**

TBA	**Traditional birth attendants**
TFR	**Total fertility rate**
TOT	**Training of Trainers**
TRM	**Technical Reference Materials**
UN	**United Nations**
UNFPA	**United Nations Population Fund**
UNICEF	**United Nations Children's Fund**
USAID	**United States Agency for International Development**
VCT	**Voluntary counseling and testing**
WHO	**World Health Organization**
WRA	**Women of reproductive age**

Section A: Executive Summary

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

Problem Statement: The West Pokot District of Western Kenya is a rural, marginalized area where the population faces a heavy burden of maternal and neonatal mortality, frequent malaria outbreaks, and a growing HIV/AIDS prevalence. A combination of difficult terrain and climate, poor infrastructure, and scant public resources has left the West Pokot District trailing in health and development; for nearly all child survival indicators, the West Pokot District lags well behind the Kenyan average. Neonatal mortality accounts for 30% of all infant deaths. Maternal mortality and morbidity are exacerbated by the extremely high prevalence of the most extreme form of female genital mutilation. The District has a consistently high malaria burden, with malaria the leading cause of mortality and morbidity. Testing at Voluntary Counseling and Testing (VCT) sites and among pregnant women shows a growing burden of HIV infection. Most health facilities in the program location are not able to provide maternal and newborn care services that meet the Ministry of Health policy. District providers have received little or no training in focused antenatal care, current delivery and postpartum practices, essential newborn care, or the integration of HIV/AIDS and malaria control interventions with maternal and newborn health care. Where trainings have occurred, no standardized practice of evaluating provider performance has been established. There is a great need to mobilize community members to seek maternal and neonatal services and to practice positive health behaviors that promote maternal and neonatal survival and health.

Target Population: The population of the program location is 257,083, including 61,699 women of reproductive age and 48,844 children under five, of which it is estimated that 11,616 are under 12 months; 10,603 are 12-23 months; and 26,625 are 24-59 months. Direct beneficiaries of the program will be women of reproductive age and children under 12 months. An additional 656 individuals will receive training, including health providers, staff of partner organizations, and community members.

Program Goal: The **Partnership for Maternal and Neonatal Health - West Pokot District Child Survival and Health Program** aims to contribute to the reduction of maternal and neonatal morbidity and mortality in five divisions of the district.

Program Objectives: The following strategic objectives will guide program activities:

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

DOW will integrate essential HIV/AIDS and malaria interventions across these objectives.

Program Results: In addition to improving facilities' ability to provide antenatal, safe delivery, emergency obstetric care, and postpartum and newborn care services, Doctors of

the World (DOW) will work with local partners to raise community awareness of maternal and neonatal health risks, positive behaviors related to maternal and neonatal health, and utilization of health services. DOW will contribute to improvements in key health indicators including, but not limited to:

- % of children age 0–23 months whose births were attended by skilled health personnel
- % of mothers of children 0-23 months who received at least four antenatal visits
- % of mothers of children 0-23 months who had at least one postpartum check-up.
- % of mothers of children 0-23 months who know at least two neonatal danger signs
- % of mother of children 0-23 months who received HIV testing and counseling services during pregnancy
- % of mothers of children 0-23 months who received IPT at least twice during pregnancy

Level of Effort (LOE): 70% of the total LOE will be devoted to MNC, 15% to HIV/AIDS, and 15% to Prevention and Treatment of Malaria.

Proposed Operations Research: In an effort to reduce barriers to utilization of safe motherhood services, DOW plans to introduce a voucher system for women attending antenatal care (ANC) at the focus program facilities. The details of this pilot project will be finalized in the second year of the project.

Local Partners: DOW will collaborate closely with the Ministry of Health (MOH) in West Pokot in the implementation of this project. DOW also works with the Evangelical Lutheran Church of Kapenguria (ELCK), Kiletat, a collective of women's groups in West Pokot, the Pastoralist Area Development Association (PADO), and two U.S.-based organizations: the Academic Model for the Prevention and Treatment of HIV/AIDS, and Population Services International.

Collaboration with Ministry of Health: DOW will continue to collaborate with MOH at all levels in developing this program. Input will be sought through regular communication and periodic meetings with representatives from the Division of Reproductive Health, the Provincial Medical Office for the Rift Valley Province, and West Pokot District Health Management Team (DHMT).

Category of CSHGP application: Standard Application

Project Period: Program duration is from October 1, 2006 through September 30, 2010.

Project Budget, Amount Requested, and Cost Share: Total budget for this program is $2,120,022. DOW has received a grant of $1,500,000 from USAID and will match these funds with $614,933, a 29% cost share contribution, from other sources.

Collaboration with USAID Mission: The proposed program was discussed with and approved by Michael Strong and Sheila Macharia of the USAID Mission in Kenya.

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Child Survival and Health Grants Program Project Summary

Jul-17-2007

Doctors of the World-USA
(Kenya)

General Project Information:

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

DOW Headquarters Technical Backstop: **Kavita Bali**
Field Program Manager: **Eunice Okoth**
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: **Sheila Macharia**

Field Program Manager Information:

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Funding Information:

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

Project Information:

Description:

Project Goal: To contribute to the reduction of maternal and neonatal morbidity and mortality in five divisions of the West Pokot District of Kenya
Interventions:
- Maternal and newborn care
- HIV/AIDS
- Prevention and treatment of malaria

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

Location:

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

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

General Strategies Planned:

(None Selected)

M&E Assessment Strategies:

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

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

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

Interventions/Program Components:

Malaria (15 %)

(IMCI Integration)
(CHW Training)
(HF Training)

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

Maternal & Newborn Care (70 %)

(IMCI Integration)
(CHW Training)
(HF Training)

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

HIV/AIDS (15 %)

(CHW Training)
(HF Training)

- Behavior Change Strategy
- PMTCT
- HIV Testing

Target Beneficiaries:

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

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	88	186	47.0%	7.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	74	186	39.0%	7.0
Percentage of children age 0-23 months whose births were attended by skilled personnel	32	186	17.0%	5.0
Percentage of children age 0-23 months who received a post-natal visit from an appropriate trained health worker within three days after birth	20	186	10.0%	4.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	108	152	71.0%	7.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's Recall)	14	33	42.0%	16.0
Percentage of children age 12-23 months who received a measles vaccination	5	12	41.0%	27.0
Percentage of children age 12-23 months who received DPT 1 vaccination before they reached 12 months	7	12	58.0%	27.0
Percentage of children age 12-23 months who received DPT 3 vaccination before they reached 12 months	6	12	50.0%	28.0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	8	22	36.0%	20.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids	9	30	30.0%	16.0
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	17	65	26.0%	10.0
Percentage of households of children age 0-23 months that	51	186	27.0%	6.0

treat water effectively				
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period	**107**	**186**	**57.0%**	**7.0**
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night	**80**	**186**	**43.0%**	**7.0**
Percentage of children age 0-23 months who are underweight (-SD for the median weight for age, according to WHO/HCHS reference population)	**17**	**186**	**9.0%**	**4.0**
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**17**	**33**	**51.0%**	**17.0**

Comments for Rapid Catch Indicators

Indicator (6) Minimum of Appropriate Feeding Practices: Full instructions on calculating this indicator were not available at the time of the KPC design and implementation. Therefore, Doctors of the World does not have calculations for this indicator at this time. We do plan to report on this indicator at midterm and at the end of the project.
Due to sampling errors for indicators reflecting specific age categories, namely children 6-23 and 12-23 months, large confidence intervals rendered these indicators statistically not significant. The issue was fully discussed with USAID and CSTS+ and plans to account for these sampling issues in future surveys have been agreed upon.

PROJECT START-UP ACTIVITIES

Initiation of the project began with a presentation in Fall 2006 to members of the District Health Management Team (DHMT) at Kapenguria District Hospital (KDH) to re-orient them to the goals and purpose of the proposed project. This was especially important since some key members of the team, including the Provincial Medical Officer (PMO) for the Rift Valley and the District Medical Officer (DMO), were newly transferred to West Pokot since the original needs assessment was conducted in 2005 and the resulting proposal was submitted to USAID. A second meeting was convened with the DMO and his executive staff to discuss the current Maternal and Neonatal Health (MNH) situation in the district, the project timeline, and types of resources each partner would need to contribute to ensure a successful collaboration.

Administrative activities included review of pre-grant assessment documents by Headquarters (HQ) staff, preparation of key job descriptions and recruitment plan, and a visit by a member of the Doctors of the World (DOW) Finance and Administration HQ staff to orient the new Project Direct on key finance policies and grant compliance issues. During a visit by the DOW Program Manager, initial contact was also made with potential in-country technical partners such as UNICEF and the Population Council, who had proven experience in MNH program implementation and evaluation. Other in-country activities included hiring of key project staff, establishment of a Child Survival and Health (CSH) project office in Kapenguria, a meeting to review the West Pokot District Health Plan 2006-2007 and to develop a draft Memorandum of Understanding (MOU) in collaboration with the DHMT. During the start-up period, design and implementation of the baseline research framework was also initiated.

DIP DEVELOPMENT

The Detailed Implementation Plan (DIP) development process began with review of the DIP guidelines and proposed timeline, relevant resource materials such as Technical Resource Materials (TRMs) and past CSHGP grantee DIP presentations in order to orient HQ and field-based staff about the DIP process. The HQ-based Program Manager and field-based Project Director also attended the CSHGP Backstop Institute from December 4-14, 2006 in Washington D.C., which detailed the Knowledge, Practices and Coverage (KPC) process and management strategies for program monitoring and evaluation. Upon return to Kenya, the Project Director began preparations for the KPC and Health Facility Assessment (HFA) surveys, qualitative research activities, community mapping of the program location, and initial meetings with local project partners including Evangelical Lutheran Church of Kapenguria (ELCK), Kiletat, and Pastoralist Area Development Corporation (PADO).

Due to the unanticipated departure of the Program Director in Kenya in early January, the Program Manager, Kavita Bali, returned to Kenya to resume DIP planning with the remaining local staff until a new Director could be identified. A meeting was held with Dr. Sheila Macharia of the USAID Mission in Kenya in late January to discuss the staffing changes and timeline of DIP activities. Ms. Bali also made a brief introduction of DOW's proposed activities at the January meeting of the Safe Motherhood Working Group, led by the Division of Reproductive Health (DRH) and visited Dr. Meshack Ndirangu and his team at the AMREF Child Survival project in Busia. Dr. Ndigrangu and his colleagues provided invaluable guidance to both the KPC questionnaire design and DIP preparation processes.

Baseline assessments carried out by DOW staff and hired consultants are detailed below. A Stakeholders' Workshop was also held on March 16, 2007 in Kapenguria to share key outcomes of the baseline assessments and solicit feedback from participants about planned program activities. Members in attendance included representatives from the DRH in Nairobi, Provincial and District Ministry of Health (MOH), local health facility supervisors, international and local Non-Governmental Organization (NGO) partners, and other community leaders. Although a formal DIP writing workshop could not be convened due to continued staffing constraints, the DIP was prepared collaboratively between DOW HQ staff, field staff, and partners in Kenya. The HQ Program Manager worked with local staff through email and phone discussions to review and revise key project indicators, target health facilities, and program activities. Budget revisions were prepared in collaboration with field staff and the Director of Finance and Administration at HQ.

BASELINE STUDIES

Two major baseline surveys served as the basis for DIP development. Kenyan nationals with prior experience in child survival programs were contracted to conduct the KPC survey, while a consultant from the Averting Maternal Death and Disability (AMDD) Program at Columbia University was hired to oversee the HFA.

Development of the KPC and HFA survey tools included review of data from the Kenyan Demographic and Health Surveys (DHS) of 2003, informal discussions with mothers and traditional birth attendants (TBAs) in West Pokot, site visits to target health facilities, and feedback from key local health personnel about the current state of maternal and newborn care in the district. Field testing of each survey in West Pokot aided in language and culture-specific adaptation prior to data collection.

Both surveys were conducted in February 2007 and concluded in a Post-Survey Analysis Workshop on February 23, 2007 that included members of the District Health Management Team (DHMT) and health facility supervisors. Workshop participants discussed key survey findings and remarked that none of the outcomes were surprising, given the ongoing health issues seen among women and children presenting at health facilities. Review of survey methodology and initial training in data analysis was also conducted in order to foster development of MOH staff capacity to monitor health trends at both the community and facility levels.

FOLLOW-UP ACTIVITIES

Activities planned after submission of the DIP include a field visit in May by the HQ-based Program Manager to assist in important project planning tasks. These include development of key qualitative studies (e.g. focus groups and client satisfaction surveys) based on results from the KPC and HFA exercises, continued discussions and dissemination of baseline findings with potential technical partners, hiring of additional project staff, signing of the MOU with the new District Medical Officer (DMO) in West Pokot, and preparation of the presentation for the DIP Mini-University. All of these activities will be undertaken with full participation from the MOH and local project staff.

Section C: Description of DIP Preparation Process

The following individuals and stakeholders were instrumental in DIP preparation:

Individual/Partner	DIP contribution	Amount of time
HQ Staff		
Kavita Bali, Program Manager	KPC survey development, program design, final drafts of DIP sections, review and final submission - will attend Mini-University	60% LOE for 3 months
Vandana Tripathi, Program Director	Continuing in-depth review of DIP drafts and strategic input into program design	10% LOE for 3 months
Rebekah Wheeler, Program Associate	Background research, drafting, review and edit of all drafts for clarity	30% for 3 months
Thu-Nhi Nguyen, Finance Associate	Review and edit of budget according to project work plan	5% LOE
Abigail Smith, Director of Finance	Final review and edit budget according to project work plan	5% LOE
Field Staff		
Eunice Okoth, MNH Project Technical Director	Convening partner meetings for planning and collecting secondary data, feedback on draft DIP	100% LOE for 2 months
Marina MacNamara, HIV/AIDS Program Director	Provision of background information for KPC survey development, review of draft DIP sections	10% LOE for 2 months
Alice Shitambisi, MNH M&E Consultant	KPC survey development, calculation of EOP targets, and presentation of results at March stakeholders' meeting	100% LOE for 3 months
Local Consultants		
Michael Ochieng	Lead consultant for baseline KPC; responsible for final report and data analysis	50% LOE for 1 month
Benard Ochieng	Assisted in design and execution of KPC, including training of core team	50% LOE for 1 month
Dr. Wilson Aruasa, OB/GYN	Participation in HFA, including adaptation of HFA tool and feedback on final report	100% LOE for 2 weeks
Edna Chekwomby, BSc Nurse	Participation in HFA, including adaptation of HFA tool and feedback on final report	100% LOE for 2 weeks
International Consultant		
Samantha Lobis, Averting Maternal Death and Disability Program, Columbia University	Lead consultant for baseline assesment of health facility capacity and services; review and analysis of secondary and HFA survey data.	100% LOE for 25 days

Section D: Revisions (from original application)

After analyzing the results of the baseline assessments, DOW has made some revisions to the original program proposal submitted in Doctors of the World's (DOW) 2005 application to the Child Survival and Health Grants Program (CSHGP). These revisions were made in consultation with DOW's local partners, including the Ministry of Health (MOH) in the West Pokot District, Kenya. Because a major goal of DOW's Partnership for Maternal and Neonatal Health is to engage in activities that are complementary to currently existing programs, the revision process has helped DOW identify interventions that support health facilities with critical unmet needs and that promote the well-being of the local community in a sustainable way.

CHANGES TO THE PROGRAM STRATEGY

I. Focus Health Facilities

DOW's interventions will now focus on nine instead of eight health facilities. As previously noted, project staff will work with Kapenguria District Hospital (KDH), the four rural health centers in Chepareria, Sigor, Kacheliba and Kabichbich, and the Konyao dispensary. Due to continued staffing problems, lack of delivery services, and limited relationships with the community, the other originally proposed dispensaries in Tamkal and Tamough will no longer be included in the program. Instead, dispensaries in Serewo and Lomut, which have greater potential to conduct safe deliveries and better community buy-in, have been chosen to increase the likelihood that any interventions initiated will be sustainable. After recognizing the important role that Ortum Mission hospital, a private hospital, serves in providing maternal and neonatal health services, this facility will now be included in planned training and related equipment procurement activities. Ortum is one of only two hospitals in the District, and an important provider of emergency obstetric care. No major renovations are planned for Ortum Mission hospital or the three dispensaries.

In addition, since learning that the four health centers present the greatest capacity for delivery and urgent needs for strengthening basic Emergency Obstetric and Newborn Care (EmONC) services, the level of effort in these facilities will be increased. As a result, there will be a more limited focus at the dispensaries. See below for additional information on the relative needs and roles of health centers and dispensaries in the program.

A. Health Centers: Analysis of the data collected in the Knowledge, Attitudes, and Practices (KPC) survey and the Health Facility Assessment (HFA) show that there is a greater need to strengthen obstetric and delivery services at rural health centers than DOW had originally anticipated. None of the focus health centers have the capacity to offer basic EmONC. This dearth in services comes from a serious need for both staff training and procurement of essential materials, supplies, and drugs. However, health centers were shown to be the preferred site of services by women interviewed in the KPC. Health centers also showed the greatest promise for expansion of capacity to handle deliveries and improve quality of care in labor and delivery.

B. Dispensaries: None of the dispensaries visited as part of the HFA were providing delivery services on a routine basis. Though all three dispensaries claimed an intention to expand

obstetric and labor services in coming years, none were close to having the capacity to handle regular deliveries.

Therefore, DOW has decided to refocus our capacity-building efforts. DOW will work with the Kapenguria District Hospital and Ortum Mission Hospital to improve the quality and range of services, including CEmONC. DOW will also work with the four focus health centers in the area to expand their capacity to offer quality BEmONC. Basic training and equipment at three dispensaries will enable providers to perform normal vaginal deliveries, neonatal resuscitation, and initiate referrals in the event of a complication. Training and equipment procurement will focus on these six facilities, with minor additional capacity building at the other lower-level facilities.

II. Vouchers to Facilitate Safe Delivery

Analysis of data from both the HFA and the KPC illustrate the necessity of implementing a voucher system to support the cost of facility-based delivery and obstetric care. DOW included a plan to pilot a transportation voucher system as part of the original Child Survival and Health (CSH) proposal, to respond to financial and logistical challenges faced by women in accessing services. Data from the KPC and HFA, however, have further highlighted the need to investigate the best way to target and implement this program. DOW therefore plans to work alongside beneficiary communities and focus health facilities and to explore the efficacy of models piloted in other areas before deciding on the most appropriate voucher system aimed at mobilizing women to seek facility-based prenatal, delivery, and postpartum/newborn services. Rather than focusing vouchers on transportation, it may be more effective to develop vouchers to cover the cost of key facility-based services.

The mechanism for vouchers will be designed in partnership with community leaders, NGOs, and providers familiar with the program location. Ultimately, women will be able to exchange vouchers for the selected transportation or delivery services in the program location. DOW will monitor the effectiveness of these vouchers in increasing utilization of facility-based delivery services; if the vouchers are found to be effective, DOW will advocate with communities and health centers to take up collective financing of the voucher model by the close of the program.

III. Training Activities

Results from the HFA and training needs assessment and subsequent discussions with the DHMT suggest that due to staff availability, current unfilled posts, and Community-Owned Resource Persons' (CORPs') current competency, the number of participants to be trained in various topics was overestimated. The number of participants involved in each training activity has therefore been revised to reflect this reality and can be found in Section E8: Training Plan. Training costs were also underestimated in the original proposal and have been revised in the attached budget.

RESPONSES TO PROPOSAL REVIEWER COMMENTS

Reviewer comments have been addressed in the appropriate sections of the DIP.

BUDGET AMMENDMENTS

Please see revised budget and budget narrative in Annex 8 for details.

CHANGES TO THE PROJECT INDICATORS

Please see revised and added indicators in Annex 11 for details.

I. Revised Indicators:

Original Indicator: Percent of HIV-positive women with children 0-23 months who received referral for PMTCT/ART services during pregnancy.

Revised Indicator: Number of pregnant women receiving HIV care.

Rationale: While we anticipated that PMTCT referral services would be available at several health facilities at the time of project implementation, the reality is that only the district hospitals currently conduct any PMTCT activities, with most of the activity happening at the DOW-sponsored HIV/AIDS clinic at KDH. There was insufficient information and reporting to obtain a baseline value but actual number of women receiving care will still provide a good measure of service expansion.

Original Indicator: Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting.

Revised Indicator: Number of pregnant women receiving a complete course of antiretroviral prophylaxis.

Rationale: Again, since we cannot determine the denominator for the original indicator due to the existing poor reporting systems, actual of number of women receiving care is a more practical measure of the uptake of PMTCT services.

Original Indicator: Percentage of pregnant women who know where to go for Voluntary Counseling and Testing (VCT) and to attain treatment for PMTCT.

Revised Indicator: Percentage of mothers of children 0-23 months who know where to go for HIV testing and counseling.

Rationale: The original indicator was a compound indicator that was not easily measurable. Because mothers are women of reproductive age, they are a good proxy for pregnant women. Knowledge about HIV counseling and testing can therefore be assessed with the new indicator. Treatment for PMTCT was dropped from the language due to the issues previously discussed.

Original Indicator: Number of women per month utilizing transportation assistance to use facility-based MNC services.

Revised Indicator: NONE—ORIGINAL INDICATOR OMITTED

Rationale: This indicator has been omitted since the type of voucher scheme to be implemented in the program location will be decided at a later stage (see section II of Changes to Program Strategy, above). Once a program strategy is determined, a new indicator will be proposed.

II. Added Indicators:

New Indicator: Percent of mothers of children 0-23 months with a maternal health card.

Rationale: In the KPC, DOW learned that 12% of women have maternal health cards, as compared to 68% of women who have child health cards, demonstrating that women are not currently prioritizing their own health. As a key IR in the program will be improve birth preparedness, mothers' use of health cards will be a useful measure.

New Indicator: Percent of mothers of children 0-23 months able to report at least two danger signs during the antenatal period.

Rationale: Although DOW did include an indicator about recognition of danger signs in the postpartum period, safe delivery requires that a woman understand the danger signs prior to labor, so this additional indicator was needed.

New Indicator: Number of women giving birth at a facility who received HIV counseling and testing services during labor and delivery.

Rationale: Because not all pregnant women will be reached through antenatal clinics and because ensuring safe delivery and prevention of vertical transmission requires that a woman know her HIV status, it important to monitor uptake of counseling and testing in both Antenatal Care (ANC) and labor and delivery.

New Indicator: Percentage of mothers of children 0-23 months who know where to go for HIV testing and counseling

Rationale: This information was captured in the KPC and is useful in understanding the complete picture of HIV knowledge among mothers.

New Indicator: Percent of households with at least one ITN.

Rationale:	Data from the KPC suggest that many more households have ITNs than use them. This indicator will be important in estimating ITN supplies needed for the program area and understanding the correlation between ITN availability and use.
New Indicator:	Number of health facilities providing Basic Emergency Obstetric and Newborn Care (BEmONC).
Rationale:	Since no facilities are currently providing BEmONC, this indicator provides a crude measure of BEmONC service expansion in the district.
New Indicator:	Number of health facilities providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC).
Rationale:	Since no facilities are currently providing CEmONC, this indicator provides a crude measure of CEmONC service expansion in the district.

MAP OF PROGRAM LOCATION

Please see Annex 7 for a map of the program location.

POPULATION OF THE PROGRAM AREA

DOW's Partnership for Maternal and Neonatal Health will work in the Chepareria, Kacheliba, Kapenguria, Lelan, and Sigor Divisions of the West Pokot District in the Rift Valley Province of Kenya. Based on projections from the 1999 National Census (the most recent), the population of the program location is 257,083, and increases at a rate of 3.1% per year.[1] Although the selected Divisions account for a small portion of the District's geographic area, they account for over two-thirds of the District's total population. The estimated number of women of reproductive age (15-49) in the program location is 61,699. The number of children under five in the program location is 48,844, of which it is estimated that 11,616 are under 12 months; 10,603 are children 12-23 months; and 26,625 are children 24-59 months.[2] Direct beneficiaries of the program will be women of reproductive age and children under 12 months. An additional 656 MOH staff and community members will directly receive training from DOW.

Because the primary focus of the program is building the capacity of the MOH to improve Maternal and Neonatal Health, DOW has chosen to focus on eight MOH facilities (Kapenguria District Hospital; Chepareria, Sigor, Kacheliba and Kabichbich health centers; and Konyao, Lomut, and Serewo dispensaries) and one private hospital (Ortum Mission Hospital).

Table 1: 2006 Projected Population Figures for Program Location.[3]

Division	Total Population	< 5 years	Female (15-49)	# of Locations	# of Sub-Locations	# of Health Facilities
Chepareria	80,754	15,343	19,381	12	45	13
Kacheliba	23,755	4,513	5,701	5	14	5
Kapenguria	74,001	14,060	17,760	9	28	12
Lelan	28,092	5,337	6,742	3	13	3
Sigor	50,481	9,591	12,115	6	21	5
TOTAL:	257,083	48,844	61,699	35	121	38
West Pokot District	**363,205**	**69,007**	**87,169**	**58**	**188**	**53**

HEALTH STATUS OF THE TARGET POPULATION

West Pokot is a poor, rural, marginalized District whose primarily ethnic minority population has limited access to health services and development infrastructure, and faces a heavy burden of health problems including high maternal and neonatal mortality, frequent malaria outbreaks, and a growing HIV/AIDS prevalence. It is estimated that 53% of the district's population is poor and that 35% live in absolute poverty.[4] In the program Divisions, absolute poverty rates range from

[1] Kenya National Census, 1999.
[2] Ibid.
[3] Ibid.
[4] Poverty here refers to: for communities in the lowlands, the number of livestock owned by a household; for communities in the highlands, food production/agricultural output.

34% to 56%.[5] Basic infrastructure in the District is poor, with few roads and an extremely weak communications network. Among Ministry of Health (MOH) facilities, only the Kapenguria District Hospital has a phone line.[6]

The combination of difficult terrain and climate, poor infrastructure, and scant public resources has left the West Pokot District trailing in health and development, with grave consequences for the health of women and children. For nearly all health indicators related to maternal and child survival, the District lags far behind Kenya as a whole. Female literacy is also a factor that influences health in the region. In Rift Valley Province, female literacy is estimated at just over 70%, as compared to 78.5% in Kenya as a whole. About one quarter (24.1%) of married women in the Rift Valley reported that they have a say in decision made about their families' welfare.[7] These statistics suggest that low rates of women's empowerment and education correlate with higher rates of maternal and child morbidity and mortality.

According to District Health Management Team (DHMT) records, leading causes of inpatient mortality (following hospital admissions) in the West Pokot District in 2004 were: malaria, anemia, pneumonia, tuberculosis (TB), gastroenteritis, dehydration, and HIV/AIDS. Leading causes of morbidity, as measured by hospital admission, were: malaria, anemia, pneumonia, gastroenteritis, injuries, respiratory infections, dehydration, abortion, typhoid, and TB.[8]

Fertility Rates and Delivery Practices: According to the 2003 Kenya Demographic and Health Survey (KDHS), the total fertility rate (TFR) in the Rift Valley is 5.8 children, which places it as the third highest among the provinces and is far above the Kenyan average TRF of 4.8.[9] TFR in the West Pokot District was estimated to be significantly higher at 7.5 in the 1999 Census.[10] Along with its impact on maternal health, high TFR has a negative impact on child survival. In Kenya, child mortality is 2.5 times higher for children 7th or higher in birth order. Neonatal mortality rises dramatically with the 7th or higher birth.[11] Throughout Kenya, likelihood of delivery by a traditional birth attendant (TBA) increases with birth order, going from 21.6% for first births to 36.3% for 7th and higher.[12]

Antenatal Care: 88% of women in Kenya receive Antenatal Care (ANC) from a medical professional, compared to 55.4% in Rift Valley.[13] The use of ANC does not translate into access to key MNH interventions; in Kenya, only 52% received two or more tetanus toxoid (TT) injections during pregnancy for their most recent birth. The KDHS showed that 4% of pregnant

[5] District Planning Unit of Kapenguria, 2001.
[6] DOW-conducted Health Facility Assessment, 2007.
[7] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[8] District Health Management Team, District Planning Unit of Kapenguria, 2001.
[9] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[10] Kenya National Census, 1999.
[11] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[12] Ibid.
[13] Ibid.

women received intermittent preventive treatment (IPT) with anti-malarial medication during ANC; this was only 2.5% in the Rift Valley.[14]

Delivery Practices: In Kenya, 59% of births take place at home; this is slightly higher in the Rift Valley, where 63% of births occur at home. The results of the KPC showed that only 17.2% of the births in the program location were attended by skilled health personnel, which was supported by data from the health facility assessment (HFA) that suggest an even smaller proportion of expected facility births (11.7%).[15] Traditional Birth Attendants (TBAs) assist in a significant number of births (28% nationally; 27.6% in the Rift Valley).[16]

Maternal Mortality and Morbidity: The Safe Motherhood goal in the Kenyan Division of Reproductive Health (DRH) National Reproductive Health Strategy (NRHS) for 1997-2010 was to reduce the maternal mortality rate (MMR) to 230 by 2005. In 2003, the MMR was still higher than 414.[17] Major causes of maternal mortality in Kenya are hemorrhage, sepsis, obstructed/prolonged labor, and complications from abortion; indirect causes are anemia and malaria during pregnancy. In the Rift Valley, maternal deaths represent 27% of all deaths for women ages 15–49, compared to 15% across Kenya.[18] DHMT members estimate MMR in the West Pokot District at 565; this is likely an underestimate, due to lack of data on community births and deaths. Provider interviews suggest that obstructed labor causes a high proportion of maternal deaths, because of the extremely high rate of Type III female genital mutilation (FGM), known as infibulation, and high prevalence of cephalopelvic disproportion (CPD) due in part to the practice of early marriage for girls.

Postpartum Care: 81% of women in Kenya, and a comparable proportion in the Rift Valley, who deliver at home do not receive postpartum care. Only 10% of women delivering outside a facility receive care within two days.[19] As the majority of maternal deaths occur in the first week after delivery, this represents missed opportunities to recognize and respond to danger signs. While 48% of mothers in West Pokot reported having at least one postpartum check after the birth of their youngest child, many of these checks were conducted by TBAs, with uncertainty about the quality of care provided to these mothers. For example, in the same survey, only 10% of the women reported that they received information on child spacing.

FGM: According to local organizations and health providers, prevalence of FGM in the District is approximately 97%. This is markedly higher than the 32.2% Kenyan average.[20] Consequences of infibulation, the type of FGM practiced in the District, include: severe pain; hemorrhage; infection (which, if not treated, can lead to infertility and/or death); and severe scar formation that can result in complete vaginal obstruction and/or difficulty in urinating; menstrual

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[14] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)

[15] Proportion of expected births was calculated by dividing the number of deliveries in all surveyed facilities by the number of expected births in West Pokot (2656/22,614) = 11.7%.

[16] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)

[17] Ashford, L. "Hidden Suffering: Disabilities from Pregnancy and Childbirth in Less Developed Countries." *Population Reference Bureau* 2, 2002.

[18] Kiragu, J. "Abortion and Human Rights in sub-Saharan Africa." *Initiatives in RH Policy* 3(2). 2000.

[19] Ibid.

[20] Republic of Kenya, Central Bureau of Statistics (CBS), 2001b. *Statistical Abstract*, 2000.

disorders; recurrent bladder and urinary tract infection; and prolonged or obstructed labor (sometimes resulting in fetal death and vesico-vaginal fistulae and/or vesico-rectal fistulae (VVF and VRF)). TBAs and nurses working in West Pokot report that it is standard practice to cut a bilateral episiotomy in order to facilitate childbirth, increasing the risk of hemorrhage and infection.[21]

Abortion and Post-Abortion Care: Abortion remains illegal in Kenya except to save a woman's life, but unsafe abortions are common. The MOH estimates that unsafe abortion causes up to one-third of maternal mortality in Kenya, and a significant portion of morbidity among women age 15-49. The MOH/DRH, in its NRHS, specified strengthening post-abortion care (PAC) as a priority response to this problem. However, few PAC cases are registered in District maternal health records. Interviews with providers suggest that women are reluctant to seek PAC for fear of legal repercussions; PAC provided before 28 weeks is handled in gynecological, rather than maternity wards; few providers have the skills for PAC; and PAC may not be registered as such to spare women stigma.[22]

Nutritional Status: In the Rift Valley, an estimated 31.6% of children under five are stunted; 7.7% are wasted; and 24% are underweight. The Rift Valley had the second-highest rates of stunting, wasting, and underweight children in the country. The KPC survey revealed that 9% of children studied were underweight. The Rift Valley was also shown to have the highest percentage of women who are severely thin (classified as having a Body-Mass-Index (BMI) of less that 16) and the second highest percentage of women who are moderately thin (BMI of 16-16.9).[23]

Infant and Neonatal Mortality: The infant mortality rate (IMR) in Kenya is estimated at 77.2 deaths per 1,000 live births.[24] In the West Pokot District, the IMR was estimated in 1999 at 87.2 per 1,000 live births.[25] Factors influencing infant mortality are HIV/AIDS, birth spacing (Kenya IMR increases to 134 per 1,000 live births when time elapsed since the previous birth is less than two years), usage of ANC, and access to safe delivery services. Neonatal care is not highly utilized, even though 50-70% of life-threatening illnesses occur within one week of delivery. DHMT records show that neonatal deaths represent 30% of all infant deaths. Causes are not disaggregated in MOH records, but records from KDH state premature delivery, neonatal sepsis, asphyxia, respiratory distress, and hypothermia as primary causes of neonatal mortality.[26] Interviews with providers and review of medical registers suggest that infibulation and CPD are again implicated, with intrapartum asphyxia cited as a leading cause of fetal death.[27]

Breastfeeding: The 2003 KDHS showed that 23.7% of children under five months were exclusively breastfed and 12.7% of children under 6 months were. The KPC conducted by

[21] WHO Report on FGM Eradication Efforts in Sub Saharan Africa. www.who.int/reproductive-health/publications/fgm/fgm_programmes_review.pdf.
[22] Ibid.
[23] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[24] Ibid.
[25] Kenya National Census, 1999.
[26] DOW HFA, 2007.
[27] Baltazar, G.M.; Chebet, K.L.; Cheluget, B.K.; Marum, L.H.; Mwikya, L.; and Stover, J. "AIDS in Kenya: Background, Projections, Impact, Interventions, Policy, Ministry of Health (MOH) and National Aids Control Council." Republic of Kenya, 2001. And DOW HFA, 2007.

DOW showed that in focus areas of West Pokot only 14.5% of children under five months of age were exclusively breastfed within the first hour of birth, but 71% were exclusively breastfed in the last 24 hours. Provider reports are corroborated by presentation at facilities of infants as young as one week with severe diarrhea. The KDHS shows that median length of exclusive breastfeeding was 1.6 months in Kenya and only 0.4 months in the Rift Valley.[28]

Child Mortality and Morbidity: The 2003 KDHS found under-five child mortality in Kenya to be 115 deaths per 1,000 live births. Under-five mortality has been estimated at 127 deaths per 1,000 live births in the West Pokot District.[29] According to the DHMT, leading causes of under-five mortality are: malaria, anemia, pneumonia, gastroenteritis, and dehydration. Nationally, 18% of children under 5 had symptoms of acute respiratory illness in the two weeks preceding the KDHS, 41% had a fever, and 17.1% had diarrhea. Nearly one-third (30.3%) of children under five are stunted, 5.6% of children are wasted, and 20% are underweight. These figures mirror those in the Rift Valley.[30] HIV/AIDS exacerbates the child health situation, and child mortality is projected to increase 75% in 2005 as a result of the epidemic.[31]

HIV/AIDS: Kenya has 1.2 million people living with HIV. An estimated 6.7% of Kenyan adults are HIV+; in the Rift Valley Province, 5.3% of adults are estimated to be HIV+, the 3rd highest prevalence among the provinces. Data gathered by District AIDS and STD Control Officers (DASCOs) across the Northern Rift Valley show that the prevalence of HIV in 2005 was 13.1%; 19.4% among women and 8.2% among men.[32] In the District, 2004 data showed a prevalence of 10.5% at five VCT sites, while data from 2005 show 15% prevalence. (Due to lack of quality controls and irregularities in data reporting throughout the district, however, these figures most likely misrepresent the actual prevalence. DOW is currently working with the DASCO to collect more accurate information.) According to national statistics, virtually all Kenyan women and men have heard of AIDS.[33] In the Rift Valley, 30.4% of women and 39.3% of men know that having the mother take certain drugs during pregnancy can reduce the risk of mother to child transmission. In West Pokot, the KPC found that only 18.3% of mothers surveyed knew at least two ways to reduce HIV infection risk.

Malaria: According to the DHMT, malaria is the leading cause of morbidity in the West Pokot District. Facility records show that 97,286 cases of malaria were reported in 2004, and 115,101 cases in 2003; the latter figure represents nearly one case for every three residents of the District. The impact of malaria on MCH is significant; 26,000 Kenyan children under five die of malaria each year. Despite the frequency of malaria epidemics, the Rift Valley lags behind on malaria control measures. Only 3% of households in the Rift Valley have an ITN, compared to nearly 6% across Kenya. Only 1.1% of households have more than one Insecticide-Treated Net (ITN), compared to 2.7% in Kenya as a whole. In Kenya, 4.6% of children under 5 sleep under ITNs,

[28] Kapenguria District Hospital, Statistical Records, 2006.
[29] Kenya National Census, 1999.
[30] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[31] Baltazar, G.M.; Chebet, K.L.; Cheluget, B.K.; Marum, L.H.; Mwikya, L.; and Stover, J. "AIDS in Kenya: Background, Projections, Impact, Interventions, Policy, Ministry of Health (MOH) and National Aids Control Council." Republic of Kenya, Nairobi, 2001.
[32] West Pokot District Central Bureau of Statistics, 2005 District Records.
[33] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)

compared to 2.5% in the Rift Valley. Of pregnant women in Kenya, only 4.4% sleep under ITNs, compared to only 1% in the Rift Valley. These findings are in line with the KPC results, which showed that 7.5% of mothers surveyed slept under ITNs the previous night. As noted above, 3.9% of women received IPT during ANC in Kenya – this was even less in the Rift Valley, only 2.5%.[34] Rapid treatment of children under 5 for fever also lags behind in the Rift Valley. Of children with fever, 26.5% took antimalarials in Kenya as a whole, 11.1% on the first day. However, in the Rift Valley, only 19.3% of children with fever took antimalarials, and only 5.9% on the first day. Research shows that antimalarial medication is perceived to be harmful to a pregnant woman or her unborn child by 74% of women in Kenya, indicating the importance of education about IPT.[35]

CURRENT STATUS OF HEALTH SYSTEMS CAPACITY

According to District records, there are 53 points of health service delivery in the West Pokot District (including MOH and private facilities). There are two hospitals in the West Pokot District, both in the program location: the Kapenguria District Hospital (KDH) and Ortum Mission Hospital. The program location also includes four health centers and 32 clinics and dispensaries of varying size. KDH is staffed by four medical officers, 118 nurses, 12 clinical officers, and two anesthetists.[36] Of these, the four medical officers rotate through the maternity, female, pediatric and other wards; none of the clinical officers work in maternity; 20 nurses work in the maternity ward; and the two anesthetists contribute to covering the operating theatre during cesarean sections and other obstetric emergencies. MOH health centers are staffed by one clinical officer, two to four nurses, one or two lab technicians, and one to two public health technicians/officers. MOH dispensaries are staffed by one to two nurses.[37]

Table 2: Human Resources Available by Health Facility[38]

Facility Location and Type	Medical Officers	Clinical Officers	Nurses	Lab Tech/ Anesthetists	Total Staff for EmONC
Kapenguria District Hospital	4	9	118	2	**133**
Ortum Mission Hospital	2	2	27	1	**32**
Kacheliba Health Center	0	1	8	0	**9**
Chepareria Health Center	0	1	9	2	**12**
Kabichbich Health Center	0	0	6	1	**7**
Sigor Health Center	0	0	6	1	**7**
Lomut Dispensary	0	0	2	0	**2**
Serewo Dispensary	0	0	2	0	**2**
Konyao Dispensary	0	0	1	0	**1**

[34] Kenya Demographic and Health Survey, 2003. (Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, ORC Macro, Centers for Disease Control and Prevention, July 2004.)
[35] Schultz, Linda J.; Steketee, R.; Parise, M.; Wirima, J.; Oloo, A.; and Nahlen, B. "A Selection of Essays: Malaria Prevention During Pregnancy: An Antenatal Intervention Strategy Whose Time Has Come." The Female Client and the Health-Care J. Hatcher and C. Vlassoff, IDRC, Canada, 1995.
[36] DOW HFA, 2007.
[37] West Pokot District Central Bureau of Statistics, 2005 District Records.
[38] DOW HFA, 2007.

Ante-Natal Care: According to MOH/ DRH policy, all facilities should be providing ANC, but actual capacity to do so is inadequate at all facilities in the District. No MOH providers have been recently trained in focused antenatal care (ANC), and visits are missed opportunities to conduct HIV/STI screening, provide education on breastfeeding and child spacing, and develop a birth plan to support facility delivery. Even at the District Hospital, providers whose ANC patients live in the most accessible part of the District estimate that less than half of these patients return for facility-based delivery. In outlying parts of the District, the proportion is lower.[39] Analysis of services provided across facilities in 2005 showed that the health centers see far more new patients for ANC than for delivery; the ratio of deliveries to new ANC patients varies from 4.4% at Sigor to 23% at Chepareria. At the two facility levels where lab services are available (health center and hospital), pregnant women are not consistently counseled and referred for STI and HIV screening; interviewed providers cite cost as the barrier to utilization of screening services, but there is no information on actual practices of providers in offering screening during ANC. Providers, even at the hospital, remain focused on risk profiling. This is an approach that ignores the fact that all deliveries can develop complications, especially in an area where close to 100% of women have been infibulated and are thus at risk for CPD and obstructed labor.[40]

Safe Delivery and EmONC services: According to MOH/DRH policy, health centers should provide safe vaginal delivery services and establish a referral system to hospitals for complications and Comprehensive Emergency Obstetric and Newborn Care (CEmONC). This is not the case in the West Pokot District. Physical capacity to provide safe delivery services and manage labor and the immediate post-partum period is inconsistent across the four health centers. Only two health centers can provide emergency transfers to a hospital. Health centers are also mandated by DRH policy to provide all components of Basic Emergency Obstetric and Newborn Care (BEmONC); however, capacity of human resources/training and equipment, supplies, and medicines, is lacking to provide EOC across health centers. Providers at health centers and dispensaries have received no formal EmOC training. They have not been trained in provision of Post Abortion Care (PAC) services; only one provider at the Kapenguria District Hospital is able to use manual vacuum aspiration (MVA) as part of PAC, and the equipment available for MVA is of limited quality and utility. Finally, because of the high prevalence of infibulation and CPD, C-section deliveries and comprehensive EmOC are frequently needed in the District, but are only available at the hospitals, at prohibitive cost.[41]

Postpartum and Newborn Care Services: While postpartum and newborn care services are more commonly used by women who deliver outside of facilities, many of those who deliver at facilities do not stay for a sufficient length of time after delivery. Only 12 postnatal care cases were registered across all facilities of the MOH thus far in 2007.[42] Providers currently advise women to come to child wellness clinics (CWCs) a month or more after delivery, precluding the provision of postpartum and neonatal care, which seem to be provided largely on an *ad hoc* basis. Although Integrated Management of Childhood Illness (IMCI) has been adopted as a national strategy in Kenya, providers in the District have not been trained in IMCI approaches, and neonatal IMCI algorithms are not understood.[43]

[39] West Pokot District Health Records and Information Officer, 2007.
[40] West Pokot District Central Bureau of Statistics, 2005 District Records.
[41] DOW HFA, 2007.
[42] Ibid.
[43] West Pokot District Central Bureau of Statistics, 2005 District Records.

HIV/AIDS and Malaria-related Services: There are five VCT sites in the District, all within the program location. These sites tested thousands of people since the inception of their program in June of 2005, while a DOW-run mobile testing clinic began counseling and testing people in 2006. While there are PMTCT sites in the District, protocols for testing women in the antepartum period are often not followed due to staffing or time constraints.[44] Offering of opt-out testing is limited, because of provider fear of delivering a positive HIV test result; inconsistent supply of test kits; inadequate supervision, and staff shortages. Antiretroviral Therapy (ART) was introduced to the West Pokot District through the National AIDS and STI Control Program (NASCOP) in early 2005. Since June 2005, a DOW-run HIV testing and treatment program has enrolled more than 850 patients in ART. According to DHMT data from 2004, HIV+ patients accounted for one-third of bed occupancy in the hospital wards. Of women who tested positive through ANC services across the Northern Rift Valley, only 26% received Nevirapine, partly due to shortage of drugs. DOW is responding to these gaps in HIV/AIDS treatment and monitoring capacity through an ongoing program, including the establishment of a comprehensive HIV/AIDS treatment clinic at the Kapenguria District Hospital and in other parts of the district through semi-mobile clinics. The MOH conducts rapid response to malaria outbreaks, and is able to consistently provide treatment for malaria. PSI plans to implement an ITN program with DOW as a distribution partner working in health facilities. There is need for training to strengthen provider ability to conduct malaria case management, provide IPT and promote ITN use. IPT is not regularly provided at the District Hospital due to provider uncertainty about protocols.[45]

Interviews with MOH staff and providers, as well as visits to health facilities revealed four primary challenges to strengthening and increasing utilization of facility-based health services:

Limited Access: Roads in the West Pokot District are extremely poor. The two major roads are in serious disrepair, making many of the outlying areas of each Division nearly inaccessible. This adds to delays in reaching health facilities and in timely transfers between facilities. In addition to poor roads, the almost non-existent communication network adds to delays, as facilities cannot be notified about patients who may be coming in need of time-sensitive care.

Lack of Training: Despite development of useful tools and curricula by the MOH and other Private Voluntary Organizations (PVOs) in recent years, providers in the District have had almost no access to these. Thus, they are not aware of or able to operationalize service improvements, such as maternal death review guidelines endorsed by the MOH and UNICEF in 2004. Though there is a DRH training team in the Southern Rift as indicated by the Division of Reproductive Health's (DRH's) decentralized training policy, there is no team in the Northern Rift Valley.

Inconsistency of Supervision and Support: There has been little supervision and support to the DHMT to improve Maternal and Neonatal Care (MNC) services. There is no DRH representative dedicated to the Northern Rift. Funding for innovations that would address gaps in MNC services identified above has been too discontinuous and short-term to enable the DHMT and other providers to institutionalize improvements of fund them locally. For example, mobile outreach services were briefly funded by the Global Alliance for Vaccines and

[44] DOW HFA, 2007.
[45] PSI: http://www.psi.org/our_programs/hiv_aids.html

Immunization (GAVI); although staff were enthusiastic, funding was not continued, and the term was not long enough to demonstrate results and advocate for MOH resources.

Inadequate Human Resources: Many health facilities, particularly dispensaries, remain understaffed and a *de facto* hiring freeze has made it difficult to address vacancies. This has led to existing staff feeling overworked and made it difficult to introduce new services.

OTHER IMPORTANT BARRIERS TO HEALTH

Lack of Health Information: Although a number of groups have conducted some HIV/AIDS education in the District, there has been little community education about MNH issues and malaria. The risk profile approach to screening pregnant women has reinforced community attitudes that facility-based MNC services are not required for 'normal' pregnancies.

Gender Inequities: The low status of women contributes to low use of MNC services, as they may not have the mobility to seek services at distant health facilities, or the funds to pay for transportation. Care for women may not be perceived as a household priority.

Perception of Facility-based Services: Providers and community members report that facility-based services do not feel comfortable to women used to home deliveries, as they are perceived as rushing women through labor and lacking the comfort of family members and TBAs. Infibulated women have confidence that TBAs understand their bodies, as TBAs carried out FGM, and often re-cutting.

Cost: The MOH fees for services, including ANC, delivery, and other MNC care, are cited by women and their families as a barrier to accessing care. Pokot pastoralists often have assets in the form of livestock, but no ready cash.

LINKAGES AND COMPLEMENTARY ACTIVITIES

There are few PVOs working in the West Pokot District or the Northern Rift Valley in comparison to the rest of Kenya. Where DOW's work does overlap with the location and mission of other PVOs, every effort has been made to ensure that all activities are complementary and not overlapping.

APHIA II: Through a consortium of partners led by, Family Health International (FHI), the AIDS, Population, and Health Integrated Assistance (APHIA II) Program has been established to provide integrated HIV, family planning, and reproductive health (RH) services in the Rift Valley Province. DOW has had initial discussions with APHIA II representatives and will continue to consult with them when designing training activities around RH and HIV.

AMPATH: DOW has been working in partnership with AMPATH since mid-2005. Throughout the Northern Rift Valley, AMPATH programs are providing HIV/AIDS services to thousands of people. DOW plans to continue to partner with their program in our HIV/AIDS and PMTCT efforts.

Handicap International: This PVO has works to offer VCT services in the Rift Valley. DOW currently partners with Handicap International (HI) to conduct HIV counseling and testing

during community mobilization sessions and to train health workers in HIV prevention and care. When DOW begins training in PMTCT, there are plans to include HI staff and past HI trainees in DOW trainings whenever possible.

Medicins Sans Frontieres (MSF): There is a Kala Azar clinic location at the Kacheliba Health Center, which is one of the focus health facilities included in DOW's program plan. DOW has been working at Kacheliba alongside MSF staff since the launch of the Kala Azar initiative, and will continue to ensure complementary activities, such as offering HIV counseling and testing to Kala Azar patients, through regular coordination and communication with MSF staff.

Pathfinder International: Elsewhere in the Rift Valley, Pathfinder International is implementing a community-based HIV/AIDS prevention, care and support program (COPHIA), whose activities include building community capacity to provide home-based care and support to orphans and vulnerable children (OVCs). Because the program locations of DOW and Pathfinder International are mutually exclusive but adjacent, the two PVOs view one another as collaborators in the region.

Population Council: In the Western Province of Kenya, Population Council has conducted a Safe Motherhood Demonstration Project that tested interventions for increasing use and quality of MNC, as well as models to expand community access to skilled care. The Population Council has developed tools for improving MNC services, such as postpartum registers. DOW will consult with Population Council to learn best practices in expanding community access to MNC. The project will seek assistance from Population Council in the form of sharing training and Monitoring and Evaluation (M&E) tools.

Population Services International: In accordance with Abuja targets, Population Services International (PSI) aims to cover 60% of women and children under 5 with ITNs. PSI sells ITNs for 30 Kenyan Shillings (about $0.40 USD) to health facilities, who sell these to clients for 50 Kenyan Shillings (about $0.60 USD) and use the profit maintain and/or upgrade services at each facility. ITN use is encouraged by PSI radio ads as well as ITN maintenance demonstrations. In the West Pokot District, this program has trained 100 staff from 48 facilities in malaria prevention and social marketing. Since December 2004, 48 facilities have distributed 26,270 ITNs. In order to reach Abuja targets another 13,000 nets will be distributed. DOW will work as a distribution partner for PSI, working with health care workers, local community leaders, and TBAs to distribute ITNs to pregnant women and mothers of young children.

Sentinelles: This Swiss NGO coordinates a project in the West Pokot District that focuses on changing harmful practices including infibulation and early forced marriage. Activities include conducting community seminars about infibulation and HIV/AIDS, supporting girls who run away from FGM or early forced marriage, conducting parent advocacy against FGM and early forced marriage, coordinating fistula repair camps, and working with the Kenyan justice system to enforce a national ban against FGM. DOW has partnered with Sentinelles on several occasions in an effort to safeguard the health of women and young girls and will continue to do so through the proposed MNH program.

UNICEF: By liaising with the central office in Nairobi, DOW has recently benefited from UNICEF's experience in Kenya with respect to maternal and newborn care. UNICEF was instrumental in providing key material resources such as weighing scales for the baseline assessments and provided key technical input in the design and implementation of the surveys. Further collaboration is planned, especially in the design of operations research and training in home-based newborn care. Because there is currently no UNICEF representative in West Pokot, DOW plans to share baseline data with the organization in order to strengthen MNC services in the area.

World Vision: In West Pokot, World Vision is promoting HIV prevention through community mobilization campaigns and supporting local Community-Based Organizations (CBOs) and NGOs in their own campaigns. World Vision also promotes care and support for OVCs and HIV+ people. DOW has worked alongside World Vision for the past two years and all activities have been coordinated between the two PVOs.

BASELINE ASSESSMENT FINDINGS AND PROGRAM PRIORITIES

Much of what was described in our original proposal related to the status of maternal and neonatal health in West Pokot is consistent with the findings of our baseline assessments. The majority of women continue to deliver at home, with few seeking antenatal or postpartum care. Maternal and newborn complications are dealt with on an ad hoc basis, often because providers lack training in management of such complications. Despite in-depth baseline assessments, an unreliable records system throughout the district has likely led to underreporting of the true burden of disease among women and children in West Pokot.

I. KPC Survey

The mean age of the respondents was 28 years old. Slightly over a third (38%) of these mothers never attended any school, with only 9% of women having completed secondary schooling or higher. The majority of children surveyed (65%) were under 6 months of age, followed by those between 6-11 months (22%), and finally few who were 12-23 months (13%). The average number of children per family was found to be 4.7 (range is 1-11) and a mean number of pregnancies 4.8 (range is 1-12).

Maternal and Newborn Care

Only 15.6% of the mothers had maternal health cards while 54% of those same mothers had cards for their children. The survey found that less than a third (28%) had attended antenatal care (ANC) at least four times before the birth of the youngest child. Skilled health attendants delivered about 17% of the children under study. The remaining mothers gave birth at home with support of Traditional Birth Attendants (TBAs) and/or relatives. While 60% of the mothers reported at least one postpartum check after the birth of the youngest child, this is likely an over-report due to possible confusion by mothers about the difference between postpartum and child wellness checks. Less than 10% received information on child spacing. In addition, only 31% of the mothers knew at least two maternal danger signs during postpartum period, while about 37% of them knew at least two neonatal danger signs. About 71% of the children younger than six months old were found to be exclusively breastfed in the last 24 hours. Interestingly, women who had any education were almost three times more likely to be counseled during ANC than women who had never attended school.

HIV/AIDS

The survey also found that only 26% of the women received HIV testing, even though 43.5% received HIV counseling services during pregnancy. Only 18.3% of mothers surveyed cited at least two correct ways of reducing the risk of HIV infection and less than half (42.5%) knew that HIV could be transmitted through breast milk.

Malaria

Thirty six percent of the children had fever in the two weeks before the survey was administered. Only 2% of the mothers of these children sought medical treatment in a health facility. Among the children with fever, only 22% were given the recommended antimalarial medications. A significantly lower proportion of the mothers (about 8%) slept under mosquito net than of the children (43%).

Analysis by supervision area revealed that Sigor Division performed poorly in the largest number of health indicators. This was not surprising given that the infrastructure is in severe disrepair; there is lack of an adequate road system and limited availability of cellular networks in this Division. The KPC report highlights indicators by supervision area, which will help us identify specific opportunities for behavior change in each Division. Further analysis of project indicators by supervision area has been undertaken in order to understand variations in health practices among Divisions.

II. Health Facility Assessment

Emergency Obstetric and Newborn Care

Because Maternal and Neonatal Care (MNC) comprises 70% Level of Effort (LOE) for this grant, the HFA focused on the availability, utilization, and quality of Emergency Obstetric and Newborn Care (EmONC) at the target health facilities. Based on the United Nations (UN) Guidelines for Monitoring the Availability and Use of Obstetric Services, West Pokot, with a population of 413,419,[1] should have a minimum of 4-5 EmONC facilities including at least one that offers comprehensive EmONC. As illustrated by the 2006 HFA conducted by DOW, West Pokot had no facility that offered the complete package of basic or comprehensive EmONC signal functions.

The two hospitals in West Pokot (one public, one private) offered cesarean sections and blood transfusion services, but both were missing assisted vaginal delivery. Ortum Mission Hospital was also missing parenteral anticonvulsants. Although health centers were potential Basic Emergency Obstetric and Newborn Care (BEmONC) facilities, which they are required to be according to Kenyan national guidelines, none of the four health centers assessed provided all components of BEmONC. Dispensaries only managed emergency deliveries and provided none of the signal functions. Assisted vaginal delivery was not offered in any facility in West Pokot.

[1] Kenya National census, 1999.

Table 3: Facilities surveyed and available signal functions in the last 3 months

	Parenteral antibiotics	Parenteral oxytocics	Parenteral anticonvulsants	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery	Neonatal resuscitation	Blood transfusion	Cesarean section	EmONC status
Kapenguria DH	√	√	√	√	√		√	√	√	Comp minus 1
Ortum MH	√	√		√	√		√	√	√	Comp minus 2
Chepareria HC	√	√			√					Basic minus 4
Kabichbich HC	√	√								Basic minus 5
Kacheliba HC	√						√			Basic minus 5
Sigor HC	√									Basic minus 6
Konyao Disp	√									Basic minus 6
Lomut Disp										Non-EmONC
Serewo Disp	√									Basic minus 6

Other MNH-related Services

There are other services that are important to consider for the reduction of maternal and neonatal death and disabilities. For example, every woman who is in active labor should be monitored with a partograph. Both hospitals had blank partographs in their labor and delivery rooms. Out of the four health centers, only Chepareria Health Center (HC) had partographs available to use in the labor and delivery room, but staff said they were not using them because they were not trained in their use. Staff at the other health centers did not use them because they were untrained and did not have the forms available. Nurses and medical officers were trained to manage breech deliveries at KDH and Ortum Mission Hospital (MH). Sigor HC also managed at least one breech delivery in the last three months. The other three health centers did not provide this service either because they had no cases or because they were not trained to manage this type of delivery. The dispensaries did not provide this service.

If women in labor/delivery do not know their HIV status, they should have the option to be tested for HIV in the delivery room and be told about prevention of maternal to child transmission (PMTCT) options. Unfortunately, the majority of facilities in West Pokot did not have rapid HIV tests available in their labor and delivery rooms. Only KDH had the supplies and routinely offered testing to women in the labor and delivery room. Ortum MH had the rapid HIV test in the labor/delivery room, but did not offer counseling and testing to every individual woman delivering. Instead, they waited until there was a small group of women who could be counseled together and then offered testing.

The Private Voluntary Organization (PVO) AMREF provided fistula repair surgery periodically at Ortum MH but there were no permanent staff at any facility in West Pokot who were trained to provide routine fistula repair surgeries.

Table 4: Other Maternal and Neonatal Health (MNH)-related services provided in last 3 months

	Partograph	Breech delivery	Rapid HIV test	Nevirapine - mother	Nevirapine - baby	Fistula repair
Kapenguria DH	√	√	√	√	√	NO
Ortum MH	√	√	NO	NO	√	NO
Chepareria HC	NO	NO	NO	NO	NO	NO
Kabichbich HC	NO	NO	NO	NO	NO	NO
Kacheliba HC	NO	NO	NO	√	NO	NO
Sigor HC	NO	√	NO	NO	NO	NO
Konyao Disp	NA	NA	NA	NA	NA	NA
Lomut Disp	NA	NA	NA	NA	NA	NA
Serewo Disp	NA	NA	NA	NA	NA	NA

Quality of Care

Not only do EmONC services need to be available and used by women with obstetric complications, they also need to be of good quality. The ability of facilities and health professionals to quickly and effectively respond to the emergencies that arise can be the difference between life and death for women and their babies.

The case fatality rate for direct obstetric complications (CFRDO) is used as a rough estimate of the quality of EmONC services by looking at the percent of women with obstetric complications managed in facilities who die. The UN Guidelines recommend a maximum of 1%.

In 2006, twelve maternal deaths were recorded in facility registers in West Pokot. Overall, the CFRDO in all facilities was 2.5%, which exceeded the maximum rate as per the UN Guideline recommendations. The CFRDO in KDH was 3.3% and 2.3% in Ortum MH. No maternal deaths were recorded at the four health centers and three dispensaries.

The nine maternal deaths from direct obstetric complications that occurred in KDH were due to complications of abortion (4 deaths), ruptured uterus (2 deaths), eclampsia (1 death), hemorrhage (1 death) and sepsis (1 death). Three direct obstetric maternal deaths were recorded at Ortum MH: sepsis (2) and ruptured uterus (1).

The reliability of the CFRDO depends on the quality and completeness of record keeping and reporting of maternal deaths and obstetric complications. If very few maternal deaths are recorded, the quality of care may falsely appear to be quite good. Similarly, if few complications are recorded, the CFRDO may be artificially high. In this assessment, it was observed that record keeping was poor and that maternal deaths and obstetric complications were not well recorded. Therefore, the CFRDO should be interpreted with care. For example, deaths that occur in the postpartum period were often not classified as maternal deaths in facility registers.

Records of newborn complications were collected at the nine facilities. Only those complications that occurred within 1-28 days of life were recorded in facility registers. When age was not recorded, the case was excluded from this study. In total, 576 cases of neonatal complications were recorded in 2006. The most frequently recorded complication was pneumonia (185 cases) followed by upper respiratory tract infections (95 cases), malaria (93 cases), sepsis (86 cases), and prematurity/low birth weight (71 cases).

In all, 84 neonatal deaths (in babies 1-28 days old) were recorded in the nine facilities; 60% percent of those deaths were recorded at KDH and 40% were recorded at Ortum MH. Only one health centre, Kacheliba HC, reported any neonatal deaths. No dispensaries reported any neonatal deaths. The most frequent cause of neonatal death was prematurity/low-birth weight (36 deaths), followed by pneumonia (20 deaths), asphyxia (17 deaths), neonatal sepsis (10 deaths) and anemia (1 death).

III. Qualitative Research

Informal Focus Group Discussions with Mother and Tradtional Birth Attendants (TBAs)

Informal focus groups were conducted with mothers and TBAs from neighboring villages around Chepararia Health Center to inform development of the KPC survey. Questions focused on health seeking practices of pregnant women and care of the newborn. From the discussion, it was clear that cultural values and lack of sensitivity from health facility staff were key factors in a woman's decision to deliver with a TBA.

Mothers acknowledged women in their villages died in child birth and attributed this to "bad luck". While many felt ANC attendance was important, they preferred to deliver at home because they felt more comfortable with TBAs, who come from the same village and share their culture. In addition, since TBAs perform female circumcision, the mothers felt that TBAs understood their bodies best and could provide the necessary herbal remedies if a pregnancy complication arose. When asked about their children, mothers cited pneumonia, fever, and diarrhea as common newborn illnesses. Though many women were not willing to deliver in a health facility, most prioritized referral to a health center or hospital if a child's health did not improve after receiving traditional remedies.

TBAs felt strongly that ANC attendance was necessary for pregnant women. In fact, some TBAs refuse to attend to pregnant women who have never made an ANC clinic visit. They cited long distances to heatlh facilities and cultural familiarity as reasons why women preferred to deliver with them at home instead of at a facility. TBAs metioned excessive bleeding and retained placenta as the most common delivery-related complications and lamented that women who died in childbirth often came to them too late after the onset of a complication. TBAs often referred premature babies to the nearest facility for further examination but routinely treated diarrhea and pneumonia with herbal remedies. Though they did encourage breastfeeding, many offered traditional herbs to women who had difficulty producing milk immediately after giving birth.

Findings from these discussions highlight the need for better education among women of reproductive age and TBAs about the importance of FANC, early referral for pregnancy-related complications, and adequate postpartum and newborn care.

Focus Group Discussions with Health Facility Providers

After the KPC survey was conducted, focus group discussions were held in March with staff from five of the health facilities included in DOW's MNH program. Questions focused on key intervention areas such as ANC and delivery services, exclusive breastfeeding, and malaria prevention. Results presented are those that were common to all facilities surveyed. The complete Focus Group Report can be found in Annex X.

With respect to ANC services, staff cited pregnant women's lack of awareness of the importance of ANC attendance, distance to the nearest health facility, long wait times due to staff shortages, and poverty as reasons for low utilization. Interestingly, staff also noted refusal of mothers to come to the clinic for fear of being forced into testing for HIV/AIDS. Low utilization rates for delivery could be attributed to the same factors mentioned for ANC. Additionally, clinicians mentioned that women preferred to delivery at home because of traditional cultural practices, fear of operations, and an unfriendliness of certain staff members.

Clinicians mentioned that exclusive breastfeeding was not regularly practiced among women in West Pokot due to low production of milk as a result of malnourishment, the need for women to work and therefore leave newborns at home, and early mixed feeding including provision of teas and other herbal remedies to sick newborns. Staff felt there was a general lack of knowledge among mothers about the benefits of exclusive breastfeeding despite routine health education sessions offered at the facilities. This suggests that more outreach is required at the community level.

In terms of malaria prevention, providers further expressed that both IPT uptake and ITN use were low in all communities. Health facility staff noted that mothers often come to ANC late in pregnancy, if at all, and clinicians are therefore unsure when to administer IPT. Staff also felt that IPT utilization was hard to track as there is often no register or inadequate time to record IPT delivery due to heavy workloads. Staff noted that malaria prevention is further complicated by lack of ITN use in most households. Some facilities have experienced a shortage of nets for distribution. However, the bigger problem lies with misconceptions about ITNs and improper use. For example, some people believe that when a woman inhales the chemical that is used to treat nets, there is a risk that she could become sterile. Therefore, ITN use among pregnant women is low. Additionally, providers noted that nets are tied around children as vests or not used at all because most of the ones that are available at the facility are rectangular instead of conical and difficult to hang in traditional huts. Finally, a family's inability to purchase even highly subsidized nets due to the extreme poverty that persists throughout the district remains an obstacle to ITN use in West Pokot.

Findings from these discussions suggest a need for sensitization of health facility staff to local cultural norms, greater support, including targeted trainings and material resources, for staff to

conduct MNH-related education and outreach activities, and advocacy with the MOH to improve ITN supply at rural health facilities.

TARGET POPULATION

Our target population is consistent with the original proposal and is detailed in section E1.

TYPES AND METHODOLOGIES OF BASELINE ASSESSMENTS

I. Knowledge, Practices, and Coverage Survey

The revised Rapid Core Assessment Tool for Child Health (CATCH) questions were used as the foundation of the KPC questionnaire. Other questions were obtained from the KPC 2000+ modules, the Minimum Activities for Maternal and Newborn Care (MAMAN) package, and UNICEF ROSA's Woman's Right to Life and Health Initiative (WRLH). The questionnaire was translated to 'Kipokot and Kiswahili', and back-translated to reduce any information bias. The survey tool was then field tested at the end of the interviewers'/supervisors' training and a pre-test was conducted in the nearby non-sampled sub-locations of *Lorkanoi* and *Tingeiket*. Based on the results from this process a KPC questionnaire was finalized. Questions related to the main intervention areas, including MNC, HIV/AIDS, and malaria, along with other child health topics.

The sampling frame used for this study was obtained from the Ministry of Planning and was based on the latest (1999) population census exercise, which provided information by division, location, sub-location and village. Using Standard LQAS methodology, the locations (villages) of interviews in each lot (Division) were selected based on population proportional to size (PPS). The sampling interval for each lot was calculated by dividing the total population by number of samples (19). A total of 95 samples for 0-23 months were obtained and an over-sampling was necessary in order to ensure at least 95 samples for 0-5 months.

Data collection took place from February 12-17, 2007. Accessing households was a significant challenge due to poor infrastructure; interviewers walked long distances to get to the villages since roads were sometimes impassable by vehicle. These problems led to the addition of a sixth day to allow for completion of the survey. Effective supervision and quality checks were built into the survey process. A ratio of one supervisor to two interviewers was utilized and the core team, a group comprised of DHMT members and DOW staff, provided ongoing quality spot checks in the field to allow for immediate feedback to supervisors. Data was entered, cleaned, and analyzed by the consultant team and a post-survey analysis workshop was convened to discuss preliminary findings.

It is important to note that while oversampling was correctly done for some indicators that required specific age categories (children 0-5 months), oversampling was not performed for indicators that involved children 6-23 months and 12-23 months. This affected mainly Rapid CATCH indicators on nutrition and immunization. For these indicators, very wide confidence intervals were calculated due to the low sample size for these age categories. The sampling problem has been thoroughly discussed with USAID and CSTS+ and it has been agreed that

because of the prohibitive costs associated with a KPC survey in a remote area like West Pokot and because most of the affected indicators are not project indicators that will be monitored on a regular basis , there is no need to redo the baseline KPC. Instead, both USAID and CSTS+ will be closely consulted when sampling frames are determined for the midterm and endline KPC surveys to ensure statistical significance of collected data.

II. Health Facility Assessment

The HFA studied all of the facilities in West Pokot that offer delivery services (two hospitals and four health centers). All but Ortum Mission Hospital were government-operated facilities. At the time of the assessment, dispensaries in West Pokot did not offer maternity services. However, four strategically located dispensaries that have high caseloads and aspire to have maternity wards were included in the review. Ten facilities were selected for this study and data were collected from nine of those facilities (Tamough Dispensary was closed when visited).

Table 5: Facilities selected and studied

Hospitals	1. Kapenguria District Hospital (DH) 2. Ortum Mission Hospital (MH)
Health centers	3. Chepareria Health Centre (HC) 4. Kabichbich Health Centre (HC) 5. Kacheliba Health Centre (HC) 6. Sigor Health Centre (HC)
Dispensaries	7. Konyao Dispensary 8. Lomut Dispensary 9. Serewo Dispensary

The instrument used for data collection was adapted from a set of tools produced by the Averting Maternal Death and Disability Program (AMDD) and from the UNICEF, WHO, UNFPA "Guidelines for Monitoring the Availability and Use of Obstetric Services." In addition, obstetricians, midwives and medical officers from Kenya were asked to review the final instrument for relevance and accuracy.

The final "West Pokot, Kenya Facility Needs Assessment" tool was composed of eleven sections covering the following:

- Background information on the facility - including size/capacity, overall infrastructure, transport, communication and cost of services.
- Availability of transport and means of communication for referral.
- Cost of maternity services.
- EmONC signal functions and other essential services - how facilities *actually* function and whether they offered all, some or none of the services necessary to treat and save women with obstetric complications. This also looked at why these services were not available.
- Human resources - including the overall staffing situation, training of staff in EmONC and the 24 hours/seven days per week coverage by health professionals in that facility.

- Facility Case Summary Form - used to collect service statistics from facility registers and records.
- Where patients come from.
- Equipment, supplies and essential drugs - used to evaluate the availability and functionality of basic infrastructure, equipment, supplies and drugs necessary for the delivery of EmONC and newborn services.

One team collected the data from the nine facilities over nine days from February 5-14, 2007. The team was comprised of one obstetrician and one BSC Nurse from Moi Teaching and Referral Hospital (Eldoret, Kenya), one consultant from AMDD, and one DOW staff person. The team received one day of training on the objectives of the assessment and use of the tool. During the training and throughout the data collection, efforts were made to ensure that all interviewers had a common understanding and interpretation of the tool. Quality control during the data collection period was ensured through daily meetings and review of completed forms at the end of each day of data collection. A data shell was created in Access 2003 for data entry. Data were exported into Excel 2003 and SPSS 14 for analysis.

III. Qualitative Research

Focus group discussions were conducted with mothers, TBAs, and health facility staff in order to better understand care-seeking practices in the community and low utilization of facility-based services. The same topic guide was used for mothers and TBAs while a separate one was developed for clinicians. Interviewers included DOW staff and providers from Kapenguria District Hospital. Interactive techniques were used to gather information and data was recorded in the form of detailed notes.

Focus group discussions with mothers and TBAs were limited to Chepararia Division due to logistical issues such as time constraints and accessibility of participants (women had to travel great distances, did not have much time to spare due to daily work commitments, or otherwise did not want to participate). Discussions with health facility staff were held at Kapenguria District Hospital and the four health centers (Chepararia, Kacheliba, Kabichbich, and Sigor).

POTENTIAL CONSTRAINTS TO ACHIEVING PROGRAM OBJECTIVES

I. Poor Infrastructure

One of the biggest obstacles DOW has faced in implementing health interventions in our current programs in West Pokot is the lack of basic infrastructure. Communication networks are nonexistent in many parts of the district and roads are few. Many residents continue to live without regular supplies of water and electricity, and it is not unusual for the health facilities, including the district hospital, to experience such shortages. Unfortunately, aside from regular advocacy with local GOK officials, there is little DOW can do to remedy this problem. For this reason, reliable vehicles to enable frequent visits to target health facilities, mobile services, and emergency referrals, will be key components to the program's success.

II. Staffing at Health Facilities

At the time of writing, several posts at all levels of health facilities remain unfilled. Due to an ongoing freeze in the recruitment and hiring of civil servants and the low allocation of resources by the central government for the district, staff shortages are likely to figure prominently throughout life of the project. DOW has requested that the DHMT ensure, as much as possible, that staff trained during the program remain in their posts. DOW will also continue to advocate at the national level for the MOH to address the issue of postings and transfers in marginalized districts such as West Pokot. DOW will also work with the DHMT to provide regular supervision at focus health facilities to ensure that quality services are available and that staff are well supported despite anticipated staff shortages.

III. Insufficient Coordination between Central, Regional, and Local MOH Departments

Due to its geographic distance from Nairobi and ongoing stereotypes in Kenya about the Pokot people, there continues to be a lag in transfer of information, supplies, and equipment from central departments to the District. For example, new maternal health registers introduced nationwide in 2006 have still not been implemented in West Pokot. In order to remedy the situation, DOW has joined the Division of Reproductive Health's Safe Motherhood Working Group in order to share program updates and challenges, and to advocate for the health needs of women and children in the district. DOW will also continue to meet regularly with the USAID Kenya Mission representatives and the Provincial MOH leadership for the same purposes.

IV. Health Policy Environment

The national policy on delivery of health services in the community has clearly stated that TBAs should not be trained in delivery services. However, the reality in West Pokot is that the majority of women still rely on TBAs working in the community for health services. DOW recognizes the important role TBAs and other community health workers play in the district and will seek to shift the role of the TBA to one of a health promoter and encourage TBAs to refer obstetric complications as early as possible to a local health facility. DOW will also continue discussions with all levels of the MOH to inform future policy decisions about the role of TBAs.

In early May 2007, Kenya's Minister of Health declared that delivery services at all public health facilities would become free on July 1, 2007. However, it is still not clear how this new policy will be implemented on the ground and many remain skeptical that it will become a reality since districts are left to implement this new policy with little guidance and funding. To date, health facilities in West Pokot are still charging women a fee for delivery services.

V. Political Situation

The most significant political change in DOW's project area is the recent division of West Pokot into two separate districts—West Pokot and North Pokot. Each district will have its own District Commissioner (DC) in charge of administering the district and a District Medical Officer (DMO) responsible for the health facilities within each district. This change has led to transfers of key health personnel from West Pokot to North Pokot. In addition, two of the nine focus facilities,

Kacheliba Health Center and Konyao dispensary, lie within the boundaries of North Pokot. Therefore, a new MOU will be signed with the DMO of North Pokot once he reports to the District Hospital. Since many of the changes associated with the redistricting have not gone into effect, it is difficult to anticipate the impact on our program activities. Fortunately, many health personnel transferred to North Pokot had previously worked in West Pokot and therefore have a relationship with DOW. As a result, we do not forsee any difficulties in working with the new district and its leaders and for the purpose of the DIP, we will continue to refer to the project area as one district, West Pokot.

In addition, with sporadic ethnic clashes ongoing and general elections coming in December 2007, the political environment is constantly changing in West Pokot. DOW regularly engages with local partners and leaders to ensure that program activities are conducted with the evolving local political situation in mind. Also, in anticipation of local and national campaigns, DOW anticipates conducting only routine project activities in the month prior to the elections. Any interventions not initiated by November 2007 will be rescheduled for early 2008.

COVERAGE ESTIMATES

(See Section E1 for further coverage estimates.)

Utilization Data for Obstetric Complications

As mentioned earlier, very few women in West Pokot delivered in health facilities in 2006. The facility assessment showed that only 11.7% of expected births took place in hospitals and health centers, and virtually no deliveries at the dispensary level. Seventy-two percent of institutional deliveries were managed at Kapenguria District Hospital, while only 11% occurred in health centers. This reinforces the need to focus on strengthening delivery services at the health center level. Interestingly, there was a more even distribution among primary and secondary facilities of management of neonatal complications than obstetric complications. (Most obstetric complications were handled by the two district hospitals.)

Complete utilization data for each of the health facilities surveyed can be found in the full HFA report (Annex 2).

Table 6: Facility Utilization in 2006

Facility	Delivery	Direct obstetric complications	Incomplete abortions	Neonatal complica tion	Caesareans	Maternal deaths	Stillbirths	Early neonatal deaths (1st 24 hours)	Neonatal deaths (1-28 days)
Kapenguria DH	1917	270	141	118	246	9 direct 6 indirect	68 Fr 31 Mac	U 2kg = 16 O 2kg = 17	50
Ortum MH	448	128	33	102	108	3 direct 1 indirect	20 Fr 13 Mac	U 2kg = 8 O 2kg = 35	33
Chepareria HC	76	20	14	84	N/A	None reported	None reported	None reported	None reported

Kabichbich HC	59	7	3	22	N/A	None reported	None reported	None reported	None reported
Kacheliba HC	106	18	6	16	N/A	None reported	3 Fr 1 Mac	None reported	None reported
Sigor HC	50	7	2	92	N/A	None reported	None reported	None reported	None reported

CURRENT DISEASE SURVEILLANCE

Another major challenge in strengthening MNH, as well as other areas related to child survival, is the state of the District's health data systems. Reviews of District health records and interviews with the DHMT revealed significant gaps in the capacity to collect, analyze, and report on key indicators relevant to MNH, HIV/AIDS, malaria control, and basic demographic trends. Tools that do exist are not used or are completed inaccurately; not all facilities (both government and private) report their information on a regular basis to the District Health Records and Information Officer (DHRIO), and current data templates allow miscoding and loss of health data. New maternal health registers developed by the MOH have not yet been supplied to West Pokot, despite repeated requests from district MOH and DOW staff.

Underutilization of Existing Tools: The DRH has created a Maternal Death Notification Form and guidelines for Maternal Death Reviews, to be used across Kenya to record and analyze information about facility-based maternal deaths. In the West Pokot District, providers have not been trained in these tools; indeed, some MNC providers interviewed by DOW had not seen this form. Thus, information on the causes of maternal mortality remains anecdotal.

Lack of Uniform Reporting across Facilities: A review of monthly Reproductive Health (RH) data collected from January 2004 to September 2005 revealed that, in each month, several public and many private facilities did not report data to the DHRIO. This compromises the DHMT's ability to allocate resources (both material and human) to facilities and to determine accurate figures for heath service seeking and utilization.

Miscoding of Health Data: A true picture of MNH needs is obscured because of classification loopholes; for example, complications or deaths occurring in women under 28 weeks of gestation are recorded as gynecological admissions, rather than maternity admissions. Due to inconsistent training, providers may often only record deaths occurring within 24 hours of delivery as maternal deaths.
Inaccurate analysis and reporting: The annual District Reproductive Health Form (DRHF), which aggregates indicators gathered through monthly forms, is created as monthly figures are entered and added by hand. This process, as well as the lack of reliability checks, leads to significant errors, such as significant differences (25%-100%) between annual totals and those in monthly and facility-specific forms.[2] As the DRHF is key source for MCH indicators, current estimates are inaccurate.

[2] Doctors of the World-conducted Health Facility Assessment, 2007.

Distorting all MNH data available in the District is the fact that virtually no data are collected from the community. While all births and deaths in the community should be collected by chiefs and reported to the Civil Registry, this does not occur. When calculating MMR in the District, the DHMT found that only one maternal death was reported from the community to the Civil Registry in the whole of 2006. Thus, the MMR of 565 calculated is likely a gross underestimate. With 80% of births estimated to occur at home, numerous maternal deaths went unreported in 2004. This underreporting makes it difficult for the DHMT to target community mobilization efforts or allocate resources to health facilities, and to set targets for key CS indicators. While cultural attitudes account for some underreporting, much is because community leaders have not been trained in the importance of gathering health data and no tools exist to guide community-based health data gathering.

OVERALL PROGRAM STRATEGY

The Results Framework is depicted in diagrams at the end of this Section.

The main goal of the Partnership for Maternal and Neonatal Health is to reduce maternal and neonatal morbidity and mortality in West Pokot, Kenya. This will be achieved through four strategic objectives:

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

DOW will integrate essential HIV/AIDS and malaria interventions across these objectives.

DOW's overall strategy is to establish a continuum of knowledge, access, skills and care from households to hospitals in the West Pokot District that can promote maternal and neonatal survival and health. DOW's efforts will aim to implement the household-to-hospital model, best summarized in an ACCESS brief on Household-To-Hospital Continuum of Care (HHCC) of Maternal and Newborn Care. [1] This model is congruent with the Kenya Essential Package for Health (KEPH), the Kenya DRH policy, and Kenya's recently introduced Community Strategy for Delivery of Level One Services. DOW will actively incorporate interventions addressing malaria and HIV/AIDS across the Continuum..

The project's overall strategy will be implemented primarily through the use of three frameworks for addressing care behaviors related to maternal and neonatal morbidity and mortality, namely the **Minimum Activities for Mothers and Newborns (MAMAN)** framework, the HHCC model (described above), and JHPEIGO's MNHP three-delays model. DOW will also consider the use of some elements from the CHANGE Project's Maternal Survival Toolkit, Saving Newborn Lives and the SEARCH Training Manual for community health workers to augment program activities. Because of Kenyan MOH/Division of Reproductive Health (DRH) policy that precludes training TBAs and other CORPs in delivery or life-saving skills, DOW will not utilize these aspects of selected frameworks. Applying the MNHP three-delays model, DOW will address:

<u>Delay in deciding to seek care:</u> DOW will address this through BCIs to encourage and mobilize women (including by educating and mobilizing men) to seek facility-based prenatal, delivery, and postpartum/newborn services as well as messages on recognizing danger signs. Multiple partners will conduct these BCIs, including providers, TBAs, CHWs, and NGOs, FBOs, and CBOs. Delays in deciding to seek ANC and other 'portable' MNC services will be addressed through the provision of mobile outreach services. This delay will also be addressed through

[1] "The Household-to-Hospital Continuum of Maternal and Newborn Care." JHPIEGO, ACCESS, USAID. October, 2005. http://pdf.dec.org/pdf_docs/PNADE623.pdf

BCIs to increase the use of birth plans and to improve client satisfaction with care offered at facilities.

Delay in reaching care: DOW will address this by expanding the locations where essential MNC services are available, including ensuring dispensary-level delivery services and the consistent provision of safe delivery and Emergency Obstetric and Newborn Care (EmONC) services at health centers, as well as bringing key MNC services such as ANC and postpartum check-ups to the community itself through mobile teams. DOW will also reduce this delay by improving capacity for emergency transportation between health facilities.

Delay in receiving care: DOW will address this by improving facilities' capacity to provide indicated services, improving procurement systems for supplies, advocating for increased human resources at selected facilities, and improving skills to provide and supervise MNC services in a timely manner.

COMMUNITY STRATEGY

Through baseline assessment activities, it became clear that the link between facilities and communities was weak or non-existent in some cases. In order to augment outreach activities such as the mobile MNC clinics (described later in this section) that would facilitate linkages, DOW will provide stipends for five community health extension workers (CHEWs)—one per Division—in year two of the program. These CHEWs will be literate and bilingual and therefore able to communicate not only with DOW and the DHMT, but more importantly with the CORPS and serve as a voice for the largely Kipokot-speaking community. DOW believes the CHEWs will be an integral part of monitoring community-level activities and ensuring community buy-in of the project. CHEWs will report directly to DOW's BCC and M&E Coordinators and will work closely with the District Public Health Officer (DPHO) and District Public Health Nurse (DPHN) to coordinate community outreach activities.

I. CORPs

The MOH in Kenya seeks to adopt a community-based approach to health care through its Strategy for Delivery of Level One Services.[2] Within this strategy, community-based health workers are referred to as Community-Owned Resource Persons (CORPs). The MOH envisions CORPs to be selected by a coordinated process in which the community and local government have equal input. The MOH strategy suggests that CORPs are literate members of the community who may have had previous health experience, with CHWs being the most likely candidates. However, this poses a unique challenge for West Pokot where the majority of community services providers are not CHWs but rather non-literate TBAs. Therefore, DOW will work with a combination of CHWs and TBAs, depending on the availability of these cadres in each Division of the project area. Thus, for the purpose of our program, CORPs encapsulates both CHWs and TBAs (with emphasis on the latter) and will be referred to as such in the remainder of the document

Because it continues to be a marginalized district, which is often last to benefit from new government policies and initiatives, West Pokot is not among the districts in which the community strategy is currently being rolled out. DOW will nevertheless work with the West

[2] "Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services", Kenya Ministry of Health. June 2006.

Pokot DHMT to use the community strategy framework in the implementation of MNH program activities. The DPHN and DPHO, who are members of the DHMT, will work closely with DOW in the coordination, community mapping, recruitment, training, and supervision of CORPs in each of the five Divisions of the intervention area. Twenty-five CORPs will be selected from each supervision area and each CORP will provide education for and gather data from roughly twenty households. While DOW already has strong relationships with many CORPs through our well-established HIV and TB programs, further selection criteria are yet to be developed to facilitate the recruitment of the most qualified people to serve as CORPs for the MNH program. Once selected, these CORPs will develop necessary knowledge and skills through MNH trainings and follow-up supervisory visits organized by DOW in collaboration with the DHMT. Through continued advocacy and capacity building DOW will strive to seamlessly transfer leadership of the CORPs training program to the DHMT thereby initiating the implementation of the MOH Strategy for Delivery of Level One Services in West Pokot. In line with MOH policies, CORPs will serve on a volunteer basis, but DOW is exploring alternative incentives such as food support from DOW's agricultural program (established through our HIV work) and public recognition for their work.

CORPs will be trained to provide community education on the importance of FANC, HIV testing for PMTCT, identification of maternal and neonatal danger signs, making timely and appropriate referral to the nearest health facility for skilled management, and newborn and postpartum care. Key surveillance activities that could be carried out by CORPs include monitoring ANC attendance among pregnant women; recording delivery outcomes, malaria incidences, immunization coverage and completion; and monitoring use of ITNs. CORPs will report these statistics on a monthly basis to CHEWs. This information will then be shared with the DHMT, healthcare facilities and village chiefs thereby providing feedback to the community. It is likely that a system of pictorial reporting will be necessary, as DOW anticipates most of the CORPs will be non-literate.

While all CHEWs and CORPs will participate in reporting activities, a more formal community-based health information system (CBHIS) will be developed in year two and piloted in two of the five Divisions in order to demonstrate the need for stronger linkages between community MNH activities (including registration of births and maternal and neonatal deaths) and health facilities. DOW will work with village chiefs to supply aggregated community data on a quarterly basis in order to provided feedback to the community. DOW staff will work with CHEWs to monitor data quality on a regular basis. DOW will work with Both CHEWs and CORPs will play a key role in maternal and neonatal health activities and act as referral point persons between households and health facilities.

In addition to the central aim of CORPs-led community outreach and education, the community strategy will also incorporate the following appraoches:

CORPs activities will be augmented with public community meetings (*brazas*), incentive programs and other behavior change methods as part of the project's Behavior Change and Communication (BCC) strategy (described below).

In order to address access barriers to seeking care which is among the top three barriers identified by the KPC survey, DOW will support health facilities in establishing mobile clinics which will bring critical ANC, postpartum, and newborn check-ups, PMTCT, distribution of ITNs, and other "portable" elements of MNC.. Mobile clinics, described further below under

Innovative Approaches, are a proven successful model in West Pokot, first established by DOWs HIV/AIDS program (see Innovative Approaches section for more details).

II. HFCs

Health facility committees (HFCs) are formal bodies of four to six community members who are proposed and elected by the community and who govern each MOH health facility. The facility in-charge represents the MOH on this committee and serves as the secretariat. While some HFCs are more active than others, each is responsible for ensuring that facilities are functioning well, that government funds are used appropriately, and that the community's health concerns are addressed adequately. HFCs therefore have an important advocacy role to play on behalf of the communities they serve, and DOW will therefore train these committees in general MNC, HIV/AIDS, and Malaria issues, FGM sensitization, data collection and use, and behavior change messaging according to the schedule outlined in the Training Plan annex. In addition, DOW will meet with HFCs at the nine target health facilities on a quarterly basis in order to share aggregated community and facility MNC utilization data.

CAPACITY BUILDING

The program will build capacity of Ministry of Health (MOH) staff, local Nongovernmental Organizations and Faith-Based Organizations (NGOs and FBOs), to improve Maternal and Neonatal Health (MNH) through provision of education and services. To accomplish sustainable improvements in capacity for all these categories of partners, DOW will design a capacity building strategy that begins with assessments of baseline capacity among District Health Management Team (DHMT), Health Facility Committees (HFCs), staff at health facilities, and staff of partner organizations. For MOH partners, DOW will build capacity at the level of individual behaviors and skills relevant to providing MNC, HIV/AIDS, and malaria services. DOW will also build capacity to operate sustainable systems for supervising, monitoring, and supporting these services, with improvements in data systems, procurements systems, and facilities being able to plan for the implementation of new and/or expanded services. The program will strengthen the DHMT's capacity to implement health programs that operationalize MOH policies. DOW will achieve expected improvements through group training, on-site workshops and planning sessions, supportive supervision in implementing new processes, and other regular Quality Assurance/Quality Improvement (QA/QI) activities. Capacity goals for partner organizations are somewhat different; DOW does not anticipate conducting organizational development through this program, but does expect to build partner staff's technical knowledge and organizations' capacity for learning, as well as capacity to plan and implement community education and behavior change interventions in a broader set of health issues than they are currently addressing.

At this time local CBOs and FBOs in West Pokot have very limited capacity. As such, initially the primary role of local CBO and FBO partners will be to mobilize the community to participate in DOW/DHMT organized community education activities. However, through these initial activities DOW hopes to identify one or more local CBOs/FBOs with the potential to plan and implement community education and behavior change activities and build their capacity to do so.

BEHAVIOR CHANGE STRATEGY

The CSH program will implement Behavior Change Interventions (BCIs) that promote positive behavior change at the individual, household, and community levels. Behavior Change Intervention (BCI) interventions will address barriers in seeking and using MNC services in a timely manner, as well as those in practicing behaviors that promote MNH and reduce the impact of HIV/AIDS and malaria. DOW will also address behaviors at the facility level, helping providers identify and address non-resource barriers to providing quality MNC, HIV/AIDS, and malaria services. The outcomes of BCIs across the program at the individual, household, and community level will be monitored using indicators in the M&E Matrix and additional indicators to be defined with the DHMT. Facility level change will be evaluated using QI tools such as the Engenderhealth's COPE (client-oriented, provider-efficient) Handbook. It is expected that community norms and MOH capacity will change to create an enabling environment for behavior change that will positively impact MNH.

Through focus group discussions detailed earlier, DOW has begun to understand challenges community members encounter in accessing and utilizing MNH services. Due to unforeseen delays in project activities, which were mostly related to the untimely departure of the former Project Director and changes in key posts within the district MOH, DOW has not formalized a complete BCC strategy. In quarter four of the first project year, DOW will work with local organizations, MOH partners, and CHEWs and CORPs to elaborate on the sample BEHAVE framework presented below to design BCIs. The complete BCC strategy will be presented in the first annual report.

Because of the low status of women in the District, DOW will also design BCIs that involve men and other household members who may have more influence on the desired behaviors. DOW and its local partners have identified select behavioral objectives that promote improvements in indicators noted in the Monitoring and Evaluation (M&E) Matrix. Because this program aims to create change across the household-to-hospital continuum, DOW will implement select activities across the range of BCI approaches, including:

- Small group activities (e.g., supporting *barazas,* community meetings, led by CORPs)
- One-on-one interventions (e.g., training nurses to provide counseling and behavioral education at facilities; training CORPs to provide counseling and MNC education in the community and in households, as well as referral for HIV testing and Prevention of Mother to Child Transmission (PMTCT)
- Distribution, promotion, and subsiding of products and services (e.g. increasing outlets for MNC services through mobile teams; strengthening facilities' ability to provide Insecticide Treated Nets (ITNs) through Antenatal Care (ANC)
- Community mobilization (e.g., using NGO/FBO networks to promote use of MNC services, engaging chiefs and assistant chiefs to support use of MNC services and ITNs)
- Centralized information and referral (e.g., facilities' ability to provide consistent MNC messages)

DOW's BCIs will build upon existing MOH efforts to educate community members about health-seeking behaviors. Specifically, it will integrate curricula developed by the MOH pertaining to educating women about the importance of seeking ANC and delivering with a

skilled birth attendant. This will complement the existing MOH priorities for achieving country-wide goals of lowering maternal and infant morbidity and mortality.

In order to meet to above-mentioned Behavioral Change (BC) goals, DOW will also develop a series of messages that will become the core of our BCI strategy. Further studies with other target groups in the community such as husbands, village chiefs, and elders will be considered. Additional planned assessment activities include client satisfaction surveys and provider self-assessments to be carried out in the summer of 2007. Information gathered from these exercises, along with feedback from beneficiary communities will then be used to plan a comprehensive BC strategy. Tools for these assessments and facilitation guides for educational sessions and *barazas* will be adapted primarily from the COPE Handbook and existing MOH curricula. The CHANGE Project's Maternal Survival Toolkit and Saving Newborn Lives' Kangaroo Mother Care will also be consulted.

Stakeholder Involvement

Key local stakeholders have been involved in the design and initial implementation of DOW's Child Survival and Health (CSH) program since its inception. Local leaders and community and facility-based health workers have given invaluable input into the priorities and key BC messages of this project through guided discussions and development of the KPC tool. Upon completion of the baseline assessments, DOW held a stakeholders meeting to present the findings from these surveys. At this meeting, participants discussed key barriers to seeking and accessing care and identified dissemination of BC messages about MNC as a priority intervention. As noted above, input from future studies with other community groups and ongoing solicitation of stakeholder feedback will be used in designing BCIs.

Training for Behavior Change

Health Providers at the focus health facilities will be trained to counsel ANC patients, pregnant women, and mothers of young children on the key BC subjects. Trainings for health providers will focus on integrating BC messages into health visits and on encouraging women to increase health-seeking behaviors for themselves and their children. Focus health facilities will become distribution points for ITNs and vouchers.

CORPs will be identified by village leaders and health facilities to be trained in identifying and educating women and men about danger signs in pregnancy and post childbirth. They will also be taught to hold educational *barazas* to inform their communities about such subjects as malaria prevention, the importance of nutrition for pregnant women and newborns, and the new health initiatives being implemented at local health centers. For some activities such as strengthening breastfeeding practices, CORPs will be trained to identify "positive deviants" in their respective communities and promote them as role models for other mothers in those communities.

DOW will train members of the DHMT and other MOH employees to monitor and evaluate the effectiveness of BCIs. Through ongoing monitoring, as well as midline and endline assessments, DOW will build the local capacity of West Pokot to evaluate the impacts of health interventions and community education. In order to monitor behavior change in facility staff, supportive

supervision and supervision checklists adapted from the COPE Handbook will be employed. Many of the approaches for evaluating providers overlap with QI strategies mentioned later in this section.

A basic BEHAVE framework for various stakeholders is listed below. This framework, along with other BC strategies and tools will be finalized in quarter four of the first project year.

Table 7: BEHAVE Framework for BCIs

Priority and Supporting Groups	Behavior	Key Factors	Activities
In order to help:	***To:***	***We will focus on:***	***Through:***
Pregnant Women	Attend Focused ANC visits while pregnant	Barriers: Travel, cost, trust in facility staff and quality of care. Facilitators: Desire for healthy infant	Education activities, initiation of incentives such as voucher for no-cost delivery services or transportation
	Deliver with a skilled birth attendant	Barriers: Distance, trust in facility staff and quality of care, lack of knowledge of specific benefits. Facilitators: Desire for healthy outcome; relative accessibility of clinical services.	Education about three delays model, improving health center capacity and quality of care, initiation of voucher system.
	Seek HIV counseling and testing services	Barriers: stigma about HIV, lack of knowledge of benefits of PMTCT Facilitators: Desire for healthy outcome for mother and newborn	*Barazas,* ANC visits, semi-mobile clinics
	Seek malaria control services, including Intermittent Preventative Treatment (IPT) and use of ITNs	Barriers: knowledge of malaria; cost of ITNs. Facilitators: PSI distribution; desire for health outcome.	*Barazas,* ANC visits, initiation of ITN distribution program.
Women in labor	Seek postnatal care	Barriers: Travel, cost, trust in facility staff and quality of care. Facilitators: Desire for healthy infant	*Barazas*, improving health center capacity and quality of care, initiation of voucher system.
	Immediate exclusive breastfeeding	Barriers: knowledge regarding nutrition cultural practices. Facilitators: desire for healthy infant; interest in	*Barazas*, improving counseling skills of health providers and TBAs.

Priority and Supporting Groups	Behavior	Key Factors	Activities
In order to help:	***To:***	***We will focus on:***	***Through:***
		new information	
Family Members	Seek appropriate health services for pregnant women and mothers of newborns	Barriers: knowledge of benefits of MNC care, lack of male involvement Facilitators: Desire for healthy outcome for mother and newborn	Development of birth plans, education about three delays model, sensitization workshops for men
Community Members	Advocate for improved MNC practices at the community and facility level	Barriers: lack of opportunities to dialogue Facilitators: Improving linkages between communities and facilities	Stakeholders' meetings, community education about the right to health
	Implement a community-based health management information system	Barriers: no formal reporting system Facilitators: opportunity for community to know its health status	Work with DHMT to assist community in the design and implementation of a CBHMIS system
CORPs	Counsel women on a variety of MNH topics	Barriers: no formal health training, cost Facilitators: interest in learning	Training in general MNH topics
	Initiate timely referral of obstetric and neonatal complications	Barriers: fear of losing livelihood Facilitators: community recognition for saving a woman's life	Provide TBAs education training such as three-delays model
	Provide support to women in caring for newborns	Barriers: knowledge on newborn care Facilitators: Desire for a healthy outcome for newborn	Education on basic topics such as cord and thermal care
Health Facility Staff	Provide quality delivery services	Barriers: knowledge on MNC Facilitators: Desire for a healthy outcome for mothers and newborns	Training on safe delivery practices, supportive supervision, mobile clinics
	Initiate timely referral of obstetric and neonatal complications	Barriers: Lack of transportation, knowledge on EmONC Facilitators: Desire for a healthy outcome for pregnant women	Education about three-delays model, Vehicles for emergency transport
	Provide mother/baby friendly services	Barriers: Workload, low staff morale	COPE assessment, implement

Priority and Supporting Groups	Behavior	Key Factors	Activities
In order to help:	***To:***	***We will focus on:***	***Through:***
		Facilitators: Desire to assist patients	supportive supervision
DHMT	Prioritize improvement of MNC services throughout the district	Barriers: knowledge on MNC topics, lack of equipment Facilitators: Desire for healthy outcomes for mothers and newborns	Provision of training and equipment, on-site supervision
	Improve HMIS	Barriers: record keeping system, data analysis capability Facilitators: interest in understanding health of population	Training on data collection and analysis, regular record review, maternal death audits
	Provide appropriate supervision for MNC services at district facilities	Barriers: lack of teaching opportunities, recognition Facilitators: interest in improving MNC	Training in supportive supervision, regular health facility monitoring visits

QUALITY IMPROVEMENT STRATEGY

The QI Strategy for this program will involve the establishment of Quality Assurance systems to be implemented at the facility level focusing on the following key methods:

- Use of high-quality curricula and job aids
- Use of QI tools
- Regular review of quality data for decision making

Curricula will be compiled and created by the DOW team in conjunction with MOH partners and with feedback from local Stakeholders. QI tools will be used throughout the project to ensure consistency. Quality data will be reviewed in meetings of project staff and partners on an ongoing basis.

Currently, clinical supervision in West Pokot takes place on an ad hoc basis. Providers report caseload and complications to the DHMT in Kapenguria in the form of montly reports, which are rarely checked against registers to ensure quality in reporting. Occasional refresher courses are held on a various topics, but follow-up supervisory visits are rarely conducted due to demand on staff time and lack of a formal system to monitor consistency and quality of MNH services. As a result, recently trained staff often do not know how to operationalize new skills when they return to their respective health facilities. This in turn leads to inappropriate clinical practice or loss of

skills altogether. DOW will, therefore, work alongside the DHMT and MOH teams to implement a structured but simple system of clinical supervision.

The main QI tools that DOW will use for facility-based QI is the Quality Improvement for Emergency Obstetric Care Toolbook (an adaptation of the COPE Handbook) and the original COPE Handbook. COPE is both a process and a set of tools designed to help healthcare staff at service delivery sites continuously assess and improve the quality of health services and is built on a framework of clients' righs and staff needs. COPE tools include self-assessment guides that contain key questions based on international clinical and service standards (e.g. client record review checklist, clients' rights checklist, staff's rights to facilitative supervision and management checklist), a client interview guide, and an action plan. Project staff will work with the DHMT to adapt these tools as necessary in order to measure quality improvement of facility processes on a regular basis. For example, "near-miss" and maternal death audits will be used to teach providers how to improve clinical response and management of obstetric emergencies. The focus of any feedback will be on supportive supervision, so that all involved in the project develop an interest in providing high quality work, and so providers learn to appreciate and value supervision. DOW has had success using this model in its HIV/AIDS programs, which conducts regular supervisory visits to participating health facilities and gives regular feedback to project partners and health providers. In addition to COPE tools, pre- and post-tests will also be used at DOW-led trainings to assess individual learning and assure the quality of these courses. Individual feedback and remedial training can then be given during follow-up supervisory visits.

Community COPE is an extension of COPE and helps supervisors and staff to learn how community members feel about the services the facility provides; to gather community members' recommendations for improving quality services; and to determine ways to encourage community members to participate in and take ownership of quality improvement efforts both at the facilities and in the community. DOW will use community COPE to strengthen linkages between health facilities and communities by facilitating a dialogue between providers and community members. This will not only encourage mutual learning and promote community initiatives for behavior change, but also demonstrate genuine respect and concern for community problems and aspirations. The DOW team has begun planning of the community dialogue, which will take place in quarter four of the initial project year. It should be noted that due to literacy issues, verbal pre and post-tests will sometimes be used when working with community members and beneficiary groups.

INNOVATIVE APPROACHES

I. Mobile Outreach Clinics for Delivery of MNH Services to Inaccessible Populations

In order to reach HIV-positive individuals who have limited access to the District hospital, DOW has initiated mobile outreach clinics. A team of clinicians and social workers from the HIV/AIDS clinic at Kapenguria District Hospital (KDH) visit one of the district's four health centers each week to provide ARVs, monitoring, and psychosocial support. Clinicians take blood samples that are brought to AMPATH's reference laboratory in Eldoret; social workers visit patients at-risk of non-adherence and convene support groups. Mobile outreach patient data is entered in the same database as the KDH HIV/AIDS clinic so that information is stored in a central location.

Since instituting mobile outreach clinics, DOW has observed a rise in the number of enrolled HIV-positive patients who live far from the Hospital. The number of patients defaulting on follow-up visits has decreased, and use of mobile outreach clinics has enabled on-site mentorship in HIV/AIDS care for health center clinicians. DOW has developed an innovative approach to meet the challenges of providing rural HIV services by building on our existing partnerships with AMPATH and the MOH.

In preliminary focus group discussions, women of reproductive age cited distance to the District Hospital and unavailability of regular ANC and postpartum care services at the rural health centers as reasons for not seeking care during and after pregnancy. Because use of mobile outreach clinics has proven effective in increasing the number of patients enrolled in HIV/AIDS care and treatment, we are confident this model can be extended to MNH services. Mobile outreach clinics will be aimed at reaching rural women in the intervention area who otherwise have difficulty accessing MNH-related services. Through training, provision of a vehicle and equipment, and implementation experience in our HIV/AIDS program, DOW will enable two-person nursing teams from each health center or from KDH to conduct MNC mobile outreach clinics on a monthly basis. In collaboration with the DHMT, DOW will train and support facility staff to provide an integrated outreach, which includes ANC, postpartum, and newborn check-ups, PMTCT, distribution of ITNs, and other "portable" elements of MNC. These mobile teams will also provide health information to the community and referrals to facilities for individual follow-up care. A Mobile Clinic Coordinator will be hired by DOW in year two to oversee the coordination of the mobile teams, but activities will be coordinated with the DPHN's office. Mobile teams will share a vehicle and divide coverage days among them. Locations for mobile teams to visit will be determined in partnership with community leaders, local providers, and other partners to ensure maximum expansion of coverage. Data on the number and types of visits will be collected by the semi-mobile outreach team with DOW staff initially leading the process of aggregating the data with the goal of transfering the responsibility to facility staff to incorporated into the facilities' routine reporting system as it is established. Semi-mobile clinics will be initiated as a pilot program at the end of year two.

II. Use of TBAs as Referralists and Change Agents

In communities where literacy remains low, advocacy and education provided by TBAs, who are respected community members, can be important factors in influencing the decision for pregnant women to seek ANC and safe delivery services. Building on our experience with TBAs as PMTCT and TB treatment referralists, DOW will train TBAs (also referred to in this document as CORPs) in MNC-related topics including recognition of maternal and neonatal danger signs and the three-delays model to encourage safe delivery practices and referral in the event of an obstetric emergency. Because of their status in the community, TBAs could also potentially serve as change agents to help stop the practice of FGM among girls and young women, which is clearly an underlying cause of maternal mortality and fetal death in the District. However, past efforts by other organizations to educate TBAs around this issue have been largely unsuccessful in community-level change in attitudes and behaviors regarding FGM. Respecting local cultures and norms, DOW will therefore need to study the problem further and solicit further feedback from community members before initiating any BC interventions.

III. Voucher System for Delivery Services

See Operations Research in M&E Section E5.

SUSTAINABILITY STRATEGY

The overall goal with respect to sustainability in this project is improved capacity of the health system to provide quality maternal and neonatal care and improved patient-provider relationships. In the community, the overall goal is a permanent change in community attitudes towards formal healthcare resulting in increased utilization of services.
This will be achieved through three main objectives:

I. Strengthen and leverage existing facilities, services, and human resources
The focus will be on expanding, extending, and improving the capacity of existing points of care and the activities of existing CORPs, as well as linking these stakeholders and points of care in order to maximize appropriate use of MNH services. All partners will be trained in managing and supervising, as well as collecting data, so that the capacity to plan and implement such programs in the future is transferred.

II. Ensure community buy-in of planned activities
At every step of planning and program implementation, community members will be encouraged to participate. For example, local medical students and nurses were hired as supervisors and enumerators for the KPC baseline survey to ensure appropriate use of local language and culture. In addition, all staff hired or trained as part of this program will be Kenyan nationals, and all partners are already active in the program location. This strategy is particularly important in West Pokot given the marginalization of the Pokot people by Kenyan society and the lack of understanding about the Pokot culture among many providers working in the formal health system.

III: Share local experience in national and international forums to advocate for improved MNH policies and expand coverage of proven best practices
In order to ensure sustainability of the project, DOW staff will utilize lessons learned from other CSH programs and try whenever possible to use existing resources such as MOH facilitators and training guides when conducting program activities. DOW will also build on our experience in West Pokot to implement proven strategies to increase access to MNH services such as semi-mobile clinics. DOW will also regularly advocate at the national, provincial, and district levels for more material and human resources in order to sustain DOW's efforts. Finally, DOW will dialogue with Kenyan counterparts at multilateral and bilateral agencies such as UNICEF and USAID about key policy issues that affect project implementation, and present program activities and accomplishments at global health conferences.

CSSA FRAMEWORK

More specifically, the Partnership for Maternal and Neonatal Health aims to track the sustainability of changes brought forth by the project through,the Child Survival Sustainability Assessment (CSSA) framework.

CSSA Component I: Health Outcomes
The combined impact of the project's activities including improvements in quality of healthcare services at health facilities, expansion of facility based services in MNC, HIV/AIDS and malaria,

introduction of mobile-clinics to combat access barries and a comprehensive community education and behavior change campaign are expected to lead to a significant improvement in health outcomes especially relating to maternal and neonatal care. The project has the advantage of working in the remote District of West Pokot where few other initiatives are taking place at the same time which will allow a very acurate measure of changes in health outcomes.

CSSA Component II: Healthcare Delivery and Utilization
The project's farthest reaching and most sustainable impact is expected at the health facility level where the majority of the project's effort is focused. Through extensive high quality training of existing staff and a Quality Improvement initiative which will see the establishment of a Quality Assurance system at all health facilities DOW is optimistic in it's ability to bring permanent improvement in the quality of care provided by the healthcare facilities in West Pokot. The Quality Improvement initiative will be conducted in a highly particpatory manner ensuring ownership by facility staff and input from community members by strengthening existing Health Facility Committees which are comprised of health facility staff and prominent community members. Particular attention will be paid to creating systems that will withstand high levels of turnover among facility staff, one of the area's greatest challenges. Concurrent community outreach and awareness campaigns informing the community of the changes taking place in facility services are expected drive higher utilization rates.

Components III & IV: Organizational Capacity and Viability
Building the capacity of DOW's primary partner, the DHMT, is an essential goal of the project. Challenging issues to be addressed include lack DHMT officials' dedication to their mandate to protect the health of the West Pokot population, high turnover and zero accountability resulting from general neglect of the region by the rest of the country including the national Minisitry of Health and other government and private entities.

Component V: Community Capacity
The project will attempt to address the low level of civil society organization in the region by engaging existing loosely organized local organizations in community mobilization efforts with the aim of identifying those with the potential to continue some of the project's activities given some capacity building support.

Component VI: Enabling Environment
There are many socio-economic factors which create significant challenges to sustainable development. Some of the key factors include: Cultural customs (such as FGM) with significant negative health consequences, poverty, language barriers, low levels of literacy and general neglect of the region by Government and the private sector.

Indicators to measure the project's progress will be finalized once organizational capacity assessments have been completed. Some will likely be drawn from the project's existing monitoring and evaluation matrix with additional indicators developed if necessary, through methods appropriate to the type of indicators needed.

COLLABORATION WITH PVOs AND PARTNERS IN WEST POKOT

DOW's current HIV/AIDS activities in the District provide synergies for the program. The past two years of HIV/AIDS programming, in which DOW has identified and enrolled over 850 HIV-

positive people and their families in comprehensive treatment and support services, have given DOW a foundation of credibility in the District and proven that DOW is able to work with MOH and community partners in the region. DOW's current activities are governed by an MOU between DOW and the Provincial MOH/DHMT (see Annex 3). DOW's ongoing programming provides opportunities for linkages to enable activities to be most effective. For example, DOW already has worked with many of the providers who would be trained through the program, and understands strengths and weaknesses of the District's resources and infrastructure.

After the MOH, the major provider of health services is the Catholic Diocese of Kitale, based in Trans Nzoia District and also covering the West Pokot District. The Catholic Diocese sponsors the Ortum Mission Hospital, operates five dispensaries, and provides the only outreach health services in the District, operating mobile clinics from three sites in the program location. From these sites, mobile clinics provide ANC, well child service, and other services at 42 stations. The Diocese credits these mobile services with increased utilization of its facility-based MNC services. DOW plans to consult with the Catholic Diocese, and with the staff of Ortum Mission Hospital in particular, on the expansion of MNH services at Kapenguria District Hospital and the focus health centers, and the expansion of the mobile clinic model to unserved areas. By learning from the strengths and challenges of this existing model, DOW will be able to maximize the effectiveness of its BC and CSH interventions.

Another FBO active in health in the District is the Evangelical Lutheran Church in Kapenguria (ELCK), which operates in the Diocese of West Pokot through 200 congregations. The ELCK has opened two health dispensaries in the Sigor Division, and will open a third in Kasei (Kacheliba Division). ELCK recently hired an HIV/AIDS coordinator to run community mobilization activities, including training TBAs and TOTs in the basics of HIV/AIDS. These TBAs and TOTs now hold sensitization sessions at *barazas,* congregational meetings, and schools in the program location. DOW will integrate ELCK providers into trainings on relevant subjects, such as PMTCT. DOW will also work together with ELCK to ensure synergy of all activities in regions where both organizations are working.

Two local NGOs with strong networks in the West Pokot District are Kiletat and the Pastoralist Area Development Organization (PADO). Kiletat is comprised of 30 women's groups across the District, whom it assists by providing micro-loans, organizational and management training, and seminars in issues as HIV/AIDS, FGM, early forced marriage, and domestic violence. PADO works with pastoralist communities, empowering marginalized people through capacity building and sustainable marketing. PADO also works with 11 cooperatives in addressing HIV/AIDS and gender inequity. Representatives from Kiletat and PADO will be included in trainings for community leaders and will be encouraged to teach their network members about MNC activities. These NGO networks will also be encouraged to invite their membership to *barazas* and other mobilization events convened by the DOW project. This will increase the impact of DOW's program among beneficiary communities, while also building the capacity of these local NGOs.

ROLES OF DOW PARTNERS

DOW has selected AMPATH, PSI, Kiletat, PADO, and ELCK as partners in the program. DOW has selected the international partners for their capacity to assist efforts to promote uptake of MNC services, particularly those related to HIV/AIDS and malaria. Local NGO and FBO partners have been selected because of their community networks and credibility, and because

their ongoing operations make it likely that they will sustain additional activities in which DOW trains them. The roles of these partners are described in Table 8 below. Other organizations will be enlisted for trainings as needed.

Table 8: Intended Roles of Program Partners

Partner and/or Collaborator	Role within project	Expected Outcome
AMPATH	Provide guidance and support in implementing PMTCT protocols and activities in focus health facilities	Lower MTCT rates and improved quality of HIV care in ANC and maternity care.
PSI	Provide ITNs for distribution at focus health facilities and IEC and training materials about malaria in pregnancy	Lower rates of Malaria in pregnancy and among children < 12 months
Kiletat	Help to organize educational seminars for beneficiaries; mobilize membership to attend program-related *barazas* and other community mobilization activities.	Expanded impact of program among women of child-bearing age
PADO	Help to organize educational seminars for beneficiaries; mobilize membership to attend program-related *barazas* and other community mobilization activities.	Expanded impact of program among women of child-bearing age
ELCK	Share experience of ANC semi-mobile clinics and help to organize educational seminars for beneficiaries	Better uptake of training information and improved quality of MNC, which in turn will lead to higher utilization of these services
MOH/DHMT	Main project partner. Become an active participant in decision-making around project priorities and progress evaluations. Make staff available for trainings when necessary, and provide assistance and supervision to MOH staff working in focus health facilities.	Integration of all interventions into the Ministry of Health District-wide health priorities. Increased sustainability and impact of all activities.

TRAINING PLAN

DOW has divided training activities into two types—facility-based training for clinicians and community-based training to address behavior change. Details on type of training, quarter in which it will be conducted, topic, and number of participants to be trained can be found in the training plan in section E8 of the DIP. Training activities will be implemented in three phases. Phase I entails training of clinicians in specific MNC skill areas to enable them to provide quality services at target facilities. Most of these trainings will be done in the first and second year of the project life. The second phase will involve training of community health workers in selected MNH, malaria, and HIV/AIDS-related topics in order to create demand for services at the target facilities, which will be initiated at the end of the second year of the project. Phase III will

involve refresher training as necessary on the aforementioned topics for both facility-based staff and CORPs.

I. Facilty-based Training Activities

As reported earlier, the HFA demonstrated underutilization of maternal and neonatal health services. While it was clear that lack of equipment and supplies and insufficient staffing were contributing factors, DOW felt it necessary to further investigate whether lack of clinical training hampered the ability of health care workers to provide quality MNH services. In March 2007, DOW conducted a rapid training assessment in target health facilities to identify gaps in clinical skills. While most trainings conducted in the last year focused on HIV/AIDS (largely due to DOW's prior efforts in this technical area), the training assessment revealed that most providers are not proficient or up-to-date in the skill areas that contribute to the reduction of maternal and neonatal morbidity and mortality. These areas include family planning, emergency obstetric and and neonatal care, IMCI, malaria in pregnancy, infection prevention, facilitative supervision, and logistics management. In addition, it is clear that client education at the facility level does not take place regularly because providers do not have adequate knowledge on important MNH-related topics.

Since clinical training will be a large component of DOW's program activities, the training approach will entail the application of various training methodologies. Competency-based sessions accompanied by the use of anatomic models (e.g. a child-birth simulator), will ensure proficiency in skills acquisition. Each facility-based training will be followed by two supervisory visits—one within a month after the training and the other after six months—to ensure that clinicians are routinely and correctly practicing newly acquired skills. In instances where case load may not be adequate within the district, alternate sites within the Province will be utilized. DOW will coordinate with the DHMT to conduct these trainings and enlist several key individuals affiliated with DOW's current program activities to serve as training facilitators. This includes the MNH Project Director, Eunice Okoth, a newly transferred OB/GYN at Kapenguria District Hospital, and Dr. Hillary Mabeya, Chariman of the OB/GYN department and Moi Teaching and Referral Hospital and DOW-Kenya board member. Additional facilitators within the district health system will be recruited if needed. Where further expertise is required, DOW will source MOH trainers form the Provincial or National level or from technical partners within Kenya such as JHPIEGO or UNICEF. Training curricula will be adapted from existing MOH curricula such as the Essential Obstetric Care Manual for Health Service Providers in Kenya except for specialized topics for which there are inadequate training materials such as the clinical management of FGM-related complications. For these special topics, internationally accepted curricula will be utilized.

II. Community-based Training Activities

DOW's BCC and Training Coordinators will work together to adapt training materials noted in the BCC strategy and according to the community strategy mentioned earlier.

TECHNICAL ADVISORY GROUP

While DOW is working closely with the MOH on every aspect of the MNH program planning and implementation, there are times when further technical assistance (TA) will be required. TA will be sought on two levels—from headquarters in New York and from field staff in Kenya. DOW-USA will consult with the ACCESS and POPPHI projects as needed to further discuss implementation of OR strategies and how to overcome challenges to implementing the HHCC continuum or in introducing new skills such as AMSTL and PAC. DOW-USA will also continue to partner with the Averting Maternal Death and Disability Program (AMDD) at Columbia University with whom DOW partnered, along with UNICEF to adapt the HFA to the local Kenyan context. DOW-Kenya has held regular meetings to seek guidance from PSI, UNICEF, AMPATH, and the OB/GYN department at Moi Teaching and Referral Hospital. More specifically, DOW worked with UNICEF to discuss the feasibility of a community-based newborn care pilot and shared culture-specific challenges to using bednets with PSI in order to find a more appropriate ITN for the West Pokot District. DOW-Kenya has also held coordination meetings with partners and stakeholders including the Division of Reproductive Health (DRH) at the MOH, Population Council, and APHIA II. These organizations will continue to serve as an informal technical advisory group (TAG) that DOW will continue to consult when the need arises. DOW will also attempt to convene biannual group meetings of the TAG either in West Pokot or Nairobi, but this has proven difficult due to conflicting schedules of key individuals and geographic distance. If group meetings continue to be challenging to organize, DOW will provide biannual updates by email to members of the TAG and solicit feedback in this manner.

CONTRIBUTION TO CSHGP PROGRAM RESULTS

Program objectives and activities will advance CSHGP objectives. Interventions will contribute to CSHGP Program Results (PR) 1, 2 and 3 by increasing use, coverage, and quality of CSH interventions that will improve MNH, and thus child survival:

PR1: Improved Health Status of Vulnerable Target Populations
PR1.1: The program will increase community knowledge about MNC, HIV/AIDS, and malaria issues, and mobilize communities for increased use of essential health services.
PR1.2: The program will increase the scope of health services at focus health facilities, and improve quality of services through refresher training and ongoing support. The program will also increase health services available at the community level through mobile outreach services.
PR1.3: The program will improve partnerships between communities and MOH, and strengthen capacity of communities, local NGOs, an FBO, and MOH to address MNH, HIV/AIDS and malaria.

PR2: Increased Scale of Health Interventions
PR2.1 The program will ensure that a greater percentage of the population is reached by essential MNH, HIV/AIDS, and malaria interventions by creating partnerships between MOH, local NGOs/FBO, and community members and using the expertise of key PVO partners.

PR3: Increased contribution of CSHGP to the global capacity for child survival and health
PR3.4: The program will enable DOW to scale up proven health interventions, bringing capacity building tools, innovative approaches, and other programming that has been supported by USAID and tested by PVOs in Kenya to a new geographic area.

CONTRIBUTION TO USAID MISSION AND PROGRAM RESULTS

The program will advance objectives in the Mission's Integrated Strategic Plan for 2001- 2005 (extended to 2008).[3] The program will contribute to these Intermediate Results (IRs):

IR3.1: Improved enabling environment for the provision of health services
IR3.1.3: The program will improve quality of health services at focus health facilities, as well as those delivered by facility providers in the community, through strengthening of facilities, increasing the scope of services, and training providers in practices endorsed by USAID, PVO partners, and MOH.

IR 3.2: Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS
IR 3.2.2: The program will enlist a network of local NGO/FBO partners, as well as MOH staff and CBHRPs, in BCIs to ensure increased knowledge and practice of HIV prevention behaviors.
IR 3.2.3: The program will strengthen the ability of health facilities to screen for and respond to HIV/AIDS and STIs among pregnant women.

IR 3.3 Increased customer use of FP/RH/CS services
IR 3.3.1: The program will expand availability of RH/CS services, particularly those advancing MNH.
IR 3.3.2: The program will include extensive community education and mobilization efforts to increase demand for and use of facility-based RH/CS services.
IR 3.3.3: The program will apply best practices from PVO and MOH RH/CS interventions to the program location, enabling improved programming for MNH and CS in the West Pokot District.

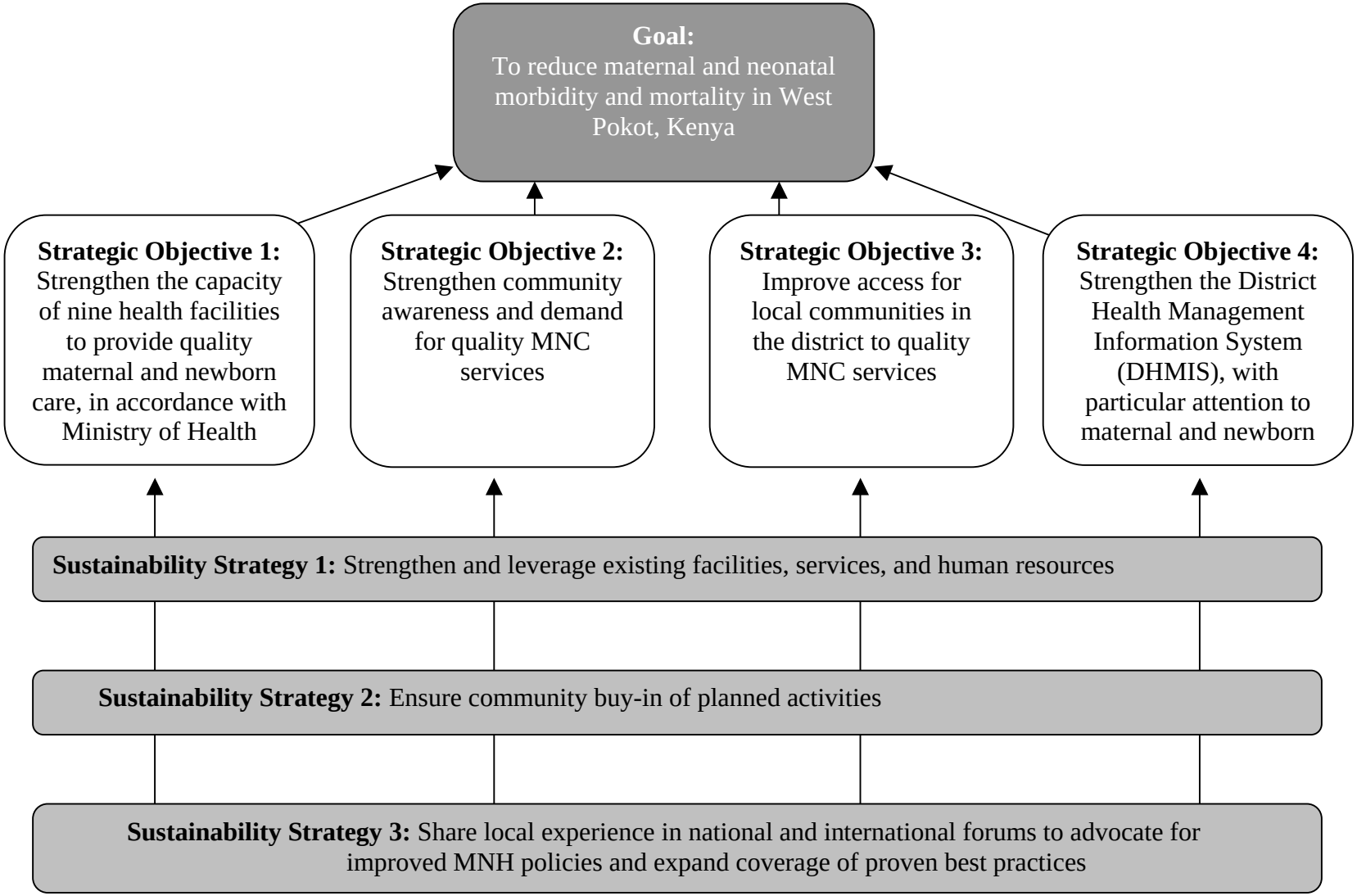
COLLABORATION WITH USAID MISSION AND MISSION SUPPORTED PROGRAMS

During program development, DOW discussed program foci and likely activities with of the USAID/Kenya Mission. The program addresses an area of Kenya identified by USAID staff as marginalized and in need of additional interventions and support. Throughout the program, DOW will communicate regularly with USAID mission staff, including soliciting and enabling Mission staff's active participation during mid-term and endline evaluations. USAID Mission staff, particularly Dr. Sheila Macharia, the Child Survival Advisor, will continue to be informed of strategic directions and approaches being used by the program, and asked to provide feedback to major decisions. Regular communication will be ensured both through phone and email conversations, and visits to the Mission office in Nairobi. All tools, resources, and reports developed through the program will be shared with USAID Mission staff in draft and final form, and Mission staff will be invited to partner meetings convened by DOW. DOW has developed the Partnership for Matneral and Neonatal Health with guidance from achievements of USAID-supported PVOs in Kenya. DOW will collaborate with PSI's ITN distribution network in the program location. DOW will also use resources developed by PATH and other PVOs as

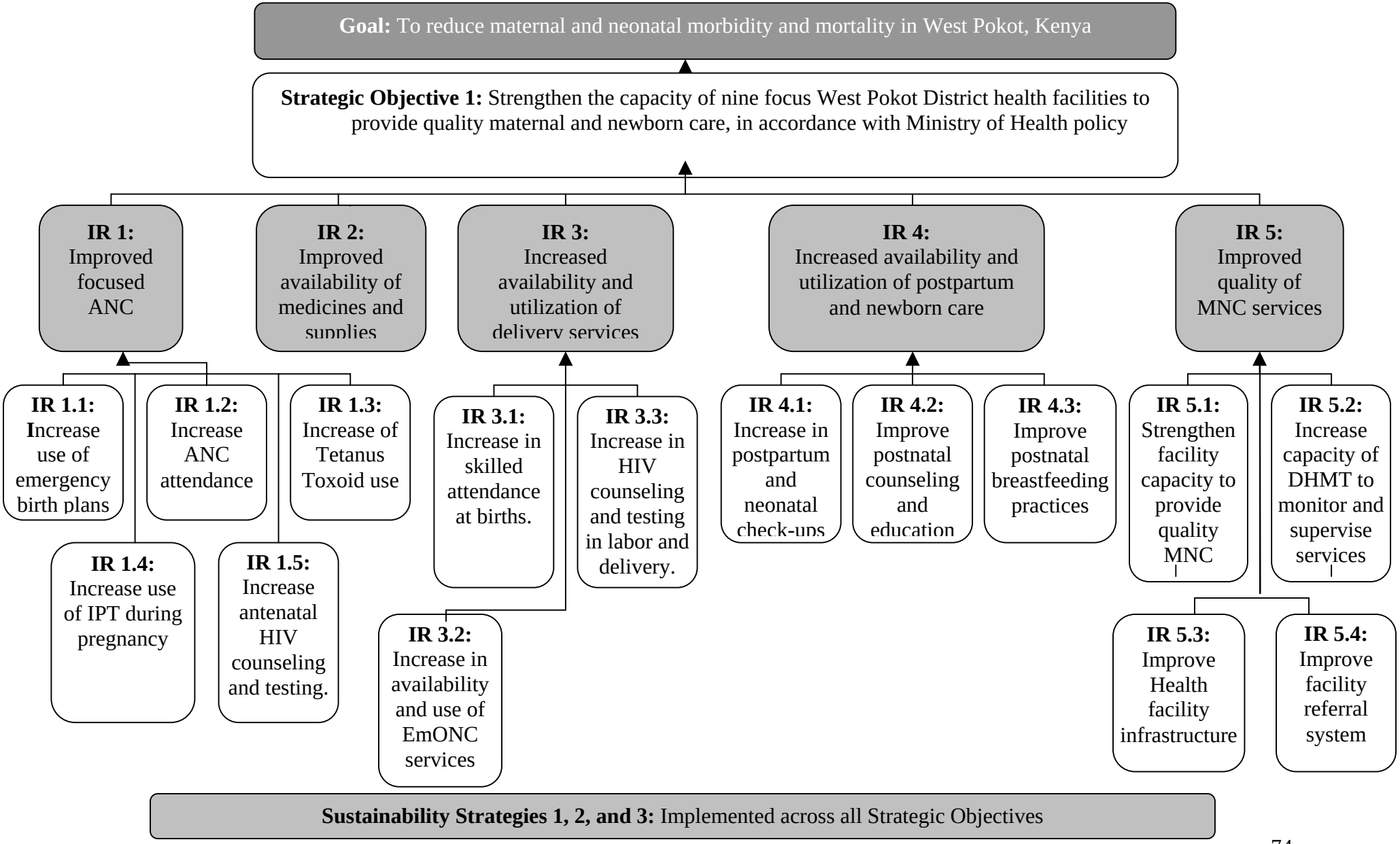
[3] USAID/Kenya Integrated Strategic Plan 2001-2005.

appropriate. DOW's program approaches will be guided by best practices identified by the Population Council's Safe Motherhood Demonstration Project. Other USAID-supported programs whose resources were used in developing approaches include the MHHP and Save the Children's Saving Newborn Lives program. DOW will also be an active participant in the CSHGP PVO network within Kenya and continue to share lessons learned with future grantees active in the region.

DOW-Kenya Results Framework with Sustainability Strategy

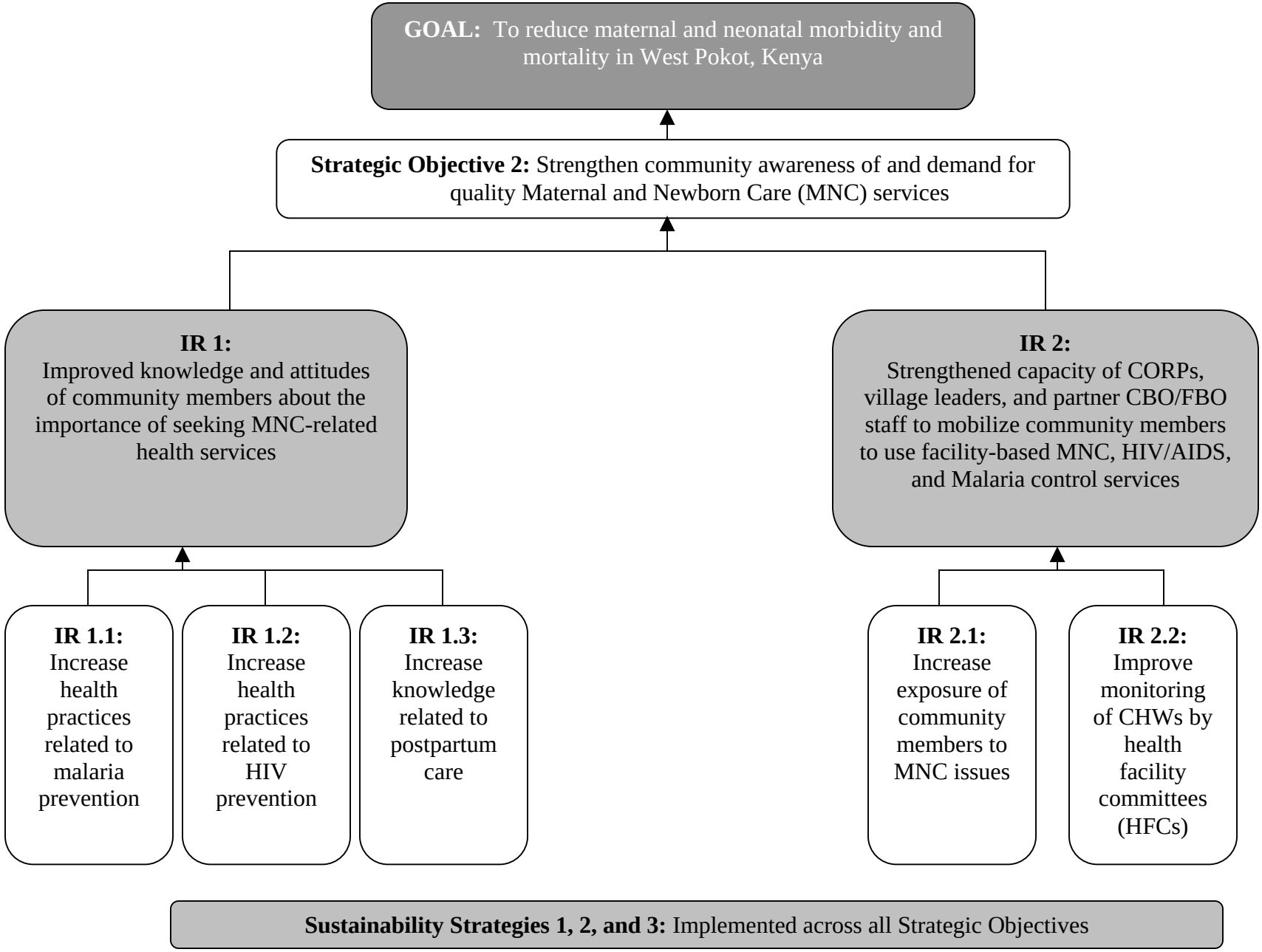


DOW-Kenya Results Framework (Strategic Objective 1)



* For process indicators see M&E Plan

DOW-Kenya Results Framework (Strategic Objective 2)



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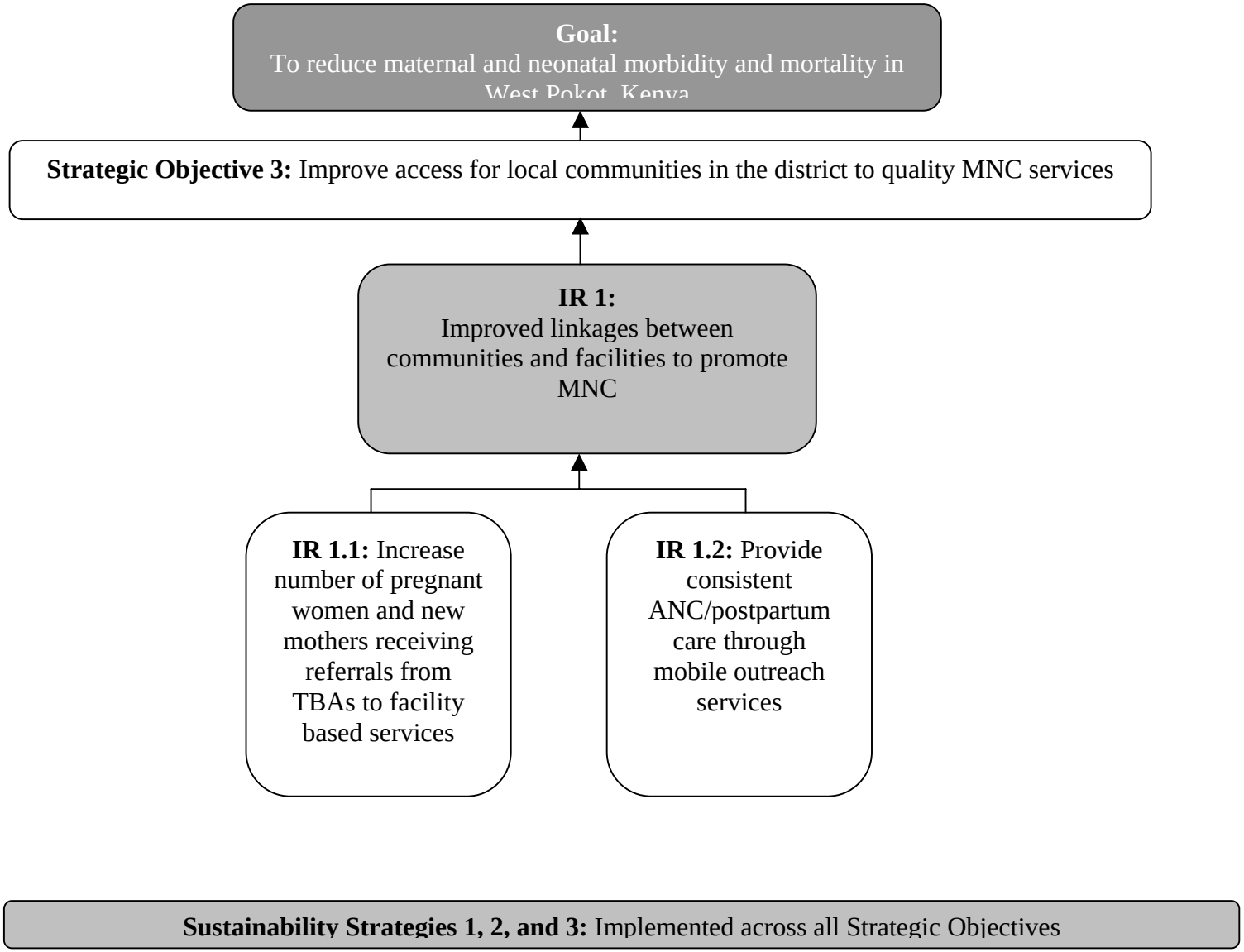
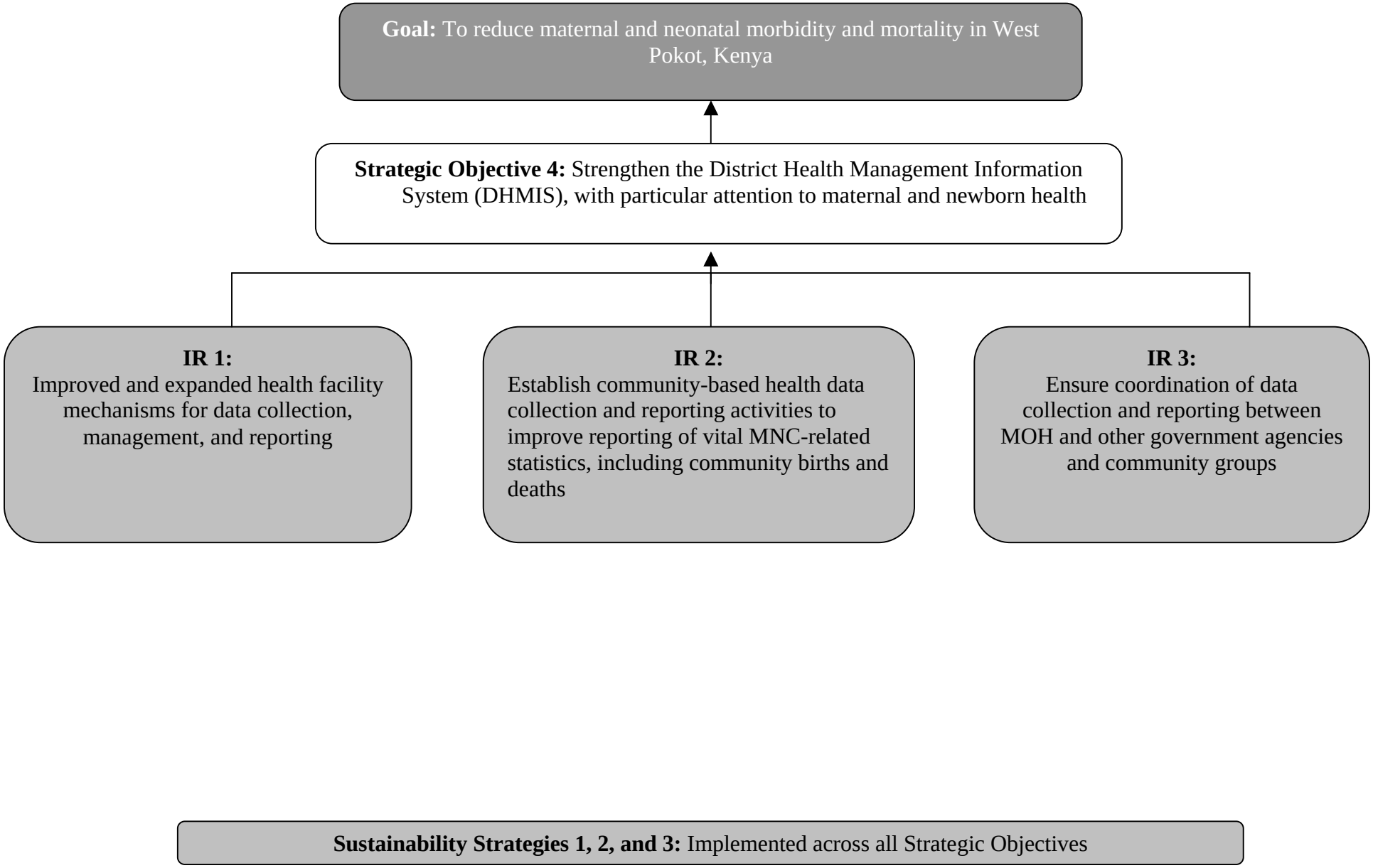


DOW-Kenya Results Framework (Strategic Objective 4)



LEVEL OF EFFORT

The focus interventions of the proposed program are:

- Maternal and Newborn Care (70% LOE)
- HIV/AIDS (15% LOE)
- Prevention and Treatment of Malaria (15% LOE)

It should be noted that while DOW will be responsible for coordinating MNH program activities, we will work in conjunction with the MOH and DHMT as our main partners. Therefore, the interventions outlined below and the training/ work plans have been developed collaboratively.

MATERNAL AND NEWBORN CARE

As discussed earlier, key problems in Maternal and Newborn Care (MNC) contributing to high Maternal and neonatal mortality and morbidity include: lack of community knowledge about available MNC services and their benefits; inadequate promotion and low utilization of antenatal care (ANC) in the community and at facilities; low utilization of facility-based delivery; lack of postpartum and neonatal care in the community and at facilities; lack of provider knowledge about MNC; and inadequate data collection and monitoring. Barriers to accessing care at health facilities such as cost of services and transportation and negative perceptions about facility-based maternity services contribute to these problems.

In order to ensure that DOW's training priorities and measured indicators reflect the best practices in the field of MNC, and to bring MNC in West Pokot up to national and international standards, DOW used results from the baseline assessments and the three major frameworks mentioned earlier (the MAMAN Package, the ACCESS HHCC Model, and MNHP Three Delays Model) to develop training activities for both community and facility-based providers.

While baseline assessments revealed that many skills are familiar to providers, few individuals can confidently perform key procedures necessary to save a woman's life in childbirth. The goal of MNH training activities is to assure that providers are competent in performing normal vaginal deliveries at all facilities and confident in stabilizing and referring women who present with complications. The two hospitals should be able to perform additional signal functions, including blood transfusions and caesarean sections. The Training Plan lists activities as facility-based trainings, further categorized into clinical and management skills, and community-based trainings, subdivided into knowledge, behavior change, skills trainings. (See the Training Plan in Section E8 for further details.) Table 9 below provides a summary of MAMAN priorities and the corresponding DOW-MOH planned trainings to illustrate congruity between DOW's interventions and globally recognized frameworks.

Table 9: Summary of MAMAN Priorities and Related DOW Trainings

Intervention	Facility-Based Training	Community-Based Training
During Pregnancy	**During Pregnancy**	**During Pregnancy**
Birth preparedness - complication readiness	FANC, including MIP and PMTCT of HIV	Birth Planning and FANC, including MIP and PMTCT of HIV
During Labor/Delivery	**During Labor/Delivery**	**During Labor/Delivery**
Delivery with skilled attendant/partograph	• Normal Delivery, including Use of Partograph, AVD, and AMSTL • EmONC, including FGM-Related Complications and Referral Mechanisms	N/A since Kenya discourages training of unskilled attendants in safe delivery
Infection prevention/clean delivery	Infection Prevention at the Facility	N/A since Kenya discourages training of unskilled attendants in safe delivery
Active mgt of 3rd stage of labor	Normal Delivery, including Use of Partograph, AVD, and AMSTL	N/A since Kenya discourages training of unskilled attendants in safe delivery
Wrap/dry and promote skin-to-skin contact	Postpartum and Newborn Care	Community-base Postpartum and Newborn Care
Initiate breastfeeding w/in 1 hr	(No specific training on breastfeeding, but will be incorporated into FANC and Postpartum training curricula)	(No specific training on breastfeeding, but will be incorporated into FANC and Postpartum training curricula)
Referral for complications	EmONC, including FGM-Related Complications and Referral Mechanisms	On-site training in MNH Referral
Immediate Postpartum Period (0–7 days)	**Immediate Neonatal Period (0–7 days)**	**Immediate Neonatal Period (0–7 days)**
Infection prevention/clean cord care	• Infection Prevention at the Facility • Postpartum and Newborn Care	Community-based Postpartum and Newborn Care
Wrap/dry and promote skin-to-skin contact	Postpartum and Newborn Care	Community-based Postpartum and Newborn Care
Promotion of colostrum/exclusively breastfeeding (BF)	(No specific training on breastfeeding, but will be incorporated into FANC and Postpartum training curricula)	(No specific training on breastfeeding, but will be incorporated into FANC and Postpartum training curricula)

Key curricula that will be adapted for these trainings are MOH-endorsed and include (but are not limited to):

Facilty:

- Essential Obstetric Care Manual: For Health Service Providers in Kenya, Third Edition, 2006 (MOH)
- Facility-Based Maternal Death Review: National Operating Guidelines (MOH-UNICEF)

Community:

- Community Reproductive Health Package for CORPs (MOH-JHPEIGO)
- Focused Antenatal Care and Malaria in Pregnancy: Orientation Package for the Community (MOH-JHPEIGO)

The actual content of each training will be decided upon jointly between DOW's Training Coordinator and the DHMT prior to each training.

I. Facility Level

Strategic decisions about how to upgrade facilities so that they provide basic or comprehensive EmONC were informed by looking at which signal functions were missing and why they were not available. Facilities might not have performed certain EmONC signal functions because there was no indication for the procedure, no staff trained and/or confident to perform the service, no available supplies and/or equipment, the particular cadre of staff working at the facility was not authorized to perform the signal function or there was no staff at all at that facility. A further analysis of availability of essential drugs and equipment was included in DOW's HFA, and results emanating from this analysis are expected shortly. DOW will work to ensure that the health centers perform the seven basic signal functions without interruption (BEmONC) and that the two hospitals are providing all nine signal functions (CEmONC). Dispensaries will be strengthened to perform normal vaginal deliveries and neonatal resuscitation.

Table 10: Facilities surveyed and available signal functions in the last 3 months

	Parenteral antibiotics	Parenteral oxytocics	Parenteral anticonvulsants	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery	Neonatal resuscitation	Blood transfusion	Cesarean section	EmONC status
Kapenguria DH	√	√	√	√	√		√	√	√	Comp minus 1
Ortum MH	√	√		√	√		√	√	√	Comp minus 2
Chepareria HC	√	√			√					Basic minus 4
Kabichbich HC	√	√								Basic minus 5
Kacheliba HC	√						√			Basic minus 5
Sigor HC	√									Basic minus 6
Konyao Disp	√									Basic minus 6
Lomut Disp										Non-EmONC
Serewo Disp	√									Basic minus 6

Strengthening Provider Skills: Through competency-based group training and follow-up supportive supervision, DOW will strengthen the skills of providers at all nine focus health

facilities to offer quality MNC services as appropriate to the level of health facility. Training will focus on the ability of providers to offer appropriate Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services. Trainings will include all health center staff, as well as hospital staff working in, cycled through, or supervising relevant wards (i.e. maternity, labor and delivery, female wards, pediatrics, etc.). This will ensure that the implementation of new skills and services is a shared responsibility and will mitigate the impact of staff reassignment and turnover. Providers will be trained in cohorts that cross facility levels, allowing dialogue about referral between facilities. Following off-site training, DOW will work with providers at their respective facilities to ensure integration of newly acquired skills and identify potential barriers, such as delays in providing care and supply stock outs, by applying the COPE methodology. DOW will also help providers prepare for the use and maintenance of new equipment, supplies, and medicines to be provided through the program.

Referral Monitoring: Obstertic referral from the dispensary or health center occurs late and on an ad-hoc basis. Referral back from a hospital to the first level facility for follow-up care is almost never done. DOW will work with the district MOH team to develop a referral system, complete with emergency transfers, communication, and registers to track referred cases. Forms that detail the reason for referral will also be created with two parts—one that the woman will take to the receiving facility and the other that stays at the sending facility. A referral register will be kept in labor and delivery, along with an envelope to file referral forms. Information will be aggregated by the M&E coordinator on a quarterly basis about the number of patients referred and cause of referrals. Individual referrals will also be cross-referenced quarterly by register and chart review to ensure that timely and appropriate referrals are being made. DOW will explore pictorial referral cards for non-literate CORPs who refer women to local facilities. DOW will also provide two of the four health centers that lack the capacity to provide emergency transfers to hospitals with one vehicle to enable this, and advocate with the MOH for resources to enable their sustained use. While the referral system is in the process of being designed, it will not be implemented until health facilities and hospitals are functioning well enough to receive referrals.

Improving Infrastructure: From the HFA, it is clear that each of the nine intervention facilities lack crucial equipment and supplies necessary to provide comprehensive MNH services. Through minor renovation where necessary and provision of equipment and supplies, as well as resource advocacy with the MOH, DOW will improve the infrastructure of focus health facilities to provide quality MNC services appropriate to the Kenya Essential Package of Health (KEPH) for each facility. In year two, DOW will work with the DHMT to begin procurement and will upgrade the capacity of four health centers to provide all six components of BEmONC. DOW will also work with two hospitals to improve the quality of their MNH services and upgrade to CEmONC status. Because understaffing is currently a large problem in the three dispensaries that DOW is targeting in West Pokot, DOW will include all dispensary staff in training activities but only focus on ensuring that assisted vaginal delivery, neonatal resuscitation, and timely referral at this level. If staffing shortages are alleviated during the life of the project, which is unlikely given the length of time posts have remained unfilled in the target dispensaries, DOW will discuss the possibility of upgrading one or all of these facilities with equipment an supplies to provide BEmONC. During quarter four of the first year, DOW's M&E Coordinator will be working with the DHMT to review equipment and supply gaps found in the HFA. A spreadsheet comparing KEPH standards for each facility level with currently available equipment and supplies will be maintained throughout the life of the project to facilitate initial procurement and ensure there are no future stock-outs.

II. Community Level

Expanding Mobile Outreach Services: (See Section E3 for a detailed description.)
Strengthening CORPs Skills: DOW will train TBAs and Community Health Workers (CHWs) as Community-Owned Resource Persons (CORPs). These CORPs will become community educators, mobilizers and referralists for MNC services, increasing their knowledge about Maternal and Neonatal Health (MNH) and their Behavior Change Communication (BCC) skills. DOW will provide CORPs with training in FANC and Postpartum and Newborn Care. CORPs will provide MNC-related education and care to individual women in the community, as well as general MNH messages at community *barazas,* or public community mobilization sessions. Additionally, male CORPs will be trained in engaging male community members to support women in accessing and using MNC services. DOW will provide travel support to CORPs who will conduct *barazas* across the Divisions. Follow-up supervision for all CORPs-related will be conducted by CHEWs, with support from DOW staff and the DHMT. (The role of CHEWs is further described earlier in Section E3.)

Training Community Leaders as Partners in Gathering Community Data: DOW will expand gathering of vital statistics in the community by facilitating meetings between the Civil Registry and the DHMT, as well as supplying community leaders (chiefs and assistant chiefs) with tools to fulfill their mandate to gather and report data on births and deaths. The community reporting system will be further developed in quarter four of the first year with assistance from the DHMT and community leaders.

Mobilizing CBOs and FBOs: DOW will train key staff at partner CBOs and FBOs in incorporating MNH information and BCC approaches into their community-based activities. Through the varied networks, community groups, and congregations convened by these partners, DOW will reach a broader segment of the District's population, including women of reproductive age, male partners, and opinion leaders who can influence access to MNC services.

III. Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is viewed as an important rite of passage among many ethnic communities and is still practiced widely in Kenya today. The Children's Act of 2001 explicitly prohibits all forms of FGM, but such laws are rarely enforced in the country. Despite a nationwide decrease in circumcision rates noted in the 2003 KDHS, the practice remains largely unchanged in the West Pokot District. DOW is concerned about FGM for many reasons, but particularly because there is evidence that women who are infibulated are more likely than other women to develop obstetric complications.[1] Such complications include increased risk of obstructed labor, obstetric fistula, and neonatal asphyxia.

In Pokot communities, the traditional birth attendant (TBA) performs both female circumcisions and home deliveries. In the type of FGM practiced, type III FGM, or infibulation, TBAs excise part or all of the external genitalia and then stitch the vaginal opening. Nearly 100% of women in Pokot communities experience type III FGM. Focus groups revealed that many women prefer to deliver at home with TBAs because these community health workers are the same ones who

[1] Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet, 367: 1835-41, 2006.

cut them in the first place. Women feel that TBAs therefore understand their bodies better than clinicians working at health facilities, but it is clear that both women and TBAs do not understand the health complications that result from this severe form of cutting.

Reducing this deeply-imbedded cultural practice will require focused and long-term work by community based partners who have credibility among Pokot leaders. However, while and INGO may not be able to effectively reduce the practice, DOW can both build the capacity of providers to mitigate the health impacts of the practice and begin to educate CORPs and community leaders about these health impacts. Because we recognize that FGM is a complicated social issue, which is difficult to adequately address in the context of a large child survival program, DOW will work with its partners who have expertise in raising awareness about the harmful practice. Sentinelles, a Swiss NGO, will continue to advocate for the rights of women and young girls through its anti-FGM outreach and education activities in the communities. DOW will collaborate with Sentinelles trainers and incorporate their training materials into sensitization trainings and refreshers for community partners, chiefs and assistant chiefs, and CORPs with the hope that these groups will help draw attention to not only the health risks associated with infibulation, but also to the right of every woman and young girl to abstain from the practice.

The HFA showed that health workers working in hospitals and health centers in West Pokot have not received any specific training on delivery women who are infibulated. Drawing on our strengths in training, DOW will train clinicians in the management of obstetric complications that present more commonly in women who have undergone cutting. The need for this type of clinical training is great and addresses one of the strategic objectives of the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999-2010, which is "to increase accessibility to adequate basic health and other social services in order to reduce morbidity and mortality from FGM practices and resultant complications." DOW will work with MOH staff to monitor clinical management of FGM through supportive supervision and provide a refresher training toward the end of the project. It should be noted that because fistula repair is a highly technical skill that requires specialized training, clinicians will be encouraged to refer fistula cases to AMREF-sponsored semi-annual fistula repair camps at Ortum Mission Hospital in which DOW's local board member, Dr. Hillary Mabeya, serves on the surgical team.

IV. Quality Assurance for MNC Activities

After completion of the HFA, DOW visited each health facility to discuss utilization data with staff members, supervisors, and in some cases, members of the health facility committees (HFCs). DOW will continue to provide feedback on utilization data to these individuals in order to inform communities about changes and improvements to health facilities. The HFA further revealed that no facility within the District provided all signal functions. This was due to lack of staff training as well as missing equipment and supplies. DOW has developed a detailed Trainig Plan and process indicators to monitor signal functions, availability of MNH services, and equipment and supplies at fixed intervals will be compiled into a checklist that will aid the DHMT in ensuring quality MNH services.

In accordance with the "National Health Sector Strategic Plan II: 2005-2010" put forth by the Kenyan Ministry of Health, DOW's Quality Assurance goals are to:

- Improve the skills of health workers;
- Improve the quality of care offered to mothers and children;
- Ensure the safety and health of providers and clients;
- Improve the relationship between clients and providers;
- Build the capacity of the health system to delivery comprehensive care to mothers and children.

The "National Health Sector Strategic Plan II" provides the following guidance for DOW's proposed program:

Antenatal Care: According to the Kenyan national strategy, focused ANC should include obstetric care as well as malaria management and HIV/AIDS counseling and testing. Focused ante-natal care should include:

- At least four visits during pregnancy;
- Education about neonatal and antepartum danger signs;
- Treatment for Sexually Transmitted Infections (STIs);
- Routine medical screening for common pregnancy complications;
- Screening for high risk deliveries;
- Education about maternal and child health;
- Intermittent Preventative Treatment (IPT) for malaria;
- Subsidized Insecticide-Treated Net (ITN) purchase.

Infant feeding: The Kenyan MOH stresses that facilities providing MNC must adhere to the national feeding policies, communicating them to staff and displaying the strategy in examination rooms. Furthermore, it is suggested that all Districts train all health care workers in skills necessary to implement this policy, including client counseling skills, so that they can provide information to pregnant women and new mothers on the benefits of breastfeeding. Health providers should know how to teach women to initiate breastfeeding within the first 30 minutes after giving birth, as well as how to breastfeed in order to maintain lactation.

Postpartum Care: According to the DRH "National Safe Motherhood and Neonatal Health Programme," the importance of postpartum visits has been widely ignored throughout Kenya. While the MOH has recently implemented a postpartum register in an attempt to strengthen the Health Management Information System, this register has not yet been introduced in West Pokot. DOW will work with the DHMT to ensure the use of this and other MNC registers. According to the national strategy, postpartum visits should be held three times and focus on care of the newborn, neonatal danger signs, and referral for medications or services not available at that facility.

DOW has designed its training and program activities in coordination with Kenyan MOH policies. This approach will meet the program goals of improving the capacity of each facility and provider to offer services that meet the national standards. Specifically, DOW has incorporated priorities and indicators from the "National Guidelines for Quality Obstetric and Perinatal Care," which was produced by the Kenyan Ministry of Health-Division of Reproductive Health in 2004. This framework puts forth the following interventions as the

highest training priorities for health workers delivering "Antenatal, Intrapartum, and Perinatal Care" in Kenya:

- Management of malaria in pregnancy
- HIV disease in pregnancy
- Management of labor and delivery
- Management of cephalo-pelvic disproportion
- Guidelines on assisted vaginal delivery
- Management of antepartum hemorrhage
- Prolonged/obstructed labor and ruptured uterus
- Management of retained placenta
- Postpartum hemorrhage
- Management of puerperal sepsis
- Postpartum care at the dispensary level in the first six hours
- Postpartum care at the health center level in the first six hours
- Postpartum care at the hospital level in the first six hours
- Postpartum care at all levels for the period six hours to six days
- Postpartum care at all levels at six weeks
- Breastfeeding and lactation management
- Early detection and prevention of postpartum infection

DOW's program activities are further supported by the key outputs outlined in the DRH Implementation Plan for RH Strategy:[2]

1. Utilization of quality and cost effective MCH/FP services (including family planning)
2. Access to quality maternal and child health care services improved
3. Demonstrate effectiveness of systems of referral and access
4. Clean and safe delivery and emergency obstetric care improved
5. Health Care facilities appropriately equipped to provide quality maternal and child services
6. Management of conditions that complicate pregnancy improved
7. Post abortion care improved
8. District audit systems on maternal and perinatal death established

Despite the clear training standards set out by these national guidelines, the health providers working at DOW focus health facilities in West Pokot have either not been trained in these topics or lack competency or confidence to perform acquired skills. Therefore, DOW will use these national standards and existing MOH training curricula such as the Kenya National Reproductive Health Curriculum for Service Providers in preparation for provider trainings. This will strengthen the capacity of the West Pokot MOH to provide health services that are in line with national standards and priorities. In addition, as previously mentioned, the "COPE for Maternal Health Services: A process and tools for improving the Quality of Maternal Health Services" will be used to assess provider competency and facility supervision needs. A diagram of the COPE process is outlined in Table 11 at the end of this section.

[2] "National Guidelines for Quality Obstetrics and Perinatal Care." Kenya Ministry of Health, Division of Reproductive Health. November, 2004.

V. Behavior Change Strategies

Although a behavior change strategy has not been finalized, BC messages at both the community and facility level will focus on the following topics, as outlined by the ACCESS HHCC model:

1. Improved antenatal preventive practices such as:
    - Malaria Prevention—IPT and ITN use
    - Adequate nutrition
    - Immunization against tetanus
2. Ensure four ANC visits
3. Improve birth planning and complication readiness for pregnant women and their families
4. Improve recognition of maternal and newborn danger signs and care-seeking by mothers
5. Ensure timely referral to nearest health facility upon recognition of danger signs
6. Promote HIV testing and counseling
7. Initiate immediate and exclusive breastfeeding within one hour
8. Maintain baby's warm: dry and wrap immediately or dry and put skin-to-skin with mother and cloth over the baby
9. Delay bathing
10. Recognize asphyxiated newborns and ensure timely referral to the nearest health facility
11. Continue exclusive breastfeeding
12. Maintain baby's warmth
13. Keep cord clean and dry
14. Provide recommended immunizations
15. Sleep with mother under ITN

HIV/AIDS

The burden of HIV/AIDS in West Pokot District is growing, as measured through seroprevalence at Voluntary Counseling and Testing (VCT) sites and in ANC patients. However, before DOW's HIV/AIDS program began in 2005, capacity to provide HIV/AIDS services at MOH facilities was limited and not well linked with MNC services. While PMTCT is a priority of the National AIDS and STD Control Program (NASCOP) and testing of pregnant women is mandated at all MOH supported health facilities, MNC services continue to represent missed opportunities to provide HIV testing, Prvention of Mother to Child Transmission (PMTCT) services, and treatment support to women with HIV. HIV education and mobilization activities in the community should be considered opportunities to improve community knowledge about MNH.

I. Facility Level

<u>Integrating PMTCT and ART programs</u>: Kenya's national policy aims to provide PMTCT services at a minimum of 80% of health facilities by the end of 2007 and to reduce the proportion of infected infants by 50% by 2010. NASCOP currently provides HIV+ mothers with prophylactic Nevirapine, but until recently, the drug was only available at the district hospital and not in rural health facilities in West Pokot. Through training and routine supervision, DOW has enabled MOH staff to properly stock and administer Nevirapine in rural sites and begin counseling and testing activities for women in ANC. As a result of DOW's efforts, MOH staff have also been able to test nearly all women in ANC and labor and delivery at the district hospital and have thus far found HIV prevalence rates of 4% and 8%, respectively. According to KPC results, 43.5% of women received HIV counseling and testing.

Due in large part to DOW's established HIV/AIDS care and treatment services at Kapenguria District Hospital, a framework is present to ensure that HIV+ pregnant women and mothers receive Antiretroviral Therapy (ART). With the support of AMPATH, DOW is able to provide any HIV+ pregnant woman with a full course of ARTs. It is anticipated that this steady supply of ARTs will be available through AMPATH for the life of the project, and no interruption in treatment is therefore expected. DOW is working closely with the MOH staff through weekly mobile outreach teams that provide care and treatment to women at rural health facilities to ensure that as many women as possible are able to access full ART if appropriate, beyond the PMTCT regimen mandated by the NASCOP. DOW has already enrolled several hundred women in HIV/AIDS care and treatment and will increase its current activities through support from CSHGP funds. DOW will expand these counseling and testing activities through mobile outreach clinics in the context of the MNH program.

Strengthening Provider Skills: At focus health facilities, DOW will provide refresher training through its AMPATH-supported HIV/AIDS program to clinicians who received initial training from DOW in HIV voluntary testing and counseling (VCT), opt-out diagnostic testing and counseling (DTC) testing, and PMTCT. DOW will integrate HIV-specific messages into MNC training, to ensure that providers are responsive to the needs of HIV+ women of reproductive age. For example, since facility staff identified fear of HIV testing as a barrier for women to attend ANC, sensitization training on this topic will be conducted by DOW's HIV/AIDs program social worker to help clinicians address women's concerns. This also includes clinical guidelines to reduce vertical HIV transmission during intrapartum/postpartum periods (e.g., reducing use of episiotomies, avoiding premature rupture of membranes, and cleaning the newborn's face immediately following birth).

II. Community Level

Promoting HIV/AIDS Education and Mobilization through CORPs: DOW will train CORPs in the basics of HIV/AIDS, including key messages about PMTCT, infant feeding in the context of HIV, the availability of comprehensive HIV/AIDS services in the District, and the impact that HIV testing and treatment can have on MNH. DOW will train CORPs to integrate these messages into their one-on-one and group education, referral and mobilization activities.

Promoting HIV/AIDS Education and Mobilization through CBOs/FBOs: DOW will provide refresher training on HIV/AIDS issues, including the messages outlined above, to CBO and FBO partners, in order to ensure that accurate and consistent messages about HIV/AIDS prevention and treatment are disseminated to their networks. Involvement of people living with HIV/AIDS (PLWHAs) is still nascent in the District, where stigma remains high; and opportunities will be explored to involve PLWHAs in designing interventions to promote supportive norms and decrease stigma.

III. Quality Assurance for HIV/AIDS Activities

DOW and AMPATH have been working in partnership since 2005 to ensure that all HIV interventions in West Pokot are in accordance with the "National Guidelines for the Prevention of Mother-to-Child Transmission" (Kenya MOH, 2002). Through this collaborative effort, DOW and AMPATH have implemented VCT, DTC, and PMTCT services at the focus health facilities. Through the MNH program, DOW will continue to build on these existing services and to expand the mandate put forth by the MOH to "improve the reliability and efficiency" of

HIV prevention and testing services. By integrating this intervention alongside ANC and delivery services, this program will expand the capacity of the health system to detect HIV and to prevent the infection to newborns, thus reducing the burden of HIV on the population of the district. These efforts will be augmented through community-based education campaigns led by CHEWs and CORPs and focus on information about PMTCT and the impact of breastfeeding on HIV transmission.

According to the "Kenya National Strategy for VCT Scale-Up" (NASCOP, 2004), all antenatal care services should offer VCT and referral to ART (when indicated). At the health facility level, DOW will conduct refresher trainings on PMTCT and working with health providers on all levels to ensure the integration of timely and consistent PMTCT activities into antenatal, labor, and postpartum services.

PREVENTION AND TREATMENT OF MALARIA

Malaria remains the leading cause of illness and death in the District, and is implicated in maternal and child mortality and morbidity. Preventive measures such as IPT and ITNs remain extremely underutilized.

I. Facility Level

ITN Procurement and Distribution at Health Facilities: Currently, health facilities in West Pokot receive subsidized long-lasting ITNS through the central MOH and UNICEF. During the KPC survey, no other type of nets were found in use, and retreatment of nets will not be a central training or education issue. While pregnant women and children are targeted for distribution, supplies, especially at the rural facilities, are limited. In focus group discussions, many women complained that the shape of the ITNs was inappropriate for their living conditions. Since many live in small huts and sleep on the floor, rectangular nets were of little use to them. Instead, they requested conical shaped nets. In order to increase distribution of context-specific long lasting ITNs to pregnant women and children under five, DOW will use its partnership with Population Services International (PSI) to procure LLITNs beginning in year two and increase the supply at focus health facilities. PSI is scheduled to visit West Pokot in quarter four of the first year to better understand the difficulty people living in the district face in using standard nets and to help DOW and the DHMT develop logistics and supply management systems for ITN procurement. ITNs will also be distributed during MNC mobile outreach clinics once they commence.

Strengthening Provider Skills in Malaria Prevention: The current first line drug for malaria is Coartem, with SP being used in IPT. While clinicians were recently trained on prescribing practices for Coartem, focus groups revealed that many clinicians did not know what to do about administering IPT, espeically if a woman came later for her first ANC visit. DOW will therefore integrate IPT and ITN use into FANC and postpartum and newborn care trainings respectively and will liaise with the MOH's Division of Malaria Control (DOMC) to organize additional training for service providers in case management if necessary. Though DOMC began training providers in 2006, the training has yet to expand to West Pokot. Because district is classified as a malaria endemic area, supply of drugs for both uncomplicated and severe malaria are regularly available. However, ensuring drug availability for malaria will be included in regular supply chain monitoring activities.

II. Community Level

Strengthening CORPs' Skills: KPC results and focus group discussions revealed that while many women had ITNs, few used them on a consistent basis or knew how to use them at all. With PSI, DOW will train CORPs in malaria prevention and provide practical demonstrations of ITN use and maintenance, so that CORPs can be involved in ITN promotion. CORPs will also be trained in BC messages regarding appropriate treatment for malaria, including seeking immediate care for fevers in young children. Because the LOE for Malaria is only 15% community case management of malaria is outside the scope of this project.

Training local partners: To enable local NGO/FBO partners and community leaders such as Chiefs and Assistant Chiefs to include BC messages about malaria prevention in their community activities, DOW and PSI will train key staff of these partners in the essentials of malaria prevention and the promotion of ITN use through their community and networks. DOW will also support these groups, along with CORPs, to conduct *barazas* to inform community members about the importance of ITN use, especially among pregnant women and children. Further community sensitization activities will be developed after the BC strategy is fully articulated.

III. Quality Assurance for Malaria Activities

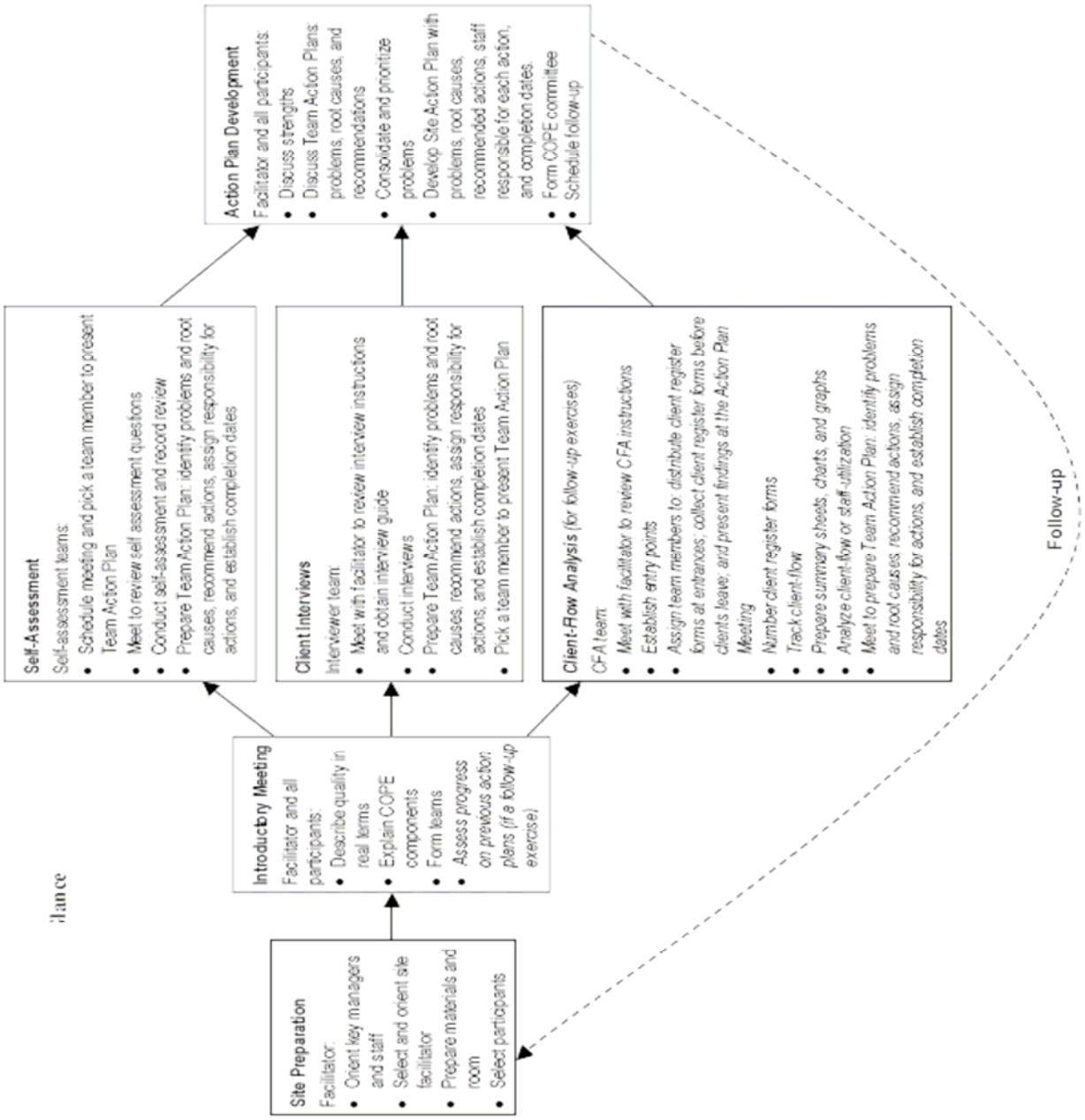
This program will adhere to MOH policies and guidelines related to IPT, ITNs, and Malaria Prevention messages. The National Malaria Control Strategy (MOH, Division of Malaria Control, 2001) includes four strategic approaches for prevention, treatment, and control:

- Access to treatment;
- Prevention and treatment for pregnant women;
- ITN use by high-risk communities (including pregnant women and children under five);
- Improved preparedness.

ACCESS TO HEALTH SERVICES

By working simultaneously at the community and health facility levels, DOW aims to improve linkages between the two. By increasing availability of KEPH-mandated services, improving quality and availability of referrals and transfers, and providing mobile services, DOW will address many of the barriers women in West Pokot face in accessing MNC services. DOW intends to leverage our prior relationship with TBAs and other CORPs who are trusted members of their respective communities to educate women on the importance of attending ANC and the need to seek facility-based services in the event of an obstetric or neonatal emergency. By sensitizing men and community leaders and by empowering women through educational activities, DOW seeks to provide some balance to unequal power relationships between men and women in West Pokot.

Table11: COPE Framework for Quality Assurance[3]



[3] http://www.engenderhealth.org/res/offc/qi/cope/toolbook/pdf/cope_maternal_toolbook.pdf

CURRENT INFORMATION SYSTEM, PROJECT'S SYSTEM, AND OVERLAP

I. Current System

The District Medical Records Information Officer (DMRIO) based at Kapenguria District Hospital (KDH) is responsible for facility data management for the West Pokot district. The District Health Management Team (DHMT) issues annual reports on the major health indicators, while the National Institute for Statistics provides reports on demographic, social and economic indicators. The District Health Management Information System (DHMIS) provides information on all public facilities in the district. Data is recorded in various registers and includes information on inpatient and outpatient visits, antenatal care (ANC), sexually transmitted infections (STIs), HIV/AIDS, and child wellness (immunizations, weight, etc.). Rural health facilities, including health centers and dispensaries are supposed to report these data on a monthly basis, but reports are often late or not filed at all and there is currently no system to monitor reliability of data recording or reporting at the health facility or district level.

The health facility assessment (HFA) revealed that the use of registers varies widely by facility and registers were often filled out incorrectly. Maternal and newborn complications and mortalities were particularly difficult to locate within the relevant registers. During the HFA, it proved very difficult to locate utilization data for the 2006 year due to inconsistencies and recording errors. Other analysis tools important for quality Maternal and Neonatal Care (MNC) were either out of stock or unused. For example, out of the four health centers, only Chepareria Health Center (HC) had partographs available to use in the labor and delivery room. At Chepareria, staff reported that they were not using the partographs because they had not been adequately trained. In most cases, stock-outs are not anticipated in a timely manner because of a lack of monitoring tools. ANC cards and registers were unavailable at the time of baseline assessments because they had not yet arrived from Nairobi, despite National standards requiring that ANC cards be available at all public facilities.

Though chiefs are required by Kenyan law to report information on births and deaths, there is no system in place for recording or reporting on deliveries or mortalities in the community. Many mothers who deliver in the community do not see a need to obtain an official birth certificate for their newborn. Furthermore, when community births are reported, there is currently no mechanism to transfer this data to the district level and capture it in the current DHMIS. The information is reported to the District Commissioner's (DC) office, but there is no formal method of data sharing between the DHMIS and the DC's office.

II. DOW's Health Information System Strategy

DOW has two approaches in strengthening the Health Information System (HIS) and data collection in the District – improving use of existing tools, and developing new tools to address gaps in data. For the first approach, there exist a number of sources of MNC, HIV/AIDS, and malaria data. DOW will collect data reported through these on a quarterly basis, and work with DHMT partners to identify barriers to their consistent and accurate use; responses may include simplifying or otherwise improving forms, working with individual facilities to determine strategies to improve reporting, and working with the DHRIO to improve entry of data from these forms and ensuring their consistent stock at facilities. Current forms include:

- Monthly Reproductive Health Data Form: These forms, filled out by facilities, include information on ANC, Child Welfare Clinics (CWC), Family Planning (FP), Postnatal Care (PNC), and Post Abortion

Care (PAC) services, as well as maternal/neonatal outcomes, including deliveries, live births, stillbirths, and neonatal deaths. Not all facilities report with these forms.

- Maternal Death Notification Forms
- Quarterly and annual forms for HIV Testing: These collect results gathered through Voluntary Counseling and Testing (VCT) sites, blood donors, and testing of pregnant women and are reported to the District AIDS and STD Control Officer (DASCO).
- Quarterly and annual malaria incidence reports
- Monthly, quarterly, and annual mortality and morbidity reports from admissions.
- Maternal and Child Health Cards
- Registers for ANC, maternity, postnatal services
- TBA Activity Monitoring Forms: These forms, developed by DOW based on AMPATH models, are being used by Prevention of Mother-to-Child Transmission (PMTCT) nurses at health centers and dispensaries to collect data on TBA activities. These forms are provided to both DOW and the DASCO.

For the above forms and others to be introduced, a Health Management Information System (HMIS) will be developed that will compute automatically relevant indicators captured by the data collected through the said forms and will based at the district records office.

Data to be Introduced by the Project

To strengthen the District's capacity to collect accurate and comprehensive health data, DOW will introduce data tools in collaboration with the DHMT and local partners. The acceptability and effectiveness of these tools in improving the ability of the District to collect, analyze, and respond to health data will be evaluated to determine whether these tools should become part of the data collection package of the District past the life of the program. Tools will include:

- CORPs activity monitoring forms for CHWs: These will allow CHWs to report on community activities, and allow supervisors at health facilities to aggregate this information, and identify any correlation between Community's Own Resource Persons (CORPs) and Community Health Worker (CHWs) activities and increased use of facility health services.
- Mobile outreach service forms: These will be adapted from service forms used by the Catholic Diocese in its outreach services. These forms will allow collection of data on the frequency and location of mobile outreach services, on clients for mobile services, and analysis of whether clients of mobile outreach services are motivated to come for facility-based follow-up services.
- New ANC, Maternity, and Postpartum Registers: These have already been endorsed by the MOH; they have yet to be introduced to the West Pokot District and DOW will help facilitate this after ensuring that they capture most of the data that address the issues being monitored by the MNC project. DOW will seek to have any data gaps with regard to the MNC project addressed at the DHMT level and hence advocate for its incorporation
- Community Vital Statistics Reporting Form: DOW will develop this form to assist community leaders in collecting and reporting information on community births and deaths. A template of a similar reporting form already developed and being discussed.
- Community Health Workers Monthly Reporting Register: This register is already developed and under discussion before its adoption

Progress on DOW activities in focus communities will be measured through process monitoring and outcome evaluations of target health facilities. All M&E activities will be led by DOW staff and

supported by the DHMT unless otherwise noted. DOW will conduct on-the-job training of appropriate MOH staff during the third project year to transfer M&E skills.

M&E PROGRAM MATRIX

Maternal and Newborn Care Project Indicators	CATCH Indicator	Numerator	Denominator	Baseline Estimate	95% CI	EOP Target
Percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy		52	186	28%	[18%, 38%]	80%
Percentage of mothers with children age 0-23 months who received two tetanus toxoid injections before the birth of their youngest child.	CATCH	74	186	39.8%	[29.8%, 49.8%]	60%
Percentage of children age 0-23 months whose births were attended by skilled health personnel	CATCH	32	186	17.2%	[7.2%, 27.2%]	70%
Percent of mothers of children age 0-23 months who had at least one postpartum check-up		112	186	60.2%	[50.2%, 70.2%]	80%
Percentage of mothers of children age 0-23 months who received child spacing information during a postpartum check-up		14	186	7.5%	[7.5%, 17.5%]	40%
Percent of mothers of infants 0-5 months who received neonatal care within two days of delivery.		92	152	60.5%	[50.5%, 70.5%]	80%
Percent of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period.		57	186	30.6%	[20.6%, 40.6%]	50%
Percent of mothers of children 0-23 months able to report at least two maternal danger signs during the antenatal period		9	186	4.8%	[4.8%, 14.8%]	40%
Percent of mothers of children age 0-23 months able to report at least two known neonatal danger signs.		69	186	37.1%	[27.1%, 47.1%]	50%
Percent of children aged 0-5 months who were exclusively breastfed in the last 24 hours.	CATCH	108	152	71%	[61%, 81%]	90%
Percent of children aged 0-5 months who were exclusively breastfed within the first hour after birth.	CATCH	22	152	14.5%	[4.5%, 24.5%]	40%
Percent of mothers of children age 0-23 months with a child health card (interviewer-confirmed) for the youngest child less than 24 months of age		101	186	54.3%	[44.3%, 64.3%]	70%

Percent of mothers of children 0-23 months with a maternal health card		29	186	15.6%	[5.6%, 25.6%]	60%
Percent of women with children 0-23 months who received HIV counseling and testing services during pregnancy.		81	186	43.5%	[33.5%, 53.5%]	60%
Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection.		34	186	18.3%	[8.3%, 28.3%]	40%
Percentage of women who know about the risks of spreading HIV through breast milk.		79	186	42.5%	[32.5%, 52.5%]	60%
Percentage of mothers of children 0-23 months who know where to go for HIV testing and counseling		20	186	10.8%	[10.8%, 20.8%]	40%
Percentage of mothers with children age 0-23 months who know that the risk of MTCT can be reduced by ART		35	186	18.8%	[8.8%, 28.8%]	50%
Percent of mothers of children 0-23 months who slept under ITNs the previous night		14	186	7.5%	[7.5%, 17.5%]	50%
Percent of children 0-23 months who slept under ITNs the previous night.	CATCH	80	186	43%	[33%, 53%]	60%
Percent of households with at least one ITN		81	186	43.5%	[33.5%, 53.5%]	70%
Percent of mothers of children 0-23 months who received IPT at least twice during ANC.		5	186	2.7%	[2.7%, 17.7%]	40%
Percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy		52	186	28%	[18%, 38%]	80%
Percentage of mothers with children age 0-23 months who received two tetanus toxoid injections before the birth of their youngest child.	CATCH	74	186	39.8%	[29.8%, 49.8%]	60%
Percentage of children age 0-23 months whose births were attended by skilled health personnel	CATCH	32	186	17.2%	[7.2%, 27.2%]	70%

OTHER RAPID CATCH INDICATORS

Other Rapid CATCH Indicators	Numerator	Denominator	Baseline	(95%) CI	EOP Target
Anthropometrics					
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for age, according to the WHO/NCHS reference population)	17	186	9%	[9%, 19%]	5%
Prevention of Illness/Death					
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	88	186	47.3%	[37.3%, 57.3%]	70%
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	17	33	51.5%	[41.5%, 61.5%]	70%
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	14	33	42.4%	[32.4%, 52.4%]	60%
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	7	12	58.3%	[48.3%, 68.3%]	70%
Percentage of children age12-23 months who received a DPT3 vaccination before they reached 12 months	6	12	50%	[40%, 60%]	70%
Percentage of children age 12-23 months who received a measles vaccine	5	12	41.7%	[31.7%, 51.7%]	60%
Management/Treatment of Illness					
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	8*	22	36.4%	[26.4%, 46.4%]	50%
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	9	30	30%	[20%, 40%]	50%
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	17	65	26.2%	[16.2%, 36.2%]	40%

Water and sanitation					
Percentage of households of children age 0-23 months that treat water effectively.	51	186	27.4%	[17.4%, 37.4%]	50%
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	107	186	57.5%	[47.5%, 67.5%]	70%

ENSURING DATA QUALITY

A number of mechanisms to ensure data quality have already been outlined in previous sections of the DIP. Supervision of data collection, development of reporting forms, and M&E training will be led by DOW's M&E Officer. Quality assurance protocols for both facility and community-based information systems will be established at the beginning of program implementation in collaboration with the MOH.

Trainings on data collection and analysis are planned at least once a year for various stakeholder groups including the DHMT, providers at health facilities, community health workers, and community leaders. Through these exercises, DOW will help participants understand the importance of collecting quality data and how to interpret it.

At facilities, regular review of facility registers will be conducted randomly and compared to monthly monitoring forms to ensure complete and correct reporting of MNH-related data. Periodic meetings with the DHMT to review problems in data collection and recording will facilitate discussion about ways to improve data reliability. At the community level, CORPs responsible for data collection will be directly supervised by DOW staff and will also include periodic random verification of submitted data through household visits. Table XX outlines some of the regular monitoring activities that will take place to ensure quality in program activities and data monitoring.

Table 12: Partial List of Project Monitoring Activities

MONITORING ACTIVITY	FREQUENCY	PERSON RESPONSIBLE
Follow-up supervision after facility-based training	Within one month of initial training and after six months	Training Coordinator and District Nursing Officer (DNO)
Follow-up supervision after community-based training	Within two weeks of initial training and after six months	Training/ BCC Coordinator and District Public Health Officer (DPHO)/ District Public Health Nurse (DPHN)
Meeting with CHEWs to discuss data and monitoring of CORPs	Monthly	BCC Coordinator and District Public Health Officer (DPHO)/ District Public Health Nurse (DPHN)
Meeting with CORPs to discuss community activities and report on community data	Monthly	CHEWs
Meeting with the DHMT to discuss ongoing program activities	Quarterly	Project Director and DHMT

Collection and monitoring of MNH utilization data at all facilities	Monthly	M&E Coordinator and District Health Records Information Officer (DHRIO)
Monitoring of MNH equipment and supply chain data	Quarterly	M&E Coordinator and District Health Records Information Officer (DHRIO)
Joint supervisory visits to each program health facility	Biannually	Project Director and District Medical Officer (DMO)
Meetings with HFCs, village chiefs, and other community stakeholders	Quarterly	BCC Coordinator
Meetings with DHMT and Civil Registry Office to discuss recording of births and deaths in the community	Quarterly	M&E and BCC Coordiator and District Health Records Information Officer (DHRIO)
Maternal and neonatal morbidity and mortality review (MMR) meetings	Quarterly	Project Director, M&E Coordinator, and DHMT

Data collected from the community and that from health facilities in a supervision area will be shared among stakeholders and the community to stimulate positive action. At community or facility catchments area, DOW will strive to post analyzed feedback on public notice boards that show comparative performances of all indicators in other supervision areas. These will be intended to stimulate positive competition within supervision areas. These will also go along way in enhancing the spirit of performance contracting which is gaining popularity in all service provision areas in Kenya.

M&E TOOLS TO BE USED

Knowledge, Practices and Coverage Surveys: Knowledge, Practices, and Coverage (KPC) surveys were developed and used during the initial assessment to identify mothers' experience related to pregnancy, childbirth, neonatal care, HIV/AIDS and malaria, and provided the baseline for all intervention indicators. Priority intervention areas include barriers to health care access, treatment seeking behavior, and the need for health education. (A more detailed description and analysis of these results are presented in Section E2.) The KPC survey will be re-administered during the midterm and endline evaluations in order to determine the change in care seeking behavior. DOW and MOH staff will analyze survey results jointly and results will be shared with appropriate local partners. These results will inform modifications to program activities.

Health Facility Assessments: The Health Facility Assessment (HFA) was conducted by a consultant from the Averting Maternal Death and Disability program at Columbia University (AMDD) and will be repeated at the end of the project. An abridged version of the HFA will be conducted at midterm, since much of the data gathered at baseline will be collected on an ongoing basis during the life of the project. The HFA is focused on the material resource components of health facilities and support staff practices, measuring the quality of obstetric and neonatal care. UN process indicators were calculated at baseline and will be calculated on an annual basis.

Table 13: Revised set of UN Process Indicators and Recommended Levels[1]

Indicator	Minimum acceptable level
#1: Amount of emergency obstetric care (EmOC): Basic EmOC and Comprehensive EmOC facilities	For every 500,000 population, there should be: At least 5 EmOC facilities (including at least 1 **Comprehensive** EmOC facility).
#2: Geographical distribution of EmOC facilities	All sub-national areas have at least 5 EmOC facilities (including at least 1 Comprehensive EmOC facility) for every 500,000 population.
#3: Proportion of all births in Basic and Comprehensive EmOC facilities; and in all surveyed facilities	Target to be set locally.
#4: Met need for EmOC: Proportion of women with serious complications who are treated in EmOC facilities and all surveyed facilities	**At least 100%** of women estimated to have obstetric complications are treated in EmOC facilities.
#5: Caesarean sections as a percentage of expected births	As a proportion of estimated births in the population, caesarean sections account for **not less than 5% nor more than 15%.**
#6: Case fatality rate for direct obstetric causes	The case fatality rate among women with direct obstetric complications in EmOC facilities is **less than 1%.**
#7: Intrapartum case fatality rate as a percentage of all births	No standard has been set.
# 8: Percentage of maternal deaths due to indirect obstetric causes in EmOC and in all surveyed facilities.	No standard has been set.

Cohort Analysis: DOW will use cohort data collected by the focus health facilities to monitor the utilization of maternal and neonatal health services in the program area. With assistance from the DHMT, forms will be developed to capture important MNC health facility data including EmONC signal functions (mentioned earlier), other MNH-related services, and utilization (reported earlier), which will be collected on a quarterly basis from the focus facilities and reviewed on an annual basis from the DHMT. (Other MNH-related service results from the baseline HFA are detailed below.) Results of the analysis of this data will be shared with health providers to inform training, IEC, and other program activities.

Table 14: Other MNH-related services provided in last 3 months

	Partograph	Breech delivery	Rapid HIV test	Nevirapine - mother	Nevirapine - baby	Fistula repair
Kapenguria DH	√	√	√	√	√	NO
Ortum MH	√	√	NO	NO	√	NO
Chepareria HC	NO	NO	NO	NO	NO	NO
Kabichbich HC	NO	NO	NO	NO	NO	NO
Kacheliba HC	NO	NO	NO	√	NO	NO
Sigor HC	NO	√	NO	NO	NO	NO
Konyao Disp	NA	NA	NA	NA	NA	NA

[1] UNICEF, WHO, UNFPA. REVISED Guidelines for monitoring the availability and use of obstetric services. Forthcoming.

Lomut Disp	NA	NA	NA	NA	NA	NA
Serewo Disp	NA	NA	NA	NA	NA	NA

Provider Training Assessments: DOW staff will conduct training assessments in order to evaluate the quality of training curricula (these reviews will not focus on provider performance). Evaluation methods will include comparisons of participants' knowledge, attitudes and practices pre- and post-training. These assessments will be conducted through short surveys and direct observation of provider performance in training exercises. Feedback from training assessments will be provided to facilitators and trainees on an ongoing basis to improve training quality. Refresher trainings will be conducted on an annual basis, or as determined by MOH staff and survey results.

Clinic Provider Performance Evaluations and Precepting: Clinic health providers (MO's, CO's, and Nurses) will be evaluated for quality of care delivered to patients post-training. Since providers' attitudes toward and treatment of patients is an important factor in patient's ability to adhere to treatment, DOW staff (including the Technical Director/Training Coordinator) will use direct observation to determine if patient-provider interactions improve after trainings. Criteria for improvement will be established in a participatory manner with the target beneficiaries during training activities and feedback mechanisms will also be established. The purpose of this activity will be to improve training protocols and provide feedback to providers rather than to conduct a performance evaluation. Evaluation methods will include direct observation of provider-client interaction, patient records, and client exit-interviews.

Client Satisfaction Surveys: DOW will adapt the client satisfaction surveys from Engenderhealth's COPE Handbook, to assess perceived quality of care. These surveys will be conducted at the beginning and end of the project and results will be shared with the DHMT as well as clinic staff.

A list of Process Indicators to be reported and analyzed by the project and not already mentioned in this section is found in Annex 11.

DATA COLLECTION METHODS

The Community Vital Statistics Reporting Form will be developed in consultation with the DMOH and community leaders. Advice will also be solicited from other Child Survival projects already implementing similar CBHIS, including Amref in Busia. The form will be initially implemented in Kapenguria Division at the beginning of Year 2 of the program in order to pilot its effectiveness. This will allow for close monitoring by DOW and the DHMT. CORPs will be trained on the importance of capturing community data and methods for effective data collection and analysis. Forms will be collected by DOW monthly and reviewed with the DMRIO on a quarterly basis. The CBHIS will be expanded to all five Divisions of the proposed project in Year 3 once initial evaluation of the pilot program has taken place and systems have been effectively integrated at the district level. Feedback mechanisms will also be developed to facilitate the flow of information back to the source so as to motivate those who are collecting it.

DATA ANALYSIS AND SHARING

Routine analysis of monitoring data by project staff and local partners will enable action planning to address implementation problems. Mechanisms for routine review of data will include monthly meetings for project staff, quarterly review meetings with partner NGO/FBO/PVO staff, and quarterly meetings with DHMT and other indicated health facility staff.

Results from data analysis exercises will be shared with the community through trainings and regular meeting with CORPs involved in data collection. Immediate feedback to facility-based providers will be given during monthly supervisory visits to hospitals, health centers, and dispensaries. Every six months, DOW's M&E Officer will also share data improvement activities in the form of a report with the DHMT and the Provincial Medical Officer's (PMO's) office. Through annual meetings organized by the Kenya USAID Mission and CSHGP grantees, program updates will also be shared with key PVO partners.

ASSESSMENT OF M&E SKILLS OF LOCAL STAFF

Regular assessments of provider M&E skills will be undertaken by DOW staff during supervisory visits as described earlier. DOW will work with the DMRIO to ensure that the MOH monthly record forms are being filled out and submitted in a timely manner and that key staff members are able to accurately fill out MNH-related registers. DOW will also work with the DHMT to ensure regular meetings of health facility staff to discuss and analyze data with the intent of transferring the responsibility for these meetings to the MOH before the end of the project.

SUSTAINABILITY OF M&E

Because DOW intends to build upon existing data collection systems mandated by the MOH, many of the M&E activities are designed to improve current data collection and analysis processes. Newly created forms to capture key data including obstetric and neonatal complications will serve as a tool to highlight the importance of MNH services at health facilities and will either be integrated into current registers or continue to be collected with supervision and guidance from the DHMT.

Although the Community-Based Health Information System (CBHIS) will be developed by DOW, current discussions with the MOH suggest that community data systems will be part of the Kenya National Health Sector Strategic Plan in the future. Through training and education of community members on the importance of data collection and analysis, communities will take ownership of monitoring and reporting activities by the end of this project. DOW staff will work with the DHMT to facilitate integration of community data into the DHIS.

OPERATIONS REASEARCH

I. Vouchers for Safe Delivery

Utilization of safe motherhood services is severely compromised by lack of infrastructure and poverty. Through focus groups with beneficiaries, DOW will identify behavioral and resource barriers to using facility-based delivery services. Based on these findings, DOW will pilot a model of either transportation or delivery vouchers to be provided to women during ANC visits as part of birth plans. The mechanism for vouchers will be designed in partnership with community leaders, NGOs, and providers familiar with the program location. Women will be able to exchange vouchers for transportation or delivery services from a network of sources in the program location. DOW will monitor the effectiveness of these vouchers in increasing utilization of facility-based delivery services; if the vouchers are found to be effective, DOW will advocate with communities and focus health centers to take up collective financing of the voucher model by the close of the program.

II. Community-Based Newborn Care

The neonatal case fatality rate (CFR) at Kapenguria District Hospital was nearly 30%—a staggering figure by any measure that suggests that the quality of newborn care in West Pokot is poor. Because we

know that most women prefer to deliver at home, this is likely an underreporting of the true neonatal CFR. While elements of routine newborn care such as drying and warming of the baby, clean cord care, and skin-to-skin contact, especially for low-birthweight babies will be taught in training of CORPs, evidence suggests that community health workers are capable of performing other life saving functions such as neonatal resuscitation. DOW has been in discussions with UNICEF to determine the feasibility of a community-based newborn care pilot. However, because it would require CORPs to provide life saving skills, special permission would have to be sought from the Kenyan government, who normally discourages unskilled workers to perform such skills. Although it may be out of the scope of this project, DOW will nevertheless continue discussions with the MOH and UNICEF to fully assess the possibility.

CONTRIBUTION TO CSHGP PROGRAM RESULTS

This information was detailed in section E3.

CONTRIBUTION TO USAID MISSION AND PROGRAM RESULTS

This information was detailed in section E3.

EVALUATION PLAN

I. Midterm Evaluation

DOW will undertake a Mid-Term Evaluation (MTE) at the end of Year 2 to assess progress on the program indicators. A MTE Consultant will be responsible for facilitating a participatory evaluation process; engaging input from DOW staff, local partners, beneficiaries, and USAID Mission staff; and authoring an evaluation report. In addition to qualitative input from beneficiaries and partners, the evaluation will draw on data collected through the project's monitoring process. The MTE will assess achievement of targets and benchmarks, and identify and strategize around barriers to the achievement of objectives. Should significant barriers or differences from the DIP be identified, project staff, core partners, and USAID Mission representatives will undertake analysis and action-planning to implement alternative methods for achieving objectives – or, if necessary, propose modified targets and objectives (for CSHGP staff input and approval).

II. End-of-Project Evaluation

DOW will also engage an Endline Evaluation Consultant to facilitate a process similar to the MTE, and to report on project results and impact. The final evaluation will compare baseline and endline data and consider progress towards indicators, as well as the effectiveness of innovative approaches. Project staff will disseminate project results, lessons learned, and best practices to Kenyan and International stakeholders.

ORGANIZATIONAL STRUCTURE

The DOW CSH program is coordinated and managed from DOW HQ in New York by **Kavita Bali, Masters in Public Health (MPH), Program Manager**. Ms. Bali works under the direction of **Vandana Tripathi, MPH, Program Director**, who reports to the **Executive Director, Thomas Dougherty, MPH**. Ms. Bali, is also a Monitoring and Evaluation (M&E) Specialist. The **Finance Director, Abigail Smith, Masters in Business Administration) MBA**, oversees budget development, as well as revenue and expense tracking and reporting to donors. Ms. Smith has presented CSHGP financial procedures to colleagues at the DIP Mini University in 2004. Ms. Tripathi, the point person for the development of this program and for DOW programs in Kenya since early 2004, continues to provide technical assistance to the program. Rebekah Wheeler serves as the Program Associate, providing research, administrative, and logistical support. **Further information on the roles of Headquarters (HQ) staff is provided in Job Descriptions (JDs) in Annex 5**.

DOW has a team of committed advisors serving on the **Program Committee** of the Board of Directors who provide additional technical support. Advisors include **Dr. Allan Rosenfield, Dean, Mailman School of Public Health at Columbia University**; **Dr. Mary Ann Chiasson, Vice President, Research and Evaluation, MHRA**; **Dr. Victoria Sharp, Director, HIV/AIDS Center for Comprehensive Care (CCC) at St. Luke's – Roosevelt Hospital**, and **Dr. Steven Arpadi, former Associate Director of the CCC**. Dr. Sharp, President of DOW's Board of Directors and a DOW volunteer, has been working closely with DOW's current HIV/AIDS project in Kenya since early 2004. Dr. Arpadi, a pediatric AIDS and Prevention of Mother to Child Transmission (PMTCT) specialist with experience in AIDS treatment programs in Africa, has served as clinical mentor and QI Specialist for all Kenya programs, and visits the programs several times a year. Dr. Rosenfield has provided guidance regarding technical interventions and recently documented best practices to be applied in this program.

In Kenya, the program is led by the **Child Survival and Health (CSH) Program Director**, **Eunice Okoth**. Ms. Okoth is a Kenyan nurse who has extensive experience in CSH and Maternal and Neonatal Health (MNH) programming and is an expert in clinical training and community education. Ms. Okoth has worked with partners to develop and implement work plans and supervise all staff and activities in the absence of a Project Director. Ms. Okoth reports to Ms. Bali in HQ, and the two are in regular daily email and telephone contact. All other project staff have been or will be recruited from within Kenya; they include a Training Coordinator, BCC Coordinator, M&E Coordinator, Mobile ANC Coordinator, and five Community Health Extension Workers (CHEWs).

Please see CVs and JDs in Annex 5 for description of the roles of these staff.

In addition to these technical staff there is a Project Assistant who provides logistical and administrative support, and an Accountant who ensures accurate and appropriate reporting of financial information. Staff from DOW's current HIV/AIDS project in Kenya provide technical support to the CSH project, sharing lessons learned from their experience working in West Pokot to ensure rapid rollout of CSH activities. The HIV/AIDS staff includes **Marina MacNamara, MPH, the HIV/AIDS Project Director**, who has been overseeing implementation of DOW's HIV/AIDS activities in Kenya since June 2005, and **Dr. Samson Kiprono**, the lead Medical

Officer on DOW's HIV/AIDS project and a former District Medical Officer for Health in the West Pokot District.

Partners involved in project management include the **District Health Management Team (DHMT)**, and particularly the **District Public Health Nurse** and the **District Health Records and Information Officer (DHRIO)**. Staff of partner NGOs/FBO work to ensure integration with activities of their community networks. Key health facility staff are responsible for management and supervision of CORP activities. As a program partner, **PSI staff** will be involved in trainings on malaria control. In all training activities, MOH trainers and staff will be involved whenever possible. Other authorities, including the **District Commissioner**, the **Provincial Medical Officer**, are kept apprised of project activities and outcomes, provide feedback and guidance, and ensure coordination between project activities and evolving MOH/Division of Reproductive Health (DRH) policy.

The **CSH Project Director** and other project staff will make regular visits to health facilities and other implementation sites for monitoring, troubleshooting, and data gathering. The HQ **Program Manager/M&E Specialist** will undertake at least one monitoring visit annually to Kenya for a duration of at least ten days. One other DOW management person will visit annually, to ensure that systems for administration and compliance with DOW and USAID policy are robust. This visit will last at least 12 days.

Regular meetings among partners will be held as opportunities to gather and report on management data and to identify and respond to problems in implementation. The HQ-based Finance & Administration Director is responsible for establishing HQ and field office financial management systems to ensure that controls and procedures are followed. Monthly funds requests will be prepared by the CSH Project Director and reviewed by the Program Manager and Finance Director at HQ prior to being authorized. The Accountant in the field will prepare monthly expense reports, which will be sent to HQ. The Accountant will ensure compliance of tracking and management with laws governing NGO activities in Kenya. To monitor project expenses against the budget at HQ, DOW uses an accrual-based accounting system that records costs by individual expense, program, and funder allocation. In addition, the Finance Director will perform at least two reviews in the field over the life of the proposed program. DOW is audited annually by an independent accounting firm, which includes an A-133 audit focusing on specific government programs.

TECHNICAL ASSISTANCE AND TRAINING NEEDS

The HQ-based Program Manager, Kavita Bali, will provide regular technical assistance (TA) for email requests from the field and anticipated needs based on upcoming program activities. On-site TA will be provided through regular field visits by Ms. Bali.

Technical areas that will require outside TA are listed below. In addition to consulting Kenyan-based individuals from various international and local NGOs and UN agencies with expertise in these intervention areas, CSTS+ staff will be consulted further about these issues.

I. Malaria Interventions

Although DOW has achieved technical competence in HIV/AIDS and MNH programming, the acute malaria burden in West Pokot requires use of new resources and approaches. We would

welcome recommendations for resources (for behavior assessment, training, etc.) that would help us integrate best practices related to malaria programming. The TRMs for malaria (and for MNC) provide an important starting point, but other suggestions are welcome.

II. MNC and FGM

DOW recognizes the definitions of basic and emergency obstetric care that are globally accepted (and promoted by the Kenyan MOH Division of Reproductive Health), and their implications for what services should be available at what facilities (e.g., C-sections are part of comprehensive obstetric care, and should be at referral/tertiary facilities). However, in our program areas, over 97% of women experience the most extreme form of FGM – infibulation. This means that a much higher than 'normal' percent of women experience prolonged labor and really need access to C-sections. (Of course, there are only two operating theaters in this large District of ~400,000 people). We have obtained a few technical resources on managing MNC among infibulated women (including recommendations for care to be provided during ANC – the current local provider recommendation that women experiencing their first pregnancy come to facilities for delivery is clearly not adequate). We anticipate identifying creative responses to this issue during the program but will seek further guidance from the Population Council in Nairobi and local experts such as Dr. Hillary Mabeya, an obstetrician who is a DOW-Kenya board member and who has managed hundreds of infibulated women over the years and performed dozens of fistula repairs in the region.

Section E7: Organizational Development Plan

Doctors of the World is not a new grantee and will therefore not submit this section.

Section E8: Training Plan

NB: All trainings will be planned by DOW's Training Coordinator and supported other DOW/MOH staff. Trainings have been categorized into Facility Level Training or Community Level Trainings. Each facility-based training will be followed by two supervisory visits—one within a month after the training and the other after six months—to ensure that clinicians are routinely and correctly practicing newly acquired skills. Each community level training will be followed up within two weeks and again after six months. All trainings will take place within the district. However, in instances where caseload may not be adequate within the district, alternate sites within the Province will be utilized for clinical trainings.

Training Topic	Participants	# of Trainings	Days	# Participnts per Training	Total # Being Trained	# of Trainers/ Materials	Quarter
FACILITY LEVEL TRAINING							
CLINCAL SKILLS							
Focused Antenatal Care (FANC) including Malaria in Pregnancy (MIP) and Prevention of Maternal to Child Transmission (PMTCT) of HIV	Providers from focus hospitals, health centers, and dispensarie	4	3	25	100	2 DOW and 2 MOH trainers/ Pelvic Model	Y1, Q4
Normal Delivery, including Use of Partographs, Assisted Vaginal Delivery (AVD), and Active Management of Third Stage of Labor (AMSTL)	Providers from focus hospitals, health centers, and dispensarie	4	3	25	100	4 MOH/DOW trainers/ Birth Simulator(Model)	Y1, Q4
Emergency Obstetric and Neonatal Care (EmONC), including Female Genital Mutilation (FGM)-related Complications and Appropriate Referral Mechanisms	Providers from focus hospitals, health centers, and dispensarie	4	3	25	100	2 DOW and 4 MOH trainers/ Birth simulators , obstetric Models & Baby Ann manikin.	Y1, Q4
Postpartum and Newborn Care	Providers from focus hospitals, health centers, and dispensarie	4	3	25	100	4 MOH/DOW trainers / baby dolls Models	Y1, Q4
Post Abortion Care (PAC)	Providers from focus hospitals, health centers, and dispensaries	2	10	12	24	4 MOH/DOW trainers. Pelvic Models, MVA kits	Y2, Q1
Facility Infection Prevention	Providers from focus hospitals, health centers, and dispensarie	4	1	25	100	4 MOH/DOW trainers	Y1, Q4
Malaria Prevention and Control Refresher	Providers from focus hospitals, health	4	1	25	100	4 MOH/DOW trainers with support from PSI.	Y1, Q4

Training Topic	Participants	# of Trainings	Days	# Participnts per Training	Total # Being Trained	# of Trainers/ Materials	Quarter
	centers, and dispensarie						
General HIV/AIDS Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y1, Q4
FANC Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y3,Q1,
Normal Delivery Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y3 Q1
EmONC/FGM Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y3 Q 1
Postpartum and Newborn Care Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y 3, Q1
PAC Refresher	Providers from focus hospitals, health centers, and dispensaries	4	1	25	100	4 MOH/DOW trainers	Y3 Q2
Facility Infection Control Refresher	Providers from focus hospitals, health centers, and dispensarie	4	1	25	100	4 MOH/DOW trainers	Y3, Q4
MANAGEMENT SKILLS							
On-site QA/QI with a focus on COPE	Providers from focus hospitals, health centers, and dispensaries	4	3	25	100	4 MOH/DOW trainers	Y2 Q1
Data collection of MNH activities and use (HMIS)	Providers from focus hospitals, health centers and dispensaries	4	3	25	100	4 MOH/DOW trainers	Y2 Q1

Training Topic	Participants	# of Trainings	Days	# Participnts per Training	Total # Being Trained	# of Trainers/ Materials	Quarter
MNH Supply Chain	DHMT and Health Facility In-charges	1	3	30	30	2 DOW trainers 2 MOH trainers	Y2 Q2
COPE Follow-up/Refresher Training (whole site)	Facility staff.	4	1	25	100	4 MOH/DOW trainers	Y3 Q2
Data Collection Refresher	Facility providers	4	1	25	100	4 MOH/DOW trainers	Y3 Q2
MNH Supply Chain Refresher	DHMT and Health Facility In-charges	1	3	30	30	4 MOH/DOW trainers	Y3 Q2
COMMUNITY LEVEL TRAININGS							
KNOWLEDGE							
Kenya National Community Strategy	PHOs, CBO/FBO staff	1	3	30	30		Y2 Q1
General MNH, HIV/AIDS, and Malaria Prevention for Community Partners	HFC members and CBO/FBO staff	2	2	35	70	4 MOH/DOW trainers.	Y1Q2
General MNH, HIV/AIDS, and Malaria Prevention for Chiefs/Asst. Chiefs	Chiefs/ Assistant Chiefs	5	1	26	130	4 MOH/DOW trainers	Y2 Q1
General MNH, HIV/AIDS, and Malaria Prevention for CORPs	CORPs	5	3	25	125	4 MOH/DOW trainers	Y2 Q1
Birth planning & Focused Antenatal Care (FANC) including Malaria in Pregnancy (MIP) and Prevention of Maternal to Child Transmission (PMTCT) of HIV	CORPs	5	3	25	125	4 MOH/DOW trainers.	Y2 Q2
General MNH, HIV/AIDS, and Malaria Refresher for Community Partners	HFC members and CBO/FBO staff	2	3	35	70	4 MOH/DOW trainers	Y3 Q1
General MNH, HIV/AIDS, and Malaria Refresher for Chiefs/ Assistant Chiefs	Chiefs/Assistant Chiefs	5	1	26	130	4 MOH/DOW trainers	Y3 Q1
General MNH, HIV/AIDS, and Malaria Refresher for CORPs	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q1
FANC Refresher	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q1
BEHAVIOR CHANGE							
Behavior Change Advocacy Messaging for HFC and Community Partners	HFC members and CBO/FBO staff	2	1	35	70	4 MOH/DOW trainers	
Behavior Change Messaging for CORPs	CORPs	5	1	25	125	4 MOH/DOW trainers	Y2 Q2
On-site training in MNH Referral	CORPs	5	3	25	125	4 MOH/DOW trainers	Y2 Q2
FGM Sensitization for Community Partners	HFC members and CBO/FBO staff	2	1	35	70	4 MOH/DOW trainers	Y2 Q3
FGM Sensitization for Chiefs/ Assistant Chiefs	Chiefs/ Assistant	5	1	26	130	4 MOH/DOW trainers	Y2 Q2

Training Topic	Participants	# of Trainings	Days	# Participnts per Training	Total # Being Trained	# of Trainers/ Materials	Quarter
	Chiefs						
FGM Sensitization for CORPs	CORPs	5	1	25	125	4 MOH/DOW trainers	Y2 Q2
On-site MNH Referral Refresher	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q1
FGM Sensitization Refresher for Community Partners	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q 4
FGM Sensitization Refresher for Chiefs/ Assistant Chiefs	Chiefs/Assistant Chiefs	5	1	26	130	4 MOH/DOW trainers	Y3 Q 4
FGM Sensitization Refresher for CORPs	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q 4
SKILLS							
Community-based Postpartum and Newborn Care	CORPs	5	1	25	125	4 MOH/DOW trainers	Y2 Q2
Data Monitoring and Reporting	CHEWs	1	2	5	5	4 MOH/DOW trainers	Y2 Q2
Data collection and use : Community-based Health Information System for Community Partners	HFC members and CBO/FBO staff	2	1	35	70	4 MOH/DOW trainers	Y2 Q2
Data collection and use: Community-based Health Information System (CBHIS) for Chiefs/ Assistant Chiefs	Chiefs/ Assistant Chiefs	5	1	26	130	4 MOH/DOW trainers	Y2 Q2
Data collection and use: Community-based Health Information System (CBHIS) for CHEWs/CORPs	CORPs	5	1	26	130	4 MOH/DOW trainers	Y2 Q2
Postpartum and Newborn Care Refresher	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q1
Data Monitoring and Reporting Refresher	CORPs	5	1	25	125	4 MOH/DOW trainers	Y3 Q1
Data collection and use Refresher for Chiefs/ Assistant Chiefs	Chiefs/ Assistant Chiefs	5	1	26	130	4 MOH/DOW trainers	Y3 Q1
Data collection and use Refresher for CHEWs/CORPs	CHEWs /CORPs	5	1	26	130	4 MOH/DOW trainers	Y3 Q1

Acronyms: MOH = Ministry of Health; PVO = Private Voluntary Organization; PSI = Population Sciences International; PHO = Public Health Officer; CBO = Community-based Organization; FBO = Faith-based Organization; MNC = Maternal and Neonatal Care; FGM = Female Genital Mutilation; BC = Behavior Change; CORP = Community-Owned Resource Person; HFC = Health Facility Committee

Section E9: Work Plan

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
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 assessments																
Conduct data quality validations service at the clinical level																
Enter and Analyze data																
Draft DIP and send to out for review																
Complete and submit DIP																
Revise, defend and approve DIP																
Identify and develop curricula for trainings based on KPC results																
Identify and develop curricula for CBHRP training to respond to baseline findings																
Assess gaps in procurement chain for MNC supplies and medications																
Review data collection tools																
Assist facilities in purchasing ITNs through provision of seed money and supervision of purchase and distribution																
Quarterly CSH-West Pokot Partner Meetings																
Annual meeting with PVO CSH Partners																

Section E9: Work Plan

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
Review District data tools and systems; work with DHMT to identify package of improved data tools																
Identify appropriate BCC and community mobilization strategies																
With HFCs, create data forms to capture CORPs activities																
Trainings Phase I: Facility Level																
CLINICAL SKILLS																
Focused Antenatal Care (FANC) including Malaria in Pregnancy (MIP) and Prevention of Maternal to Child Transmission (PMTCT) of HIV																
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), including Female Genital Mutilation (FGM)-related Complications and Appropriate Referral Mechanisms																
Postpartum and Newborn Care																
Post Abortion Care (PAC)																
Facility Infection Prevention																
Malaria Prevention and Control																
General HIV/AIDS																
MANAGEMENT SKILLS																
On-site QA/QI with a focus on COPE																
Data collection of MNH activities and use (HMIS)																
MNH Supply Chain																
Trainings Phase II: Community Level																
KNOWLEDGE																
Kenya National Community Strategy																

Section E9: Work Plan

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, HIV/AIDS, and Malaria Prevention for Community Partners																
General MNH, HIV/AIDS, and Malaria Prevention for Chiefs/Asst. Chiefs																
General MNH, HIV/AIDS, and Malaria Prevention for CORPs																
Birth planning & Focused Antenatal Care (FANC) including Malaria in Pregnancy (MIP) and Prevention of Maternal to Child Transmission (PMTCT) of HIV																
BEHAVIOR CHANGE																
Behavior Change Advocacy Messaging for HFC and Community Partners																
Behavior Change Messaging for CORPs																
On-site training in MNH Referral																
FGM Sensitization for Community Partners																
FGM Sensitization for Chiefs/ Assistant Chiefs																
FGM Sensitization for CORPs																
SKILLS																
Community-based Postpartum and Newborn Care																
Data Monitoring and Reporting																
Data Collection and Use : Community-based Health Information System for Community Partners																
Data collection and use: Community-based Health Information System (CBHIS) for Chiefs/ Assistant Chiefs																
Data collection and use: Community-based Health Information System (CBHIS) for CHEWs/CORPs																
Training Phase III: Refreshers																
Facility Level Refreshers																

Section E9: Work Plan

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
CLINICAL SKILLS																
FANC Refresher																
Normal Delivery Refresher																
EmONC/FGM Refresher																
Postpartum and Newborn Care Refresher																
PAC Refresher																
Facility Infection Control Refresher																
MANAGEMENT SKILLS																
COPE Follow-up/Refresher Training (whole site)																
Data Collection Refresher																
MNH Supply Chain Refresher																
Community Level Refreshers																
KNOWLEDGE																
General MNH, HIV/AIDS, and Malaria Refresher for Community Partners																
General MNH, HIV/AIDS, and Malaria Refresher for Chiefs/ Assistant Chiefs																
General MNH, HIV/AIDS, and Malaria Refresher for CORPs																
FANC Refresher																
BEHAVIOR CHANGE																
On-site MNH Referral Refresher																
FGM Sensitization Refresher for Community Partners																
FGM Sensitization Refresher for Chiefs/ Assistant Chiefs																
FGM Sensitization Refresher for CORPs																
SKILLS																

Section E9: Work Plan

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
Postpartum and Newborn Care Refresher																
Data Monitoring and Reporting Refresher																
Data collection and use Refresher for Chiefs/ Assistant Chiefs																
Data collection and use Refresher for CHEWs/CORPs																
Project Activities Cont'd																
Implement sustainable solutions to supply gaps at health facilities																
Develop, implement and monitor MNC transportation system																
Renovate and equip four health centers for improved MNC, delivery and EOC services																
Quarterly QA/QI monitoring visits to focus sites by DHMT																
Quarterly coordination meetings of DHMT and District Civil Registry Monitoring Committee																
Develop curricula for all CBHRP trainings																
CORPs conduct *barazas* on HIV/AIDS and prevention and malaria																
Develop and implement plan with facilities, AMPATH, and DOW HIV/AIDS clinic to enroll MNC clients in full ART through referral and mobile HIV management teams																
Conduct quarterly supervision meetings with NGOs/FBO																
Quarterly meeting with DHMT on use of maternal death reviews																
Provide vehicles to health centers for patient transfers																
Nurses conduct monthly TBA monitoring visits at 8 MOH sites																
Conduct training of HFCs and health centers in monitoring CHWs																

Section E9: Work Plan

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
HFCs conduct monthly monitoring meetings with CHWs																
Regular meetings with NGOs/FBO to collect data from activities																
Conduct training for chiefs in community data collection and the importance of registering community births and deaths																
Work with DHMT to incorporate data collected from CORPs																
Implement community MNC services with mobile outreach teams																
Midterm and End line Evaluation																

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 1:
Response to Application Debriefing

Annex 1: Response to Application Debriefing

This annex provides feedback on the comments made by reviewers of the original proposal.

USAID
FROM THE AMERICAN PEOPLE

May 15, 2006

Thomas Dougherty
Doctors of the World
375 West Broadway, 4th Floor
New York, NY 10012

Re: Child Survival and Health Grants Program Application Review FY 2006

Dear Mr. Dougherty:

I am pleased to inform you that the Doctors of the World application submitted for Kenya for th FY 2006 Child Survival and Health Grants Program was recommended for award.

The Office of Acquisition and Assistance (OAA) will be contacting you shortly to begin negotiations and request additional budget information and/or clarifications. OAA will make a pre-award responsibility determination and evaluate costs for fairness and reasonableness. In the meantime, you must not incur expenses attributable to the activities outlined in your application. This letter does not commit USAID to awarding a cooperative agreement.

An orientation meeting for FY 2006 grantee recipients will be held in early October to which your organization will be invited.

I would like to congratulate you on your success in this very competitive process. The FY 2006 review process was highly competitive due to the number and quality of applications submitted. Enclosed is a debriefing packet that provides a summary score sheet as well as consolidated reviewer comments with recommendations to consider in the detailed implementation plan.

We appreciate the effort that your organization devoted to preparing this application and thank you for your interest in USAID's child survival and health programs.

Sincerely yours,

Richard S. Greene

Richard S. Greene
Director
Office of Health, Infectious Disease and Nutrition
Bureau for Global Health

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
www.usaid.gov

Annex 1: Response to Application Debriefing

GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2006

Applicant: Doctors of the World
Country: Kenya
Category: Standard

Categories	Entry	Standard	TB	Expanded	FP
Number reviewed	11	8	6	14	2
Number funded	4	3	1	4	0
Highest score	91.77	93.16	93.68	97.41	82.62
Lowest score	55.58	83.07	80.26	76.55	76.30
PVO App. Rank		2			
PVO App. Score		91.90			

Individual Category Scores for Standard: (Maximum Points in Parentheses)

Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Performance M&E	Management Plan	Collaboration w/USAID Mission	Total Points
(1)	(4)	(25)	(25)	(25)	(10)	(10)	(100)
.91	3.70	23.13	22.88	22.96	8.88	9.45	**91.90**

Annex 1: Response to Application Debriefing

Name of Applicant: **Doctors of the World**
Name of Country: **Kenya**
Application Category: **Standard**

EXECUTIVE SUMMARY

Strengths

This section is clear, concise, and responsive to the RFA guidelines. It summarizes the problem statement, project goal, objectives, and major indicators. There are important references to national and target area vital statistics.

Weaknesses

Descriptions of quality and access issues could provide even more of an understanding of the difficult area. These are well described later in the text and could be pulled forward and summarized here.

DESCRIPTION OF THE APPLICANT

Strengths

This section clearly presents DOW's mission and major sectors. It describes prior experience in child survival and neonatal health in several countries, including strengthening health services, delivery of health services at the community level, and developing linkages. DOW is currently a recipient of CSHGP funds in Romania.

DOW is a registered NGO in Kenya where its prior experience has been with HIV/AIDS programming. It is willing to take on new intervention areas, utilizing its existing platform. It is beginning an HIV/AIDS program in West Pokot District, the proposed project site, in collaboration with the USAID Mission's very successful PEPFAR project, AMPATH.

Weaknesses

Most of DOW's documented experience-to-date with USAID-funded programs and the CSHGP has been in relation to HIV/AIDS or TB, with limited prior experience in MNC or malaria control programs.

SITUATIONAL ANALYSIS

Strengths

This section includes a comprehensive health assessment, with referenced sources for key information. The geographical locations in the proposed district are those of greatest need, and the target population is one of the neediest groups in Kenya.

There is a detailed description of the various components of maternal, child, and neonatal health, and the reasons for the high levels of maternal and neonatal morbidity and mortality indicate a complex problem associated with several interrelated factors. DOW discusses fertility and birth spacing issues which are relevant to its maternal health intervention. The major issues around HIV/AIDS are presented: the magnitude of the problem, issues of care of orphans and vulnerable children (OVC) and people living with HIV/AIDS, availability of ARV therapy, and the lack of reliable data on HIV prevalence. DOW presents a rationale for including HIV/AIDS activities as an integral part of maternal and reproductive health services.

DOW discusses the current capacity of the local health system in relation to MNC, HIV/AIDS, and malaria services. There is a clear description and comprehensive assessment of socioeconomic factors which indicates DOW's understanding of the local situation. There is mention of female genital cutting (FGC), indicating its magnitude and demonstrating that it will be among the most difficult problems the project will have to address. Physical barriers to accessing health services (e.g. obstetric and neonatal services) are described. Identified cultural and medical barriers and health seeking behavior around breastfeeding practices and immunizations are directly related to the strategies and activities proposed.

DOW has provided a thorough description of programs in the district implemented by other organizations and PVOs. The discussion includes opportunities for collaboration with these organizations in order to complement available expertise and to ensure sustainability. Letters of collaboration and endorsement from USAID, the MOH (provincial) and other partners are provided in the application. An inclusive application planning process is described involving stakeholders in the district and with the MOH.

Weaknesses

This section could be strengthened by a more comprehensive discussion of the existing health system, including community resources and structures, to clearly understand the foundation for the proposed project. At the community level, the application needs to indicate which community resources will be utilized, who will conduct supervision, what the referral chains are, etc. At the health system level, the application needs to indicate which types of capacity building efforts will take place at the various levels of the system. Since the application is very dependent on training providers, it would be helpful to

include background information on available training experiences and to explore and exploit other mechanisms to improve provider performance.

It would be helpful to include additional information on community health practices, especially for malaria and pneumonia. Key child survival practices (e.g. Vitamin A coverage, ORT use) need further elaboration. It would also be useful to include a broader discussion of issues associated with prevention of mother to child transmission of HIV/AIDS (PMTCT) and how DOW intends to strengthen integration of services.

This section will need to go further in examining barriers at community and household levels, going beyond identification to analysis. The discussion of issues surrounding post-partum care and providers should contain much richer information. It would be valuable to bring forward some of the discussion on the three delays discussed later in the application. Since a majority of births take place at home, it is important to discuss the role of TBAs and DOW's strategy to redirect their role to that of educators. Due to the relatively higher number of post-partum deaths, information regarding the feasibility of adapting the timing of post-partum care and other issues which could have an impact on deaths from hemorrhage would be relevant.

Additional socioeconomic factors relevant to the proposed interventions need to be added to the general discussion. For example, literacy levels have a great impact on maternal and child health practices.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

The goal, objectives and indicators appropriately respond to the identified health needs. The application provides a valuable systems thinking and there is a clear and systematic description of the proposed interventions with an appropriate balance of health facility and community activities. The program contributes to CSHGP and USAID/Kenya strategic objectives and results.

DOW anticipates working with existing USAID partners and NGOs. There is an excellent description of the program's potential linkages with ongoing health activities, particularly the HIV/AIDS intervention. The discussion includes links with AMKENI, PSI, the Population Council and Save the Children's Saving Newborn Lives and highlights opportunities to utilize innovative approaches and materials related to PMTCT, insecticide treated nets (ITNs), safe motherhood and newborn care. For example, DOW will adapt new approaches developed by global partners, such as the household-to-hospital continuum of care (HHCC) developed by ACCESS and other relevant JHPIEGO/MNH materials.

Accessibility and logistic issues are addressed. DOW plans to provide mobile services to improve transportation for the DHMT through assistance for MOH vehicle maintenance, enabling monitoring and supervision of services. Capacity building is very critical to program success and has been addressed at the MOH level and through other partners. DOW discusses its plan to strengthen the existing MOH health management information system (HMIS) and current data collection to improve reporting, contributing to national MNC, HIV and malaria program reporting.

DOW is addressing an important gap in MNC in the target area. This section describes an appropriate MNC framework which is based on overcoming the three identified delays. It respects MOH policies; for example, TBAs will be used as community educators rather than receive training on safer birthing techniques. Basic equipment to upgrade the health facilities to conduct quality emergency obstetric care is reasonable. Some clarification is needed for the reason why episiotomy has been ruled out as a clinical intervention since technically it forms a necessary part of obstetric management in FGC clients.

The application focuses on MNC but also strengthens links with HIV/AIDS and malaria programs. It introduces and strengthens antenatal care to address missed opportunities for HIV/PMTCT and malaria prevention. It builds on an existing HIV/AIDS program implemented by DOW in other areas. The advantages of sharing staff time and expertise are recognized and built into the application.

Several innovative approaches will be implemented and documented, including the transportation vouchers for mothers in the community. It is recommended that the team keep careful records of the costs and effectiveness, looking ahead to potential replication of successes.

Weaknesses

The community mobilization strategy as well as the involvement and role of TBAs needs to be better defined and described. How motivated are TBAs to make a change in their work from providers to mobilizers? It may be helpful to further discuss the success DOW has had elsewhere in using TBAs for referral. It would be useful to discuss the potential role TBAs could have in advocacy to stop FGC.

This section would be strengthened with further discussion on increasing the use of facilities. The relationship between facility improvements (e.g. upgrading facilities, strengthening referral systems, etc.) and how these will lead to increased service use needs further explanation.

The capacity building approach focuses mainly on training through workshops and classes. However, since a very important component of performance improvement results from monitoring and in-service training and mentoring, these activities need to be further elaborated on in the application. The maintenance of MOH vehicles and

provision of mobile services, although excellent, raises sustainability issues which need to be addressed. It will also be important to address the high staff turnover since this could adversely affect the proposed program.

It is understood that DOW's HIV/AIDS prevention activities are complementary to MNH and therefore do not have the expected classic community level program components such as working with the adolescent population and other special groups. However, it is important to describe in this section any other partners or organizations that will be conducting community-level HIV/AIDS prevention activities.

The malaria intervention needs further detail, particularly its approach for fostering behavior change. The discussion should include an explanation of how malaria cases will be treated, the implementation of intermittent preventive treatment (IPT) and other new treatment policies, and availability of drug supplies and the transition period to ACTs.

PERFORMANCE MONITORING AND EVALUATION

Strengths

This section includes a very comprehensive program matrix covering objectives, indicators, targets and planned activities. The M&E approach makes use of the existing MOH information and surveillance subsystems. The plans to obtain baseline information are comprehensive and will produce important information to develop the DIP. There is good use of existing tools for the baseline survey. Midterm and final evaluations are planned with the participation of external consultants.

The application describes technical backstopping from headquarters for M&E systems, and relies locally on the MOH's existing capacity. There are good linkages to the District Health Information Officer, thus strengthening the MOH HMIS.

DOW will test and evaluate reports which include data that the MOH plans to collect that have been recommended by other partners, in addition to improving data collection for current reports. DOW proposes to create new sources of information, mainly community-based, but will also introduce new data collection to support district capacity.

The selected indicators for the planned MNC, HIV/AIDS and malaria interventions match the program objectives and respond to the three strategic approaches: health facility upgrading, strengthening community awareness and improving the HMIS.

Weaknesses

Since the project relies heavily on the existing HMIS, which is mostly health facility-based to provide essential information on the number of cases seen and attended (e.g. estimation of malaria and HIV through surveillance, etc), it is essential to consider and

discuss the quality of information generated by the current system. The Situation Analysis, for example, mentions that surveillance systems are unreliable.

The two community-based health information systems (CBHRP and community vital statistics forms) will need further discussion to demonstrate their feasibility. It is often the case that CHWs have difficulty understanding forms, even sensitive forms made pictographically. It can be difficult to initiate the routine collection and reporting of information at the CHW level, particularly if health staff is not accustomed to processing community-based information on a systematic and routine basis.

It is recommended that DOW reassess what information can be obtained at the community level. Useful qualitative information could be collected. While not intending to be prescriptive, if CHWs and/or TBAs had notebooks, they could have the names of their clients and some important vital events in the community recorded. An experienced health worker could use those notebooks to recall important information.

A CV needs to be provided for the proposed monitoring and evaluation manger.

MANAGEMENT PLAN

Strengths

This section describes a clear organizational structure with a good balance of staff from the HQ and the local office. There is a description of collaboration with local partners, which provide most of the community-based staff. DOW supports the clinical interventions. The work plan is clearly written; however, planning for and scheduling training across all the proposed areas will be a challenge to include in the work plan.

Weaknesses

The organizational chart itself is vague and needs to better depict the organizational structure described in the application. It would be helpful to demonstrate clear linkages to sources of expertise, particularly for MNC, and to other partners. The CVs for technical and managerial personnel need to include the key positions in Kenya, in addition to those provided at the headquarters level. It was also unclear as to why two HIV/AIDS Project Directors are proposed at 5% and 10% LOE; the rationale for two positions will need to be clarified.

An experienced MNC coordinator/technical advisor-type position will need to be proposed as a key personnel position for this project. The HQ Program Director has mainly HIV/AIDS experience in comparison to MNC, and most likely, in line with the position's responsibilities, would have insufficient time to look at many critical and technical issues related to MNC programming.

Although the application mentions frequent visits to the field, it would be helpful for DOW to clarify if it will open an office in the target province which would be ideal for day-to-day monitoring and supervision. Perhaps infrastructure exists already with DOW's other project and sharing of these is planned. Therefore, it is also important to provide further clarification on the relationship between the staff from DOW's existing project and the new program.

COLLABORATION WITH USAID FIELD MISSIONS

Strengths

The Mission's SO and IRs are identified and congruent with the proposed project. The application's objectives and indicators complement the Mission M&E indicators and are an excellent complement to the Mission's health program and PEPFAR efforts both geographically and programmatically. There has been good collaboration between DOW and the Mission and a communication channel is proposed for on-going Mission input. A letter of support is provided from the Mission. DOW aims to assist a very needy and largely ignored district and the project would strengthen the Mission's proposed expansion of health service delivery within the Rift Valley Province. There are very few partners working in this district because of the difficult terrain and previous turbulent politics.

Weaknesses

It would be very useful to establish a more formal or "official" Project Advisory Committee and to invite the Mission to participate in order to ensure Mission and bilateral partner input on an on-going basis.

Annex 1: Response to Application Debriefing

The following document provides feedback on the comments made by reviewers of the original program budget.

Comment:
Certification IV, Prohibition on Assistance to Drug Traffickers For Covered Countries and Individuals: While you signed for the Key Individual and the Participant, you missed a signature line stating that you read the Prohibition in ADS 260 and are responsible for it. Please print a new page and sign. Also please note that your KEY INDIVIDUAL will be your in-country program director. Your proposal indicates that you have not hired him/her yet. Once you have done so, your organization will be responsible for submitting a signed certification to the Agreements Officer.

Response:
We are sending this newly signed certification. Once our in-country Program Director is hired, he/she will sign the Key Individual certification and we will send that form to the Agreements Officer as well.

Comment:
Letter of Credit: Does DOW have a letter of Credit with USAID? If so, please provide a number. If not, please indicate such in Section VI. 4. Please indicate accordingly and resubmit the page.

Response:
DOW does not have a letter of credit with USAID, as indicated in Section VI. 4. We are resubmitting that section.

Comment:
Non-Expendable Property: Section VI. 5. c. requires DOW to list all of the non-expendable property that will be purchased under the agreement. Currently it states none is planned; however, five vehicles are listed in the budget and program narrative. Presumably, DOW intends to purchase these vehicles. Please indicate as such in this section and resubmit.

Response:
A table showing all of the non-expendable property that will be purchased under the agreement was added to Section VI. 5. c. for the two vehicles that we expect to purchase with USAID funds. We will resubmit that section.

Comment:
Source Origin, Componentry of Goods: Section VI. 5. d. has a slight deviation with the budget table. In this section, office furniture is listed at $3,000 and the budget lists it at $2,800. Also this section shows only 7 Exam Tables; the budget also shows 7 in the unit/quantity section; however, the budget is based on 11 units. Please correct to indicate the true number in all sections.

Response:
The office furniture was incorrectly listed at $3,000 in section Section VI. 5. d and has been changed to $2,800. The correct number of exam tables is 7, but the budget calculation was

incorrectly based on 11, and was subsequently updated. The budget worksheets are also being resubmitted with this correction.

Comment:
Please confirm that DOW has knowledge of the general prices of goods, services and salaries in Kenya either through direct experience or through a survey (formally or informally) of DOW's professional network.

Response:
DOW has knowledge of the general prices of goods, services and salaries in Kenya through its current HIV/AIDS program in Kenya (since July 2005), and through discussion with other NGOs working in Kenya during our assessment visit for this proposal.

Comment:
On the sheet titled Program Consultants, Consultant 3 is missing the number of days.

Response:
The text in the table was corrected. The calculations already included the number of days so there is no change to the total amount.

Comment:
On the sheet titled Travel, it is unclear which member(s) of HQ staff will make the trips to Kenya for the Monitoring and Evaluation section and the HQ Management and Oversight. It appears that the listed FTE will be insufficient to support this number of trips. If it is one individual, is it DOW's intent to send someone twice a year to Kenya in years 1 and 3?

Response:
We have indicated on the Travel Budget worksheet the individuals who will be traveling. The Program Manger will make one trip per year. This is now shown on the Travel worksheet page as “Monitoring /Evaluation - HQ Prog. Mgr.” Additionally, one member of the DOW HQ staff – either the Executive Director, Program Director or Finance Director – will make one trip in Year 1 and one trip in Year 3 - shown on the Travel Budget worksheet as “Management and Oversight - DOW Exec. Director or Program Director or Finance Director” for HQ Management and Oversight, and a financial review and audit if necessary. We would select the appropriate individual to travel during the course of the project depending on our determination as to the support and oversight most needed for the project at that time.

Comment:
On the sheet titled Travel, please indicate the number of days for the Ex-Pat annual leave section. It is understood that s/he will be only traveling one day; however, DOW should indicate how long you anticipate him/her to be out of the country. Also, please clarify what the $400 local travel represents? Does the $2,400 price indicate the price from Kenya to the USA as opposed to the US to Kenya? Will DOW buy 'one year' round trip tickets?

Response:
We updated the Ex-Pat annual leave section to indicate a 15-day annual leave out of the country as this has been the average amount of time provided to Ex-Pats in the past. The $400 local

travel represents the cost of a trip between Eldoret and Nairobi, Kenya. The $2,400 price indicates the price of a round trip ticket between the USA and Kenya. In the past year (2005-2006) DOW's travel costs from NYC in the US to Nairobi, Kenya has averaged $2,000. However, because we are not yet certain whether the Ex-Pat will be traveling to NYC or somewhere else in the US as their home of record, we budgeted $2,400 for further travel within the US if not New York. DOW usually buys 'one year' round trip tickets and the Ex-Pats use the return portion at the start of their annual leave and then another round-trip is purchased to return them to Kenya and a leave at the end of the second year.

Comment:
On the sheet titled Travel, the flight prices vary from $2,000 to $2,400. Why the variation? Please review the current market prices including all fees and adjust accordingly. Please add any upward adjustment to DOW's stated cost share.

Response:
$2,000 assumes that the flight will depart from or arrive in New York, to or from Kenya. As stated above, travel to and from NYC-Nairobi has averaged $2,000 for project staff and consultants on our HIV/AIDS project there. The $400 variation is to account for travel to/from anywhere else in the U.S. than New York. While we can be sure that DOW Program staff will travel to and from NYC, we allowed $400 additional for other travelers (consultants) that may need to travel from elsewhere in the U.S.

Comment:
On the sheet titled Travel, please review all per diem rates. They seem low and are probably the 2005 rates. Notably DC and Nairobi are higher than the stated sums. Please add any upward adjustment to DOW's stated cost share.

Response:
DOW travelers consistently spend far less than the official per diem rates for all travel and therefore we do not generally use US government per diems in our budgets because we want to budget expenses based on lower (realistic) projections of what will be spent. DOW staff travel to Washington DC several times per year and staff and consultants have traveled for DOW to and from Nairobi in the past year, and so our budget uses rates that reflect what amounts we have spent in practice. Should actual per diem costs turn out, in the course of this project, to be higher than we have budgeted for, DOW will cover this out of additional cost share funds.

Comment:
On the sheet titled Training and Conferences, the Training entitled Staff list 25 participants but the organizational chart indicates only six employees. Please clarify.

Response:
The training is actually entitled "Training in Monitoring / Supervision / Data Collection of MNC Activities for HFCs and Clinical Staff" – the full text was not visible because the row height was only one line and the full text wrapped to two lines. The formatting was updated to show the full text. The 25 participants refer to the HFCs and Clinical Staff, not DOW staff.

Comment:

Annex 1: Response to Application Debriefing

On the sheet titled Rent and Maintenance, there is reference to an Office 2. Will there be a 2nd office? If so, the rent should be listed. In the portion regarding cleaning, it indicates cleaning for Office 2 but not Office 1. If there will not be a 2nd office, please remove any reference to it. Also, the cleaning section has January, February, March, April for headings instead of Year 1, 2, 3, 4. Please clarify and make appropriate adjustments.

Response:
There will not be a 2nd office – that was an error caused by not deleting unused rows from a budget template. We removed all references to it. We also updated the portion regarding cleaning to indicate that it applies to Office 1, not the non-existent Office 2, and changed the headings from January, February, March, April to Year 1, 2, 3, 4.

Comment:
On the sheet titled Supplies Materials Equipment, the copier and printers have been left off the total. Fortunately, it appears that the correct number (with these items included) has been factored into the text of the application and other tables. Please adjust the table and confirm that the number is correct elsewhere.

Response:
The copier and printers had inadvertently been left off the total, but were added back into the total column on the backup sheet. As noted, there is no effect on the total budget numbers.

Comment:
On the sheet titled Supplies Materials Equipment, there is a blank column labeled Year 5. Please delete as this is a 4 year agreement and all other sheets only have a Year 4. If there is a compelling reason for the column, please explain.

Response:
The column labeled Year 5 was deleted.

Comment:
On the sheet titled Supplies Materials Equipment, DOW lists 7 monitoring meetings 12 times a year at $25 a meeting. It is unclear why it is not simply listed as 84 meetings. Presumably there are 7 sites that will be visited each month.

Response:
Yes, there are 7 sites that will be visited 12 times a year and the sheet has been updated to clarify that fact.

Comment:
On the sheet titled Year 1 Cash Projections, Cell AD 35 and AF 35 do not match but both represent the annual cash needs for Consulting/Contracting. It appears that AF 30 has already counted the insurance line item and then subsequently adds it a second time in cell AF 31. Please review and make appropriate corrections.

Annex 1: Response to Application Debriefing

Response:
Column AF was only there for us to double check the totals (though obviously it wasn't serving that purpose very well, if it had incorrect numbers) – it should not have been left in our submitted file (and was not included in the printed pages submitted) – and has now been removed from the electronic file.

Comment:
Further question via email on 7/10/06:
I noticed that the number of clinics to be supported seems to be either 7 or 8. It refers to 8 in Section 4.1 (page 11) of the technical proposal but the budget narrative page 4 refers to renovating or upgrading just 7 facilities.

Response:
DOW will be working with a total of 8 facilities - the District Hospital in Kapenguria (KDH), four health facilities, and three dispensary units. One objective of the project is to network the hospital and the 7 other facilities so that referrals, support, and supervision can be coordinated. The district hospital is not expected to require rehabilitation or furnishing (e.g. exam tables) and therefore we have included costs for renovation and furnishing at the 7 facilities only. The budget and project call for several types of training and follow-up training for the traditional birth attendants (TBAs) and community health workers (CHWs) at the 7 smaller facilities - as you will note from the budget worksheet, many of the trainings are scheduled for those seven sites. Much of that will not be required for staff at the hospital facility, however staff at the hospital will be responsible for supervision and transfers/referrals to/from the hospital, therefore some trainings have been planned for hospital staff in certain skill areas and in supervision.

REPORT ON THE KNOWLEDGE, PRACTICE AND COVERAGE BASELINE SURVEY

DOCTORS OF THE WORLD USA IN PARTNERSHIP WITH WEST POKOT DHMT

WEST POKOT CHILD SURVIVAL PROJECT

MARCH 2007

FUNDED BY THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

COOPERATIVE AGREEMENT NUMBER

Quite a number of people contributed immensely in various ways to the preparation, implementation and finalization of this baseline survey. This note is meant to acknowledge their assistance. Top on this list are the target community members who enthusiastically provided information on the children under 24 years old under their care through response to our interviews, discussions and all manner of dialogue on the issues of the survey. The survey benefited greatly from their input and this report is confirmation of that.

Special thanks go to the entire survey team in West Pokot, led by Kavita Bali, the Technical Advisor for the project and the District Health Management Team (DHMT). Thanks to the entire Core Team who devoted their time during their own training, training of interviewers & supervisors and also overseeing the data collection process. Special thanks, too, to Fredrick Olwal for data entry and preliminary cleaning. Many thanks are also due to DOW partners, HIV/AIDS Project Staff and community leaders whose support made the process possible: Their dedication and commitment to the process ensured that data collection was completed in time. Valuable comments on the draft report were received from various people and especially Marina MacNamara and Alice that helped to concretize the entire survey. The comments and advice are hereby acknowledged. It is not possible to mention by name all those who contributed to the successful completion of this exercise but named or not, we direct this note of thanks to all of you.

For Doctors of the World:
Michael, Bernard & Kavita Bali
February 2007
Kenya

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Illness
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
AQ	Amodiaquine
BCC	Behavior Change Communication
CATCH	Core Assessment Tool for Child Health
CBS	Central Bureau of Statistics
CI	Confidence Interval
CORE	Child Survival Collaborative and Resources Group
CSTS+	Child Survival Technical Support Plus Project
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DOW	Doctors of the World
DTC	Diagnostic Counseling and Testing
EmOC	Emergency Obstetric Care
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunization
FANC	Focused Antenatal Care
FBO	Faith Based Organizations
FGD	Focus Group Discussion
FP	Family Planning
GOK	Government of Kenya
HIV	Human Immune Deficiency Virus
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Child Illnesses
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
IUCD	Intra Uterine Contraceptive Device
KPC	Knowledge, Practice and Coverage
LLIN	Long Lasting Insecticidal Net
LQAS	Lot Quality Assurance Sampling
MAMAN	Minimum Activities for Maternal and Newborn
MDG	Millennium Development Goal
MIH	Maternal and Infant Health
MIP	Malaria in Pregnancy
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NGO	Non Governmental Organization
OVC	Orphaned and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PHO	Public Health Officer

PHT	Public Health Technician
PPC	Post Partum Care
RH	Reproductive Health
SP	Sulfadoxine-Pyrimethamine
SPSS	Statistical Package for Social Sciences
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TOST	Training of Survey Trainers
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WRA	Women of Reproductive Age

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ANNEXES

EXECUTIVE SUMMARY

Introduction: West Pokot District is located in North – Rift bordering Uganda to the West, Turkana to the North, Baringo and Marakwet to the East and Trans Nzoia to the South. It covers an area of 9,100km2 with a projected population of 413, 419. he maternal mortality rate in the District is estimated to be 565 deaths per 100,000 births, perceived to be an undercount due to the lack of comprehensive data on community-based maternal deaths. The infant mortality rate is estimated at 87.2 per 1,000 live births and the under-five mortality is estimated at 127 deaths per 1,000 live births. Neonatal mortality accounts for 30% of all infant deaths. The programme targets 5 divisions. The population of the program location is 257,083. This includes 61,699 women of reproductive age and 48,844 children under five years, of which, it is estimated, 11,616 are under 12 months; 10,603 are 12-23 months; and 26,625 are 24-59 months

Objectives: The goal is to contribute to the reduction of maternal and neonatal morbidity and mortality in five Divisions of the West Pokot District of Kenya. Dow's objectives are, by September 2010, to:

- Strengthen capacity of eight focus West Pokot District health facilities to provide quality maternal and newborn care, as appropriate within Ministry of Health policy.
- Strengthen community awareness of, demand for, and access to quality MNC services in the West Pokot District.
- Strengthen District Health Management Information System, particularly as related to maternal and newborn health.

Methods: Core Team members were trained by TOST trainers who later trained interviewers and supervisors. LQAS (Lot Quality Assurance Sampling) methodology was used to select children 0-23 and allowing over sampling 0-5 where the first sample fell above this bracket. Data was collected from a total of 126 respondents of children 0-23 months. Data was entered and analyzed using both Epi info and SPSS. The results were then discussed during post survey training before dissemination to stakeholders.

Findings:

Maternal and Newborn Care:

Only 3 out of 12 who had maternal cards had at least 2 TT injections by card compared to 68% (65/95) by recall. A third (31%) had attended ANC at least 4 times before the birth of the youngest child. Skilled health attendants delivered only about 26% of the children under study. About half (48%) of the mothers had at least one post partum check after the birth of the youngest child. Only 10% received information on child spacing during this period. Forty eight percent knew at least 2 maternal danger signs during post partum period while 72% of knew at least 2 neonatal danger signs.

Malaria:

Thirty eight percent of the children had fever in the last two weeks before the survey. Two percent sought medical treatment in a health facility. Only 22% were given the recommended anti-malarials (Amodiaquine, quinine and ACT drug). Much lower proportion of the mothers (5%) slept under mosquito net compared to 41% of the children.

HIV/AIDS:
Only 31% cited at least two correct ways of reducing the risk of HIV infection. HIV transmission through breast milk was cited by about 38% of the women interviewed. About 26% of the women received HIV counseling and testing services during pregnancy.

Other (CATCH) Indicators:
The survey found that 18% of the children were malnourished. In terms of severity, only 3% were found to be severely malnourished. About 26% of the households studied treated their water. However, when it came to use of soap or locally appropriate cleanser at the place of hand washing, only 18% had these supplies as observed by the interviewers.

Conclusions:

In a nutshell, respondent age had no association with the health indicators. However, there was significant association between women who work to earn money and number of ANC attendances; women who ever attended school and counseling during ANC, testing during ANC and 2TT. A lot of programmatic effort should be directed towards Kacheliba followed by Sigor and Lelan for the project to be able to over ally show significant improvements in the project indicators. A lot of effort should also be put to reach women who never attended school and use of appropriate methodologies to this category of people in both training and awareness creation.

1.0 BACKGROUND

1.1 PROJECT LOCATION AND BACKGROUND OF THE AREA

1.1.1 Location, administrative divisions, area and population: West Pokot District is located in North – Rift bordering Uganda to the West, Turkana to the North, Baringo and Marakwet to the East and Trans Nzoia to the South. It covers an area of 9,100km2 with a projected population of 413, 419. There are 10 administrative divisions and a total of 52 health facilities most of which are poorly staffed. West Pokot is a poor, rural, marginalized District whose primary ethnic minority population has limited access to health services and development infrastructure, while facing a heavy burden of health problems including high maternal and neonatal mortality, frequent malaria outbreaks, and a growing HIV/AIDS prevalence (DOW TOR, 2006).

1.1.2 Other health indicators

Over half of the District's population is poor, with 35% living in absolute poverty. A combination of difficult terrain and climate, poor infrastructure, and scant public resources has left the West Pokot District trailing in health and development; for nearly all health indicators related to child survival West Pokot District lags well behind the Kenyan average. The maternal mortality rate in the District is estimated to be 565 deaths per 100,000 births, perceived to be an undercount due to the lack of comprehensive data on community-based maternal deaths. The infant mortality rate is estimated at 87.2 per 1,000 live births and the under-five mortality is estimated at 127 deaths per 1,000 live births. Neonatal mortality accounts for 30% of all infant deaths. Maternal mortality and morbidity are exacerbated by the extremely high prevalence of the most extreme form of female genital mutilation. (Ministry of Finance and Planning, 2002)

The District has a consistently high malaria burden, with malaria as the leading cause of mortality and morbidity. Testing at VCT sites and among pregnant women shows a growing burden of HIV infection. Most health facilities in the program location are not able to provide maternal and newborn care services as recommended in Ministry of Health policy. District providers have received no training in focused antenatal care, current delivery and postpartum practices, essential newborn care, or the integration of HIV/AIDS and malaria control interventions with maternal and newborn health care. Community-based Health Resource Persons such as traditional birth attendants and community health workers, and local organizations such as NGOs and FBOs remain untapped partners for mobilizing community members to seek maternal and neonatal services and to practice positive health behaviors that promote maternal and neonatal survival and health. (Ministry of Finance and Planning, 2002)

1.2 CHARACTERISTICS OF THE TARGET BENEFICIARY POPULATION

The programme targets 5 divisions. The population of the program location is 257,083. This includes 61,699 women of reproductive age and 48,844 children under five years, of which, it is estimated, 11,616 are under 12 months; 10,603 are 12-23 months; and 26,625 are 24-59 months (Ministry of Finance and Planning, 2002). The program targets women of reproductive age and children under 12 months. An additional 865 individuals will receive training from DOW, including health providers, staff of partner organizations, and community members.

1.3 SOCIAL, ECONOMIC AND HEALTH CONDITIONS WITHIN THE PROJECT AREA

1.3.1 Literacy: The literacy level for the district by sex is 53.5% for males and 35.5% for females. Primary school enrolment rates are 64% for boys and 57% for girls respectively. Drop out rates are 3% for boys and 2% for girls (Ministry of Finance and Planning, 2002).

1.3.2 Economic conditions: Absolute poverty stands at 35%, with greatest impact being in the rural areas (53%). However both these poverty figures are much lower than indicated national poverty levels (56%). Agriculture is the main employer contributing to 78% of the income earning opportunities (Ministry of Finance and Planning, 2002). Among other contributory causes which include underdeveloped infrastructure, low literacy levels, and inter-clan warring especially over cattle, prevailing insecurity is cited as major cause of poverty in the area. Insecurity and related conflicts lead to scenarios that constantly deprive communities of their livelihood; leads to abandonment of homesteads, closure of markets and more often than not, suspension of all forms of economic activities, leaving already struggling communities more vulnerable. Within this generalized scenario, the most affected divisions with insecurity problems within the project area are Sigor, Kacheliba and Chepareria divisions (Ministry of Finance and Planning, 2002)

***1.3.3 Health Care Delivery* :** In the year 2002 there were an estimated 6 health facilities out of which 2 are hospitals. The patient to doctor ratio was pegged at 1:84,528 with an average distance to the health facility at 15km (Ministry of Finance and Planning, 2002).

1.3.4 HIV/AIDS: The district recorded a total of 11,200 patients since 1988 when the first case was diagnosed. The trend of HIV/AIDS picked up in 1990 to ever increasing cases to data, where more than 183 lives have been claimed. In the country however, the district is considered a low prevalence district. Although VCT centers are not common in West Pokot (only 5 working at any one time), PMTCT and DTC testing has been developed in 20 health facilities around the district. Statistics from these sites together show a prevalence rate among pregnant women of almost 3%; 25% among TB patients; and between 8 and 10% at VCT and general outpatient DTC testing sites (Ministry of Finance and Planning, 2002).

1.4 National Standards/Policies Regarding Maternal and Child Health

Key existing national standards for Maternal and Child Health include: Family Planning (FP); Focused Antenatal Care (FANC) and Malaria in Pregnancy (MIP); Prevention of Mother to Child Transmission of HIV(PMTCT); Essential Obstetric Care(EOC); targeted post-partum care; Integrated Management of Child hood Illnesses(IMCI); and Expanded Programme on Immunization(EPI). These are published policy documents which the project will need to abide with during implementation. There are a number of policies including HIV/AIDS and Malaria that are in process. For treatment of malaria, Artemisinin Lumefanthrine (AL) is currently recommended as first line drug in Kenya.

1.5 Overview of the Project: Partners, Goals, Objectives

The primary implementing partners for this project are DOW Kenya and West Pokot District Health Management Team (DHMT).

1.5.1 DOW: Doctors of the World-USA (DOW) is a U.S. Private Voluntary Organization (PVO) founded in 1990 by a group of volunteer physicians. DOW works within a network of 12

Doctors of the World/delegations; these are active in over 90 countries. DOW's mission is to mobilize the health sector to promote and protect health and other basic human rights for all people. Working with local partners, DOW projects build solutions to health crises with a focus on tuberculosis (TB) and HIV/AIDS, orphans and vulnerable children (OVCs), maternal and infant health (MIH), and survivors of rights abuses

1.5.2 West Pokot DHMT: The mission of DHMT is to promote and participate in provision of integrated and high quality Promotive, Preventive, Curative and Rehabilitative health care services to all residents of West Pokot District, Kenya. The DHMT plans, implements and monitors the delivery of healthcare within the district, and directly oversees management of most of the health facilities in the five divisions. The DHMT is therefore strategically positioned to influence the health of women and children in the project area. The team was selected as the partner to maximize the gains made by the project and importantly, ensure sustainability. To achieve these, the project will strengthen DHMT's management, supervision, and M&E skills, enabling it to better fulfill its responsibilities.

1.5.3 Project goal and objectives: The goal is to contribute to the reduction of maternal and neonatal morbidity and mortality in five Divisions of the West Pokot District of Kenya. Dow's objectives are, by September 2010, to:

- Strengthen capacity of eight focus West Pokot District health facilities to provide quality maternal and newborn care, as appropriate within Ministry of Health policy.
- Strengthen community awareness of, demand for, and access to quality MNC services in the West Pokot District.
- Strengthen District Health Management Information System, particularly as related to maternal and newborn health.

DOW will integrate essential HIV/AIDS and malaria interventions across these objectives. In addition to improving facilities' ability to provide antenatal, safe delivery, emergency obstetric care, and newborn care services as indicated in national policy, DOW will also work with local non-governmental and faith-based organizations and community-based health resource persons to raise community awareness of maternal and neonatal health risks, positive behaviors related to maternal and neonatal health, and utilization of related health services.

1.6 OBJECTIVES OF THE KPC SURVEY

The objectives of the KPC survey process were two-fold::

- To establish baseline information on critical maternal and child health indicators in the five target programme divisions.
- To build the capacity of DHMT and other local partners in carrying out KPC survey

2.0 PARTNERSHIP BUILDING

2.1 METHODS OF IDENTIFYING AND ENGAGING LOCAL PARTNERS

Before rolling out the program, the implementing agency (DOW) organized and undertook introductory meetings with potential Civil Society organization partners and Ministry of Health's DHMT. These meetings also availed opportunity for sharing program plans and information in preparation for undertaking the baseline survey exercise. An oversight body for the baseline survey exercise, termed core team, was formulated consisting of 5 DHMT representatives, one local CSO, the Pastoralist Area Development Organization (PADO) and three senior DOW staff

2.2 ROLE OF THE CORE TEAM

As already indicated, the Core team had oversight for the survey process. As expected and owing to participatory nature of KPC surveys, the core team received requisite training (from the team of engaged Survey consultants) that saw then plan for and undertake required training of survey supervisors and interviewers. The core team played crucial role of ongoing 'survey quality check' during the field data gathering process as well as in the post survey discussions and preliminary analysis of survey findings

3.0 METHODOLOGY

3.1 QUESTIONNAIRE DEVELOPMENT

3.1.1 KPC 2000+: The revised Rapid Core Assessment Tool for Child Health (CATCH) questions were used as the foundation of the KPC questionnaire. Other questions were obtained from the KPC 2000+ modules, as well as Minimum Activities for Maternal and Newbon Care (MAMAN) questionnaires: Respondent Background Information was also added. The questionnaire had the following sections: Background (pg 1-3), child spacing (pg 3-4), Antenatal (4-7), Delivery (7-11), Post partum (11-13), HIV/AIDS (13-15), Breastfeeding (15-18), Child immunization (18-19), Malaria – Treatment (19-20), Control of diarrhea (20-21), ARI/Pneumonia (21-22), Water and sanitation (22-23), Malaria – ITN use (23-24), Health contacts/IEC (25) and Anthropometrics (25) See annex A, KPC Survey Questionnaire

3.1.2 Field-testing and translation: The questionnaire was translated to 'Kipokot and Kiswahili', and back translated to reduce any information bias. These tools were then field tested at the end of the interviewers/supervisors training for veracity. The pre-test was carried out in identified and nearby non-sampled sub-locations of *Lorkanoi* and *Tingeiket*. The purpose of the field pre test was to check clarity of questions, translation, time taken to administer survey to an individual respondent as well as to re-affirm understanding of respondent selection procedures by the survey team. On the basis of observations, errors of commission or omission in the survey tools and survey team understanding of respondent selection procedures during the field test process, final tools were produced.

3.2 DOW KPC INDICATORS

The objectives and indicators for the project measured in this KPC survey are outlined below

Table 3.1: Objectives and indicators

Objectives/intervention area	Indicator	Definition of Indicator
Maternal and New born care Antenatal Care	Percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy	# of Mothers who mentioned attending ANC at least 4 times (Q16>3 times)/Total # mothers interviewed
	Percentage of mothers with children age 0–23 months who received two tetanus toxoid injections before the birth of their youngest child.	# of Mothers who receiving at least 2 TT injections (Q19 + Q21=>2)/Total # mothers interviewed
Safe delivery	Percentage of children age 0–23 months whose births were attended by skilled health personnel	# of children age 0-23 months whose birth was attended by skilled health personnel (Q31=A, B or C)/Total # of mothers interviewed
Post natal Care/Post partum care	Percent of mothers of children age 0-23 months who had at least one postpartum check-up	# of mothers who had at least 1 postpartum check up (Q46=1 and Q48=A, B or C)/ Total # of mothers interviewed
	Percentage of mothers of children age 0-23 months who received child spacing information during a postpartum check-up	# of mothers mentioned to have discussed family planning (Q42=B/ Total # of mothers interviewed
	Percent of mothers of infants 0-5 months who received neonatal care within two days of delivery.	# of mothers of 0-5 months who received neonatal care within 2 days of delivery (Q50<2 days)/Total # of mothers of 0-5 months children interviewed
	Percent of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period.	# of mothers reporting at least 2 known maternal danger signs (Q45=A,B,C,D,E or F/ Total # of mothers interviewed
	Percent of mothers of children age 0-23 months able to report at least two known neonatal danger signs.	# of mothers reporting at least 2 known neonatal danger signs (Q53=A,B,C,D,E,F,G,H or I/ Total # of mothers interviewed
Child health	Percent of children aged 0-5 months who were exclusively breastfed in the last 24 hours.	# of children age 0-5 months who drank milk in the previous 24 hours (Q68=1 and Q70A=1) AND did not drink any other liquid in the previous 24hrd (Q70B-Q70G=2) AND was not given any other foods or liquids in the previous 24 hours (Q71A-Q71O = 2)/Total # of mothers 0-5 months interviewed.
	Percent of children aged 0-5 months who were exclusively breastfed within the first hour after birth.	# of children 0-5 months who were put to the breast within 1 hour of delivery (Q64=1 AND Q65 Hours = 0)/Total # of mothers with 0-5 months interviewed
	Percent of mothers of children age 0-23 months with a child health card (interviewer-confirmed) for the youngest child less than 24 months of age	# of children with child health cards (Q75=1)/Total # of children included in the interview
HIV/AIDS	Percent of women with children 0-23 months who received HIV counseling and testing services during pregnancy.	# of mothers counseled and tested for HIV (Q29=1)/ Total # of mothers interviewed

Objectives/intervention area	Indicator	Definition of Indicator
	Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.	# of mothers who cite at least 2 ways of reducing HIV risk of infection (Q55=1 AND Q56=A,B,C,D,E,F,G,or H)/Total # of mothers interviewed
	Percentage of women who know about the risks of spreading HIV through breast milk.	# of women who mentioned the risk of spreading HIV through breast milk (Q63=A)/Total # of mothers interviewed
Malaria	Percent of mothers of children 0-23 months who slept under ITNs the previous night	# of mothers who slept under ITN (Q107=88=Mother)/Total # of mothers interviewed
	Percent of children 0-23 months who slept under ITNs the previous night.	# of children 0-23 who slept under ITN (Q107=1)/Total # of mothers interviewed
	Percent of mothers of children 0-23 months who know at least 2 ways to prevent malaria.	# of women who mentioned atleast two ways to prevent malaria/Total # of mothers interviewed

3.3 Sampling Design

3.3.1 Target population and sampling method: The survey-targeted mothers of children 0-23 months. LQAS (Lot Quality Assurance Sampling) was selected as a sampling methodology since DOW intends to monitor performance by supervision area and again it is the most suitable in child survival programmes. The terrain of West Pokot and population distribution also could not augur well with cluster sampling methodology requirements. A supervision area (also known as Lot) was defined as a Division in this case, which is also a supervision area according to the MOH structure. The project area has 5 supervision areas, each under a Public Health Officer (PHO). (Annex B, Map of Project Area).

3.3.2 Sampling frame: The sampling frame used for this study was obtained from the Ministry of Planning. The template, with reference from 1999 population census exercise, provided information by division, location, sub-location and village (See Annex C, Sampling Frame). The table below shows the distribution of villages and households in the project area (Table 3.1).

Table 3.1: Distribution of villages and households in the project area

Lot	Division/Supervision Area	Number of Sub locations	Population
1	Kacheliba	14	27,042
2	Chepareria	46	91,943
3	Kapenguria	28	84,195
4	Lelan	13	31,978
5	Sigor	21	44,257
	Total	**122**	**279,415**

3.3.3 Identifying interview locations: Using Standard LQAS methodology, the locations (villages) of interviews in each lot (Division) were selected based on population proportional to size (PPS) i.e. the sub location with a larger population had a much higher chance of being selected than the others. In some sub locations more than one village was selected due to small sizes. The sampling interval for each lot was calculated by dividing the total population by number of samples (19). This was then used to obtain the first interview location (villages) and the subsequent ones determined by adding the sampling interval to it until 19 samples were obtained.

3.3.4 Selecting households and respondents: Selection of household was carried out in the field. Spin the bottle method was used. The core team as well as the interviewers were trained on the technique. The supervisors together with the interviewers moved to the population centre of the village and then spun the bottle to obtain the first home at random. Once in the home then they would list the qualifying households and select one at random. At the household they would include the youngest child under 2 years as the reference child. In case of twins, then they would use a coin secretly to select a child for inclusion.

3.3.5 Use of over sampling techniqu e: If the respondent's youngest child was under six months of age then there would be no need for over sampling since this age bracket included both 0-5 and 0-23 months. But if the first sample was over 5 months then they would move to the next home whose gate was closest to the first home then check if an under 6 months child was present. This process would be followed until a child under 6 months was found. At this point then they would move to the next village to obtain the next sample. During the exercise over sampling could not be carried out adequately since children 0 – 5 could not be obtained in some villages which required an over sample.

3.3.6 Sample size: A sample size of 19 respondents per lot was used. A total of 95 samples for 0-23 months were obtained (19samples x 5 lots). An over sample was also obtained to ensure at least 95 samples for 0-5. At the end of the data collection exercise, 95 samples of 0-23 and 91 samples of 0-5 were obtained for the survey. This low number was because it was not possible to obtain 0-5 months in some lots. The 4 over sampled questionnaires were excluded since over sampling was done in the same village they had obtained 0-5 months at first interview.

3.4 KPC TRAINING

3.4.1 KPC training cu rriculum: The materials used to train the Core Team, Supervisors & Interviewers and post survey analysis team included: KPC 2000+, Field Guide, KPC Training Module 1; KPC training Module 2; and KPC training Module 3 respectively. These were obtained from the CSTS+ website.

3.4.2 Training of the Core Team: The Core Team had overall oversight of the KPC baseline process. The core team members consisted of 5 DHMT members, 3 DOW Program staff, a member of staff from a local NGO. The team underwent a 4-day training at the school of Nursing, Kapenguria District Hospital. The two Training and Survey consultants engaged in this exercise are USAID/CORE group/CSTS trained Survey trainers (TOST) in KPC methodology with guidance from the consultants; the core team developed the survey tools, the sampling

protocol and field data collection plan. As required, the core team took charge in training survey supervisors and interviewers with technical support from contracted consultants.

3.4.3 Selection and training of supervisors and interviewers: The Core Team working hand in hand with DOW identified and selected five supervisors and ten enumerators for the survey exercise. The 10 interviewers were a combination of trained nurses and final year nursing students from Ortum Mission Hospital while the 5 supervisors were drawn from Moi University School of Medicine. The medical learning and/or practicing background were desired given the focus (Maternal and Child Health) of the program. Care was also taken to ensure that significant number of the supervisor and interviewer team members are able to speak local language (Kipokot) for ease of communication since target respondents were expected to be predominantly semi or illiterate. The team was taken through a three day training covering basics of Survey planning and administration, understanding of survey tools and finally a pre-test exercise on the fourth and last day for practical exposure to what would more or less be the scenario during the survey exercise. (See Annex D, list of participants)

3.4.4 The Post-survey Analysis workshop: One week after the field data collection exercise and following successful data entry and preliminary data analyses by survey consultants, a post survey discussion and analysis workshop was organized. The workshop attended by core team members, Public Health Officers (PHOs) drawn from districts health facilities, representatives of government's Statistics and Registrar of Births and deaths, took opportunity to discuss preliminary survey findings including discussions of findings or emerging phenomenon requiring further investigation. The session also provided opportunity for discussing levels of effort for achieving set program indicators; a work in progress to be completed by DOW.

3.5 Data Collection and Quality Control Procedures

3.5.1 Data Collection: Data collection was a six-day exercise running from the 12-17 February 2007. Average questionnaire completion time was estimated at 50-60 minutes for the first two days. This duration reduced to about 30-45 minutes per respondent. While data collection went on relatively smoothly, a few challenges were encountered. For example some of the villages listed were not found and as such the core team selected another village at random from the list – until one was found that actually existed. Secondly, it was strenuous finding children under 6 months in some villages. Again access due to poor infrastructure was a big problem and interviewers walked long distances to get to the villages since routes were sometimes impassable by vehicle. These problems led to the addition of the sixth day to allow for completion of the survey. See Annex E, the logistics plan

3.5.2 Quality Control: Effective supervision and quality checks were in built into the survey process. A ratio of one supervisor to two interviewers was utilized for close support. In addition Core team provided on going quality spot checks at field level with immediate feedback to supervisors, including the point of submission of completed tools,

At the data management level, the data coordinator reviewed all the questionnaires and assigned them unique codes as well as undertaking cleaning before entry. Data capture screen was done in

Epi info to allow for possibility of checks and skips during data entry. The data entry was undertaken by two experienced data entry clerks under the supervision of the lead consultant who ensured the process was devoid of interruptions or distraction
Consistently, quality of the data entry process was monitored by randomly checking a sample of entered records to ensure that the data was entered accurately. Frequencies of all the fields were run to identify any outliers and suspect data and also to ensure that the correct denominators for all indicators were captured. The data coordinator ensured that the data entry clerks adhered to data back-up protocols.

The Data Coordinator using Epi-Info wrote the QES, CHK and PGM files. This made data entry easy and minimized keying errors. The data entry program had field validations (CHECK) to help control the keystrokes and limit acceptable data entry to only values that are valid for specific questions. The program also created jumps between data entry fields, following skips patterns in the questionnaire.

Data was exported to SPSS for Windows from Epi-info for cleaning and analysis. Running frequencies to identify any inconsistencies and missing entries was also undertaken to clean data. Records that had incorrect entries were confirmed from the relevant questionnaire and corrections made to reflect questionnaire entries.

3.5.3 Data Analysis: Post data entry cleaning was done before any analysis was conducted. Frequencies and cross tabs were run and these were shared with the post survey analysis team to confirm and also provide explanation to some occurrences. They also identified issues that required further qualitative investigations. Confidence intervals were also calculated for the indicators. Analysis by supervision area was also done and used to identify areas that would need a lot of effort in order to generally improve on specified indicators.

4.0 RESULTS AND FINDINGS

4.1 COVERAGE FOR PROJECT AND CATCH INDICATORS

4.1.1 Project Indicators:

Table 4.1: Coverage levels and corresponding confidence intervals for project indicators

Maternal and new born care Indicators	CATCH Indicator	Numerator	Denominator	Proportion Estimate	95% CI
Percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy		29	95	30.5	22% - 40%
Percentage of mothers with children age 0–23 months who received two tetanus toxoid injections before the birth of their youngest child.	CATCH	65	95	68.4	59% - 77%
Percentage of children age 0–23 months whose births were attended by skilled health personnel	CATCH	25	95	26.3	17% - 35%
Percent of mothers of children age 0-23 months who had at least one postpartum check-up		46	95	48.4	38% - 58%
Percentage of mothers of children age 0-23 months who received child spacing information during a postpartum check-up		9	95	9.5	4% - 16%
Percent of mothers of infants 0-5 months who received neonatal care within two days of delivery.		34	91[1]	37.4	27% - 47%
Percent of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period.		46	95	48.2	38% - 58%
Percent of mothers of children age 0-23 months able to report at least two known neonatal danger signs.		69	95	72.6	64% - 82%
Percent of children aged 0-5 months who were exclusively breastfed in the last 24 hours.	CATCH	18	95	19.8	12% - 28%
Percent of children aged 0-5 months who were exclusively breastfed within the first hour after birth.	CATCH	11	91	12.1	5% - 19%
Percent of mothers of children age 0-23 months with a child health card (interviewer-confirmed) for the youngest child less than 24 months of age		55	95	57.9	48% - 68%
HIV & AIDS Indicators		**Numerator**	**Denominator**	**Proportion Estimate**	**95% CI**

1 Four questionnaires were excluded since they were over sampled from same village where the first sample was taken.

Percent of women with children 0-23 months who received HIV counseling and testing services during pregnancy.		25	95	26.3	17% - 35%
Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.		29	95	30.5	22% - 40%
Percentage of women who know about the risks of spreading HIV through breast milk.		36	95	37.9	28% - 48%
Malaria Indicators		**Numerator**	**Denominator**	**Proportion Estimate**	**95% CI**
Percent of mothers of children 0-23 months who slept under ITNs the previous night		5	95	5.3	1% - 9%
Percent of children 0-23 months who slept under ITNs the previous night.	CATCH	39	95	41.1	31% - 51%

4.1.2 CATCH Indicators:

Table 4.2: Coverage levels for CATCH indicators that are not project indicators

Other Rapid CATCH Indicator Table	Numerator	Denominator	proportion
Anthropometrics			
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for age, according to the WHO/NCHS reference population)	17	94	18.1
Prevention of Illness/Death			
Percentage of children age 0-23 who received a post-natal visit from an appropriate trained health worker within three days after the birth of the youngest child	8	35	22.9
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	88	103**	77.7
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	Sample size too small[2]		
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	Sample size too small		
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	Sample size too small		
Percentage of children age12-23 months who received a DPT3 vaccination before they reached 12 months	Sample size too small		
Percentage of children age 12-23 months who received a measles vaccine	Sample size too small		
Management/Treatment of Illness			
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	8*	36	22.2
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	8	20	40.0
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	17	26	65.4
Water and sanitation			
Percentage of households of children age 0-23 months that treat water effectively.	25	95	26.3
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	17	95	17.9

*Note that only Amodiaquine, quinine and ACT were considered as appropriate treatment since they are the currently recommended drugs for malaria

** Estimated out of total 126 samples which include over samples. 23 did not indicate date of birth.

2 The sample of 95 children 0-23 months could not give adequate sample for 6-23 and 12-23

4.2 Social and Demographic Characteristics

4.2.1 Characteristics of children stu died: Slightly more than half (54%) (61/94) of the children under study were males while females comprised 46%. Majority of the children (65%) were under 6 months followed by those between 6-11 months (22%) and the least being 12-23 (13%). In one of the children, the age was not stated.

4.2.2 Respondent characteristics: The mean age of the respondents was 28 years. About 38% of these mothers never attended any school. Out of those who attended, majority (66%) had some primary school level of education while only 9% had completed secondary or higher.

The average number of children per family was found to be 4.7 ranging from 1 to 11 and a mean number of pregnancies at 4.8 ranging from 1 - 12.

4.3 Maternal and Newborn Care

4.3.1 Antenatal care: Only about 12% (11/95) of the mothers had maternal cards. And out of those who had cards only 3 of them had at least 2 TT injections by card compared to 68% (65/95) by recall. Concerning ANC attendance, the study finding was that about a third (31%) had attended ANC at least 4 times before the birth of the youngest child.

4.3.2 Delivery care: Skilled health attendants delivered only about 26% of the children under study. The remaining 74% of the mothers gave birth at home with support of TBA s and relatives.

4.3.3 Postpartum Care: About half (48%) of the mothers had at least one post partum check after the birth of the youngest child. During post partum checkup, only about 10% received information on child spacing. Forty eight percent of the mothers knew at lease two maternal danger signs during post partum period while about 72% of them knew at least 2 neonatal danger signs.

4.4 Breastfeeding, Nutrition and Anthropometry

4.4.1 Breastfeeding and Nutrition: Only about one in five of the children younger than six months old were found to be exclusively breast-fed. During the first hour after birth, the study found that only 12% were exclusively breastfed. In the case of the latter, mothers of rest of the children (88%) fed the children fresh animal milk, water, tea and porridge in addition to breast milk.

4.4.2 Anthropometry: Weight for age was considered as a measure for malnutrition during this survey. The survey found that 18% of the children were malnourished. In terms of severity, only 3% were found to be severely malnourished.

4.5 Childhood Immunizations

About 68% of the children had immunization card. However, immunization coverage could not be measured during this study since the sample size of 12-23 months was too small for statistical reliability

4.6 Malaria

Thirty eight percent of the children had fever in the last two weeks before the survey. Out of these only 2% sought medical treatment in a health facility. Among the children with fever, only 22% were given the recommended anti-malarials (Amodiaquine, quinine and ACT drug). Much lower proportion of the mothers (5%) slept under mosquito net compared to 41% of the children.

4.7 HIV/AIDS

The survey established that only 31% cited at least two correct ways of reducing the risk of HIV infection. HIV transmission through breast milk was cited by about 38% of the women interviewed. The survey also found that only 26% of the women received HIV counseling and testing services during pregnancy.

4.8 WATER AND SANITATION

Concerning effective water treatment before drinking, it can be shown that 26% of the households studied treated their water. However, when it came to use of soap or locally appropriate cleanser at the place of hand washing, only 18% had these supplies as observed by the interviewers.

4.9 HEALTH CONTACTS AND SOURCES OF INFORMATION

The findings show that Nurses/Midwives are the major sources of health information under the formal networks category. They provided information to half of the mothers (50%) as shown in table 4.3 below. At 8%, doctors came in second as health information providers while NGO/CBO came last (1%). Informally, most of health information was obtained through the provincial administration (12% by chief and assistant chiefs). The majority of the informal networks did not seem to provide health information at all as seen in table 4.3.

Table 4.3: Sources of health information

Signs and symptoms	*Label*	*n*	*%*
Formal Networks	Doctors	8	8.4
	Nurses/Midwives	47	49.5
	TBA	4	4.2
	NGO/CBO	1	1.1
Informal Networks	Husband/partner	0	
	Mothers in law	1	1.1
	Grandparent	0	0
	Other relatives	3	3.2
	Traditional healer	0	
	Chief/Ast chief	11	11.6
	Village elder	5	5.3
	Church	4	4.2

4.10 RESULTS BY LOT

The key finding of the study were also analyzed by supervision area. The purpose of this analysis is to identify supervision areas that would require more effort in order to change the indicators generally. The table below presents the comparison by intervention and supervision area

Table 4.4: Indicator performance by supervision area

Annex 2a: Baseline KPC Report

Key: Supervision Areas; 1=Kacheliba, 2=Chepareria, 3=Kapenguria, 4=Lelan, 5=Sigor
NB: In LQAS, skips and missing are never included in the sample size when using decision rule

	Indicator	Supervision Area (SA)					Remarks
		1	2	3	4	5	
Percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy	# correct	6	6	8	4	5	SA 4 and 5 are weak in this indicator
	Sample	14	13	17	18	16	
Percentage of mothers with children age 0–23 months who received two tetanus toxoid injections before the birth of their youngest child.	# correct	6	13	14	16	16	SA1 is very weak in this indicator
	Sample	18	16	18	17	17	
Percentage of children age 0–23 months whose births were attended by skilled health personnel	# correct	4	3	7	2	9	SA 3 and 4 are the weakest in this indicator
	Sample	19	19	19	19	19	
Percent of mothers of children age 0-23 months who had at least one postpartum check-up	# correct	5	9	10	9	13	SA 1 is the weakest in this indicator
	Sample	19	19	19	19	19	
Percentage of mothers of children age 0-23 months who received child spacing information during a postpartum check-up	# correct	2	3	4	0	0	All the SAs have a problem
	Sample	19	19	19	19	19	
Percent of mothers of infants 0-5 months who received neonatal care within two days of delivery.	# correct	4	3	7	7	13	SA 1 and 2 are the weakest here
	Sample	17	15	18	19	22	
Percent of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period.	# correct	12	13	10	6	5	SA 4 and 5 are the weakest
	Sample	19	19	19	19	19	
Percent of mothers of children age 0-23 months able to report at least two known neonatal danger signs.	# correct	16	13	15	13	12	Well performed in all SAs
	Sample	19	19	19	19	19	
Percent of children aged 0-5 months who were exclusively breastfed in the last 24 hours.	# correct	6	2	0	3	0	Poorly performing in all SAs
	Sample	17	15	18	19	22	
Percent of women with children 0-23 months who received HIV counseling and testing services during pregnancy.	# correct	3	5	9	7	1	SA1,2 and 5 poorly performing
	Sample	19	19	19	19	19	
Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.	# correct	6	6	11	2	4	Only SA 3 performed well
	Sample	19	19	19	19	19	
Percentage of women who know about the risks of spreading HIV through breast milk.	# correct	5	7	10	12	2	SA 1 and 5 are weak here
	Sample	19	19	19	19	19	
Percent of children 0-23 months who slept under ITNs the previous night.	# correct	8	7	9	3	12	SA 4 is the weakest performing
	Sample	19	19	19	19	19	

4.11 TEST OF ASSOCIATION

Table 4.5: Association between respondent age and health indicators

Factors	*Labels*	*Age of respondent %*		*P-value*	*Odds Ratio (OR)*	*Confidence interval (95%)*
		< 35yrs	*35+yrs*			
No of ANC attended	< 4 times	62.3	72.7	0.5137	0.62	0.11 – 3.03
	4 or more	37.7	27.3			
During ANC were you counseled	Yes	40.3	46.2	0.6998	0.78	0.20 – 3.06
	No	59.7	53.7			
During ANC were you tested	Yes	30.6	30.8	0.9930	0.99	0.24 – 4.43
	No	69.4	69.2			
Number of TT received	< 2TT	14.5	23.1	0.5115	0.61	0.11 – 3.51
	2+TT	85.5	76.9			
Received IPT during pregnancy	Yes	45.2	61.5	0.2858	0.51	0.13 – 2.01
	No	54.8	38.5			
Birth attended by skilled attendant	Yes	22.6	38.5	0.2344	0.47	0.11 – 1.97
	No	77.4	61.5			
At least 2 maternal danger signs known	Yes	50.0	23.1	0.0782	3.33	0.74 – 17.06
	No	50.0	76.9			
Know at least 2 ways of HIV transmission	Yes	33.9	30.8	0.8303	1.15	0.28 – 5.18
	No	66.1	69.2			
Ever had HIV test	Yes	30.9	41.7	0.4755	0.63	0.15 – 2.70
	No	69.1	58.3			
Ever breastfed child	Yes	80.3	84.6	0.7219	0.74	0.10 – 4.36
	No	19.7	15.4			
Child health card present	Yes	73.1	72.7	0.9812	1.02	0.18 – 5.18
	No	26.9	27.3			

More younger women (38%) attended ANC 4 times or more compared to the older women (27%). However, the difference was not statistical significant (p=0.62). The same trend was also observed on TT as more younger women than older ones received 2 or more TT (p=0.61). Almost twice as much younger women than the older ones knew at least 2 maternal danger signs. This however was also non significant (0.0782). None of the variables tested showed significant association with respondents' age. See table 4.5 for more details.

Table 4.6: Association between working status and health indicators

Factors	***Labels***	***Respondent working outside home to earn money %***		***P-value***	***Odds Ratio (OR)***	***Confidence interval (95%)***
		Yes N	***o***			
No of ANC attended	< 4 times	59.3	64.7	0.6380	0.79	0.27 – 2.31
	4 or more	40.7	35.3			
During ANC were you counseled	Yes	40.6	41.9	0.9033	0.95	0.36 – 2.46
	No	59.4	58.1			
During ANC were you tested	Yes	31.3	23.8	0.4388	1.45	0.51 – 4.14
	No	68.8	76.2			
Number of TT received	< 2TT	13.3	30.4	0.0816	0.35	0.09 – 1.30
	2+TT	86.7	69.6			
Received IPT during pregnancy	Yes	53.1	34.9	0.0900	2.11	0.82 – 5.51
	No	46.9	65.1			
Birth attended by skilled attendant	Yes	31.3	23.8	0.4388	1.45	0.51 – 4.14
	No	68.8	76.2			
At least 2 maternal danger signs known	Yes	40.6	52.4	0.2811	0.62	0.24 – 1.60
	No	59.4	47.6			
Know at least 2 ways of HIV transmission	Yes	50.0	20.6	0.0030	3.85	1.39 – 10.79
	No	50.0	79.4			
Ever had HIV test	Yes	37.0	26.8	0.3432	1.61	0.54 – 4.78
	No	63.0	73.2			
Ever breastfed child	Yes	75.0	82.0	0.4310	0.66	0.21 – 2.09
	No	25.0	18.0			
Child health card present	Yes	79.2	67.9	0.3150	1.79	0.51 – 6.60
	No	20.8	32.1			

More women who work outside their homes to earn money attended at least 4 ANC (41%) compared to their counterparts (35%). This however was not statistically significant (p=0.6380). The same trend was also observed on TT injections as more working women received at least 2 TT (87%) compared to non-working women (70%). Women working to earn money were 3.9 times more likely to know at least 2 ways of HIV transmission compared to those who do not work (p=0.003, OR=3.85[CI=1.39 – 10.79]). None other than the latter variable showed statistical significance as shown in table 4.6

Table 4.7: Association between education status and health indicators

Factors	*Labels*	*Ever attended school %*		*P-value*	*Odds Ratio (OR)*	*Confidence interval (95%)*
		Yes N	*o*			
No of ANC attended	< 4 times	62.0	64.3	0.8422	0.91	0.31 – 2.63
	4 or more	38.0	35.7			
During ANC were you counseled	Yes	50.8	25.7	0.0174	2.99	1.10 – 8.28
	No	49.2	74.3			
During ANC were you tested	Yes	33.9	13.9	0.0326	3.18	0.79 – 10.98
	No	66.1	86.1			
Number of TT received	< 2TT	15.1	39.4	0.0112	0.27	0.09 – 0.85
	2+TT	84.9	60.6			
Received IPT during pregnancy	Yes	45.8	33.3	0.2347	1.69	0.66 – 4.38
	No	54.2	66.7			
Birth attended by skilled attendant	Yes	25.4	27.8	0.8015	0.89	0.32 – 2.50
	No	74.6	72.2			
At least 2 maternal danger signs known	Yes	47.5	50.0	0.8109	0.90	0.36 – 2.25
	No	52.5	50.0			
Know at least 2 ways of HIV transmission	Yes	37.3	19.4	0.0684	2.46	0.84 – 7.40
	No	62.7	80.6			
Ever had HIV test	Yes	33.3	24.1	0.3868	1.57	0.51 – 4.96
	No	66.7	75.9			
Ever breastfed child	Yes	84.5	71.4	0.1324	2.18	0.70 – 6.81
	No	15.5	28.6			
Child health card present	Yes	70.6	73.1	0.0910	2.15	0.81 – 5.77
	No	29.4	26.9			

Women who ever attended school were found to be almost 3 times more likely to be counseled during ANC compared to those who had never attended school (p=0.0174, CI=2.99[1.10 – 8.28]). Women who ever attended school were 3.18 times more likely to be tested during ANC compared to those who never attended school (p=0.0326, CI=3.18[0.79 – 10.98]). However, this was not statistical significant since the confidence interval included 1. The study also found that women who ever attended school were 0.27 times as likely (i.e. less likely) to receive less than 2 TT compared to their counterparts (p=0.0112, CI=0.27[0.09 – 0.85]) as presented in table 4.7 above.

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

The three key indicators around HIV/AIDS; mothers receiving HIV counseling plus testing, respondents able to correctly cite ways of reducing HIV infection and mothers aware of risk of spreading HIV through breast milk generally surveyed low.

Survey results by lot (supervision areas) also highlight cases, which shall require area specific intervention and monitoring. For example in Kacheliba site, percentage of mothers with children age 0–23 months surveyed to have received two tetanus toxoid injections before the birth of their youngest child is on average half the case in the other four target sites. Consistently Kacheliba ranks lowest in percentage of mothers of children age 0-23 months who had at least one postpartum check up.

Compared to other three sites (Kacheliba, Kapenguria and Chepareria) Lelan and Sigor sites have exceptionally low survey figures for percent of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy and percent of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period. Generally, looking at all project indicators, Kacheliba, Lelan and Sigor are performing poorly in at least 7 of the 13 indicators.

The percentage of mothers of children age 0-23 months who received child spacing information during a postpartum check-up emerges as a challenge in the whole target district.

In a nutshell, respondent age had no association with the health indicators. However, there was significant association between women who work to earn money and number of ANC attendances; women who ever attended school and counseling during ANC, testing during ANC and 2TT.

Overall survey findings that need further investigation include:

- Case of low retention of keeping of maternal child health cards (12%)
- How the district achieves the relatively high ANC attendance (at least 4 times) by expectant mothers.
- Why the seeming absence or dearth in provision of child spacing info during post partum care (10 units of 48%)
- Why malnutrition is a big problem (18%)

5.2 RECOMMENDATIONS

Going forward, it will be imperative to put in place specific interventions for following indicators:

- HIV/AIDS counseling during pregnancy (26%)
- Trigger preference and enhance access to skilled health attendance during deliveries (26%)
- Improving water and sanitation practices: only 18% of households had cleansing agent or soap
- Improving exclusive breastfeeding for first hour after birth including and closely working with MoH to improve FP activities
- Enhancing knowledge and practice on HIV and AIDS which was found to be very low; a worrying fact given country level conclusion that estimates HIV/AIDS knowledge at 99% leading to limited interest in awareness focused interventions
- Stepping up ITN use (now below 50%) considering contribution of Malaria to child mortality

A lot of programmatic effort should be directed towards Kacheliba followed by Sigor and Lelan for the project to be able to over ally show significant improvements in the project indicators. A lot of effort should be put to reach women who never attended school and use of appropriate methodologies to this category of people in both training and awareness creation.

6.0 BIBLIOGRAPHY

1. Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MoH) [Kenya], and ORC Macro. (2004). Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MoH, and ORC Macro
2. DOW programme matrix
3. Ministry of Finance and Planning (2002). West Pokot District Development Plan, 2002-2008; Effective Management for Sustainable Economic Growth and Poverty Reduction
4. Ministry of Health (1997); National Reproductive Health Strategy: 1997-2010
5. Ministry of Health (2001); National Malaria Strategy: 2001-2010
6. Ministry of Health, (2005); National AIDS and STI Control Programme, Ministry of Health, Kenya. AIDS in Kenya, 7th ed. Nairobi: NASCOP; 2005

7.0 ANNEXES

Annex A: Sampling Frame

SUPERVISION AREA NAME: KACHELIBA [1]		
Formula for calculating a sampling interval: SAMPLING INTERVAL = Total population to be surveyed / Number of clusters		
A =	**TOTAL POPULATION IN THE PROGRAM AREA**	= 27,042
B =	TOTAL NUMBER OF SAMPLES IN THE SURVEY	= 19
C =	A / B (27,042/19)	= 1, 423
*IT IS OKAY TO ROUND THE SAMPLING INTERVAL TO THE NEAREST WHOLE NUMBER. FOR EXAMPLE, IF THE SAMPLING INTERVAL CALCULATED ABOVE WAS EQUAL TO 10,039.3, YOU WOULD ROUND TO 10,039. IF IT WAS EQUAL TO 10,039.5, ROUND UP TO 10,040.		

Using Systematic Sampling to Select 19 Samples with PPS

RANDOM NUMBER =____1, 135_____; SAMPLING INTERVAL = _____1,423_____

No.	Name of Community/Sub-location	Population	Cumulative Population	Sample	Sample names (Villages)
1.	Kapyen	3,443	3,443	1, 2	Cheptokol, Tuwit
2.	Konyao	2,119	5,562	3, 4	Chepurporkoo, Katilisia
3.	Karamer	1,605	7,167	5	Lulunga
4.	Kodich	3,119	10,286	6,7	*
5.	Cherangan	1,699	11,985	8	*
6.	Orolwo	2,072	14,057	9, 10	Kaporiot, Cheptaresia
7.	Lokichar	1,718	15,775	11	Cheptapesia
8.	Kalemngorok	1,679	17,454	12	Nakwapur
9.	Ngengechwo	2,462	19,916	13, 14	Kariamachin, Asilong
10.	Kacheliba	2,582	22,498	15, 16	Longorkau, Samaken
11.	Karon	2,555	25,053	17	Naliliamit
12.	Nakuyen	1,354	26,407	18	Kosia
13.	Kanyerus	62	26,469		
14.	Kopulio	573	**27,042**	19	Kopulio

SUPERVISION AREA NAME: CHEPARERIA [2]		
Formula for calculating a sampling interval: SAMPLING INTERVAL = Total population to be surveyed / Number of clusters		
A =	**TOTAL POPULATION IN THE PROGRAM AREA**	= 91, 943
B =	TOTAL NUMBER OF SAMPLES IN THE SURVEY	= 19
C =	A / B (91, 943/19)	= 4, 839
*IT IS OKAY TO ROUND THE SAMPLING INTERVAL TO THE NEAREST WHOLE NUMBER. FOR EXAMPLE, IF THE SAMPLING INTERVAL CALCULATED ABOVE WAS EQUAL TO 10,039.3, YOU WOULD ROUND TO 10,039. IF IT WAS EQUAL TO 10,039.5, ROUND UP TO 10,040.		

Using Systematic Sampling to Select 19 Samples with PPS

RANDOM NUMBER =_____2, 717_____; SAMPLING INTERVAL = _____4, 839_____

No.	Name of Community/Sub-location	Population	Cumulative Population	Sample	Sample villages	No.	Name of Community/Sub location	Population	Cumulative Population	Sample	Sample villages
1.	Kasitei	1,887	1,887			26.	Chesra	1,665	36,730	8	*
2.	Chewarany	1,162	3,049	1	Kanaa	27.	Pserum	3,202	39,932		
3.	Cheputram	1,571	4,620			28.	Morpus	4,617	44,549	9	Psirwo
4.	Krich	1,748	6,368			29.	Sobukwo	1,775	46,324	10	Korokposesoi
5.	Kesot	2,228	8,596	2	Ninyit	30.	Ortum	5,542	51,866	11	Ortum centre
6.	Ptoyo	2,057	10,653			31.	Kerelwa	3,815	55,681		
7.	Ketyam	2,362	13,015	3	Loitopon	32.	Sebit	2,897	58,578	12	Chemiromo
8.	Tamrukwo	739	13,754			33	Parua	3,268	61,846	13	*
9.	Merur	503	14,257			34	Chepkoriong	2,292	64,138		
10.	Rukei	625	14,882			35	Pusol	2,919	67,057	14	Psamar
11.	Nakwijit	538	15,420			36	Mongorion	1,742	68,799		
12.	Tunoyo	408	15,828			37	Kapchemogen	3,074	71,873	15	Rekeret
13.	Kola	1,863	17,691	4	Cheptoch	38	Ywalateke	2,116	73,989		
14.	Tamugh	1,959	19,650			39	Propoi	2,099	76,088	16	Sobukwo
15.	Letwa	1,405	21,055			40	Chepareria	3,149	79,237		
16.	Tindar	678	21,733			41	Kosulol	5,005	84,242	17	Cheporuso
17.	Chepnyal	1,508	23,241	5	Katikomor	42	Tampalal	1,865	86,107	18	Katars
18.	Mungit	994	24,235			43	Korrelach	2,025	88,132		
19.	Tompul	717	24,952			44	Chepturgeny	852	88,984		
20.	Psapai	527	25,479			45	Senetwo	1,314	90,298	19	Mintritwo
21.	Chekomos	455	25,934			46	Sla	1,645	**91,943**		
22.	Simat	357	26,291								
23.	Kochar	521	26,812								
24.	Shalpogh	4,210	31,022	6	Chemwarwach						
25.	Chepkopegh	4,043	35,065	7	Loyamuruk						

SUPERVISION AREA NAME: KAPENGURIA [3]		
Formula for calculating a sampling interval: SAMPLING INTERVAL = Total population to be surveyed / Number of clusters		
A =	**TOTAL POPULATION IN THE PROGRAM AREA**	= 84, 195
B =	TOTAL NUMBER OF SAMPLES IN THE SURVEY	= 19
C =	A / B (84, 195/19)	= 4, 431

Using Systematic Sampling to Select 19 Samples with PPS

RANDOM NUMBER =_____814_____; SAMPLING INTERVAL = _____4, 431_____

No.	Name of Community/Sub-location	Population	Cumulative Population	Sample	Sample villages
1.	Mortome	366	366		
2.	Cheptuya	2,495	2,861	1	Pser
3.	Lokornoi	428	3,289		
4.	Tartar	2,908	6,197	2	Miti moja
5.	Keringet	4,926	11,123	3	Kamorow A
6.	Psigirio	8,777	19,900	4, 5	Murkijit S, Makutano C
7.	Kapsurum	1,900	21,800		
8.	Chepkoti	2,301	24,101	6	Chepoka B
9.	Talau	1,161	25,262		
10.	Kipkorinya	1,287	26,549		
11.	Kaibos	1,987	28,536	7	Makatit
12.	Kapkatet	1,226	29,762		
13.	Siyoi	5,268	35,030	8	Kaprech
14.	Kapchila	2,270	37,300	9	Kapchila
15.	Paraywa	1,231	38,531		
16.	Sakuk/Sukut	2,179	40,710	10	Sakuk/Sukut
17.	Kishaunet	4,608	45,318	11	Kadongogh
18.	Lityei	7,968	53,286	12	Lityei
19.	Naramam	942	54,228	13	Prumbot
20.	Chepkechir	790	55,018		
21.	Ngoleyo	996	56,014		
22.	Komol	1,471	57,485		
23.	Tilak	1,587	59,072	14	Tilak Kapkoris
24.	Kaprom	2,580	61,652		
25.	Chemwochoi	6,766	68,418	15, 16	Mawingo 3, Mawingo 7
26.	Kamatira	3,690	72,108	17	Chepkeneroi
27.	Chewoyet	5,861	77,969	18	K.F.A
28.	Mwotot	6,226	**84,195**	19	Bandera C

SUPERVISION AREA NAME: LELAN [4]		
Formula for calculating a sampling interval: SAMPLING INTERVAL = Total population to be surveyed / Number of clusters		
A =	**TOTAL POPULATION IN THE PROGRAM AREA**	= 31, 978
B =	TOTAL NUMBER OF SAMPLES IN THE SURVEY	= 19
C =	A / B (31, 978/19)	= 1, 683
*IT IS OKAY TO ROUND THE SAMPLING INTERVAL TO THE NEAREST WHOLE NUMBER. FOR EXAMPLE, IF THE SAMPLING INTERVAL CALCULATED ABOVE WAS EQUAL TO 10,039.3, YOU WOULD ROUND TO 10,039. IF IT WAS EQUAL TO 10,039.5, ROUND UP TO 10,040.		

Using Systematic Sampling to Select 19 Samples with PPS

RANDOM NUMBER =_____672_____; SAMPLING INTERVAL = _____1, 683_____

No.	Name of Community/Sub-location	Population	Cumulative Population	Sample	Sample villages
1.	Chepkono	4,090	4,090	1, 2, 3	Kasai, Chesoromuya, Munis
2.	Tonoyon	1,850	5,940	4	Daraja mungu
3.	Simotwo	2,903	8,843	5	Simotwo
4.	Kabichbich	1,911	10,754	6	Melewa
5.	Kapkanyar	1,284	12,038	7	Chepkieny
6.	Mbayai	2,503	14,541	8, 9	Centre, Porong
7.	Chesubet	1,879	16,420	10	Purkuta
8.	Kapsait	1,734	18,154	11	Lemlem
9.	Mokoyon	2,488	20,642	12	Mokoyon
10.	Meshau	1,940	22,582	13, 14	Kaptum, Meshau
11.	Cheparten	2,723	25,305	15	Mtia
12.	Kaptabuk	3,608	28,913	16, 17	*
13.	Kapsangar	3,065	**31,978**	18, 19	Kamukul, Kamsis

SUPERVISION AREA NAME: SIGOR [5]		
Formula for calculating a sampling interval: SAMPLING INTERVAL = Total population to be surveyed / Number of clusters		
A =	**TOTAL POPULATION IN THE PROGRAM AREA**	= 44, 257
B =	TOTAL NUMBER OF SAMPLES IN THE SURVEY	= 19
C =	A / B (44, 257/19)	= 2, 329
*IT IS OKAY TO ROUND THE SAMPLING INTERVAL TO THE NEAREST WHOLE NUMBER. FOR EXAMPLE, IF THE SAMPLING INTERVAL CALCULATED ABOVE WAS EQUAL TO 10,039.3, YOU WOULD ROUND TO 10,039. IF IT WAS EQUAL TO 10,039.5, ROUND UP TO 10,040.		

Using Systematic Sampling to Select 19 Samples with PPS

RANDOM NUMBER =_____1, 989_____; SAMPLING INTERVAL = _____2, 329_____

No.	Name of Community/Sub-location	Population	Cumulative Population	Sample	Sample villages
1.	Nasolot	1,064	1,064		
2.	Parek	1,099	2,163	1	Choria
3.	Sarmach	1,424	3,587		
4.	Amolem	1,241	4,828	2	Amolem
5.	Akiramet	1,139	5,967		
6.	Tikit	1,323	7,290	3	Katabos
7.	Chepkondol	4,640	11,930	4, 5	Kooi/Chepton, Sabori/Sapai
8.	Mbara	3,543	15,473	6	Tokoren
9.	Sostin	1,974	17,447	7	Sostin
10.	Orwa	2,018	19,465	8	Maghany
11.	Soka	847	20,312		
12.	Wakorr	1,640	21,952	9	Toton
13.	Yawyaw	2,316	24,268	10	Yawyaw West
14.	Korrelach	4,909	29,177	11, 12	Otorel, Korrelach
15.	Sangat	2,201	31,378	13	Ipeet
16.	Ptokou	2,323	33,701	14	Kosholoi
17.	Takar	821	34,522		
18.	Kitoyo	1,860	36,382	15	Kitoyo
19.	Karapogh	2,116	38,498	16	Psiyoi
20.	Ptalam	1,885	40,383	17	Ptela
21.	Solion	3,874	**44,257**	18, 19	Mariny, Solion

Annex B: List of KPC Survey Participants

NAMES OF INTERVIEWERS/NURSES

SN	NAME	DIVISION	CONTACT
1.	HENRY LOWANA	SIGOR	0734129315
2.	JOSEPH K. NAKOPIR	CHEPARERIA	0721255278/0734458287
3.	JOSPHAT MILIWAN	LELAN	0735603000
4.	SAMUEL K. LOPAR	CHEPARERIA	0735893428/0722 946431
5.	JONAH K. KIGEN	CHEPARERIA	0736782978
6.	PETER K. LOSIA	KAPENGURIA	0735 727274
7.	LOSEM K. SAMSON	KAPENGURIA	0725 011681
8.	EDWARD POWEN	KACHELIBA	0736136704
9.	ALICE C. LOKEDI	KACHELIBA	0735 551830
10.	CAROLINE S. CHEPKORIR	CHEPARERIA	0726 903876/0736 961805
11.	RICHARD LEMNGIRO	CHEPARERIA	0733 955417

NAMES OF SUPERVISORS		CONTACT
1.	PETER WABWIRE	0720 598872
2.	RACHEL KINYANJUI	0721 459355
3.	DAVID WANIKINA	0721 517633
4.	FESTUS KIGEN	0721 357713
5.	TAPSON MULUNDA	0720 644999

NAMES OF CORE TEAM		TITLE/ORG	CONTACT
1.	DAMARIS KAPERUR	DOW	0734 641628/0727 259397
2.	ALICE SHITAMBASI	DOW	0722 369272/0734 709543
3.	KAVITA BALI	DOW	0728 293501
4.	GEOFREY K.SANGWATEI	PADO	0736 242945
5.	PAUL RUMOSIA	MOH	0734 931994/0725 966720
6.	BENARD CHEPKWONY	ORTUM (*Nursing School*)	0735 861332
7.	REBECCA KIMANI	MOH	0722 426099
8.	BENJAMIN N. MWAURA	MOH	0734 264218/0724 403413
9.	CATHERINE C. MUKENYANG	MOH	0736 595307
10.	LILLIAN K. MARITA	MOH	0720 578382
11.	JANE MOKUA	MOH	0733 253755
12.	JAMES M. NYAMEINO	MOH	0722 892078

Annex C: Logistics plan

Team	Supervisor	Interviewers	Day/Date	Target Site-Division & Samples/Villages	Accommodation Point (Full time/Day prior)	Work Completion Checklist (tick)
Kacheliba	Wanikin a David	Caroline S. Chepkorir Joseph K. Nakopir	12/02/07	1. Longork au A 2. *Samaken B 3. Nali amit 4. Kos ia 5. ²Kopuluo 6. Lakatel	Kapenguria.	1 2 3 4
			13/02/07	1. Kase s 2. Cheptokol 3. Chepurpo rkoo 4. Katelis ia	**Kacheliba Guest** 1	2 3 4
			14/02/07	1. Lulunga 2. Tim ale 3. Kodi ch 4. Nakwij it	Kapenguria. 1	2 3 4
			15/02/07	1. Kapor iot, 2. Lalat 3. Cheptape sia 4. Nakwa purwo 5. Ngenge chwo 6. As ilong	**Kacheliba** 1	2 3 4 5 6
			Opti	onal		

Annex 2a: Baseline KPC Report

Team	Supervisor Interviewers		Day/Date	Target Site-Division & Samples/Villages	Accommodation Point (Full time/Day prior)	Work Completion Checklist (tick)
Chepareria	Tapson Mulunda	Samuel K. Lupar Jonah K. Kigen	12/02/07	1. Sobukwo 2. Cheporuso 3. Sosurwo 4. Mtiritwo 5. Regeret	Kapenguria. **SPECIAL VEHICLE -THRU**	1 2 3 4 5
			13/02/07	1. Chepngap it 2. Mungit 3. Kaitap ok 4. Cheptoch 5.Katkikomor/Katimoril	Chepnyal Guest House	1 2 3 4 5
			14/02/07	1. Chemarwach 2. Loiyamoruk 3. Parian 4. Psirwo 5. Korokposesoi	Kapenguria.	1 2 3 4 5
			15/02/07	1. Ortum centre 2. Cherpusu 3. Parwa central 4. Psamar	Ortum 1	2 3 4
			Optional			

Team	Supervisor	Interviewers	Day/Date	Target Site-Division & Samples/Villages	Accommodation Point (Full time/Day prior)	Work Completion Checklist (tick)
Kapenguria	Racheal Kinyajui	Peter K. Losia Losem K. Samson	12/02/07	1. Mawingo 3 2. Mawingo 2 3. K.F.A 4. Bendera A 5. Tilak Kapkoris 6. Makutano C	Kapenguria 1	2 3 4 5 6
			13/02/07	1. Pser 2. Kam orow A 3. *Miti moja 4. Murkijit South 5. Lityei	Kapenguria 1	2 3 4 5
			14/02/07	1. Cherok B 2. Mjakit 3. Kaprech 4. Kapchilla	Kapenguria	1 2 3 4
			15/02/07 1	. Sakuk 2. Kadongou 3. Prumbot 4. Chepkeneroi	Kapenguria 1	2 3 4
			Optional			

Team	Supervisor	Interviewers	Day/Date	Target Site-Division & Samples/Villages	Accommodation Point (Full time/Day prior)	Work Completion Checklist (tick)
Lelan	Festus Kigen	Josphat Miliwan Alice C. Lokedi	12/02/07	1. Kasai 2. Chesoromu 3. Munis 4. Daraja Mungu 5. Simotwo	Kapenguria. 1	2 3 4 5
			13/02/07	1. M elewa 2. Chepkieny 3. Centre 4. Poron g 5. E wan	Kapenguria. 1	2 3 4 5
			14/02/07	1. Lem lem 2. Kariamakitai 3. Kaptabuk 4. Kamkul 5. Kapsis	Kapenguria. 1	2 3 4 5
			15/02/07	1. Mtia 2. Kaptum 3. Meshau 4. Mokoyon	Kapenguria 1	2 3 4
			Optional			

Team	Supervisor	Interviewers	Day/Date	Target Site-Division & Samples/Villages	Accommodation Point (Full time/Day prior)	Work Completion Checklist (tick)
Sigor	Peter Wabwire	Henry Lowana Richard Lemngiro Edward Powen	12/02/07	1. Otorel 2. Korelach 3. Ipet 4. Kosholoi	Kapenguria. **SPECIAL VEHICLE - THRU**	1 2 3 4
			13/02/07	1. M aghany 2. Sostin 3. Toko ren 4. Cheptem 5. Saboi 6. kaporo	Sigor 1	 2 3 4 5 6
			14/02/07	1. Kitoyo 2. Psiyoi 3. Ptela 4. Mariny 5. Solion	Kapenguria. 1	 2 3 4 5
			15/02/07	1. Yoton 2. Yaw Yaw west 3. Kaitab os 4. Am olem	Sigor 1	 2 3 4
			Optional			

* Over sampling not available

[2] No target group found

DOW/MOH KPC BASELINE SURVEY – WEST POKOT DISTRICT
Consent Section

INFORMED CONSENT

Hello. My name is _____, and I am working with (DOCTORS OF THE WORLD USA/MOH). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help (DOCTORS OF THE WORLD USA/MOH) to plan health services and assess whether it is meeting its goals to improve maternal and children's health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED ..... RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .....

Ask the mother if she has a biological child under 24 months who lives with her. If yes, proceed with interview, if no thank the mother and end the interview.

Identification			
Lot Number (1-5)			
Household Number			
Sample Number (Cycle)	1=First Sample	2=Over sample	
Village			
Sub Location			
Location			
Division			
Name of Mother		Age of Child (Months)	
Name of Supervisor			
Data Entered by		Date: ___/___/____ day/month/year	

	1	2	3	Final Visit
Interview date	___/___/____ day/month/year	___/___/____ day/month/year	___/___/____ day/month/year	*For Supervisor*
Name of Interviewer				Day Month Year
Result Code*				Result Code

*Result Codes:
1. Completed
2. Respondent not at home
3. Postponed
4. Refused
88. Other_____
(Specify)

Questionnaire

ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A BIOLOGICAL CHILD LESS THAN 24 MONTHS OF AGE.

RESPONDENT BACKGROUND			
No.	**Questions and Filters**	**Coding Categories**	**Skips**
1	In which language(s) do you feel most comfortable communicating? CIRCLE **ALL** MENTIONED.	KIPOKOT…….....A KISWAHILI……..B OTHER_____.....X (SPECIFY)	
2	How old are you now?	AGE (in completed years) ☐☐	
3	Do you work outside of the home to earn money?	YES……...1 NO……....2	→ **5**
4	What kind of work do you do? CIRCLE **ALL** MENTIONED.	FARMING…….....A TENDING ANIMALS……..B SELLING VEGETABLES/ FRUITS.....C SELLING PREPARED FOODS……...D SHOP KEEPER/STREET VENDOR……...E SERVANT/HOUSEHOLD WORKER……F DAY LABORER…….....G OTHER_____.....X (SPECIFY)	
5	Have you ever attended school?	YES……...1 NO……....2	→ **7**

6	What is the highest level of school you attended? CIRCLE **ONE** ONLY.	NONE……..……1 SOME PRIMARY……2 COMPLETED PRIMARY……..3 SOME SECONDARY……4 COMPLETED SECONDARY OR HIGHER……..5	
7	What is your current marital status? IF MARRIED, PROBE TO SEE IF THERE IS MORE THAN ONE WIFE. IF RESPONDENT IS THE ONLY WIFE, CHECK "ONLY WIFE". IF THERE IS MORE THAN ONE WIFE, CHECK "MORE THAN ONE WIFE".	MARRIED……1 ONLY WIFE...……..…..☐ MORE THAN ONE WIFE……☐ SINGLE……..……2 WIDOWED…..……..3 DIVORCED……..……4 OTHER_____.....88 (SPECIFY)	

INTRODUCTION/ CHILD SPACING

No.	Questions and Filters	Coding Categories	Skips
8	How many children are you currently taking care of?	TOTAL NUMBER OF CHILDREN ☐☐	
9	How many times have you been pregnant?	TOTAL NUMBER OF PREGNANCIES ☐☐	
10	How many children did you give birth to?	TOTAL NUMBER OF CHILDREN ☐☐	
11	Of the children you gave birth to, how many are alive now?	TOTAL NUMBER OF CHILDREN ☐☐	

12	What is the name, sex, date of birth of your youngest child that you gave birth to?	Youngest Child NAME _____ Sex MALE……..1 FEMALE……..2 Date of Birth DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐	
13	CHECK QUESTION #11. IF RESPONSE WAS ONE CHILD, SKIP TO QUESTION #14. IF RESPONSE WAS MORE THAN ONE CHILD, ASK: What is the name, sex, date of birth of your second youngest child that you gave birth to?	Second Youngest Child NAME _____ Sex MALE……1 FEMALE……2 Date of Birth DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐	

ANTENATAL CARE

No.	Questions and Filters	Coding Categories	Skips
14	Did you see anyone for antenatal care while you were pregnant with (NAME)?	YES……1 NO……....2 DON'T KNOW……....……..9	 → **17** → **17**

15	IF YES, ASK: Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND CIRCLE **ALL** PERSONS MENTIONED BY THE MOTHER.	HEALTH FACILITY STAFF DOCTOR……..A NURSE……B UNSPECIFIED HEALTH FACILITY STAFF……..C COMMUNITY MEMBERS TRADITIONAL BIRTH ATTENDANT.....D RELATIVE/FRIEND……..……E NO ONE……...……F OTHER_____.....Z (SPECIFY)	
16	How many times did you receive antenatal care while you were pregnant with (NAME)?	NUMBER OF TIMES ☐ DON'T KNOW……9	
17	What are the symptoms during pregnancy indicating the need to seek health care? CIRCLE **ALL** MENTIONED.	FEVER……....A SHORTNESS OF BREATH……B BLEEDING……C SWELLING OF THE BODY, HANDS AND/OR FACE……..D OTHER_____…….X (SPECIFY) DON'T KNOW……..……..Z	
18	During your pregnancy with (NAME) did you receive an injection in the arm to prevent the baby from convulsions after birth (tetanus)?	YES……1 NO……....2 DON'T KNOW……..…..9	 **→ 20** **→ 20**
19	If you did receive this injection, how many times did you receive the injection while pregnant with (NAME)?	ONE……..……1 TWO……....2 THREE OR MORE……3 DON'T KNOW……...……..9	

20	Before the pregnancy with (NAME), did you ever receive a tetanus toxoid injection?	YES……1 NO……....2 DON'T KNOW…….……..9	 → **22** → **22**
21	Before the pregnancy with (NAME), how many times did you receive a tetanus injection?	ONE……..……1 TWO…….……....2 THREE OR MORE……3 DON'T KNOW……...……..9	
22	Do you have an antenatal card for your pregnancy with (NAME)?	YES, CARD AVAILABLE……..…1 HAS CARD, BUT NOT SEEN……..…2 NEVER HAD A CARD……3	 → **26** → **26**
23	LOOK AT CARD AND RECORD THE NUMBER OF ANTENATAL VISITS WHILE THE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF ANC VISITS: ☐☐	
24	RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD	day/month/year FIRST……____/____/_____ SECOND……____/____/_____ THIRD……____/____/_____ FOURTH……____/____/_____ FIFTH……..____/____/_____ SIXTH……____/____/_____ RECORD THE TOTAL NUMBER OF TT DOSES COMPLETED DURING THE MOST RECENT PREGNANCY _____	

25	RECORD THE DATES FOR EACH IPT DOSE LISTED ON THE CARD. RECORD WHICH DRUG WAS TAKEN.	NAME OF DRUG day /month/year _____ ____/____/_____ _____ ____/____/_____ _____ ____/____/_____ _____ ____/____/_____ _____ ____/____/_____ _____ ____/____/_____ WERE TWO OR MORE DOSES GIVEN DURING THE MOST RECENT PREGNANCY? YES……1 NO……..2	
26	When you were pregnant with (NAME) did you take any drugs to prevent you from getting malaria?	YES……1 NO……....2 DON'T KNOW……..……..9	 → **28** → **28**
27	Which drugs did you take? CIRCLE **ALL** MENTIONED AND WRITE THE NUMBER OF TIMES EACH DRUG WAS TAKEN DURING PREGNANCY WITH (NAME).	ANTIMALARIAL YES NO DK #TIMES A. SP/FANSIDAR……1 2 9 _____ B. CHLORQUIN……1 2 9 _____ C. AMODIAQUI……1 2 9 _____ D. QUININE……..1 2 9 _____ E. ACT/AL……1 2 9 _____ X. OTHER_____....1 2 9 _____ (SPECIFY)	
28	IF RESPONDENT RECEIVED ANC IN THE LAST PREGNANCY (QUESTION 14), THEN ASK: During your pregnancy with (NAME) when you attended ANC, did you receive HIV counseling?	YES……1 NO……....2 DON'T KNOW……...……..9	
29	You don't have to share with me your status, but during your pregnancy with (NAME) when you attended ANC, were you tested for HIV?	YES……1 NO……....2 DON'T KNOW……...……..9	
	DELIVERY		
No.	**Questions and Filters**	**Coding Categories**	**Skips**

30	Where did you give birth to (NAME)? IF SOURCE IS HOSPITAL, HEALTH CENTER DISPENSARY, OR PRIVATE CLINIC, RECORD THE NAME OF THE FACILITY. _____ (NAME OF FACILITY)	AT HOME YOUR HOME……A TBA'S HOME……..……..B ON THE WAY TO FACILITY……..C HEALTH FACILITY HOSPITAL…….....D HEALTH CENTER……E DISPENSARY……..……F PRIVATE CLINIC……G OTHER_____.....X (SPECIFY)	
31	Who assisted with the delivery of (NAME)? Anyone else? PROBE FOR THE TYPE(S) OF PERSON(S) AND CIRCLE **ALL** MENTIONED. IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.	HEALTH FACILITY STAFF DOCTOR……..A NURSE……B UNSPECIFIED HEALTH FACILITY STAFF…….....C COMMUNITY MEMBERS TRADITIONAL BIRTH ATTENDANT……..D RELATIVE/FRIEND……..……E NO ONE……..……F OTHER_____.....X (SPECIFY)	
32	What instrument was used to cut the cord? CIRCLE **ONE** ONLY. IF RESPONDENT DELIVERED AT FACILITY IN Q. 30, SKIP TO Q. 33.	NEW RAZOR BLADE..... 1 NEW AND BOILED RAZOR BLADE..... 2 USED RAZOR BLADE..... 3 USED AND BOILED RAZOR BLADE.....4 NEW SCISSORS..... 5 NEW AND BOILED SCISSORS..... 6 USED SCISSORS..... 7 USED AND BOILED SCISSORS..... 8 KNIFE..... 9 SHARP ROCK..... 10 REED……..11 (TBA) USED HER NAILS ……..12 OTHER_____.....88 (SPECIFY) DON'T KNOW……..……99	

33	Did you have any complications or problems during or after delivery of (name)?	YES……1 NO…….....2 DON'T KNOW…….. ……..9	 → **36** → **36**
34	IF YES, THEN ASK: What complications or problems did you experience? CIRCLE **ALL** MENTIONED.	HEAVY BLEEDING……A SEVERE HEADACHE..…….....B FITS……...……...C SWOLLEN HANDS AND FEET……....D FEVER…...……...……E FOULING SMELLING DISCHARGE……..F PROLONGED/OBSTRUCTED LABOR.....G RETAINED PLACENTA…….…..H OTHER_____.....X (SPECIFY)	
35	Who was the first person to recognize the emergency problem?	SELF……1 HUSBAND...……....2 MOTHER-IN-LAW…….……3 OTHER RELATIVE/FRIEND……..…..4 TRADITIONAL BIRTH ATTENDANT…..5 DOCTOR…….....6 NURSE……..……..7 OTHER_____.....88 (SPECIFY) DON'T KNOW……..……..9	

36	What do you think you could do to prepare for a possible emergency during your next pregnancy or delivery? CIRCLE **ALL** MENTIONED.	RECOGNIZE THE EMERGENCY ON TIME……A KNOW WHERE TO GO FOR TREATMENT ……B GO TO A HEALTH FACILITY QUICKLY……C ARRANGE MONEY IN ADVANCE……..D ARRANGE TRANSPORT IN ADVANCE....E REGULAR ANTENATAL CARE……F OTHER_____.....X (SPECIFY) DON'T KNOW……..Z	
37	If you had an emergency during your pregnancy, where would you go? WRITE THE NAME MENTIONED OF THE NEAREST FACILITY TO RESPONDENT'S HOME. _____ (NAME OF FACILITY)	HOSPITAL……1 HEALTH CENTER……....2 DISPENSARY……..3 PRIVATE CLINIC……...4 I WOULDN'T GO TO ANY FACILITY…….5 DON'T KNOW……..9	
38	How would you get to the health facility? CIRCLE **ALL** MENTIONED.	ON FOOT……A BICYCLE...……....B MOTORCYCLE……C OWN CAR/VEHICLE…….. …..D PRIVATE TAXI……...……E PUBLIC TAXI (MATATU)……..F AMBULANCE……....G OTHER_____.....X (SPECIFY) DON'T KNOW……Z	

39	How long does it take you to reach the health facility? IF LESS THAN ONE HOUR, ENTER # OF MINS IF MORE THAN ONE HOUR BUT LESS THAN ONE DAY, ENTER # OF HOURS IF MORE THAN 24 HOURS, ENTER # OF DAYS	MINUTES ☐☐ HOURS ☐☐ DAYS ☐☐ DON'T KNOW……..…99	
40	Immediately after (NAME) was born, before the placenta was delivered, did you receive an injection to prevent you from bleeding too much?	YES……1 NO……....2 DON'T KNOW……..9	
41	Immediately after (NAME) was born, did the birth attendant hold your stomach and pull on cord to help the placenta come out?	YES……1 NO……....2 DON'T KNOW……..……..9	
42	Immediately after the placenta was delivered, did someone massage your uterus to make it contract strongly and to prevent you from bleeding too much?	YES……1 NO……....2 DON'T KNOW……..…..9	
43	Was (NAME) dried (wiped) immediately after birth before the placenta was delivered?	YES……1 NO……....2 DON'T KNOW……..…..9	
44	Was (NAME) wrapped in a warm cloth or blanket immediately after birth before the placenta was delivered?	YES……1 NO……....2 DON'T KNOW……..9	

45	What are the danger signs that mean a newborn baby is ill and needs medical care? CIRCLE **ALL** MENTIONED.	NOT BREATHING WELL……..……....A NOT FEEDING WELL……...B NOT ACTIVE……..…..C FEVER……..D COLD……...……E EYE INFECTION……..……F REDNESS AROUND THE CORD……..G JAUNDICE……..……..H LOW BIRTHWEIGHT/ BIRTH BEFORE BABY DUE……I OTHER_____.....X (SPECIFY) DON'T KNOW……Z	
	POST-PARTUM CARE		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
46	Did a health care provider or traditional birth attendant check on your health after the delivery of your youngest child, either at a health facility, home or other location?	YES……1 NO……..2 DON"T KNOW/ DON'T REMEMBER…...…9	 → **49** → **49**
47	How long after the delivery did the first check take place? IF LESS THAN ONE HOUR, ENTER 00 IN HOURS IF LESS THAN ONE DAY, RECORD # OF HOURS IF LESS THAN ONE WEEK, RECORD # OF DAYS IF MORE THAN 6 DAYS, RECORD # OF WEEKS	HOURS 1 [ ][ ] DAYS 2 [ ][ ] WEEKS 3 [ ][ ] DON'T KNOW……...…99	
48	Who checked your health at that time? PROBE FOR THE MOST QUALIFIED PERSON AND CIRCLE **ONE** RESPONSE.	HEALTH FACILITY STAFF DOCTOR……..1 NURSE……..2 UNSPECIFIED HEALTH FACILITY STAFF……..3 COMMUNITY MEMBERS TRADITIONAL BIRTH ATTENDANT……..4 RELATIVE/FRIEND……..……..5 NO ONE……6 OTHER_____.....88 (SPECIFY)	

49	After (NAME) was born, did any health care provider or traditional birth attendant check on (NAME'S) health?	YES……1 NO……....2	→ **52**
50	How long after the birth of (NAME) did the first check take place? IF LESS THAN ONE HOUR, ENTER 00 IN HOURS IF LESS THAN ONE DAY, RECORD # OF HOURS IF LESS THAN ONE WEEK, RECORD # OF DAYS IF MORE THAN 6 DAYS, RECORD # OF WEEKS	HOURS ☐☐ DAYS ☐☐ WEEKS ☐☐ DON'T KNOW……99	
51	Who checked on (NAME'S) health at that time? PROBE FOR THE MOST QUALIFIED PERSON AND CIRCLE **ONE** RESPONSE.	HEALTH FACILITY STAFF DOCTOR……..1 NURSE……2 UNSPECIFIED HEALTH FACILITY STAFF……...3 COMMUNITY MEMBERS TRADITIONAL BIRTH ATTENDANT……...4 RELATIVE/FRIEND……5 NO ONE……6 OTHER_____.....88 (SPECIFY)	
52	After you gave birth to (NAME), what topics were discussed with you? CIRCLE **ALL** MENTIONED.	NONE……A FAMILY PLANNING……..B RESTING……C BREASTFEEDING……..D BABY EYE-CHECK…… E RESPIRATORY RATE……..F CORD CARE……... G OTHER_____.....X (SPECIFY)	

53	After a woman has given birth, what are the danger signs that she is ill and needs medical care? CIRCLE **ALL** MENTIONED.	EXCESSIVE BLEEDING……...A FEVER……..B FOUL VAGINAL DISCHARGE……..C BREAST ENGORGEMENT……..…D INCONTINENCE (NO URINE OR FECAL CONTROL……..……E ABDOMINAL PAIN……F OTHER_____.....X (SPECIFY) DON'T KNOW……..…….....Z	
	HIV/AIDS		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
54	IF RESPONDENT HAS RECEIVED PMTCT COUNSELING AND TESTING (YES ON QUESTION #28), THEN SKIP TO QUESTION# 55. Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	YES……...1 NO……..2 DON'T KNOW……..…….9	→ **64**
55	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES……...1 NO……..2 DON'T KNOW……..…..9	→ **57** → **57**

56	What can a person do to avoid getting AIDS? Anything else? ASK FOR MORE WAYS TO AVOID AIDS. DO NOT PROMPT. CIRCLE **ALL** MENTIONED.	ABSTAIN FROM SEX……A USE CONDOMS……B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER……...C LIMIT NUMBER OF SEXUAL PARTNERS……D AVOID SEX WITH PROSTITUTES…….E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS……F AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX……..G AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY……..H AVOID BLOOD TRANSFUSIONS……I AVOID INJECTIONS……..J AVOID KISSING……K AVOID MOSQUITO BITES……...L SEEK PROTECTION FROM TRADITIONAL HEALER……..M AVOID SHARING RAZORS, BLADES……...N OTHER:_____..... X (SPECIFY) OTHER:_____.....Y (SPECIFY) DON'T KNOW……Z	
57	**Can the virus that causes AIDS be transmitted from a pregnant mother to her baby?**	YES……...1 NO……2 DON'T KNOW……9	 **→ 60** **→ 60**
58	If YES, ask, how can HIV be transmitted from mother to her baby? THEN ASK EACH OF THE FOLLOWING: A. During Pregnancy? B. During Delivery? C. By Breastfeeding?	YES NO DK A ……..1 2 9 B ……..1 2 9 C ……..1 2 9	

59	What can a mother do to prevent passing on the virus to her child? DO NOT PROMPT. CIRCLE **ALL** MENTIONED.	TAKE ANTIRETROVIRAL DRUGS…….A TAKE HERBS……B CONTINUE EXCLUSIVE BREASTFEEDING……C OTHER:_____..... X (SPECIFY) OTHER:_____.....Y (SPECIFY) DON'T KNOW……Z	
60	You don't have to share with me the results, but have you ever gone for an HIV test?	YES……...1 NO……2	**→62**
61	IF NO ASK, If you wanted to know your HIV status, where would you go for testing?	NEAREST VCT CENTER……....1 _____ (NAME OF FACILITY) HEALTH FACILITY….. ……..……...2 _____ (NAME OF FACILITY) OTHER……..……..3 _____ (NAME OF FACILITY) DON'T WANT TO KNOW STATUS…..…..4 DON'T KNOW……..……9	
62	After delivery, is it possible for HIV+ mother to pass on the virus to the new baby?	YES……...1 NO……2 DON'T KNOW……9	**→64** **→64**
63	If YES, how? CIRCLE **ALL** MENTIONED.	THROUGH BREASTFEEDING……..…A THROUGH MIXED FEEDING……. B OTHER_____.....X (SPECIFY) DON'T KNOW……..……..Z	
	BREASTFEEDING		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
64	Now I would like to ask you some more questions about (NAME). Did you ever breastfeed (NAME)?	YES……1 NO……....2	**→ 70**

65	How long after the birth did you first put (NAME) to the breast? IF LESS THAN 1 HOUR, ENTER 00 FOR HOURS IF LESS THAN 24 HOURS, ENTER # OF HOURS IF 24 HOURS OR MORE, ENTER # OF DAYS	HOURS ☐☐ DAYS ☐☐ DON'T KNOW……99	
66	During the first three or four days after delivery, before your regular milk began flowing, did you give (NAME) the liquid (colostrum) that came from your breasts?	YES……1 NO……2 DON'T KNOW……9	
67	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES……1 NO……2 DON'T KNOW…… …..9	
68	Are you still breastfeeding (NAME)?	YES……1 NO……2	**→ 70**
69	For how many months did you breastfeed (NAME)? IF LESS THAN 1 MONTH, RECORD 00	MONTHS ☐☐	
70	Now I would like to ask you about liquids (NAME) had yesterday during the day or at night. Did (NAME) drink: READ THE LIST OF LIQUIDS (A THROUGH G, STARTING WITH BREAST MILK)		
A	Breast milk?	A……..1 2 9	
B	Fresh animal milk?	B……..1 2 9	
C	Commercially-produced infant formula?	C……..1 2 9	
D	Plain Water?	D……..1 2 9	
E	Any fortified, commercially available infant and young child food [e.g. Cerelac]?	E……..1 2 9	
F	Any (other) porridge or gruel?	F……..1 2 9	
G	Tea or coffee?	G……..1 2 9	
X	Other	X……Other _____ (SPECIFY)	

71	Now I would like to ask you about other foods that (NAME) may have had yesterday during day or at night. I am interested in whether your child had the item, even if it was combined with other foods.					
	Did (NAME) eat:		YES	NO	DK	
A	Bread, rice, ugali or other foods made from grains?	A……..1		2	9	
B	Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?	B……..1		2	9	
C	Irish potatoes, white yams, cassava or any other foods made from roots?	C……..1		2	9	
D	Any dark green leafy vegetables?	D……..1		2	9	
E	Ripe mangoes or papayas or any other vitamin-A rich fruits?	E……..1		2	9	
F	Any other fruits or vegetables?	F……..1		2	9	
G	Liver, kidney, heart or other organ meats?	G……..1		2	9	
H	Any meat, such as beef, pork, lamb, goat, chicken or duck?	H……..1		2	9	
I	Eggs?	I……..1		2	9	
J	Fresh or dried fish?	J……..1		2	9	
K	Any foods made from beans, peas, lentils or nuts?	K……..1		2	9	
L	Cheese, yogurt or other milk products?	L……..1		2	9	
M	Any oils, animal fats, or butter or foods made with any of these?	M……..1		2	9	
N	Any sugary foods such as chocolates, sweets, candies, pastries, cakes or biscuits?	N……..1		2	9	
O	Insect or other small protein?	O……..1		2	9	
X	OTHER	X……..1		2	9	

72	How many times did (NAME) eat solid, semi-solid or soft foods other than liquids yesterday during the day or at night? IF ANSWER IS 7 OR MORE TIMES, RECORD 7. PROBE WITH EXAMPLES OF LOCAL SOLID AND SEMI SOLID FOOD, SUCH AS PORRIDGE, GRUEL, OR STEW. FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL. SMALL SNACKS SUCH AS ONE OR TWO BITES SHOULD NOT BE COUNTED. LIQUIDS DO NOT COUNT FOR THIS QUESTION. DO NOT INCLUDE LIQUIDS, THIN SOUPS OR BROTH, OR WATERY GRUEL. USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY.	NUMBER OF TIMES ☐ DON'T KNOW……9	
73	Has (NAME) ever received a Vitamin A dose (like this/any of these)? SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS	YES……1 NO……....2 DON'T KNOW……..……..9	 → **75** → **75**
74	Did (NAME) receive a Vitamin A dose within the last six months?	YES……1 NO……....2 DON'T KNOW……..……..9	
	CHILD IMMUNIZATIONS		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
75	Do you have a card or child health booklet where (NAME'S) vaccinations are written down? IF YES, ASK: May I see it?	YES……1 NO……....2 DON'T KNOW……..9	 → **78** → **78**
76	RECORD THE DATES FOR EACH VITAMIN A DOSE LISTED ON THE CARD. IF VACCINE NOT RECORDED IN CHILD HEALTH CARD, FILL IN 99/99/9999.	day/month/year FIRST…….____/____/_____ SECOND…….____/____/_____ THIRD…….____/____/_____	

77	COPY VACCINATION DATE FOR DPT1, DPT3 AND MEASLES FROM THE CARD OR BOOKLET. IF VACCINES ARE NOT RECORDED IN THE CHILD HEALTH CARD OR BOOKLET, FILL IN 99/99/9999. IF MEASLES IS RECORDED ON CARD SKIP TO **Q78**.	Day Month Year DPT1……|__|__| / |__|__| / |__|__|__|__| DPT3…...|__|__| / |__|__| / |__|__|__|__| Measles…|__|__| / |__|__| / |__|__|__|__|	→ **79**
78	Did (NAME) ever receive an injection in the arm to prevent measles?	YES……1 NO……....2 DON'T KNOW……..9	

MALARIA – TREATMENT OF FEVER OF CHILD

No.	Questions and Filters	Coding Categories	Skips
79	Has (NAME) been ill with fever at any time during the last two weeks?	YES……1 NO……....2 DON'T KNOW……..……..9	 → **85** → **85**
80	Did you seek treatment for the fever?	YES……1 NO……....2	 → **85**
81	How many days after the fever began did you first seek treatment for (NAME)?	SAME DAY……..1 NEXT DAY……..……2 TWO OR MORE DAYS……..……...3	
82	Where did you first go for advice or treatment? CIRCLE ONLY **ONE** RESPONSE. IF SOURCE IS HOSPITAL, HEALTH CENTER, DISPENSARY, OR PRIVATE CLINIC, WRITE THE NAME OF THE FACILITY. _____ (NAME OF FACILITY)	HEALTH FACILITY HOSPITAL ……..1 HEALTH CENTER……..2 DISPENSARY..……..…3 PRIVATE CLINIC……..…..4 OTHER SOURCE TRADITIONAL HEALER……5 TRADITIONAL BIRTH ATTENDANT…..6 SHOP/ DUKA……..…7 PHARMACY……..8 FRIEND/RELATIVE……..9 OTHER_____.....88 (SPECIFY)	

83	At any time during the illness did (NAME) take any drugs for the fever?	YES……1 NO……....2 DON'T KNOW……..……..9	 → **85** → **85**
84	What drugs did (NAME) take? Any other drugs? CIRCLE **ALL** MENTIONED. FOR EACH ANTIMALARIAL MEDICINE ASK: How long after the fever started did (NAME) start taking the medicine? CIRCLE THE APPROPRIATE CODES FOR EACH TYPE OF ANTIMALARIAL MEDICINE: 0 = SAME DAY 1 = NEXT DAY AFTER THE FEVER 2 = TWO OR MORE DAYS AFTER THE FEVER 9 = DON'T KNOW IF TYPE OF DRUG IS UNKNOWN, ASK TO SEE DRUG(S). IF TYPE OF DRUG IS STILL NOT DETERMINED, SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT.	ANTIMALARIAL A. SP/ORODAR……..……..0 1 2 9 B. CHLORQUINE……..……...0 1 2 9 C. AMODIAQUINE……0 1 2 9 D. QUININE……...0 1 2 9 E. ACT……...….0 1 2 9 OTHER DRUGS F. ASPIRIN…….....0 1 2 9 G. PANADOL/ PARACETAMOL..……....0 1 2 9 H. CO-TRIMOXAZOLE/ SEPTRIN……...……0 1 2 9 X. OTHER……..……..0 1 2 9 _____ (SPECIFY) Z. UNKNOWN DRUG……...0 1 2 9	

CONTROL OF DIARRHEA

No.	Questions and Filters	Coding Categories	Skips
85	Has (NAME) had diarrhea in the last two weeks?	YES……1 NO……....2 DON'T KNOW……..…..9	 → **92** → **92**
86	Was she/he given any of the following to drink at any time since she/he started having diarrhea:	YES NO DK	
A	A fluid made from a special packet called ORS?	A……..1 2 9	
B	A government-recommended homemade fluid?	B……..1 2 9	

87	Was anything (else) given to treat the diarrhea?	YES……1 NO……...2 DON'T KNOW……..…..9	 → **89** → **89**
88	What (else) was given to treat the diarrhea? Anything else? CIRCLE **ALL** TREATMENTS MENTIONED.	PILL OR SYRUP ANTIBIOTIC/ SEPTRIN……..……A ANTIMOTILITY……...……B ANTIPARASITIC/ FLAGYL……..C (IV) INTRAVENOUS……..…...D HOME REMEDY/ HERBAL MEDICINE……..E OTHER_____.....X (SPECIFY) DON'T KNOW……..Z	
89	When (NAME) was sick with diarrhea, did you breastfeed him/her less than usual, about the same, or more than usual?	LESS……1 SAME……2 MORE ……..3 CHILD NOT BREASTFED……4 DON'T KNOW……..….9	
90	When (NAME) was sick with diarrhea, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS……1 SAME……2 MORE ……..3 DON'T KNOW……..……9	
91	When (NAME) was sick with diarrhea, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS……1 SAME……2 MORE ……..3 DON'T KNOW……9	
	ARI/PNEUMONIA		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
92	Has (NAME) had an illness with a cough that comes from the chest at any time in the last two weeks?	YES……1 NO……..2 DON'T KNOW……..9	 → **99** → **99**
93	When (NAME) had an illness with a cough, did he/she have trouble breathing or breath faster than usual with short, fast breaths?	YES……1 NO……..2 DON'T KNOW……..9	

94	Did you seek advice or treatment for the cough/fast breathing?	YES……1 NO……..2	→ **97**
95	Who gave you advice or treatment? Anyone else? CIRCLE **ALL** MENTIONED.	DOCTOR……A NURSE……B MEDICAL ATTENDANT……..……..C TRADITIONAL BIRTH ATTENDANT……..D OTHER_____.....X (SPECIFY)	
96	Which medicines were given to (NAME)? CIRCLE **ALL** MENTIONED.	NOTHING……....A ASPIRIN……...……...B PANADOL/ PARACETAMOL……C PIRITON SYRUP……D CO-TRIMOXAZOLE/ SEPTRIN……E AMOXICILLIN……..…F ERYTHROMYCIN……..…..G AZITHROMYCIN……....H OTHER_____.....X (SPECIFY) DON'T KNOW……Z	
97	When (NAME) was sick with a cough, did you breastfeed him/her less than usual, about the same, or more than usual?	LESS……1 SAME……2 MORE ……..3 CHILD NOT BREASTFED……4 DON'T KNOW……9	
98	When (NAME) was sick with a cough, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS……1 SAME……2 MORE ……..3 DON'T KNOW……..9	
	WATER AND SANITATION		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
99	Do you treat your water in any way to make it safe for drinking?	YES……1 NO……..2	→ **101**

100	If Yes, what do you usually do to the water to make it safer to drink? ONLY CIRCLE MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND BOILING.	LET IT STAND AND SETTLE/SEDIMENTATION……A STRAIN IT THROUGH CLOTH……B BOIL……C ADD WATERGUARD……D WATER FILTER (CERAMIC, SAND, COMPOSITE)……E OTHER_____.....X (SPECIFY) DON'T KNOW……Z	
101	Can you show me where you usually wash your hands and what you use to wash hands? ASK TO SEE AND OBSERVE. CIRCLE **ONE** RESPONSE (CHOOSE MOST FREQUENTLY USED PLACE TO WASH HANDS).	INSIDE/NEAR TOILET FACILITY……1 INSIDE/NEAR KITCHEN/COOKING PLACE……2 ELSEWHERE IN YARD……3 OUTSIDE YARD……4 NO SPECIFIC PLACE……5 NO PERMISSION TO SEE……6	 **→ 103** **→ 103**
102	**OBSERVATION ONLY**: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANER? THIS ITEM SHOULD BE EITHER IN PLACE OR BROUGHT BY THE INTERVIEWEE WITHIN ONE MINUTE. **IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE, CHECK NONE EVEN IF BROUGHT OUT LATER.**	SOAP……1 DETERGENT……2 ASH……3 MUD/SAND……4 NONE……6 OTHER……88	 **→ 105** **→ 105** **→ 105** **→ 105**
103	Did you use soap of any kind for any reason yesterday during the day or night?	YES……1 NO……2	 **→ 105**
104	When you used soap yesterday in the day or night, what did you use it for? IF WASHING HANDS IS MENTIONED, PROBE FOR REASON. DO NOT READ THE ANSWERS. (DO NOT READ THE ANSWERS, ASK TO BE SPECIFIC, ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CHECK **ALL** THAT APPLY.)	BEFORE FOOD PREPARATION……A BEFORE FEEDING CHILDREN……B AFTER DEFECATION……C AFTER ATTENDING TO A CHILD WHO HAS DEFECATED……D OTHER_____.....X (SPECIFY)	
	MALARIA – ITN USE		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
105	Does your household have any mosquito nets that can be used while sleeping?	YES……1 NO……2	 **→ 111**

106	From where was the mosquito net obtained?	HOSPITAL……A HEALTH CENTER……....B DISPENSARY……..……..C PRIVATE CLINIC……...D SHOP/ DUKA……..E OTHER_____.....X (SPECIFY) DON'T KNOW……..……..Z	
107	Who slept under a mosquito net last night? LISTEN TO ALL RESPONSES AND IF THE CHILD (NAME) IS MENTIONED, CIRCLE CHILD. IF NOT CIRCLE OTHER.	CHILD (NAME)……1 NO ONE……..……..2 OTHER……88	 → **111** → **111**
108	ASK THE RESPONDENT TO IDENTIFY THE BRAND OF NET THAT THE CHILD SLEPT UNDER. SHOW SAMPLES OF TYPICAL NET TYPES AND BRANDS.	<u>PERMANENT NET</u> PERMANET……..…1 OTHER BRAND OF PERMANENT NET….2 PRETREATED NET…..……..3 UNTREATED NET……4 OTHER_____.....88 (SPECIFY) DON'T KNOW BRAND……...9	 → **111** → **111** → **111**
109	Was the mosquito net that (NAME) slept under last night ever soaked or dipped in a liquid treated to repel mosquitoes or bugs?	YES……1 NO……....2 DON'T KNOW……..9	 → **111** → **111**
110	How long ago was the net last soaked or dipped? IF LESS THAN 1 MONTH AGO, RECORD 00 MONTHS. IF LESS THAN 2 YEARS AGO, RECORD MONTHS AGO. IF 12 MONTHS AGO OR 1 YEAR AGO, PROBE FOR THE EXACT NUMBER OF MONTHS.	MONTHS [ ][ ] MORE THAN 2 YEARS AGO……11 DON"T KNOW……..……..99	
111	When you were pregnant with (NAME), did you sleep under a bednet? IF YES, ASK: How often did you sleep under a bednet? IF NO, CIRCLE 5 FOR NEVER.	ALWAYS, EVERY NIGHT……..…..1 USUALLY, MOST NIGHTS……..……2 OCCASIONALLY……..……3 RARELY……4 NEVER……..5	
	HEALTH CONTACTS AND IEC		
No.	**Questions and Filters**	**Coding Categories**	**Skips**

112	From whom do you get information about health? CIRCLE **ALL** MENTIONED.	FORMAL NETWORK DOCTORS……..……A NURSES/MIDWIVES……....B TRADITIONAL BIRTH ATTENDANT……..…..C CBO/NGO……D OTHER HEALTH WORKER_____.....E (SPECIFY) INFORMAL NETWORK HUSBAND/PARTNER……....F MOTHER/MOTHER-IN-LAW……...…..G GRANDPARENT……H OTHER RELATIVE/ FRIEND……...I TRADITIONAL HEALER……...J VILLAGE CHIEF/SUB-CHIEF……..……K VILLAGE ELDER……L OTHER _____.....X (SPECIFY)	
	ANTHROPOMETRICS		
No.	**Questions and Filters**	**Coding Categories**	**Skips**
113	May I weigh (NAME)?	YES……1 NO……....2 |___||___| . |___| KILOGRAMS	END

THANK THE RESPONDENT FOR TAKING THE TIME TO BE INTERVIEWED. MAKE SURE ALL SECTIONS ARE COMPLETE BEFORE MOVING ON TO THE NEXT HOUSEHOLD

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 2b: Baseline Health Facility Assessment Report

West Pokot Facility Needs Assessment – Maternal and Newborn Care

INTRODUCTION

To reduce maternal and neonatal mortality in West Pokot, the health system must be strengthened. In February 2007, a needs assessment was conducted to learn about the functioning of the West Pokot district health system. The specific objectives of the assessment were:

- To determine the availability, utilization and quality of emergency obstetric and newborn care (EmONC) services in West Pokot district
- To identify gaps in service delivery
- To provide a baseline from which to monitor and evaluate the impact of future interventions in the district

An essential component of this study was the collection of data, used to calculate a set of indicators known as the 'UN Process Indicators.' Issued by UNICEF, WHO and UNFPA in 1997, the UN Process Indicators are used to answer the following questions:

- Are there sufficient facilities providing EmONC?
- Are they well distributed?
- Are enough women using them?
- Are the right women using them?
- Are enough critical services being provided?
- Is the quality of the services adequate?

The set of indicators are presented in Table 1.

Table 1: The Revised set of UN Process Indicators and Recommended Levels[1]

Indicator	Minimum acceptable level
#1: Amount of emergency obstetric care (EmOC): Basic EmOC and Comprehensive EmOC facilities	For every 500,000 population, there should be: At least 5 EmOC facilities (including at least 1 **Comprehensive** EmOC facility).
#2: Geographical distribution of EmOC facilities	All sub-national areas have at least 5 EmOC facilities (including at least 1 Comprehensive EmOC facility) for every 500,000 population.
#3: Proportion of all births in Basic and Comprehensive EmOC facilities; and in all surveyed facilities	Target to be set locally.
#4: Met need for EmOC: Proportion of women with serious complications who are treated in EmOC facilities and all surveyed facilities	**At least 100%** of women estimated to have obstetric complications are treated in EmOC facilities.
#5: Caesarean sections as a percentage of expected births	As a proportion of estimated births in the population, caesarean sections account for **not less than 5% nor more than 15%.**
#6: Case fatality rate for direct obstetric causes	The case fatality rate among women with direct obstetric complications in EmOC facilities is **less than 1%.**
#7: Intrapartum case fatality rate as a percentage of all births	No standard has been set.
# 8: Percentage of maternal deaths due to indirect obstetric causes in EmOC and in all surveyed facilities.	No standard has been set.

These UN Process Indicators were developed based upon an understanding that EmONC is made up of the following nine "signal functions" or services that are necessary to save the lives of women with obstetric complications and newborns during the intrapartum period:

1 Parenteral antibiotics
2 Parenteral oxytocic drugs;
3 Parenteral anticonvulsants;
4 Manual removal of placenta;
5 Removal of retained products (e.g. Manual vacuum aspiration);
6 Assisted vaginal delivery (e.g. vacuum extraction, forceps);
7 Neonatal resuscitation;
8 Surgery (e.g. caesarean section); and
9 Blood transfusion.

These signal functions are used to classify health facilities as either basic or comprehensive EmONC facilities. If a health facility provides the first seven functions within a three-month period, it is classified as a basic EmONC facility. If it provides all nine signal functions, it qualifies as a comprehensive EmONC facility.

METHODOLOGY

Sample

The needs assessment studied all of the facilities in West Pokot that offer delivery services (2 hospitals and 4 health centers). All but Ortum Mission Hospital were government-operated facilities.

Dispensaries in West Pokot did not offer maternity services. However, four strategically located dispensaries that have high caseloads and aspire to have maternities were included in the facility assessment.

In total, 10 facilities were selected for this study and data were collected from 9 of those facilities (Tamough Dispensary was closed when visited). The results of this assessment reflected services provided in the nine facilities during the 2007 calendar year (Table 2).

Table 2: Facilities selected and studied

Hospitals	1. Kapenguria District Hospital (DH) 2. Ortum Mission Hospital (MH)
Health centers	3. Chepareria Health Centre (HC) 4. Kabichbich Health Centre (HC) 5. Kacheliba Health Centre (HC) 6. Sigor Health Centre (HC)
Dispensaries	7. Konyao Dispensary 8. Lomut Dispensary 9. Serewo Dispensary

Data collection tools
Under the guidance of Doctors of the World, the tool used for data collection was adapted from a set of tools produced by the Averting Maternal Death and Disability Program (AMDD) and from the UNICEF, WHO, UNFPA "Guidelines for Monitoring the Availability and Use of Obstetric Services." In addition, obstetricians, midwives and medical officers from Kenya were asked to review the tools for relevance and accuracy.

The final 'West Pokot, Kenya Facility Needs Assessment' tool was composed of 11 sections covering the following:

- Background information on the facility - including size / capacity, overall infrastructure, transport, communication and cost of services.
- Availability of transport and means of communication for referral.
- Cost of maternity services.
- EmONC Signal functions and other essential services - how facilities *actually* function and whether they offered all, some or none of the services necessary to treat and save women with obstetric complications. It also looked at why these services were not available.
- Human resources - including the overall staffing situation, training of staff in EmONC and the 24 hour – 7 day per week coverage by health professionals in that facility.
- Facility Case Summary Form - used to collect service statistics from facility registers and records.
- Where women are coming from.
- Equipment, supplies and essential drugs - used to evaluate the availability and functionality of basic infrastructure, equipment, supplies and drugs necessary for the delivery of EmONC and newborn services.

The final facility needs assessment data collection forms can be found in Appendix 1.

Data collection
One team collected the data from the nine facilities over nine days from February 5-14, 2007. The team was made up of one obstetrician and one BSC Nurse from Moi Teaching and Referral Hospital (Eldoret, Kenya), one consultant from AMDD and one DOW staff person. The team received one day of training on the objectives of the assessment and use of the tool.

During the training and throughout the data collection, efforts were made to ensure that all interviewers had a common understanding and interpretation of the tool. Quality control during the data collection period was ensured through daily meetings and review of completed forms at the end of each day of data collection.

Data processing and analysis
A datashell was created in Access 2003 for data entry. Data were exported into Excel 2003 and SPSS 14 for analysis.

Ethical consideration
Personal identification data were not collected throughout the study and all interviewees and other participants were anonymous.

AVAILABILITY OF SERVICES

General infrastructure

Electricity
In order for health workers to do their jobs well, they need to have adequate light to perform their tasks. Kapenguria District Hospital and all four health centres in West Pokot had some electricity. Only Kapenguria District Hospital and Chepareria Health Centre accessed electricity from government powerlines. Ortum Mission Hospital and Kabichbich, Kacheliba and Sigor Health Centres got their electricity from generators or solar panels.

Ortum Mission Hospital reported many problems with electricity, especially during the day when the generators were not turned on. During the evening, the generators only ran for a few hours.

In the case that there were cuts in power, it was also important to have some sort of backup generator available. Kapenguria DH had a backup generator available. The health centres did not have backup generators.

Table *: Electricity

	Electricity available?	Electricity functioning?	Electricity available 24/7?	Source of electricity	Backup generator available?
Kapenguria DH	√	√	√	Powerlines (government)	√
Ortum MH	√	NO	NO	Generator and solar	√
Chepareria HC	√	√	√	Powerlines (government)	NO
Kabichbich HC	√	√	NO	Generator and a cycle light (chargeable battery)	NO
Kacheliba HC	√	NO	NO	Solar	NO
Sigor HC	√	√	√	Solar	NO
Konyao Disp	NO				
Lomut Disp	NO				
Serewo Disp	NO				

Water
Clean and potable water is essential for infection prevention. Of all the facilities surveyed, Kapenguria DH reported having the most trouble accessing potable water. Ortum MH and the four health centres seemed to have access to water most of the time. Lomut and Serewo Dispensaries had functioning water; Konyao Dispensary had no potable water available.

Table *: Water

	Potable water available?	Water system functioning?	Source of water	Water accessibility inside facility
Kapenguria DH	√	NO	Inside plumbing (government system)	Faucet
Ortum MH	√	√	Inside plumbing (water pumped from local spring / ground)	Faucet
Chepareria HC	√	√	Inside plumbing (government system)	Faucet
Kabichbich HC	√	√	Protected storage with pump	Faucet, Jerry can
Kacheliba HC	√	√	Outdoor pump from nearby river (constructed by MSF)	Jerry can
Sigor HC	√	√	Inside plumbing (government system)	Faucet
Konyao Disp	NO			
Lomut Disp	√	√	Inside plumbing (private system)	Faucet
Serewo Disp	NO			

Human resources

In the two hospitals and four health centres, normal deliveries were managed by registered and enrolled nurses. In Kacheliba and Chepareria Health Centres clinical officers also managed deliveries.

There were no obstetricians, pediatricians or BSC nurses working in West Pokot district. Medical officers were only posted at the two hospitals. Registered nurses were posted at all surveyed facilities except for Konyao Dispensary. Enrolled community health nurses were present at all surveyed health facilities.

Other cadres of workers present in the facilities included: subordinates, lab technicians, casuals, nursing students, public health technicians, theatre technicians and watchmen.

Table *: Health personnel currently working in surveyed facilities

	Medical officers	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Kapenguria DH	4	29	89	9
Ortum MH	2	5	22	2
Chepareria HC	0	1	8	1
Kabichbich HC	0	1	5	0
Kacheliba HC	0	5	3	1
Sigor HC	0	2	4	0

	Medical officers	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Konyao Disp	0	0	1	0
Lomut Disp	0	1	1	0
Serewo Disp	0	1	1	0

The two hospitals in West Pokot had nurses posted specifically to the maternity ward. At Kapenguria District Hospital, medical officers and clinical officers rotated and none were posted to the maternity ward 24/7. At Ortum Mission Hospital, 2 medical officers and 2 clinical officers were posted to the maternity ward. In the health centres, all nurses rotated between departments and were on-call for the maternity.

Table *: Health workers posted to maternity ward

	Medical officers	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Kapenguria DH	0/4 (rotate)	4/29	16/89	0/9
Ortum MH	2	5	4/22	2

Availability of EmONC

According to the UN Guidelines, for every 500,000 population, there should be, at a minimum, five facilities offering EmONC including one facility offering comprehensive EmONC (for definitions of 'comprehensive EmONC' and 'basic EmONC' facilities, please refer to the introductory section).

Based on the UN Guidelines, West Pokot, with a population of 413,419[2], should have a minimum of 4-5 EmONC facilities including at least one that offers CEmONC. As illustrated by the needs assessment, West Pokot had no facility that offered the complete package of basic or comprehensive EmONC signal functions.

The two hospitals in West Pokot offered cesarean sections and transfused blood but both were missing assisted vaginal delivery. Ortum Mission Hospital was also missing parenteral anticonvulsants. Although health centres were potential basic EmONC facilities, none of the 4 health centres assessed qualified as basic EmONC facilities. Dispensaries only managed emergency deliveries and provided none of the signal functions. Assisted vaginal delivery was not offered in any facility in West Pokot.

Table *: Recommended and actual number of EmONC facilities

	Population	Minimum number EmONC facilities ***recommended***	Minimum number Comp EmONC facilities ***recommended***	***Actual*** number EmONC facilities	***Actual*** number Comp EmONC facilities (minus 1 or 2)
West Pokot	413,419	4.13	0.83	0	1 = CEmONC minus AVD 1= CEmONC minus AVD + anticonvulsants

Availability of EmONC Signal Functions

Strategic decisions about how to upgrade facilities so that they provide basic or comprehensive EmONC were informed by looking at which signal functions were missing and why they were not available. Facilities might not have performed certain EmONC signal functions because there was no indication for the procedure, no staff trained and/or confident to perform the service, no available supplies and/or equipment, the particular cadre of staff working at the facility was not authorized to perform the signal function or there was no staff at all at that facility. An analysis of this sort was extremely useful because it revealed systemic problems and related solutions.

The needs assessment showed the following gaps in services:

Parenteral antibiotics

- The two hospitals and four health centres surveyed provided parenteral antibiotics in the last three months.
- The three dispensaries had parenteral antibiotics available; Konyao and Serewo Dispensaries treated one case of sepsis each in the last three months.

Parenteral oxytocics

- Both hospitals provided parenteral oxytocics in the last three months. Kapenguria DH used ergometrine and Ortum MH used both ergometrine and oxytocin.
- Two out of the four health centers provided parenteral oxytocics in the last three months. Chepareria and Kabichbich Health Centres used ergometrine. Kacheliba HC did not provide parenteral oxytocics because there was no indication. Sigor HC did not provide this signal function because the drugs were not available.
- The dispensaries did not provide this signal function.

Parenteral anticonvulsants

- Kapenguria DH provided parenteral anticonvulsants in the last three months. Diazepam was used in spite of the fact that magnesium sulfate was available in the pharmacy and was a more effective drug. Ortum MH did not provide this signal function because there were no diagnosed cases of eclampsia in the last three months.
- The four health centres did not provide this signal function in the last three months either because there was no indication (Chepareria, Kabichbich and Sigor) or because staff

was not trained in the management of eclampsia (Kacheliba). The one case of eclampsia diagnosed in the last three months was referred to Kapenguria DH.
- None of the three dispensaries provided parenteral anticonvulsants for treatment of eclampsia.

Manual removal of placenta
- Ortum MH and Kapenguria DH both provided manual removal of placenta in the last three months. At both facilities, only medical officers were authorized and trained to provide this service.
- The four health centres did not provide manual removal of placenta in the last three months. Nurses were not trained and authorized to provide this service but clinical officers were. In theory, the health centres staffed by clinical officers should have been able to manually remove placentae (Chepareria and Kacheliba HCs). Kabichbich and Sigor HC were only staffed by nurses, so in order for this signal function to be provided, clinical officers must be deployed or nurses should be trained in this signal function.
- The three dispensaries did not provide this signal function because staff were not trained and authorized (only nurses staffed these facilities).

Removal of retained products
- The two hospitals in West Pokot both provided this signal function in the last three months. Both hospitals used dilation and curettage. Manual vacuum aspiration (MVA) was not available in either facility.
- The only health centre to provide removal of retained products was Chepareria HC. The Clinical Officer at Chepareria was trained to use MVA to manage incomplete abortions and had received two disposable MVA kits. The other three health centres did not provide this signal function because their staff were not trained to use the MVA and they did not have the requisite equipment.
- The three dispensaries did not provide this signal function because staff were not trained and they did not have equipment.

Assisted vaginal delivery
- The two hospitals did not provide assisted vaginal delivery because there was no equipment and because staff were not trained to know when this procedure was indicated.
- The four health centres did not provide assisted vaginal delivery because there was no equipment and because staff were not trained to provide this important signal function.
- The three dispensaries did not provide this signal function because they do not have equipment and staff were not trained in its use.

Neonatal resuscitation
- Ortum MH regularly provided neonatal resuscitation and was the only facility that had all of the requisite equipment, supplies and oxygen. Kapenguria DH had some of the necessary equipment and staff were trained to resuscitate newborns. However, they did not have key items including infant face masks and oxygen.
- The only health centre that provided neonatal resuscitation was Kacheliba HC in spite of the fact that the facility was missing some of the key equipment and supplies to properly provide this service. The other three health centres did not provide this signal function in the last three months because there were no cases managed. In addition, the three health centres did not have the equipment and supplies.

- The three dispensaries did not provide this service because there was no indication and because they did not have supplies.

Blood transfusion

- Both hospitals provide blood transfusion and their blood came from the central blood bank in Eldoret.
- Health centres did not provide blood transfusion.
- Dispensaries did not provide blood transfusion.

Cesarean delivery

- Ortum MH and Kapenguria DH both performed cesarean deliveries. Kapenguria DH used general and spinal anesthesia. Ortum MH used either spinal or ketamine for anesthesia.
- Health centres did not have operating theatres and did not provide cesarean deliveries.
- Dispensaries did not have operating theatres and did not provide cesarean deliveries.

Table *: Facilities surveyed and available signal functions in the last 3 months

	Parenteral antibiotics	Parenteral oxytocics	Parenteral anticonvulsants	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery	Neonatal resuscitation	Blood transfusion	Cesarean section	EmONC status
Kapenguria DH	√	√	√	√	√		√	√	√	Comp minus 1
Ortum MH	√	√		√	√		√	√	√	Comp minus 2
Chepareria HC	√	√			√					Basic minus 4
Kabichbich HC	√	√								Basic minus 5
Kacheliba HC	√						√			Basic minus 5
Sigor HC	√									Basic minus 6
Konyao Disp	√									Basic minus 6
Lomut Disp										Non-EmONC
Serewo Disp	√									Basic minus 6

Table *: Who is trained and authorized to perform critical services at **hospitals**

	Medical officers	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Parenteral antibiotics	√	√	√	√
Parenteral oxytocics	√	√	√	NO

Parenteral anticonvulsants	√	√	√	Kapenguria - √ Ortum – NO
Manual removal of placenta	√	NO	NO	NO
Removal of retained products	√	NO	NO	NO
Assisted vaginal delivery	√	NO	NO	NO
Resuscitate newborn with bag and mask	√	√	√	Kapenguria – NO Ortum - √
Blood transfusion	√	√	√	√
Surgery (cesarean delivery)	√	NO	NO	NO
Provide anesthesia	√	NO	NO	Kapenguria - √ Ortum – NO
Breech delivery	√	√	√	NO

Table *: Who is trained and authorized to perform critical services at **health centres**

	Medical officers (MO)	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Parenteral antibiotics	No MO	√	√	√
Parenteral oxytocics	No MO	√	√	√
Parenteral anticonvulsants	No MO	√	√	√
Manual removal of placenta	No MO	NO (although at least one RN at Kacheliba HC claims to provide this service)	NO (although at least one enrolled nurse at Kacheliba HC claims to provide this service)	√
Removal of retained products	No MO	NO (although at least one RN at Kabichbich HC claims to provide this service)	NO	Chepareria - √ Kacheliba – NO
Assisted vaginal delivery	No MO	NO	NO	NO
Resuscitate newborn with bag and mask	No MO	√	√	√
Blood transfusion	No MO	NO	NO	NO

	Medical officers (MO)	Registered nurses	Enrolled community health nurse / enrolled midwife	Clinical officer
Surgery (cesarean delivery)	No MO	Not applicable	Not applicable	Not applicable
Provide anesthesia	No MO	Not applicable	Not applicable	Not applicable
Breech delivery	No MO	NO (although at least one RN at Sigor HC claims to provide this service)	NO (although at least one RN at Sigor HC claims to provide this service)	NO

Other MNH-related services
There are other services that are important to consider for the reduction of maternal and neonatal death and disabilities.

Partograph
Every woman who is in active labour should be monitored with a partograph. Both hospitals had blank partographs in their labour and delivery rooms. Out of the four health centres, only Chepareria HC had partographs available to use in the labour / delivery room but staff said they were not using them because they were not trained. Staff at the other health centres did not use them because they were untrained and did not have the forms available.

Breech delivery
Nurses and medical officers were trained to manage breech deliveries at Kapenguria DH and Ortum MH. Sigor HC also managed at least one breech delivery in the last three months. The other three health centres did not provide this service either because they had no cases or because they were not trained to manage this type of delivery. The dispensaries did not provide this service.

Rapid HIV testing in labour / delivery room
If women in labour/delivery do not know their HIV status, they should have the option to be tested for HIV in the delivery room and be told about prevention of maternal to child transmission (PMTCT) options. Unfortunately, the majority of facilities in West Pokot did not have rapid HIV tests available in their labour and delivery rooms. Only Kapenguria DH had the supplies and routinely tested women in the labour and delivery room. Ortum MH had the rapid HIV test in the labour / delivery room, but did not offer counseling and testing to every individual woman delivering. Instead, they waited until there was a small group of women who could be counseled together and then offered testing.

Prevention of maternal to child transmission
For women who are HIV+, only Kapenguria DH, Ortum MH and Kacheliba HC offered PMTCT.

Obstetric fistula repair
AMREF provided fistula repair surgery periodically at Ortum MH but there were no permanent staff at any facility in West Pokot who were trained to provide routine fistula repair surgeries.

Table *: Other MNH-related services provided in last 3 months

	Partograph	Breech delivery	Rapid HIV test	Nevirapine - mother	Nevirapine - baby	Fistula repair
Kapenguria DH	√	√	√	√	√	NO
Ortum MH	√	√	NO	NO	√	NO
Chepareria HC	NO	NO	NO	NO	NO	NO
Kabichbich HC	NO	NO	NO	NO	NO	NO
Kacheliba HC	NO	NO	NO	√	NO	NO
Sigor HC	NO	√	NO	NO	NO	NO
Konyao Disp	NA	NA	NA	NA	NA	NA
Lomut Disp	NA	NA	NA	NA	NA	NA
Serewo Disp	NA	NA	NA	NA	NA	NA

Active management of third stage of labour

Active management of third stage of labor (AMTSL) facilitates delivery of the placenta and prevents post-partum hemorrhage by averting uterine atony. According to the ICM/FIGO Joint Statement[3] AMTSL should be used by all skilled birth attendants regardless of where they practice. The ICM/FIGO Joint Statement lists the following components of AMTSL:

- Administration of oxytocin or another uterotonic drug within one minute after the birth of the baby
- Controlled cord traction
- Uterine massage after delivery of the placenta

Staff working in the maternity wards of the hospitals and health centers were asked to describe their actions during the third stage of labour. Staff in all six facilities responded that they did something during the stage of labour but none performed all three steps defined by the Joint Statement. The most frequent response was 'controlled cord traction.'

Table *: Aspects of management of third stage of labor

	Immediate oxytocin, misoprostol or ergometrine	Controlled cord traction	Uterine massage	Nothing	Other
Kapenguria DH		√	√		
Ortum MH		√	√		Catheterization
Chepareria HC		√			
Kabichbich HC		√			
Kacheliba HC		√	√		
Sigor HC		√	√		

Management of women who are infibulated during labour/delivery

According to local estimates, 97% of women in West Pokot are infibulated. Women who are infibulated are more likely than other women to develop obstetric complications[4]. Therefore,

according to international guidelines[5], proper management and counseling of women who are infibulated must be routinely practiced.

The assessment showed that health workers working in West Pokot hospitals and health centers have not received any specific training on delivering women who were infibulated. However, health workers in all facilities said that they performed either a bilateral or unilateral episiotomy at the crowning of the baby's head.

Equipment, supplies and essential medicines

All deliveries

Complete delivery kits should be available in sufficient numbers and be ready for every woman who arrives in labour. According to the Standards for Maternal Care in Kenya[6] (2002), a delivery pack contains:

- Kidney-dish (2)
- Artery forceps (2)
- Cord-cutting / blunt-ended scissors (1)
- Cord ties (2)
- Gloves (2 pairs)
- Plastic sheeting (1)
- Gauze swabs (4)
- Cloth (1)

The facility assessment showed that all facilities except for Kabichbich Health Centre and Konyao Dispensary had delivery kits. All facilities had at least one or two items missing from their kits.

All hospitals and health centres in West Pokot had at least one delivery table. Only Ortum MH had more than one table and could handle more than one woman delivering at once. Ortum MH and Chepareria HC were the only facilities in the district that had delivery tables with stirrups. None of the dispensaries had delivery tables.

All Labour and Delivery rooms must be equipped with blood pressure cuffs. Ortum MH had one functioning cuff and two of the health centres had functioning blood pressure cuffs (Kabichbich and Kacheliba did NOT have blood pressure cuffs). Kapenguria DH had one but it was broken. Two out of the three dispensaries had functioning blood pressure cuffs (Konyao did not have any cuffs).

All facilities except for Kacheliba HC had fetal stethoscopes. Only Ortum MH, Sigor HC, and Lomut and Serewo Dispensaries had adult stethoscopes.

Kapenguria DH had two oral thermometers (1 digital and 1 mercury-in-glass) available in the labour/ delivery room. Ortum MH had one functioning digital thermometer. The four health centres did not have any type of thermometer in their labour / delivery rooms.

Obstetric and neonatal complications

For most obstetric complications, it is essential to have oxygen and mask and bag. Only Ortum MH had a filled oxygen tank (with cylinder carrier and key to open the valve) in the labour and delivery room.

There are some key medications that must be available in labour and delivery rooms to treat obstetric complications including: magnesium sulfate (for eclampsia), oxytocin and ergometrine (injection) (to prevent and treat post-partum hemorrhage), and ampicillin (IV), gentamicine and metronidazole (for sepsis and complications of abortion)[7]. In West Pokot, many of these essential drugs were missing from facilities:

- Magnesium sulfate was not found in any of the labour and delivery wards. At the time of the assessment, Kapenguria DH had it in stock in the pharmacy but the drug was not being used for obstetric cases. The 2nd choice drug for treatment of eclampsia was Diazepam (IV) and all nine facilities carried that drug.
- Ortum MH, Kapenguria DH and Konyao Dispensary have oxytocin. The four health centres and two of the dispensaries did not have oxytocin. Ergometrine was available at the two hospitals, at Kacheliba HC, the pharmacy at Kabichbich HC and at Konyao Dispensary. Chepareria and Sigor HC had neither oxytocin nor ergometrine.
- A broad-spectrum antibiotic (and sometimes a combination of antibiotics) must be available to treat uterine infection following childbirth or abortion. For serious infections, the WHO recommends giving ampicillin (IV) + gentamicin (IV) + metronidazole. Sometimes it is necessary to add additional antibiotics. The assessment showed that ampicillin was only available at Ortum MH. Gentamicin was available in the labour/delivery room at Ortum and in the pharmacies at the eight other facilities. Metronidazole was available at both hospitals but not at the health centres and dispensaries. Kapenguria DH had ceftriaxone available in their pharmacy.

The only facility that was found to have dipstick tests for proteinurea was Ortum MH.

According to the WHO[8], certain medications must be available to treat neonatal complications including: ampicillin and gentamicin for pneumonia and sepsis and some type of artemisinin-based combination drug to treat malaria.

- As explained above, the assessment showed that ampicillin was only available at Ortum MH. Gentamicin was available in the labour/delivery room at Ortum MH and in the pharmacies at the eight other facilities.
- Coartem was the artemisinin-based combination drug used to treat malaria in Kenya. It was available in the pharmacies of both hospitals, three out of the four health centres (Kabichbich HC did not have Coartem in stock) and in all three dispensaries.

The two hospitals had functioning incubators. The health centres and dispensaries did not have incubators.

None of the facilities surveyed had low-reading thermometers for neonatal use.

Infection prevention

All nine facilities had bleach available in their labour and delivery rooms. Six out of the nine facilities had functioning autoclaves. Lomut Dispensary's autoclave was broken. Kabichbich Health Centre and Konyao Dispensary did not have autoclaves.

Sterile gloves were available in every facility except they were not available in the labour/delivery room at Kapenguria DH (only non-sterile gloves were available). Non-sterile

gloves were available in all facilities except for the labour/delivery room at Chepareria HC (where only sterile gloves were available).

Post-HIV exposure prophylactic treatment was not available in any of the facilities surveyed for this assessment.

24/7 coverage

To be considered fully functional, a health facility offering maternity services should provide care on a 24-hour basis seven days per week. With respect to providing delivery services, nurses were on-site at both hospitals 24/7 and were able to manage normal deliveries and administer many of the emergency medications. Medical officers, who are the only ones able to do many of the key basic and comprehensive EmONC signal functions, were on-call at night (VERIFY) and in the case of Ortum MH, were also on-call on the weekends. All but one health centre (Sigor) had nurses onsite 24/7 who can manage normal deliveries. Sigor Health Centre had staff onsite only during the day and staff on-call at night.

ACCESS TO SERVICES

Referral and counter-referral

Prompt access to EmONC services is only possible if there is a functioning referral system. Murray et al summarize the requirements of an effective referral system as having:[9]

- A well resourced facility serving as the referral centre
- Designated transport
- Communications and feedback systems
- Protocols for the identification and management of complications at each level of the health system
- Personnel trained in the use of the protocols
- Teamwork between referral levels
- Unified records system
- Mechanisms to discourage bypassing of lower levels of the referral system (but only once the lower level facilities are functioning well)

Based on Murray et al's requirements for a referral system, West Pokot did not have a functioning referral system. Kapenguria DH, as the first referral level for the four health centres and dispensaries in West Pokot, was missing some of the key resources (as shown above). Staff in the maternity ward said that sometimes Kapenguria DH had problems with electricity so women with obstetric complications must be referred to Kitale DH (ADD distance and time). Ortum MH, another option for EmONC in the district, was expensive and not accessible to all women in West Pokot. Ortum MH also had problems with electricity and sometimes also had to refer women to either Kapenguria DH (40 km which takes 1.5 hours) or Kitale DH (ADD km and takes 2.5 hours).

Transport between facilities was problematic in West Pokot. The distance between the four health centres and Kapenguria DH was on average 32.5 km and ranged from 20 km (Chepareria) to 40 km (Kacheliba and Sigor). The time that it took to travel that distance (in a good 4x4 car) was one to two hours (see Table * below). The three dispensaries visited during this assessment were 20-60 km away from Kapenguria DH, and it could take one to 2.5 hours to travel that distance in a good 4x4 car.

Table *: Distances to KDH

Location	Distance to Kapenguria DH	Time to Kapenguria DH (4x4)
Ortum MH	40km	1:30
Chepareria HC	20km	1:00
Kabichbich HC	30km	1:30
Kacheliba HC	40km	1:00
Sigor HC	40km	2:00
Konyao Disp	60km	2:00
Serewo Disp	20km	1:00
Lomut Disp	60km	2:30

The only facility that provided free transport to patients who required referral was Kapenguria DH. Transport was provided by their one functioning ambulance. Ortum MH had three functioning ambulances and they too provided transportation in case of referral. The one difference was that patients at Ortum MH who required referral payed for this service. The four health centres did not provide transportation for patients who needed referral. If referral was required, patients' families had to arrange and pay for the transportation to Kapenguria DH. Chepareria, Kabichbich and Kacheliba health centres did not have any functioning ambulances, other vehicles, or motorcycles that could be used for transportation. Only Sigor HC had a functioning motor vehicle (non-ambulance) and a motorcycle. Konyao and Lomut Dispensaries did not have any vehicles or motorcycles. Serewo Dispensary had one functioning motorcycle ambulance yet patients and their families had to arrange and pay for their own transportation.

In West Pokot, there was no official transport provided to women for their travel between the villages and any of the health facilities.

Table *: Transportation – availability and functioning

	No. Functional motor vehicle ambulances	No. Functional motorcycle ambulances	No. Other functional other motor vehicles	No. Other functional motorcycles
Kapenguria DH	**1**	0	**1**	0
Ortum MH	**3**	0	0	0
Chepareria HC	0	0	0	0
Kabichbich HC	0	0	0	0
Kacheliba HC	0	0	0	0
Sigor HC	0	0	**1**	**1**
Konyao Disp	0	0	0	0
Lomut Disp	0	0	0	0
Serewo Disp	0	**1**	0	0

Communication between facilities was another key aspect of a functioning referral system. Kapenguria DH had the only functioning land-line telephone. Ortum MH had a cell phone designated for hospital use. The four health centres relied on the use of personal mobile telephones. Only Chepareria HC provided funding from their Facility Improvement Fund to cover the cost of airtime. Staff at the other health centres had to pay out of pocket for any

airtime used for referral-related phone calls. Staff at the three dispensaries also had to rely on use of their personal mobile telephones for work-related calls and they were not reimbursed for airtime. Lomut Dispensary was the only facility that was outside of mobile telephone coverage. Staff at Lomut Dispensary traveled 5 km in order to get a signal. There was no radio equipment in any of the facilities surveyed.

Table*: Communication – availability and functioning

	No. Functional land telephones	No. Functional mobile telephones (designated for hospital use)	No. Functional radios	Other
Kapenguria DH	**1**	0	0	
Ortum MH	0	**1**	0	
Chepareria HC	0	0	0	Airtime for use of personal mobile telephones provided by the Facility Improvement Fund
Kabichbich HC	0	0	0	Health workers used personal mobile telephones and paid for airtime out of pocket
Kacheliba HC	0	0	0	
Sigor HC	0	0	0	
Konyao Disp	0	0	0	
Lomut Disp	0	0	0	No mobile telephone coverage (closest network coverage is 5 km away from facility
Serewo Disp	0	0	0	

Cost

User fees are a known barrier to accessing maternal health services[10]. In West Pokot, the out-of pocket expense for women seeking institutional delivery and obstetric care was substantial.

In all facilities except for Konyao Dispensary, a registration fee was required upon entering the facility. The registration fee at Kapenguria DH and Ortum MH was 50 Ksh. The fee was 20 Ksh at the four health centres and at Serewo Dispensary. Lomut Dispensary charged 10 Ksh. No facility reported that they required payment before a woman could receive emergency care.

Only 33% of facilities surveyed posted fee schedules in visible and public places (Kapenguria District Hospital, Chepareria Health Centre and Sigor Health Centre).

Among the facilities surveyed, there was a good deal of variation in fees charged for delivery services. The cost of normal delivery was most expensive at Ortum MH (1000-1200 Ksh). The cost of normal delivery at the government-operated facilities ranged from 70 Ksh at Kacheliba HC to 600 Ksh at Kapenguria DH. Treatment for complications, such as post-partum hemorrhage, ranged from 200-300 in government facilities to 400-900 in Ortum MH. Cesarean deliveries at Kapenguria DH cost, at a minimum, 2500 Ksh. A cesarean delivery at Ortum MH was more than double the cost at Kapenguria DH (6000 Ksh).

The two hospitals in West Pokot had waiver systems in place for women who were unable to pay their hospital bills. It was difficult to obtain detailed information about how the waiver systems worked. At both hospitals the data collection team learned that many women absconded without paying.

Table *: Cost of maternal health services

	Registration fee (Ksh)	Normal delivery (Ksh)	Treatment of post-partum hemorrhage (Ksh)	Cesarean section (Ksh)
Kapenguria DH	50	500 (+100 per day for a bed; typical stay is one day)	300	2500 (+ 100 per day for a bed; typically stay 3-7 days)
Ortum MH	50	1000-1200	Oxytocin / ergometrine = 40 (per ampule) Transfusion = 900 Bed in ward = 350 per day	6000
Chepareria HC	20	100	200	Not applicable
Kabichbich HC	20	100	*Not available*	Not applicable
Kacheliba HC	20	70	*Not available*	Not applicable
Sigor HC	20	200	*Not available*	Not applicable
Konyao Disp	No registration fee required	*Not available*	Not applicable	Not applicable
Lomut Disp	10	100 (for emergency delivery)	Not applicable	Not applicable
Serewo Disp	20	*Not available*	Not applicable	Not applicable

UTILIZATION OF SERVICES

In order to reduce maternal and neonatal mortality, not only do life-saving services need to be available and accessible, they must be utilized by the women and babies who have complications.

Proportion of expected births in surveyed facilities

Very few women in West Pokot delivered in health facilities. The facility assessment showed that only 11.7% of expected births took place in the 2 hospitals and 4 health centres surveyed. Seventy-two percent of the institutional deliveries were managed at Kapenguria DH. Only 11% of institutional deliveries were managed at the four health centres. The health centre with the most deliveries was Kacheliba HC. (For facility level results, please refer to the Appendix).

Table *: Proportion of expected births in facilities

	Expected births (CBR = 54.7 per 1000 pop) [11]	No. Deliveries in all surveyed facilities	Proportion of expected births in surveyed facilities
West Pokot	22,614	2656	11.7%

Met need for EmOC

Met need for EmOC is an indicator of the utilization of health services by women who develop obstetric complications during pregnancy, labour and delivery. It is estimated that 15% of pregnant women will develop complications. Therefore, to eliminate maternal mortality, we want to find 100% of these women receiving good-quality treatment in facilities offering the full range of EmOC signal functions.

The major obstetric complications that are included in the calculation of met need for EmOC are: hemorrhage (post-partum and ante-partum), sepsis, prolonged or obstructed labour, eclampsia/severe pre-eclampsia, complications of abortion, ruptured uterus and ectopic pregnancy.

The needs assessment revealed that met need for EmOC in the nine facilities surveyed was 14%. This means that 86% of women with potentially life-threatening complications did not receive services.

Not all incomplete abortions become a complication but some do. If the calculation for met need for EmOC is calculated with all managed cases of incomplete abortion, met need increases to 20%. However, this is still under the minimum recommended by the UN Guidelines.

Of the women receiving treatment at facilities, 57% were treated at Kapenguria DH and 27% received treatment at Ortum MH. Health centres managed 11% of the complications recorded and less than 5% were managed at the three dispensaries.

Almost half of the 473 complications recorded at the nine facilities were diagnosed as prolonged / obstructed labour. Twenty-two percent of complications were diagnosed as sepsis and 20% were diagnosed as hemorrhage.

Table *: Met need for EmOC

	Expected complications	No. Direct obstetric complications in all surveyed facilities (No. with incomplete abortions)	Met need for EmOC in all surveyed facilities (Met need for EmOC with incomplete abortions)
West Pokot	3,392	473 (675)	13.9% (20.0%)

Cesareans as a percentage of expected births

Caesarean section as a percentage of expected births is an indicator that shows both the functioning of facilities and whether critical life-saving services are being used by the women in

need of care. The UN Guidelines state that this proportion should not be less than 5% and not more than 15%.

In West Pokot, it was found that 1.6% of expected births were by cesarean section. This was under the recommended minimum of 5% and meant that many women were not receiving the care they needed. Some women from West Pokot might be traveling outside of the district for cesareans, especially when Kapenguria DH had no water or electricity. But, it would be unlikely that many women were doing so.

Almost 70% of cesarean deliveries in West Pokot were performed at Kapenguria DH. Kapenguria DH had only two cesarean packs and the operating theatre staff reported that this was insufficient for their needs.

Table *: Percentage of expected births by cesarean section

	Expected births	No. Cesarean Sections	Cesareans as a percentage of expected births
West Pokot	22,614	354	1.6%

QUALITY OF CARE

Not only do EmONC services need to be available and used by women with obstetric complications, they also need to be of good-quality. The ability of facilities and health professionals to quickly and effectively respond to the emergencies that arise can be the difference between life and death for women and their babies.

Case fatality rate for direct obstetric complications
The case fatality rate for direct obstetric complications (CFRDO) is used as a rough estimate of the quality of EmONC services by looking at the percent of women with obstetric complications managed in facilities who die. The UN Guidelines recommend a maximum of 1%.

In 2006, twelve maternal deaths were recorded in facility registers in West Pokot. Overall, the CFRDO in all facilities was 2.5% which exceeded the maximum rate as per the UN Guideline recommendations. The CFRDO in Kapenguria DH was 3.3% and 2.3% in Ortum MH. No maternal deaths were recorded at the four health centres and three dispensaries.

The nine maternal deaths from direct obstetric complications that occurred in Kapenguria DH were due to complications of abortion (4 deaths), ruptured uterus (2 deaths), eclampsia (1 death), hemorrhage (1 death) and sepsis (1 death). Three direct obstetric maternal deaths were recorded at Ortum MH: sepsis (2) and ruptured uterus (1).

The reliability of the CFRDO depends on the quality and completeness of record keeping and reporting of maternal deaths and obstetric complications. If very few maternal deaths are recorded, the quality of care may falsely appear to be quite good. Similarly, if few complications are recorded, the CFRDO may be artificially high. In this assessment, it was observed that record keeping was poor and that maternal deaths and obstetric complications were not well recorded. Therefore, the CFRDO should be interpreted with care.

Table *: Case fatality rate

	No. Direct obstetric maternal deaths in all surveyed facilities	No. Direct obstetric complications in all surveyed facilities	Case fatality rate for direct obstetric complications
West Pokot	12	472	2.5%

Percentage of maternal deaths due to indirect obstetric causes
In addition to the 12 direct obstetric maternal deaths, an additional seven indirect maternal deaths were recorded. Six out of the seven deaths (or 86%) were due to malaria.

Table *: Percentage of maternal deaths due to indirect obstetric causes

	Maternal deaths due to indirect causes	All maternal deaths (direct + indirect causes)	Percent of maternal deaths due to indirect obstetric causes
West Pokot	7	19	36.8%

Neonatal intrapartum case fatality rate
The proportion of births in the facility that die during the intrapartum period is an indicator that shows the quality of care provided. When appropriate and timely care is provided during labour and delivery, early neonatal deaths can be prevented.

In West Pokot, the facility-based neonatal intrapartum case fatality rate was found to be 5.5%.

Table *: Neonatal intrapartum case fatality rate

	Fresh stillbirths	Early neonatal deaths (within 24 hours) over 2kg	Deliveries in all facilities surveyed	Intrapartum CFR
West Pokot	93	52	2656	5.5%

Forty-five macerated stillbirths were recorded at the nine facilities.

Neonatal complications and deaths
Newborn complications were collected at the nine facilities. Only those complications that occurred within 1-28 days of life were recorded. When age was not recorded, the case was excluded from this study. In total, 576 cases of neonatal complications were recorded. The most frequently recorded complication was pneumonia (185 cases) followed by upper respiratory track infections (95 cases), malaria (93 cases), sepsis (86 cases) and prematurity / low birth weight (71 cases).

Eighty-four neonatal deaths (in babies 1-28 days old) were recorded in the nine facilities. Sixty percent of those deaths were recorded at Kapenguria DH and 40% were recorded at Ortum MH. Only one health centre, Kacheliba HC, reported any neonatal deaths. No dispensaries reported

any neonatal deaths. The most frequent cause of neonatal death was prematurity / low-birth weight (36 deaths) followed by pneumonia (20 deaths), asphyxia (17 deaths), neonatal sepsis (10 deaths) and anemia (1 death).

INFORMATION SYSTEMS: FACILITY REGISTERS AND RECORD KEEPING

Having good-quality data to monitor and evaluate the progress of interventions is vital. But often, overly complicated data collection systems requiring too much attention from health workers can take them away from providing emergency care for their patients. Finding a balance between collecting enough quality data and not over-burdening health workers can be a challenge. The ultimate goal is using the data once they are collected to inform and improve management and clinical practices.

Overall, information on obstetric complications and maternal deaths was difficult to find in all of the facilities surveyed. One problem is that the new maternity register being introduced throughout Kenya provides no space to record obstetric complications (except under the narrow column labeled ‘comments’).

In comparison to government facilities, it was easier to find obstetric complications at Ortum MH; most were recorded in their ‘Final Diagnosis Book’ (for the maternity ward).

CONCLUSIONS

The findings of this assessment indicate that in order to reduce the number of maternal deaths in West Pokot, the availability and coverage of good-quality EmONC must be improved. In those facilities already offering some EmONC, the quality of care needs to be ameliorated and delays in the provision of care must be reduced immediately. Once quality of care is improved, it is likely that utilization will also increase.

To further improve utilization, access to the EmONC facilities must be facilitated for all women by improving referral systems and by bringing EmONC closer to communities at the health centre level.

RECOMMENDATIONS

Improve the availability of EmONC:

- Ensure that all nine signal functions are provided 24/7 at Kapenguria DH and Ortum MH
    - Train medical officers, clinical officers and nurses in providing the signal functions according to Kenya Ministry of Health and international protocols
    - Equip both hospitals with all requisite drugs, supplies and equipment to provide the nine signal functions
    - Introduce the use of vacuum delivery in both hospitals
    - Ensure an adequate supply of magnesium sulfate in both hospitals and train medical officers, clinical officers and nurses in the use of the drug for treatment of eclampsia
    - Provide manual vacuum aspiration equipment and training for medical officers, clinical officers and nurses

    - Train and authorize nurses to manually remove placenta
- Repair electricity and water systems at Kapenguria DH and Ortum MH and health centres
- Upgrade the four health centres to provide Basic level EmONC (first seven signal functions)
    - Equip and supply all health centres with the requisite medications, equipment and supplies
    - Train nurses and clinical officers in the seven signal functions (according to Kenyan and international protocols)
    - Create systems for supportive supervision for nurses and clinical officers working at the health centres
- Establish and implement strict infection prevention guidelines
- Provide all health facilities with post-HIV exposure prophylactic treatment
- Train all skilled birth attendants to:
    - Actively manage the third stage of labour
    - Use the partograph
    - Properly manage women who are infibulated
- Ensure that all labor/delivery rooms are equipped with rapid HIV tests and staff are trained to counsel women and administer ARVs for PMTCT

Improve access to EmONC facilities:

- Establish a district referral plan and train all health workers in its implementation
- Provide health centres with ambulances to use for referral to Kapenguria DH
- Replicate / adapt the system that Chepareria HC uses for reimbursement of mobile telephone airtime so that staff do not pay out of pocket for work-related, referral-related phone calls
- Consider the possibility of reducing / eliminating / standardizing the cost of maternity care at health centres and Kapenguria DH

Improve quality of EmONC:

- Train all health workers in EmONC protocols
- Establish a system of supportive supervision
- Introduce a team-approach to treating obstetric and neonatal complications
- Conduct routine near-miss, criterion-based and maternal death audits
- For more specific quality improvement interventions, conduct a more in-depth study using EngenderHealth and AMDD's 'Quality Improvement for Emergency Obstetric Care: Leadership Manual and Toolbook' (available at: http://www.engenderhealth.org/res/offc/mac/emoc/index.html#qi-emoc)

Improve utilization of EmONC:

- Improve quality of care in health facilities
- Work with health committees to inform communities about changes and improvements to the health facilities
- Establish community-based emergency loan funds at the village level for transport and to cover emergency care[12]
- Work with women during antenatal care to create birthing plans

Coordination and collaboration of EmONC interventions:

- Strengthen the district monitoring and evaluation system

- Create a district-wide maternal and neonatal mortality committee

Appendix 1 – Facility snapshots

1. Kapenguria District Hospital
2. Ortum Mission Hospital
3. Chepareria Health Centre
4. Kabichbich Health Centre
5. Kacheliba Health Centre
6. Sigor Health Centre
7. Konyao Dispensary
8. Lomut Dispensary
9. Serewo Dispensary

Kapenguria District Hospital (KDH)

Overall description
Kapenguria District Hospital (KDH) is government-operated. Of the 156 beds in the hospital, 44 beds are exclusively dedicated to obstetric patients. Eight obstetric beds are for the labor ward and 36 for the ante/postnatal ward. KDH has functioning electricity from power lines, available 24 hours a day (Electricity available 90% of the time). There is one back-up generator. Clean/potable water should be available through inside plumbing provided by the government system. However, the supply of water is inadequate and additional water is brought in and stored in buckets.

Staffing
- 4 Medical Officers (0 in maternity ward currently – rotate PT)
- 29 Registered Nurses (4 in maternity; 2 in operating theatre)
- 89 Enrolled (Community) Nurses (16 in maternity; 4 in operating theatre)
- 12 Clinical Officers (9 currently working in facility; 0 in maternity; 2 in operating theatre)
- 2 Anesthetists – 2 Clinical Officers serve as anesthetists in operating theatre.
- 1 Subordinate

EmOC Signal Functions in the last three months

Parenteral antibiotics	√
Parenteral oxytocics	√
Parenteral anticonvulsants	√
Manual removal of placenta	√
Removal of retained products	√
Assisted vaginal delivery	
Neonatal resuscitation	√
Blood transfusion	√
Cesarean section	√
EmOC status	**Comprehensive minus 1**

Other Essential Services
- Partograph used in last 3 months to manage labor.
- Breech delivery performed in last 3 months.
- Rapid HIV testing provided to mothers of unknown HIV status in last 3 months.
- Nevirapine provided to mothers and newborns in last 3 months.
- Misoprostol has been used but it must be purchased at a private pharmacy in Kitale.
- For management of 3rd stage of labor – controlled cord traction; uterine massage.
- No health worker trained to repair obstetric fistulae.

- There is at least one health worker who received training on how to manage labor and delivery of women who are infibulated. Training received over 20 years ago in college at Ortum. Management includes bilateral episiotomy following crowning.
- MVA not performed in 4 years – need equipment.

Referral for EmOC

- KDH provides EmOC services.
- Sometimes refer women to Kitale DH when there are problems with water or electricity.
- If patients referred to Kitale, KDH provides transport at no cost to the patient.
- The hospital has 1 land telephone and 1 mobile phone in the nursing office.
- There is 1 motor vehicle ambulance and 1 motor vehicle (non ambulance) currently functioning. When the motor vehicles need repair, a repair person is hired and funds are generally available to pay for the service. There is not sufficient fuel for the facility's caseload.
- Women came to KDH from 100 villages; 19% from Mukatano; 4% each from Chepareria, Karas, and Bendora.

Utilization, 2006

No. deliveries	1917
No. direct obstetric complications	270 total • 57% prolonged / obstructed labour; • 14% sepsis • 12% hemorrhage • 8% eclampsia / pre-eclampsia • 4% complications of abortion • 3% ectopic pregnancy • 1% ruptured uterus
No. incomplete abortions	141
No. neonatal complications treated	118 (33% pneumonia; 24% sepsis; 21% premature LBW)
No caesareans	246
No. maternal deaths	9 direct obstetric cause • 4 complications of abortion • 2 ruptured uterus • 1 hemorrhage • 1 sepsis • 1 eclampsia 6 indirect maternal deaths • 5 malaria • 1 HIV/AIDS
No. stillbirths	68 fresh 31 macerated
No. early neonatal deaths (1st 24 hours)	Under 2kg = 16 Over 2kg = 17
No. neonatal deaths (1-28 days)	50 recorded: • 17 premature / low-birt√hweight

	• 13 asphyxia • 12 pneumonia • 7 sepsis • 1 anemia

Information systems: facility registers and record keeping

At Kapenguria DH, data on obstetric complications occurring during labour and delivery were found in four registers: the labour/delivery admissions register, labour/delivery report book, the post-natal ward register and the operating theatre register (major surgery). Complications of abortion and ectopic pregnancies were found in two registers: the female/gynecology ward admissions register and the operating theatre registers. Maternal deaths were located in

Maternal deaths were difficult to locate.

Ortum Mission Hospital

Overall description
Ortum Mission Hospital is run by the Catholic mission. Thirty out of the 110 beds in the facility are dedicated to obstetric patients. The facility has electricity provided by a solar generator (7-10pm daily), but it is not currently functional. Electricity is rationed for the baby special care and maternity wards.

There is a maintenance person who can repair electricity. Clean and potable water is obtained through a rainwater catchment tank and protected spring, and accessed via faucet and plastic jerry can. The facility is sometimes without water, especially during the rainy season, when pipes are blocked.

Staffing
Two medical officers, two registered nurses, 1 enrolled midwife, three enrolled nurses, and two subordinates currently work in the maternity ward. Overall staffing is as follows:

- 2 Medical officers
- 5 Registered nurses
- 1 Enrolled midwife
- 21 Enrolled nurses (1 CNR)
- 1 Clinical officer
- 2 +Diploma RN students

- 1 Clinical officer
- 1 Pediatrician
- 3 Theatre technicians
- 1 Lab assistant
- 2 Subordinate

EmOC Signal Functions in the last three months

Parenteral antibiotics	√
Parenteral oxytocics	√
Parenteral anticonvulsants	
Manual removal of placenta	√
Removal of retained products	√
Assisted vaginal delivery	
Neonatal resuscitation	√
Blood transfusion	√
Cesarean section	√
EmOC status	**Comprehensive minus 2**

Other Essential Services

- Spinal and ketamine anesthesia are available and provided by medical officer.
- A partograph has been used to manage labor in last 3 months.
- Breech delivery has been performed in last 3 months by medical officer, registered or enrolled nurse, or enrolled midwife.
- Rapid HIV testing is not available in LD room, but is available in post-natal. Insufficient trained staff to counsel and test every woman individually.
- Nevirapine has not been given to mothers; no indication.
- Nevirapine has been given to newborns in last 3 months. Nevirapine is not available.
- Misoprostol is not used.
- Steps mentioned for management of 3rd stage of labor were controlled cord traction, uterine massage, and catheterization.
- No staff members are able to repair obstetric fistula. Fistula operations done by AMREF/Mayleya team.
- There is a maternity waiting home next door do Ortum with 20 beds.
- None of the staff have received training on management of labor and delivery for women who are infibulated, but they manage women who are infibulated during labour and delivery by unilateral or bilateral episiotomy at crowning of head.
- Ortum MH has an ultrasound, but nobody can operate it.
- Basic EmOC is available during the day Monday-Friday, but services are only available on an on-call basis during nights and weekends. Staff members take about 20-30 minutes to arrive; intercoms in home.

Referral for EmOC

- Ortum can provide EmOC but sometimes has to refer women when there is no electricity. Women are referred to KDH and sometimes to Kitale since KDH theatre does not always work.
- The facility has one working mobile phone, but no longer has a land phone.
- Ortum has three motor vehicle ambulances, but relatives are asked to pay fuel for transport.
- Ortum is about 1.5 hours away from Kapenguria District Hospital.
- Women came to Ortum from 58 villages; 7% from Ortum and Sebit each, and 6% from Chepareria and Sook each.

Utilization, 2006

No. deliveries	448
No. direct obstetric complications	128 total • 48% prolonged / obstructed labour; • 42% hemorrhage • 5% sepsis • 2% eclampsia / pre-eclampsia • 2% ruptured uterus • 1% complications of abortion
No. incomplete abortions	33

No. neonatal complications treated	102 (44% premature LBW; 32% pneumonia; 19% sepsis)
No caesareans	108
No. maternal deaths	3 direct obstetric cause • 2 sepsis • 1 ruptured uterus 1 indirect maternal deaths • malaria
No. stillbirths	20 fresh 13 macerated
No. early neonatal deaths (1st 24 hours)	Under 2kg = 8 Over 2kg = 35
No. neonatal deaths (1-28 days)	33 recorded: • 19 premature / low-birt√hweight • 4 asphyxia • 7 pneumonia • 3 sepsis

Chepareria Health Centre

Overall description
Chepareria Health Centre is government-operated. One out of the total 18 beds in the facility is dedicated to obstetric patients. The facility has functioning electricity supplied and partially maintained by the government. There is no backup generator available. Clean and potable water is providing through a functional plumbing system operated by faucets, and is supplemented by a storage tank.

Staffing
No staff exclusively dedicated to maternity ward; all rotate.

- 1 Registered nurse
- 8 Enrolled nurses
- 1 Clinical officer
- 2 Lab technicians
- 1 Sub. Staff
- 2 Watchmen
- 2 Clerks

EmOC Signal Functions provided in the last 3 months

Parenteral antibiotics	√
Parenteral oxytocics	√
Parenteral anticonvulsants	
Manual removal of placenta	
Removal of retained products	√
Assisted vaginal delivery	
Neonatal resuscitation	
Blood transfusion	Not applicable
Cesarean section	Not applicable
EmOC status	**Basic minus 4**

Other Essential Services

- The clinical officer can provide local anesthesia.
- No staff members are trained to use a partograph to manage labor, but there is at least one copy of a partograph available.
- HIV testing is available at the VCT center but not in the labour/delivery room.
- Nevirapine is not available, and has not been given to mothers or newborns.
- Misoprostol is not used.
- The only step mentioned for management of 3rd stage of labor was controlled cord traction.

- None of the staff have received training on management of labor and delivery for women who are infibulated; when presented with such cases, staff members perform bilateral episiotomies when the head crowns.
- Few drugs are available for infection prevention.

Referral for EmOC

- Chepareria does not provide EmOC services; women are referred to Kapenguria DH (KDH) and Ortum Hospitals, based on relatives' preference and staff preference for Kapenguria (government-run).
- The facility has no means of transport or communication via phone or radio; patient's family must provide transport. Chepareria is about 1 hour away from KDH.
- Staff members can use personal mobile phone, airtime provided by the Facility Improvement Fund.
- Chepareria is the closest facility studied to KDH.
- Women came to Chepareria from 32 villages; 22% from Chepareria village; 9% from Kosubuk, and 6% from Propei.

Utilization, 2006

No. deliveries	76
No. direct obstetric complications	20 (85% diagnosed as sepsis)
No. incomplete abortions	14
No. neonatal complications recorded	84 (75% pneumonia; 11% sepsis; 10% malaria)
No. maternal deaths	0 reported
No. stillbirths	0 reported

Maternal mortality may be underestimated here since obstetric emergencies are referred to hospitals and Chepareria does not transport patients: we do not know what happens to these patients once they leave the facility.

Kabichbich Health Centre

Overall description
Kabichbich Health Center is government-operated. Three of the 6 beds in the facility are exclusively dedicated to obstetric patients. Only 1 of the 3 delivery beds is functioning and this table has no stirrups. The facility has functioning electricity, provided by a generator and charging battery light, with a back-up generator, but there is no electricity in the labour/delivery room or post natal ward. The electricity is not available 24 hours per day and District Maintenance (based at Kapenguria DH) is responsible for electricity repair. Clean/potable water is available from a protected spring with pump and is accessed by faucet and jerry can.

Staffing

- 1 Registered nurse
- 1 Enrolled midwife
- 5 Enrolled nurses
- 1 Lab technicians

There is a rotation of these staff members. Only one at maternity at a time.

- 2 Public Health Techs
- 1 Public Health Officer
- 2 Casual

EmOC Signal Functions in the last three months

Parenteral antibiotics	√
Parenteral oxytocics	√
Parenteral anticonvulsants	
Manual removal of placenta	
Removal of retained products	
Assisted vaginal delivery	
Neonatal resuscitation	
Blood transfusion	Not applicable
Cesarean section	Not applicable
EmOC status	**Basic minus 5**

Other Essential Services

- Partograph not used in the last 3 months - **not** available.
- HIV testing for mothers of unknown status **not** performed within the last 3 or 12 months - no policy.
- Nevirapine **not** provided to mothers **or** to newborns – **no** policy.
- Misoprostol is **not** used.
- The procedure for management of 3rd stage of labor - controlled cord traction.
- **No** trained staff to manage labor and delivery for women who are infibulated. Unilateral episiotomy is used for management of infibulation.

- The registered nurse and enrolled nurses are trained to perform breech delivery, but refer to another facility.
- The facility cannot provide emergency newborn care because there is **no oxygen**.
- Laboratory functions can be performed during the day, Monday-Friday. The tech is on-call only in the evening and travels on weekends. There is no functional refrigeration for the lab.
- **No** complete delivery packs available.
- An autoclave supplied January 2007 by KEMSA. It is not yet operational, but staff know how to use it.

Referral for EmOC

- Kabichbich does not provide basic or comprehensive EmOC services.
- This facility refers patients in need of EmOC to Kapenguria District Hospital (KDH).
- Decision-making factors in the referral process are listed as 'government hospital, near enough.'
- The distance from Kabichbich to Kapenguria is 30 km, approximately 1 hour and 30 minutes travel time.
- The patient's family is responsible for transport arrangements to KDH.
- Staff have personal cell phones, but receive no airtime from the hospital.
- Women came to this facility from 14 villages: 32% from Kabichbich village and one woman from each of the other 13 villages.

Utilization, 2006

No. deliveries	59
No. direct obstetric complications	7 (100% diagnosed as sepsis)
No. incomplete abortions	3
No. neonatal complications recorded	22 (41% pneumonia; 32% malaria; 18% sepsis; 9% URTI)
No. maternal deaths	0 reported
No. stillbirths	2 fresh

Facility not trained to use Maternal Death Notification Forms and do not have copies of these forms. Most women with obstetric complications are referred to KDH.

Kacheliba Health Centre

Overall description
Kacheliba Health Center is government-operated. Of 13 total beds, 2 are exclusively dedicated to obstetric patients, but only 1 of the 2 obstetric beds is functional. The facility has solar electricity, which is not currently functioning. The District Technician is responsible for electrical repair. Clean/potable water is available, through an outdoor pump built by Médecins Sans Frontiers. The facility also uses rainwater catchment. The water is accessible by jerry can, as the taps are not functioning.

Staffing
- 5 Registered Nurses (rotating)
- 3 Enrolled Nurses (rotating)
- 1 Clinical Officer (in maternity on as-needed basis)
- 2 Casuals (1 Watchman, 1 Cleaner)
- 1 Subordinate

EmOC Signal Functions in the last three months

Parenteral antibiotics	√
Parenteral oxytocics	
Parenteral anticonvulsants	
Manual removal of placenta	
Removal of retained products	
Assisted vaginal delivery	
Neonatal resuscitation	√
Blood transfusion	Not applicable
Cesarean section	Not applicable
EmOC status	**Basic minus 5**

Other Essential Services
- The partograph has not been used to manage labor in last 3 months.
- There are 2 delivery packs available.
- There is no oxygen available at the facility.
- HIV testing of mothers is not provided - not routine; no policy in place. HIV tests are available in the laboratory. No rapid testing kits.
- Nevirapine provided to mothers in the last 3 months through the mobile clinic, but not provided to newborns because of a lack of supplies/drugs.
- Misoprostol is not used.
- To manage 3rd stage of labor – controlled cord traction; uterine massage.
- No staff trained to manage labor and delivery of women who are infibulated. To manage, staff can perform bilateral episiotomy (Most FGM levels III-IV).

- The drug register lists no oxytocin, but a note reports that oxytocin is stored in the immunization refrigerator.

Referral for EmOC

- Refer patients to Kapenguria District Hospital (KDH).
- Decision-making factors for referral include: whether or not the operating theatre at KDH is functioning; refer because there are doctors at KDH; KDH is a government facility and is close and relatively accessible.
- There is no available form of communication-no landline, mobile phone or radio.
- There is a motorcycle, but it is almost always at KDH. The MOH is responsible for repairs and pays the bills. Fuel is insufficient and a doctor or patient must contribute for fuel. Most of the time there is no fuel.
- Kacheliba is 40 km from KDH, approx. 1-hour drive.
- Women came to Kacheliba from 17 villages; 30% from Kongelai village; 24% from Kacheliba village.
- Kacheliba staff report a need for a separate labor ward, with a theatre and doctors. In addition, the staff requested training in MVA, manual removal of placenta, and management of pre-eclampsia.

Utilization, 2006

No. deliveries	106
No. direct obstetric complications	18 (72% diagnosed as sepsis)
No. incomplete abortions	6
No. neonatal complications recorded	16 (94% pneumonia; 6% asphyxia)
No. maternal deaths	0 reported
No. stillbirths	3 fresh 1 macerated

Facility not trained to use Maternal Death Notification Forms and they do not have copies of these forms. Most women with obstetric complications are referred to KDH.

Sigor Health Centre

Overall description
Sigor Health Centre is government-operated. Four out of the 20 beds in the facility are dedicated to obstetric patients. The facility has functioning solar electricity, but there is no backup generator available and nobody trained to fix the system if it breaks. Clean and potable water is available through a functional plumbing system and is accessed by faucets inside the facility.

Staffing
One registered nurse and one enrolled nurse currently work in the maternity ward. Overall staffing is as follows:

- 1 Registered nurse currently working, 2assigned
- 4 Enrolled nurses
- 1 Clinical officer posted, but not yet reported

- 6 student nurses
- 1 lab tech currently working, 2 assigned
- 1 Watchman
- 2 Subordinate

EmOC Signal Functions in the last three months

Parenteral antibiotics	√
Parenteral oxytocics	
Parenteral anticonvulsants	
Manual removal of placenta	
Removal of retained products	
Assisted vaginal delivery	
Neonatal resuscitation	
Blood transfusion	Not applicable
Cesarean section	Not applicable
EmOC status	**Basic minus 6**

Other Essential Services

- No staff members are trained to use a partograph to manage labor, and there is no partograph available.
- Rapid HIV testing is not available; no trained staff.
- Nevirapine has not been given to mothers or newborns
- Misoprostol is not used.
- The only step mentioned for management of 3rd stage of labor was controlled cord traction and uterine massage.

- None of the staff have received training on management of labor and delivery for women who are infibulated.
- Few drugs are available for infection prevention.

Referral for EmOC

- Sigor does not provide EmOC services; women are referred to Kapenguria DH (KDH), based on need for operation/ER services.
- The facility provides transport via motor vehicle or motorcycle that is uninsured by the district health office. There is no source of repair should the motor vehicle or motorcycle break down; there is also insufficient fuel or funding for repair.
- Sigor is about 2 hours away from KDH.
- Women came to Sigor from 7 villages; 40% from Sigor village; 10% from Korelach.

Utilization, 2006

No. deliveries	50
No. direct obstetric complications	7 (71% diagnosed as sepsis)
No. incomplete abortions	2
No. neonatal complications recorded	92 (42% URTI; 30% malaria; 12% sepsis)
No. maternal deaths	0 reported
No. stillbirths	0 reported

Konyao Dispensary

Overall description
Serewo is a government-operated dispensary. There is no electricity or potable water.

Staffing
- 1 enrolled nurse – works every day, on call all nights, off for church on Sundays.
- 1 nurse aid.
- Extremely understaffed.

Facility
- 0 beds; 0 delivery packs.
- Maternity currently being built w/ government funding – no estimated date of completion.

EmOC Referral
- No EmOC services are available at Konyao. They do see some deliveries.
- Konyao is 2 hours from Kapenguria DH (KDH).
- There is no form of communication or transport.

Equipment and Supplies
- No neonatal resuscitation materials available.

Utilization, 2006
- Women came to Konyao from 9 villages; 31% from Napatuiisa; 15% from Konyao village.

No. outpatient visits	7691
No. direct obstetric complications	11 (82% diagnosed as sepsis)
No. incomplete abortions	1
No. maternal deaths	0 reported
No. neonatal complications recorded	14 (36% pnuemonia; 21% malaria; 21% sepsis)

Quality of care
Two cases of obstetric complications that were managed at Konyao Dispensary were reviewed by the obstetrician who was part of the data collection team. In his opinion, the treatment provided was problematic:

1. Threatened Abortion:
    - Drugs prescribed: Amoxil, Phenobarbitone, Ventolin.
    - Not clear why Amoxil is used; there should be evidence of infection.
    - Phenobarbitone may have value for bed rest.
    - Ventolin causes uterine relaxation and may actually exacerbate uterine bleeding.
    - Overall, how the diagnosis is made is suspect (e.g. do they do vaginal examinations or not?).
2. Puerperal sepsis:

- Drugs prescribed: Amoxil, Brefen.
- This diagnosis would normally warrant admission and appropriate parenteral antibiotics.
- Value of oral Amoxil alone in doubt.
- Flagyl tablets available at this facility – this would have provided useful cover for analgesic bacteria but it was not prescribed in this case.

Lomut Dispensary

Overall description
Lomut is a government-operated dispensary. There is no electricity, but there is potable water accessed via faucet and plumbing system.

Staffing
- 1 registered nurse
- 2 enrolled nurses
- 1 community health worker
- 2 subordinates
- 1 watchman

Facility
- 0 beds
- 1 delivery pack
- The maternity has just been completed.

EmOC Referral
- No EmOC services are available at Lomut. They do see some deliveries.
- Women with obstetric complications are referred to Ortum (because it is close-by) or Kapenguria DH (KDH).
- Lomut is 2.5 hours from KDH.
- Patients' families must pay and arrange transport.
- No cell phone service – must cycle to network area to make call.

Equipment and Supplies
- No neonatal resuscitation materials available.

Utilization, 2006
- Women came to Lomut from 9 villages; 20% each from Koposes and Lomut, and 13% each from Kamanau and Toghono.

No. outpatient visits	4745
No. direct obstetric complications	2 (both diagnosed as complications of abortion)
No. incomplete abortions	1
No. maternal deaths	0 reported
No. neonatal complications treated	85 (38% URTI; 36% malaria; 12%pnuemonia)

Serewo Dispensary

Overall description
Serewo is a government-operated dispensary. There is no electricity or potable water.

Staffing
- 1 registered nurse
- 1 enrolled nurse (on leave for two months)
- Extremely understaffed.

Facility
- 10 beds available, 0 dedicated to obstetric patients.
- 2 delivery packs.
- Maternity currently being built – should be finished in 6 months.

EmOC Referral
- No EmOC services are available at Serewo. They do see some deliveries. Women with obstetric complications are referred to Kapenguria DH (KDH), if the woman hemorrhages, is having a difficult labor, and/or has previous scars.
- Serewo is 1 hour from KDH.
- There is one motorcycle ambulance available to transport patients to KDH. Facility director is responsible for ensuring that the motorcycle is working, but there is no available source of repair nor the funding or fuel to keep the motorcycle running.

Equipment and Supplies
- No neonatal resuscitation materials available.

Utilization, 2006
- Women came to Serewo from 10 villages; 14% each from Krewso, Kuntong, Serewo, and Singon.

No. outpatient visits	4036
No. direct obstetric complications	10 (90% diagnosed as sepsis)
No. incomplete abortions	1
No. maternal deaths	0 reported
No. neonatal complications recorded	43 (47% URTI; 26% malaria; 12% sepsis)

[1] UNICEF, WHO, UNFPA. REVISED Guidelines for monitoring the availability and use of obstetric services. Forthcoming.
[2] Kenya National Census, 1999.
[3] ICM/FIGO Joint Statement : Prevention and Treatment of Post-Partum Haemorrhage – New Advances for Low Resource Settings. November 2006. http://www.figo.org/docs/PPH%20Joint%20Statement%202%20English.pdf
[4] WHO study group on female genital mutilation and obstetric outcome. 2006. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet, 367: 1835-41.
[5] WHO. 2001. Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutiliation – Report of a WHO Technical Consultation – Geneva, 15-17 October 1997. Geneva: WHO. http://www.who.int/reproductive-health/pages_resources/listing_fgm.en.html
[6] National Joint Steering Committee for Maternal Health Kenya. 2002. Standards for Maternal Care in Kenya. Nairobi, Kenya.
[7] WHO. Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. 2003. http://www.who.int/reproductive-health/impac/index.html
[8] WHO. Pocket Book of Hospital Care for Children – Guidelines for the management of common illnesses with limited resources. 2005. http://www.who.int/child-adolescent-health/publications/CHILD_HEALTH/PB.htm
[9] Murray S, Davies S, Phiri RK, Ahmed Y. 2001. Tools for monitoring the effectiveness of district maternity referral systems. Health Policy and Planning; 16(4): 353-361.
[10] Nanda P. 2002. Gender dimensions of user fees: Implications for women's utilization of health care. Reproductive Health Matters; 10(20): 127-134.
[11] Kenya Census, 1999.
[12] Chiwuzie J, Okojie O, Okolocha C et al. 1997. Emergency loan funds to improve access to obstetric care in Ekpoma, Nigeria. International Journal of Gynecology and Obstetrics; 59(2): S231-S236.

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 3:
MOUs and Letters of Support

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

MEMORANDUM OF UNDERSTANDING BETWEEN:

DOCTORS OF THE WORLD-USA/KENYA AND WEST POKOT DISTRICT HEALTH MANAGEMENT TEAM

RIFT VALLEY PROVINCE, KENYA

I. Parties

This Memorandum of Understanding "MoU" with its annexes is entered into and is effective as from the date of signing this contract (The "Effective date") by and between the following parties:

BETWEEN: **Doctors of the World-USA/Kenya –Partnership for Maternal and Neonatal Health, West Pokot District Child Survival and Health Program (hereby referred to as DOW)** having its headquarters at 80 Maiden Lane, New York, New York, 10038, USA; and its local office in Kapenguria at PO Box 1035 Kitale,

AND: **The District Health Management Team (hereby referred to as DHMT)**, West Pokot, Rift Valley Province, Kenya, PO Box 63, Kapenguria.

II. General Principles of MOU

1 DOW and the District Health Management Team (DHMT) have a common goal and commitment to contribute to the reduction of maternal and neonatal morbidity and mortality in five divisions of the West Pokot District of Kenya. These divisions are, Chepareria, Kacheliba, Kapenguria, Lelan, and Sigor by September 2010.

2 DOW and the DHMT seek guidelines to structure and guide partnership for Maternal and Neonatal Health program to foster closer and binding cooperation in order to achieve the desired program objectives.

3 Presently DOW is in receipt of a four year grant effective from 1st October 2006 from USAID (United States Agency for International Development) to build capacity of Ministry of Health staff to improve maternal and neonatal health in targeted divisions of West Pokot District.

III. Provisions of the MOU

1. This MoU is between DOW and DHMT, Rift Valley Province, under whose authority maternal and neonatal health care is delivered in the targeted areas.

2. The goal of this MoU is to enhance partnership between the parties in the work areas and to recognize the developments and specifications made by DOW and West Pokot District Health Management Team.
3. Each party operates according to its own respective policies and procedures.

The parties desire through this MoU to establish specific guidelines regarding the implementation of program interventions as stipulated in the Detailed Implementation Plan (DIP) and proposal, sharing of relevant documents, sharing of relevant data/information, allowances, support, staffing, project supervision, meetings, planning and project implementation activities.

IV. Key Aspects of Collaboration

DOW began formally working with the MOH in June 2005 when it partnered with NASCOP and AMPATH to establish a comprehensive HIV/AIDS treatment program in the West Pokot District. Since that time, it has become clear that there are several overlapping priority concerns in the District, including the provision of maternal and neonatal health care as recommended by Kenya's Ministry of Health (MOH) policy. Working closely with the DHMT, DOW wrote a proposal in November 2005 that addressed the primary concerns posed by the DHMT and other stakeholders in the district. In 2006, DOW was awarded a four-year Child Survival and Health grant by USAID to address those concerns cited. To this end, from 2006-2009, DOW proposes to partner with key stakeholders in the West Pokot District, including the DHMT, to implement interventions that will work to link communities with health facilities in order to achieve the four following goals:

1) To improve maternal and neonatal health care services in eight facilities in the five most populous divisions in the West Pokot District.
2) To improve community awareness about both prevention and treatment interventions related to maternal and neonatal health care.
3) To increase utilization of maternal and neonatal health care services, especially in targeted health facilities.
4) In an effort to assist the district to mobilize further resources, to improve data collection systems related to maternal and neonatal health care.

The following sections outline DOW's commitments to the improvement of maternal and neonatal health care services in the West Pokot District. All activities have been and will be carried out by DOW in cooperation with the National, Provincial and District health authorities. Finally, it is important to note that all activities are subject to change depending on resource availability.

1. Document Sharing

a) Each party encourages the sharing of documents to all of its respective members.

b) Documents from one party which are made available to the other party are intended to be accessible on equal terms to all members of the other party.

c) DOW provides with this MoU copies of the Projects' Proposal, and the Detailed Implementation Plan jointly developed for the duration of the Program

d) The two parties shall routinely provide each other with relevant project documents as mentioned herein. DOW shall provide DHMT with copies of project quarterly progress reports. The DHMT through their representative shall provide DOW with

relevant Government circulars, District Health Plans, and maternal and neonatal policies and guidelines.

2. Sharing of data

On request, each party shall access any information or data collected by the other party which is related or relevant to maternal and neonatal health program. This data shall be accessed through the custodian of such data here referred to as District Health Records and Information Officer for West Pokot DHMT, and Project Director, maternal and neonatal health program for DOW.

3. Representation

a) The DHMT shall select a Team of no more than three who will collaborate with DOW on monitoring and evaluation/supervision activities at all Project sites.

b) One member of this Team shall be designated as a focal person who will provide the link between the Team, the DHMT and DOW in the implementation of the maternal and neonatal health program interventions. The person shall ensure that the DHMT is regularly updated on the program progress.

c) The DHMT, through their selected Team, will ensure that the Project is consistent with National Policies and Guidelines.

d) Both parties shall ensure that all formal communication to relevant officers is done through the identified focal person and DOW Project Director for maternal and neonatal health program.

4. Activities and Personnel

a) The DHMT shall participate in the process of developing Detailed Implementation Plan for maternal and neonatal health and hereby agrees to implement interventions and activities outlined in that Plan.

b) The DHMT shall encourage staff trained through support from DOW to continuously work in the project areas and consistently support maternal and neonatal health activities during the project implementation period and after.

c) The DHMT shall ensure that the staff trained consistently implements maternal and neonatal health activities in which they are trained.

d) The DHMT shall ensure availability of staff such as drivers where vehicle support for maternal and neonatal health services is donated by DOW.

e) DHMT shall ensure that targeted health facilities have adequate qualified staff to consistently support maternal and neonatal health services as provided for in Ministry of Health Guidelines and policies.

5. Project Supervision

a) The DHMT and DOW shall undertake to supervise and monitor the project interventions on biannual basis and provide regular reports to the DHMT. The supervision and monitoring shall be undertaken during the first month of the

succeeding half-year and the reports shall be written and disseminated within 30 days from the end of each supervision.

b) Designated MOH staff and DOW staff shall undertake quarterly monitoring and supervision of maternal and neonatal health activities of Community-Owned Health Resource Persons (CHWs,TBAs ,and Health Facility Management Committees). Written reports of these activities shall be submitted to both parties within 7 days of the exercise.

c) The DHMT through their focal person shall ensure that DOW receives reports emanating from internal supervisions of maternal and neonatal health activities.

6. Identification of Project Divisions and Facilities

a) The DHMT identified divisions and facilities for intervention and support should be supported by feasibility findings and based on District priorities on improving maternal and neonatal health services.

b) In case of any renovations to be undertaken by DOW, DHMT will identify and agree on the sites and nature of work to be undertaken.

c) In the event that DOWs to undertake any construction or renovation works, the DHMTs shall ensure that relevant protocols are followed and relevant departments such as Public Works are informed and brought on board in a timely manner.

d) Upon completion of any construction or renovation works, DOW shall issue certificates of completion to the DHMT.

e) DHMTs shall be held responsible for maintenance and relevant operations of facilities constructed or renovated by DOW.

7. Meetings

a) DOW and the Project stakeholders, including the DHMT, will hold biannual meetings (every six months) at the District Hospital to review progress of the Project and plan. These meetings will be preceded by one/two days of fieldwork where the Team[1] will assess the progress made in specific project sites. Dates of the meetings will be forwarded to the Offices of the DMOH as soon as possible.

b) Either party shall convene a meeting to discuss issues emanating from project implementation that requires the attention of the other party. The full costs of such meetings shall be incurred by the convening party.

8. Support to MOH

a) DOW support to MOH shall be guided by interventions and activities stipulated in the maternal and neonatal health project detailed implementation plan, donor specifications and Doctors of the World-USA/Kenya operations and guidelines.

b) DHMTs shall ensure that DOW donated equipment and materials are used as outlined in the donation certificates. Any desired changes shall be communicated to DOW

[1] This team shall be comprised of: at most three members of the DHMT and one representative from each of the three primary collaborating organizations (PADO, Kiletat, and ELCK).

Project Director for maternal and neonatal health project and should only be effective upon agreement.

c) DHMT shall ensure that equipment and materials donated by DOW are entered into official inventories and are well maintained.

d) In the event of donation of a vehicle by DOW, the DHMT shall ensure consistency in the use of such vehicles to support maternal and neonatal health services in the target divisions by providing fuel and preventive maintenance.

e) DOW shall monitor through joint supervisory visits the effective use of materials and equipment provided to the DHMT.

f) MOH shall mobilize resources from other stakeholders to complement the support provided by DOW in strengthening maternal and neonatal health services in the district.

g) Details of program activities and responsibilities will be outlined and shared with Project stakeholders during the development of the Details Implementation Plan.

9. Conflict Resolution

In cases of conflict between the parties, every effort will be made to achieve amicable resolution at District level. In the case of non-resolution, the DOW Project Director for maternal and neonatal health, and the Office of the PMO will strive to resolve the issues. If resolution is still impossible, DOW Headquarter Office and the Director of Medical Services, Kenya Ministry of Health will be informed.

10. Cost of Joint activities

Costs of joint activities shall be incurred by both parties depending on the nature of activity and the party initiating the activity as outlined below:

i. DHMT and DOW shall share costs related to joint field visits within project areas. DHMT shall provide vehicles and DOW shall incur fuelling costs, at a rate stipulated in the DOW guidelines, or vice versa. Each party will provide for their own lunches during such visits.

ii. For trainings sponsored by DOW in which the curriculum is also provided by DOW, facilitation allowance paid to MOH staff shall be 1,500 Ksh per half-day or less, 2,500 Ksh per full day; and 1000 Ksh per day shall be paid to any Training Coordinator. For all other situations, rates shall follow the most recent Government of Kenya guidelines.

iii. DOW will not pay out-of-pocket expenses during training, meetings, supervisions visits or any other sanctioned project related activities.

iv. Should sanctioned project activities (including trainings (both facilitators and participants), meetings, exchange visits) occur one night or more outside work stations, DOW will provide transportation and accommodation and meals to MOH staff at the following rates:

1. No transportation reimbursement will be provided to individuals participating in activities conducted at their work stations; for activities conducted within Kapenguria/Makutano, but away from the individual's work station, transportation will be reimbursed at 200 Ksh per day; for all others, transportation will be reimbursed

based on public transportation fares from work station to activity location.

2. Individuals will receive 2,000 Ksh, to include both accommodation and food, for each night spent away from one's work station.

V. Outcomes

Through realizing the activities outlined in this MoU, DOW and DHMT hope to achieve the following outcomes:

1) Improved services for maternal and neonatal health care services at eight public health facilities in five divisions of the West Pokot District.
2) Increased community awareness about how to improve maternal and neonatal health care in five division of the West Pokot District.
3) Increased utilization of maternal and neonatal health care services in five division of the West Pokot District.
4) Improved data collection related to maternal and neonatal health care services in five division of the West Pokot District.

VI. Limitation to Liability

b) Either party shall accept liability for those actions or events it has formally authorized or approved.

VII. Term, Termination, and Amendments

a) This Memorandum shall be effective immediately and shall remain in force until 2010, the expected date of completion of funding through USAID.
b) This Memorandum may be amended at any time by unanimous consent of the Partners.
c) This MoU may be terminated by either party upon thirty (30) days written notice to the other party specifying the reasons for termination. If the reasons are not agreeable to the other party the conflict resolution process mentioned therein shall be followed

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum by their duly authorized representatives.

West Pokot District Health Management Team

By: _____
Dr. Kimei, District Medical Officer of Health
DATE: _____
Doctors of the World-USA

By: _____
Tom Dougherty, Executive Director
DATE: _____

USAID | KENYA
FROM THE AMERICAN PEOPLE

November 14, 2005

USAID/GH/HIDN Room 3.7.74
Ronald Reagan Building International
Trade Center
1300 Pennsylvania Ave. N.W
Washington, D.C 20523-3700

Re: Doctors of the World USA: Proposal for a Child Survival Project in West Pokot District, Kenya

Dear Madam:

Doctors of the World USA has met with USAID/Kenya and requested the Mission's support for their application to USAID/W under the GH/HIDN Child Survival and Health Grants Program.

USAID/Kenya is familiar with Doctors of the World USA's current partnership with Indiana University's AMPATH program, which provides HIV/AIDS services in Rift Valley Province Kenya. The AMPATH Program is a very critical component of the Missions Emergency Plan.

We have discussed the proposed activities with Doctors of the World and noted the potential to increase the availability of comprehensive maternal and child health services in Rift Valley Province. USAID/Kenya is supportive of their application which reflects the Mission's current strategy in child survival. We look forward to working with GH/HIDN in reviewing the final proposals to select one or more grantees that will support the Mission's efforts to improve child survival and health in Kenya.

Sincerely,

for Janet Paz-Castillo Michael Schoy
Chief
Office of Population and Health

U.S. Agency for International Development
USAID Kenya
P.O. Box 629
Village Market 00621
Nairobi, Kenya

Courier Address:
USAID/Kenya
ICIPE Complex
Kasarani Road
Nairobi, Kenya

U.S. Postal Address:
USAID Kenya
Unit 64102
APO AE 09831-4102

Tel: 254-20-862 2000
Fax: 254-20-862 2680 / 2682
www.usaidkenya.org

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

WISHARD MEMORIAL HOSPITAL

DEPARTMENT OF MEDICINE

Indiana University
Medical Center
1001 West 10th Street

Indianapolis, Indiana
46202

317-630-7682
Fax: 317-630-7066

November 11, 2005

Child Survival and Health Grants Program
USAID
Ronald Reagan Building International Trade Center
1300 Pennsylvania Avenue NW
Washington, DC 20004-3700

To Whom It May Concern:

On behalf of the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH) implemented by Indiana and Moi Universities in Kenya, I am writing to express the support for the submission by Doctors of the World-USA (DOW) in response to the Child Survival and Health Grant Program's FY2006 RFA.

I have overseen AMPATH's work since its inception; we have successfully enrolled and treated thousands of patients through a comprehensive prevention, treatment, and support program, including activities in areas such as HIV testing, prevention of mother-to-child transmission, delivery of anti-retroviral therapies and nutritional support to HIV+ people, and community support for HIV/AIDS orphans. AMPATH is supported by U.S. government funds, including from USAID and CDC. As a result of my meetings with DOW, AMPATH invited DOW to extend AMPATH's successful model delivering care and support to HIV/AIDS patients to the more remote, rural communities and nomadic communities in the West Pokot District, focusing on the catchment areas of the Kapenguria District Hospital and surrounding health centers. AMPATH has asked DOW to replicate our model to bring it to more communities, the first time a PVO partner will do so. AMPATH is providing funding, technical support and mentoring to DOW to conduct this program. DOW has done a good job of building relationships with the Ministry of Health in West Pokot and of working closely with AMPATH staff to ensure that the model is implemented successfully.

AMPATH is confident in DOW's ability to implement high quality health programs, and is supportive of DOW's proposed program to integrate HIV/AIDS activities with expanded efforts to address maternal and newborn health in the West Pokot District, where these needs are very serious, and where there has been almost no capacity building activity. I believe that DOW's technical and organizational expertise, as well as their collaboration and coordination with existing efforts in this area, will create a valuable contribution in the challenging and under-resourced West Pokot District.

Sincerely,

Joe Mamlin

Joseph J. Mamlin, MD
Field Director IU-Kenya Partnership
Eldoret, Kenya

Amendment # 1

between

The Doctors of the World (USA)

and

The Trustees of Indiana University

This amendment is entered into this 15th day of September, 2006 to amend the agreement dated August 22, 2005 between Doctors of the World (USA) (hereinafter referred to as DOW) and the Trustees of Indiana University (hereinafter referred to as Indiana).

DOW and Indiana have previously entered into an agreement for work to be performed by DOW under Indiana's grant from Columbia University, awarded under USAID Award No. AID GPO-A-00-03-0000. Indiana's grant is under the direction of Dr. Robert Einterz. Indiana has received a time extension for the award and wishes to amend the subcontract to extend DOW's period of performance.

THEREFORE, it is agreed as follows:

1. Article 2. Period of Performance
The period of performance of this agreement shall begin on March 1, 2005 and shall terminate on September 1, 2006 unless changed by mutual consent of the parties by written amendment to this agreement.

2. All other terms and conditions remain in effect and full force.

Doctors of the World (USA)	Indiana University
Name:	Janice C. Froehlich
Title:	Interim Vice Chancellor for Research

Attachment A

Statement of Work

Responsibilities for the sub contracts for PEPFAR 1.5 and 1.0

Doctors of the World-USA (DOW) is a U.S. non-governmental organization registered as a 501(c)(3). DOW, with extensive experience implementing U.S. government programs in global health, focuses on TB and HIV/AIDS, women's health, the health of orphans and vulnerable children, and the health of survivors of gross human rights abuses. DOW is currently active in Asia, Africa, Eastern Europe and the Former Soviet Union and the Americas. DOW projects provide essential care and services, but, more importantly, focus resources on training and building the capacity of local counterparts to carry on the mission of health at the conclusion of our efforts. Services, training, and systems development are combined with appropriate advocacy to ensure that our impacts are broad-based and sustainable.

DOW is partnering with the AMPATH program of Indiana University, Moi University, and Moi Teaching and Referral Hospital, to replicate the AMPATH model in Kapenguria. DOW is working closely with AMPATH to maintain the quality and rigor of the comprehensive AMPATH model, while adapting outreach, service, and networking approaches to reflect the challenges of the West Pokot District, where Kapenguria is located.

DOW is beginning by establishing an AMPATH site at the Kapenguria District Hospital, training MOH providers to staff this site, and working with facilities across the District to scale up HIV testing, PMTCT, ART provision, and coordinated TB/HIV care. DOW is also coordinating the implementation of other elements of the AMPATH model, such as food distribution and patient support, at Kapenguria. DOW will also be identifying mechanisms to enable patient enrollment from across the nomadic, low infrastructure West Pokot District by reaching from the main Kapenguria site to health centers, communities, and community-based provider networks across and the District.

In all these activities, DOW is closely supervised and supported by AMPATH, applying AMPATH protocols and training modules, as well as data collection systems. DOW's project staff in Kenya are also closely supervised by DOW's staff and technical advisors in New York. DOW is also working closely with the Ministry of Health's District Health Management Team in West Pokot, as well as local representatives of the National AIDS an STD Control Program.

Annex 3: Agreements with Partners

MINISTRY OF HEALTH

Telegrams "MEDICAL" Kapenguria
Telephone (054) 62080 62214 62209
Fax: (054) 62080

KAPENGURIA DISTRICT HOSPITAL,
P.O. BOX 63,
KAPENGURIA.

7th November, 2005

To whom it may concern.

I am writing to express my support for Doctors of the World – USA's (DOW's) upcoming proposal submission in response to the USAID Child Survival and Health Grants Program FY2006RFA. I have been working with DOW during the development implementation of HIV/AIDS prevention and treatment activities in the West Pokot District, and have been pleased at DOW's partnership with the West Pokot District Health Management Team (DHMT) and with the results of activities thus far. I support DOW's interest in expanding from HIV/AIDS activities to address the needs in maternal and neonatal health in this district. I support the areas of intervention identified by DOW to reduce maternal and neonatal mortality and morbidity, as well as the selected gaps in integrating these interventions with HIV/AIDS and malaria issues. I and the other members of the West Pokot DHMT are ready to collaborate with DOW as a main implementing partner to address these issues if DOW's proposal is successful.

I understand that, if funded, DOW will focus on five Divisions in the District (Chepareria, Kacheliba, Kapenguria, Lelan and Sigor). In addition to community activities, the proposed program will strengthen services at the District Hospital in Kapenguria, the four Health Centres in the District and at three dispensaries that can and should take on additional maternal health services. I support the three objectives identified by DOW through a recent assessment:-30

- Objective 1: Strengthen capacity of focus West Pokot District health facilities to provide quality MNC as appropriate within MOH/Division of Reproductive Health Policy.
- Objective 2: Strengthen community awareness of demand for and access to quality MNC services in the West Pokot District by September 2010.
- Objective 3: strengthen District Health Management Information System particularly as related to maternal and newborn health by September 2010.

If funded DOW's planned activities would bring much needed support to our under-resourced District. Based on DOW's current activities in the West Pokot and cooperation with the DHMT thus far, I believe that the proposed program would be an important contribution to efforts to reduce maternal and neonatal mortality in the West Pokot District.

Sincerely

P.P.

Dr. Jamal.
District Medical Officer, West Pokot District
Ministry of Health, Republic of Kenya.

POKOT KILETAT WOMEN GROUP CONSUMER CO-OPERATIVE SOCIETY LIMITED, P.O. BOX 265, KAPENGURIA. TEL.NO. 054-62202,
Email: pokilewg@africaonline.co.ke

November 18, 2005

To Whom It May Concern:

I am writing on behalf of Pokot Kiletat Women Group Consumer Co-operative Society Limited to express support for Doctors of the World-USA's (DOW's) upcoming proposal submission in response to the USAID Child Survival and Health Grants Program FY2006 RFA.

Pokot Kiletat Womens Group Consumer Co-operative Society, Limited was registered 2nd July 1981 with registration number 3498 under the Ministry of Co-operative Development and Marketing. Kiletat works with 30 womens groups in 7 divisions out of 10 divisions in West Pokot District. The activities of the organization range from providing small loans to Members and conducting organizational and management training. We also carry out informational seminars in such crosscutting issues as HIV/AIDS and gender- related areas, including (FGM) Female Genital Mutilation and Early Forced Marriage (EFMA), both traditional practices that are harmful to the health of women and children.
It is in this light that we not only support DOW's proposal but also commit to collaborating with regard to training and community mobilization through our cooperatives for maternal and neonatal health as well as HIV/AIDS.

In particular, DOW's proposed areas of intervention will greatly enhance the health and wellbeing of the communities in which Kiletat works. I therefore support the objectives and activities identified by DOW to reduce maternal and neonatal mortality and morbidity, specifically:

- Objective 1: Strengthen capacity of focus West Pokot District health facilities to provide quality MNC, as appropriate within MOH/Division of Reproductive Health policy.
- Objective 2: Strengthen community awareness of, demand for, and access to quality MNC services in the West Pokot District by September 2010.
- Objective 3: Strengthen District Health Management Information System, particularly as related to maternal and newborn health by September 2010.

If DOW is funded to implement this program, Kiletat is ready to collaborate in the effort to promote the uptake of improved maternal and neonatal services in the West Pokot District.

Sincerely,

Dinah Katina
Manager
Pokot Kiletat Women Group Consumer
Co-operative Society Limited.

EVANGELICAL LUTHERAN CHURCH IN KENYA
(E.L.C.K.)

NORTH WEST DIOCESE

For God so loved the world that
He gave his only son that whoever
Believes in him should not perish
But have eternal life.

(John 3:16)

P.O. Box 642, 30600
Kapenguria - Kenya
Tel. /Fax: 054 62406, Tel.054 62034
Email: pip@africaonline.co.ke

November 16, 2005

To Whom It May Concern:

I am writing on behalf of the Evangelical Church in Kenya (ELCK) to express support for Doctors of the World-USA's (DOW's) upcoming proposal submission in response to the USAID Child Survival and Health Grants Program FY2006 RFA.

In the diocese of the West Pokot, the ELCK works in a total of five divisions (the same in which DOW would like to focus), divided into 30 parishes, and 200 congregations. We support a total of 7000 members in our community. In addition to the establishment of three dispensaries that address primary health needs in two divisions, we have also expanded our activities to focus on HIV/AIDS. We have thus far trained four community educators in each of the five divisions as well as 25 TBAs, all of whom work to educate community members with regard to HIV/AIDS. We are eager to expand our activities to also address PMTCT, and, in turn, maternal and neonatal health care. It is in this light that we not only support DOW's proposal but also commit to collaborating with regard to community mobilization through our previously trained educators as well as through our congregations for maternal and neonatal health as well as HIV/AIDS.

In particular, DOW's proposed areas of intervention will greatly enhance the health and wellbeing of the communities in which the ELCK exists. I therefore support the objectives and activities identified by DOW to reduce maternal and neonatal mortality and morbidity, specifically:

- Objective 1: Strengthen capacity of focus West Pokot District health facilities to provide quality MNC, as appropriate within MOH/Division of Reproductive Health policy.
- Objective 2: Strengthen community awareness of, demand for, and access to quality MNC services in the West Pokot District by September 2010.
- Objective 3: Strengthen District Health Management Information System, particularly as related to maternal and newborn health by September 2010.

If DOW is funded to implement this program, the ELCK is ready to collaborate in the promotion of uptake of maternal and neonatal services in the West Pokot District.

Sincerely,

E.L.C.K. NORTH WEST DIOCESE
DIOCESAN SECRETARY OFFICE
DATE 16.11.2005
BOX. 642. KAPENGURIA

Reverend Francis Kamondich
Diocesan Secretary, Northwest Diocese

PASTORALIST AREA DEVELOPMENT ORGANIZATION
P. O. BOX 48,
CHEPARERIA.
E-mail: thepadowest@yahoo.com

November 11, 2005

To Whom It May Concern:

I am writing on behalf of the Pastoralist Area Development Organization (PADO) to express support for Doctors of the World-USA's (DOW's) upcoming proposal submission in response to the USAID Child Survival and Health Grants Program FY2006 RFA.

PADO is a registered non-governmental organization (NGO) working with the pastoralist communities in the West Pokot district. PADO currently works to empower the economically marginalized people of this district through capacity building and sustainable marketing of livestock, handicraft and honey. Two primary cross-cutting strategies in its work with 11 different cooperatives in two different divisions (four women's, three youth, and four mixed men and women) include HIV/AIDS and increasing gender parity. It is in this light that we not only support DOW's proposal but also commit to collaborating with regard to community mobilization through our cooperatives for maternal and neonatal health as well as HIV/AIDS.

In particular, DOW's proposed areas of intervention will greatly enhance the health and wellbeing of the communities in which PADO works (as well as beyond.) I therefore support the objectives and activities identified by DOW to reduce maternal and neonatal mortality and morbidity, specifically:

- Objective 1: Strengthen capacity of focus West Pokot District health facilities to provide quality MNC, as appropriate within MOH/Division of Reproductive Health policy.
- Objective 2: Strengthen community awareness of, demand for, and access to quality MNC services in the West Pokot District by September 2010.
- Objective 3: Strengthen District Health Management Information System, particularly as related to maternal and newborn health by September 2010.

If DOW is funded to implement this program, PADO is ready to collaborate in the promotion of uptake of maternal and neonatal services in the West Pokot District.

Sincerely,

Geoffrey Sangwatei
PADO Coordinator

THE PASTORALIST AREA DEV. ORGANIZATION
DATE 15/11/05
THE PADO BOX 48, CHEPARERIA

Annex 3: Agreements with Partners

FROM : PROVINCIAL GEN HOSPITAL NAKURU PHONE NO. : 2540512216497 Nov. 17 2005 04:47PM P1

MINISTRY OF HEALTH

Telegrams PROVMED
Tel: Nakuru 41962, Fax 216109
When replying please quote

Provincial Medical Office,
Rift Valley Province,
P.O. Box 2060,
NAKURU

17th November 2005

TO WHOM IT MAY CONCERN

DOCTORS OF THE WORLD UP COMING PROPOSAL IN WEST POKOT

Doctors of the world have a proposal for strengthening maternal and mental health in West Pokot District in Rift Valley Province.

During the visit by the project Director Dr. Marina MacNamara and the Program Director Dr. Vandama Tripatlu, the Provincial Co-ordinator for Reproductive Health Dr. Osore and I found it fit to integrate the HIV/AIDS and Malaria activities.

This is to endorse a letter of recommendation for the activities to:

- Objective 1) Strengthen capacity of focus West Pokot District health facilities to provide quality MNC as appropriate within MOH/Division of Reproductive Health policy.
- Objective 2) Strengthen community awareness of demand for and access to quality MNC services in the West Pokot District by 2010.
- Objective 3) Strengthen District Health Management information system, particularly as related to maternal and newborn health by September 2010.

DR. I. B. AMIRA
PROVINCIAL MEDICAL OFFICER
RIFT VALLEY PROVINCE

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

MEMORANDUM OF UNDERSTANDING BETWEEN:

DOCTORS OF THE WORLD-USA/KENYA AND WEST POKOT DISTRICT HEALTH MANAGEMENT TEAM

RIFT VALLEY PROVINCE, KENYA

I. Parties

This Memorandum of Understanding "MoU" with its annexes is entered into and is effective as from the date of signing this contract (the "effective date") by and between the following parties:

BETWEEN: **Doctors of the World-USA/Kenya –Partnership for Maternal and Neonatal Health, West Pokot District Child Survival and Health Program (hereby referred to as DOW)** having its headquarters at 80 Maiden Lane, New York, New York, 10038, USA; and its local office in the County Council building, Kapenguria.

AND: **The District Health Management Team (hereby referred to as DHMT)**, West Pokot, Rift Valley Province, Kenya, PO Box 63, Kapenguria.

II. General Principles of MOU

The purpose of this agreement is to establish a working relationship (herein referred to as "Partnership") between the West Pokot District Health Management Team (DHMT) and Doctors of the World-USA/Kenya (DOW)[1] by which the two institutions (herein referred to as "the Partners") will work cooperatively to strengthen maternal and neonatal health care services in the West Pokot District of Kenya. The Partners will contribute, within their means, the necessary resources toward ensuring the success of the activities.

III. Provisions of the MOU

Under the guidance of the MOH, the DHMT and DOW will work closely with each other throughout every stage of the program outlined in this MoU. Partnership activities will be coordinated to ensure that the program is developed and implemented in a cooperative manner and that DOW activities are not conducted in isolation from the broader District Health strategy. Reflecting the spirit of cooperation and collaboration among all health care partners in Kenya, DOW will also communicate with and include other stakeholders working in health in Partnership activities. All Partnership activities will be planned with the aforementioned considerations in order to strengthen, rather than duplicate, efforts to improve health services in the district.

[1] For background information on DOW, please see Appendix I.

DOW and the District Health Management Team (DHMT) have a common goal and commitment to contribute to the reduction of maternal and neonatal morbidity and mortality in five divisions of the West Pokot District in Kenya by 2010. These divisions include Chepareria, Kacheliba, Kapenguria, Lelan, and Sigor. Presently DOW is in receipt of a four year grant effective October 1, 2006 from USAID (United States Agency for International Development) to build capacity of Ministry of Health staff to improve maternal and neonatal health in targeted divisions of West Pokot District. The parties desire through this MoU to establish specific guidelines regarding the implementation of program interventions as stipulated in the Detailed Implementation Plan (DIP) and proposal, sharing of relevant documents, sharing of relevant data/information, allowances, support, staffing, project supervision, meetings, planning and project implementation activities.

IV. Key Aspects of Collaboration

DOW began formally working with the MOH in June 2005 when it partnered with NASCOP and AMPATH to establish a comprehensive HIV/AIDS treatment program in the West Pokot District. Since that time, it has become clear that there are several overlapping priority concerns in the District, including the provision of maternal and neonatal health care as recommended by Kenya's Ministry of Health (MOH) policy. Working closely with the DHMT, DOW wrote a proposal in November 2005 that addressed the primary concerns posed by the DHMT and other stakeholders in the district. In 2006, DOW was awarded a four-year Child Survival and Health grant by USAID to address those concerns cited. To this end, from 2006-2010, DOW proposes to partner with key stakeholders in the West Pokot District, including the DHMT, to implement interventions that will work to link communities with health facilities in order to achieve the four following goals:

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

The following sections outline DOW's commitments to the improvement of maternal and neonatal health care services in the West Pokot District. All activities have been and will be carried out by DOW in cooperation with the National, Provincial and District health authorities. It is important to note that all activities are subject to change depending on resource availability.

A tentative workplan for the life of the project is attached as Annex II. A more specific workplan for each project year shall be developed jointly by DOW and the DHMT upon final approval of the Detailed Implementation Plan by the donor (USAID) in June 2007.

1. Document Sharing

a) Each party encourages the sharing of documents to all of its respective members.

b) Documents from one party which are made available to the other party are intended to be accessible on equal terms to all members of the other party.

c) DOW provides with this MoU copies of the Projects' Proposal, and the Detailed Implementation Plan jointly developed for the duration of the Partnership.

d) The two parties shall routinely provide each other with relevant project documents as mentioned herein. DOW shall provide the DHMT with copies of project progress

reports. The DHMT through their representative shall provide DOW with relevant Government circulars, District Health Plans, and maternal and neonatal policies and guidelines.

2. Sharing of data

On request, each party shall access any information or data collected by the other party which is related or relevant to maternal and neonatal health program. This data shall be accessed through the relevant MOH officers in charge and Project Director, maternal and neonatal health program for DOW.

3. Representation

a) The DHMT shall select a Team of no more than **two** who will collaborate with DOW on monitoring and evaluation/supervision activities at all Project sites.

b) The DHMT, through their selected Team, will ensure that the Project is consistent with National Policies and Guidelines.

c) DOW shall also communicate activities from the HIV/AIDS project to the selected Team to ensure that any overlapping or cross-cutting activities are coordinated with DHMT.

d) Both parties shall ensure that all formal communication to relevant officers is done through the DMOH and DOW Project Director for maternal and neonatal health program.

4. Activities and Personnel

a) The DHMT shall encourage staff trained through support from DOW to continuously work in the project areas and consistently support maternal and neonatal health activities during the project implementation period and thereafter.

b) The DHMT shall ensure that the staff trained consistently implements maternal and neonatal health activities in which they are trained.

c) The DHMT shall ensure availability of staff such as drivers where vehicle support for maternal and neonatal health services is donated by DOW.

d) The DHMT shall ensure that targeted health facilities have adequate qualified staff to consistently support maternal and neonatal health services as provided for in Ministry of Health Guidelines and policies.

5. Project Supervision

a) The DHMT and DOW shall undertake to supervise and monitor the project interventions on biannual basis and provide regular reports to the DHMT.

b) Designated MOH staff and DOW staff shall undertake regular monitoring and supervision of maternal and neonatal health activities of Community-Owned Health Resource Persons (CHWs,TBAs ,and Health Facility Management Committees).

c) The DHMT shall ensure that DOW receives reports emanating from internal supervisions of maternal and neonatal health activities.

6. Identification of Project Divisions and Facilities

a) The DHMT identified divisions and facilities for intervention. These decisions should be supported by feasibility findings and based on District priorities on improving maternal and neonatal health services.

b) In case of any renovations to be undertaken by DOW, DHMT will identify and agree on the sites and nature of work to be undertaken.

c) In the event that DOW is to undertake any construction or renovation works, the DHMTs shall ensure that relevant protocols are followed and relevant departments such as Public Works are informed and brought on board in a timely manner.

d) Upon completion of any construction or renovation works, DOW shall issue certificates of completion to the DHMT.

e) DHMTs shall be held responsible for maintenance and relevant operations of facilities constructed or renovated by DOW.

7. Meetings

a) DOW and the Project stakeholders, including the DHMT, will hold biannual meetings (every six months) at the District Hospital to review progress of the Project and plan. Dates of the meetings will be forwarded to the Office of the DMOH as soon as possible.

b) Either party shall convene a meeting to discuss issues emanating from project implementation that require the attention of the other party. The full costs of such meetings shall be incurred by the convening party.

8. Support to MOH

a) DOW support to MOH shall be guided by interventions and activities stipulated in the maternal and neonatal health project detailed implementation plan (DIP), donor specifications and Doctors of the World-USA/Kenya operations and guidelines.

b) DHMT shall ensure that DOW donated equipment and materials are used and maintained as outlined in equipment-specific contracts. Any desired changes shall be communicated to the DOW Project Director for the maternal and neonatal health project and should only be effective upon agreement.

c) The DHMT shall ensure that equipment and materials donated by DOW are entered into official inventories and are well maintained.

d) In the event of donation of a vehicle by DOW, the DHMT shall ensure consistency in the use of such vehicles to support maternal and neonatal health services in the target divisions by providing fuel and preventive maintenance.

e) During the period of this MoU, DOW shall monitor the effective use of materials and equipment provided to the DHMT through joint supervisory visits.

f) The MOH shall mobilize resources from other stakeholders to complement the support provided by DOW in strengthening maternal and neonatal health services in the district.

9. Conflict Resolution

In cases of conflict between the parties, every effort will be made to achieve amicable resolution at District level. In the case of non-resolution, the DOW Project Director for maternal and neonatal health, and the Office of the PMO will strive to resolve the issues. If resolution is still impossible, DOW Headquarter Office and the Director of Medical Services, Kenya Ministry of Health will be informed.

10. Cost of Joint activities

Costs of joint activities shall be incurred by both parties depending on the nature of activity and the party initiating the activity as outlined below:

i. The DHMT and DOW shall share costs related to joint field visits within project areas. DHMT shall provide vehicles and DOW shall incur fuelling costs, at a rate stipulated in the DOW guidelines, or vice versa. Each party will provide for their own lunches during such visits.

ii. For trainings sponsored by DOW in which the curriculum is also provided by DOW, facilitation allowance paid to MOH staff shall be 1,500 Ksh per half-day or less, 3,000 Ksh per full day; and 1000 Ksh per day shall be paid to any Training Coordinator. For all other situations, rates shall follow the most recent Government of Kenya guidelines.

iii. DOW will not pay out-of-pocket expenses during training, meetings, supervisions visits or any other sanctioned project related activities.

iv. Should sanctioned project activities (including trainings (both facilitators and participants), meetings, exchange visits) occur one night or more outside work stations, DOW will provide transportation and accommodation and meals to MOH staff at the following rates:

1. No transportation reimbursement will be provided to individuals participating in activities conducted at their work stations; for activities conducted within Kapenguria/Makutano, but away from the individual's work station, transportation will be reimbursed at 200 Ksh per day; for all others, transportation will be reimbursed based on public transportation fares from work station to activity location.
2. Where lunch is not already provided during activities lasting a full day or more, it will be reimbursed at a rate of 200 Ksh per person.
3. Where accommodation and food are not already provided, individuals will receive 2,000 Ksh, to include both accommodation and food, for each night spent away from one's work station.

V. Outcomes

Through realizing the activities outlined in this MoU, DOW and DHMT hope to achieve the following outcomes:

1) Improved services for maternal and neonatal health care services at nine focus health facilities in five divisions of the West Pokot District.
2) Increased community awareness about how to improve maternal and neonatal health care in five division of the West Pokot District.
3) Increased utilization of maternal and neonatal health care services in five divisions of the West Pokot District.
4) Improved data collection related to maternal and neonatal health care services in five divisions of the West Pokot District.

VI. Limitation to Liability

b) Either party shall accept liability for those actions or events it has formally authorized or approved.

VII. Term, Termination, and Amendments

a) This Memorandum shall be effective immediately and shall remain in force until 2008, and may be renewed upon unanimous consent of the partners.
b) This Memorandum may be amended at any time by unanimous consent of the Partners.

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum by their duly authorized representatives.

West Pokot District Health Management Team:

By: _____
Dr. Kiprotich, District Medical Officer of Health

DATE: 16/5/2007

Doctors of the World-USA:

By: _____
Tom Dougherty, Executive Director

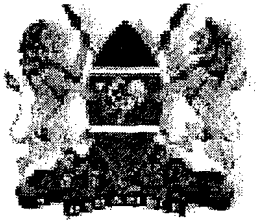
DATE: 03/07/2007

APPENDIX I: History of Doctors of the World – USA

Doctors of the World-USA (DOW) is an international health and human rights organization founded in 1990 by a group of volunteer physicians including the late Dr. Jonathan Mann, a pioneer in the field of health and human rights. DOW works within a network of 12 Médecins du Monde (MDM) delegations and combined, MDM/DOW delegations are active in over 90 countries. Working with local partners around the world where health is diminished or endangered by violations of human rights and civil liberties, DOW projects build long-term solutions focused on TB and HIV prevention and treatment, caring for neglected and abandoned children, women's health, and assistance to torture survivors.

DOW's goal is to support the development of self-sustaining, locally managed care systems in environments where human rights are in jeopardy. DOW projects are developed in close collaboration with local organizations and community groups, and, where possible, host country governments, to ensure that projects meet identified needs and reach at-risk populations in participatory and sustainable ways. In addition to training and health education to build the capacity of local institutions, professionals, and communities, DOW continues to uphold its founding mission of sending volunteer health professionals to partner service sites in underserved areas to provide direct health care.

In addition to work in the United States, DOW has operated programs in over 30 countries. In the United States, DOW's volunteer physicians work directly with survivors of torture and human rights abuses seeking safe haven and with a wide range of advocacy organizations seeking to protect the civil rights of vulnerable people. Many DOW programs around the world bridge health assistance with other sectors, including social and legal services, civil society strengthening, human rights advocacy, infrastructure development, income generation, agronomy and food security, and literacy.



Comprehensive HIV/AIDS Care and Support in the West Pokot District, Kenya

MEMORANDUM OF UNDERSTANDING BETWEEN:
DOCTORS OF THE WORLD-USA/KENYA AND WEST POKOT DISTRICT HEALTH MANAGEMENT TEAM
RIFT VALLEY PROVINCE, KENYA

I. Parties

This Memorandum of Understanding "MoU" with its annexes is entered into and is effective as from the date of signing this contract (The "Effective date") by and between the following parties:

BETWEEN: **Doctors of the World-USA/Kenya – (hereby referred to as DOW)** having its headquarters at 80 Maiden Lane, New York, New York, 10038, USA; and its local office in Kapenguria at PO Box 1035 Kitale,

AND: **The West Pokot District Health Management Team (hereby referred to as DHMT)**, West Pokot, Rift Valley Province, Kenya, PO Box 63, Kapenguria.

II. General Principles of MOU

The purpose of this agreement is to establish a working relationship (herein referred to as "Partnership") between the West Pokot District Health Management Team (DHMT) and Doctors of the World-USA/Kenya (DOW)[1] by which the two institutions (herein referred to as "the Partners") will work cooperatively to strengthen health care services related to HIV/AIDS in the West Pokot District of Kenya. The Partners will contribute, within their means, the necessary resources toward ensuring the success of the activities.

III. Provisions of the MOU

Under the guidance of the MOH, the DHMT and DOW will work closely with each other throughout every stage of the program outlined in this MoU. Partnership activities will be coordinated to ensure that the program is developed and implemented in a cooperative manner and that DOW activities are not conducted in isolation from the broader District Health strategy. Reflecting the spirit of cooperation and collaboration among all health care partners in Kenya, DOW will also communicate with and include other stakeholders working in health in Partnership activities. All Partnership activities will be planned with the aforementioned considerations in order to strengthen, rather than duplicate, efforts to improve health services in the district.

IV. Key Aspects of Collaboration

DOW's HIV/AIDS-related activities are supported in large part by the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH), based in Eldoret. In this way, the HIV/AIDS treatment clinic in Kapenguria is closely aligned with AMPATH practices and principles.

[1] For background information on DOW, please see Appendix I.

However, responsibility for the overall development and expansion of the AMPATH model in West Pokot resides with DOW, under the guidance of the PASCO and the DHMT. It is this last relationship that is outlined in this MoU.

DOW, in consultation with the Ministry of Health staff and other public and private stakeholders, has identified the following gaps in the provision of health care in West Pokot:

- Insufficient human capacity, including too few trained clinical providers and leaders to support delivery of health services
- Low uptake of HIV testing
- Lack of community awareness, particularly in nomadic and semi-nomadic areas, of HIV/AIDS issues, including prevention and treatment
- The need to couple treatment/prevention services with programs that foster food and economic security at the household level
- The need to improve services for persons co-infected with TB and HIV
- The limited capacity for communities/extended families to provide a nurturing environment for HIV orphans

In response to these gaps, a work plan has been developed between DOW, the PASCO, and the WPDHMT[2] of which key activities are noted below, that outlines capacity building activities in target sites to achieve the following two goals:

1) To reduce HIV transmission
2) To provide comprehensive care and support to HIV+ individuals and their families

The following sections outline DOW's commitments to the improvement of comprehensive HIV/AIDS treatment services in the West Pokot District. All activities have been and will be carried out by DOW in cooperation with the Provincial and District health authorities. It is important to note that all activities are subject to change depending on resource availability.

A. Activities

1. Accomplishments to Date

This project began in June 2005. The program goals and objectives are listed below, with key accomplishments noted under each objective:

GOAL 1: To reduce HIV transmission in the West Pokot District

Objective 1: To increase testing throughout the district.

Accomplishments in 2005:

- Training of trainers (nurses) in PMTCT referral for 25 clinicians around the West Pokot District (through PASCOP).
- Initial training of 600 TBAs at 20 sites in the district (through those trained above).
- Training of 29 clinicians from 20 sites in PMTCT referral (through AMPATH).

[2] Please see Appendix II.

Accomplishments in 2006:

- Training of 25 clinicians from the District Hospital, four health centers, and three dispensaries in DTC.
- Bimonthly supervisory visits to all DTC and PMTCT sites to ensure consistent, quality testing and referral services at each site.
- Refresher training for almost 60 TBAs in PMTCT referral.

Objective 2: To improve awareness within communities around the health centers and dispensaries of the means of transmission and prevention of HIV.

Accomplishments in 2006:

- Information sessions about HIV/AIDS services in the district combined with testing have been held in Alale, Kacheliba, and Sigor Divisions. In attendance were: head school teachers, local administrative officials, religious leaders, other NGO/CBO representatives.
- Following the request of community members, community mobilization sessions combined with testing have been held in: Tamough, Murkwijit, Kabichbich, and Makutano.

GOAL 2: To provide comprehensive care and support to HIV+ individuals and their families in the West Pokot District.

Objective 1: To increase local capacity to provide necessary treatment (including ARVs and OI meds) to all HIV+ individuals

Accomplishments in 2005:

- Construction of an HIV/AIDS treatment clinic at the Kapenguria District Hospital, which was merged with that of the MOH's expanded VCT unit such that all District-level HIV activities may operate from under the same roof. Currently, this clinic is open two days per week (Tuesday and Wednesday). This clinic is staffed with the following MOH staff:
    - One Medical Officer
    - One Clinical Officer (one more CO has been hired directly by AMPATH such that we do not overburden the MOH staff)
    - Two Nurses (one has become full-time, and has since been replaced in the MCH department by an AMPATH-hired registered nurse).
    - One Nutritionist (and one alternate)
    - One Pharmacist
    - Three Laboratory Technicians (who rotate monthly)

  These individuals were recruited from the District Hospital and trained in antiretroviral therapy through the AMPATH center in Eldoret, with DOW support. At the District Hospital, these staff assist not only with the provision of quality treatment but also with social support through, for example, referral to DOW social workers.

Accomplishments in 2006:

- Provision of comprehensive HIV/AIDS treatment at four semi-mobile sites around the district: each Thursday, clinic staff rotate between the health centers in an effort to bring treatment closer to our patients. On these days, clinic staff are also able to provide onsite mentorship to health center clinicians in HIV/AIDS treatment.
- Provision of on-site clinical mentoring from a visiting U.S. volunteer physician who specializes in pediatric HIV/AIDS care.

Objective 2: To increase local capacity to provide adequate nutritional support to all HIV+ individuals.

Accomplishments in 2006:

- Development of an agricultural program that is designed to provide patients with the knowledge and tools to supplement their income and their nutritional intake through sustainable, bio-intensive agricultural techniques. Three demonstration plots have been established around the district that are currently being used as educational tools.

Involvement in AMPATH's food distribution program for particularly needy patients (conducted in collaboration with the World Food Program). A total of 160 people benefit from this program (almost 40 patients and their families).

Objective 3: To increase local capacity to provide emotional support to all HIV+ individuals.

Accomplishments in 2006:

- Hiring of one social worker and one peer education counselor who, together, have developed a psychosocial program for HIV+ individuals that is being implemented at the District Hospital and the four health centers. This program consists of: weekly support groups; home visits to patients who default on their appointments, their medication, or who simply have difficult situations at home; and monthly educational seminars on topics selected by the patients themselves.
- Initiate a network of patient volunteers. These volunteers have been thus far limited to providing support to HIV+ patients in the District Hospital wards.

2. Activities to be Accomplished in 2007

DOW affirms that, rather than establishing independent services and facilities, DOW strives to work hand-in-hand with those structures and resources already in place, including those of NASCOP, community-based organizations, and other actors. To that end, DOW has conducted the aforementioned activities through network building with local initiatives, community mobilization both in the highlands and the lowlands (in the settled and semi-nomadic communities), and essential capacity building in areas deemed in need by NASCOP and DOW.
DOW hopes to expand its activities using the same strategy. Thus, in addition to our ongoing activities, we would like to expand our activities in the following areas (please see Appendix II for more details),:

Goal 1: To reduce HIV transmission in the West Pokot District

- To expand the number of sites conducting PMTCT and DTC testing through holding additional trainings for MOH staff.

- To strengthen the PMTCT referral system through TBAs through refresher trainings, consistent supervisory meetings, etc.
- To improve knowledge of HIV/AIDS through frequent community mobilization sessions around the district.
- To improve knowledge about the availability of HIV/AIDS testing and treatment services around the district through frequent community mobilization sessions, that also offer testing.

Goal 2: To provide comprehensive care and support to HIV+ individuals and their families in the West Pokot District.

- Adding an additional site for semi-mobile clinics: the Amakuriat Catholic Dispensary.
- Providing mentorship in HIV/AIDS treatment to all staff in each semi-mobile clinic site through two-week long sessions based at the Kapenguria HAART clinic.
- To increase the number of home visits for on-site technical training in agricultural techniques.
- To develop a beekeeping program among clients.
- To expand DOW's network of volunteers throughout the district to assist with:
  - Community mobilization
  - House-to-house HIV/AIDS education
  - Providing basic emotional support to other HIV+ individuals in need.

B. Supervision and Collaboration

1. Document Sharing

a) Each party encourages the sharing of documents to all of its respective members.

b) Documents from one party which are made available to the other party are intended to be accessible on equal terms to all members of the other party.

c) The two parties shall routinely provide each other with relevant project documents, including relevant Government circulars, District Health Plans, and HIV/AIDS policies and guidelines.

2. Sharing of data

On request, each party shall access any information or data collected by the other party, which is related or relevant to the HIV/AIDS program, including reports from supervisory visits, monthly data reports, etc. This data shall be accessed through the relevant MOH officers in charge, and Project Director, HIV/AIDS program for DOW.

3. Representation

a) For this program, DOW shall work most directly with the DASCO. However, depending on the activity, DOW shall also work with other relevant members of the DHMT.

b) DOW shall also communicate activities from the Partnership for Maternal and Neonatal Health to the DASCO and other relevant members of the DHMT to ensure that any overlapping or cross-cutting activities are coordinated with the DHMT.

c) The DHMT will ensure that the Project is consistent with MOH National Policies and Guidelines.

d) Both parties shall ensure that all formal communication to relevant officers is done through the DMOH and DOW Project Director for the HIV/AIDS program.

4. Personnel

a) The DHMT shall encourage staff trained through support from DOW to continuously work in the project areas and consistently support HIV/AIDS activities during the project implementation period and thereafter.

b) The DHMT shall ensure that the staff trained consistently implements HIV/AIDS activities in which they are trained.

d) The DHMT shall ensure availability of staff such as drivers where vehicle support for HIV/AIDS health services is donated by DOW.

e) The DHMT shall ensure that targeted health facilities have adequate qualified staff to consistently support HIV/AIDS health services as provided for in MOH guidelines and policies.

5. Meetings

a) DOW and the program partners, including the DHMT, will hold biannual meetings (every six months) at the District Hospital to review progress of the Project.

b) Either party shall convene a meeting to discuss issues emanating from project implementation that requires the attention of the other party. The full costs of such meetings shall be incurred by the convening party.

6. Support to MOH

a) DOW support to the MOH shall be guided by interventions and activities stipulated in the attached work plan, donor specifications, and DOW operations and guidelines.

b) The DHMT shall ensure that DOW donated equipment and materials are used and maintained as outlined in equipment-specific contracts. Any desired changes shall be communicated to the DOW Project Director for the HIV/AIDS project and should only be effective upon agreement.

c) The DHMT shall ensure that equipment and materials donated by DOW are entered into official inventories and are well maintained.

d) In the event of donation of a vehicle by DOW, the DHMT shall ensure consistency in the use of such vehicles to support health services in the target divisions by providing fuel and preventive maintenance.

e) During the period of this MoU, DOW shall monitor the effective use of materials and equipment provided to the DHMT through joint supervisory visits.

The MOH shall mobilize resources from other stakeholders to complement the support provided by DOW in strengthening HIV/AIDS activities in the district.

7. Conflict Resolution

In cases of conflict between the parties, every effort will be made to achieve amicable resolution at District level. In the case of non-resolution, the DOW Project Director for HIV/AIDS/TB, and the Office of the PMO will strive to resolve the issues. If resolution is still impossible, Doctors of the World-USA Office and the Director of Medical Services, Kenya Ministry of Health will be informed.

8. Cost of Joint activities

Costs of joint activities shall be incurred by both parties depending on the nature of activity and the party initiating the activity as outlined below:

i. The DHMT and DOW shall share costs related to joint field visits within project areas. DHMT shall provide vehicles and DOW shall incur fuelling costs, at a rate stipulated in the DOW guidelines, or vice versa. Each party will provide for their own lunches during such visits.

ii. For trainings sponsored by DOW in which the curriculum is also provided by DOW, facilitation allowance paid to MOH staff shall be 1,500 Ksh per half-day or less, 3,000 Ksh per full day; and 1000 Ksh per day shall be paid to any Training Coordinator. For all other situations, rates shall follow the most recent Government of Kenya guidelines.

iii. DOW will not pay out-of-pocket expenses during training, meetings, supervisions visits or any other sanctioned project related activities.

iv. Should sanctioned project activities (including trainings (both facilitators and participants), meetings, exchange visits) occur one night or more outside work stations, DOW will provide transportation and accommodation and meals to MOH staff at the following rates:

1. No transportation reimbursement will be provided to individuals participating in activities conducted at their work stations; for activities conducted within Kapenguria/Makutano, but away from the individual's work station, transportation will be reimbursed at 200 Ksh per day; for all others, transportation will be reimbursed based on public transportation fares from work station to activity location.
2. Where lunch is not already provided during activities lasting a full day or more, it will be reimbursed at a rate of 200 Ksh per person.
3. Where accommodation and food are not already provided, individuals will receive 2,000 Ksh, to include both accommodation and food, for each night spent away from one's work station.

In addition to the collaborative support of the aforementioned activities, the following materials shall also be provided by the DHMT/NASCOP:

- Rapid test kits at all PMTCT/DTC sites

- Appropriate reporting forms for PMTCT/DTC-trained health facility staff members, including those related to activities conducted, laboratory inventories, etc.

V. Outcomes:

Through realizing the activities outlined in this MoU, DOW and the DHMT hope to achieve the following outcomes:

Increased HIV testing through:

- Consistent implementation of PMTCT testing at all MOH facilities.
- Improved integration of DTC in both inpatient and outpatient services, especially TB and STIs.
- Refresher training in PMTCT referral for TBAs around 14 dispensaries.
- Increased number of testing sites throughout the district through expanded training opportunities for MOH staff.

Improved comprehensive care and support to HIV+ individuals and their families through:

- Continued provision of quality, comprehensive treatment services to patients throughout West Pokot District.
- Improved care of OIs through further training of clinicians.
- Continued expansion of agricultural program services to all enrolled patients and their families.
- Continued expansion of psychosocial support program services to all enrolled patients and their families.

VI. Limitation to Liability

Either party shall accept liability for those actions or events it has formally authorized or approved.

VII. Term, Termination, and Amendments

- This Memorandum shall be effective immediately and shall remain in force until 2008, the expected date of completion of funding through AMPATH.

- This Memorandum may be amended at any time by unanimous consent of the Partners.

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum by their duly authorized representatives.

West Pokot District Health Management Team:

By: _____ Date: 16/8/2007

Dr. Kiprotich, District Medical Officer of Health

Doctors of the World-USA:

By: _____ Date: 3/07/2007

Tom Dougherty, Executive Director

APPENDIX I: History of Doctors of the World – USA

Doctors of the World-USA (DOW) is an international health and human rights organization founded in 1990 by a group of volunteer physicians including the late Dr. Jonathan Mann, a pioneer in the field of health and human rights. DOW works within a network of 12 Médecins du Monde (MDM) delegations and combined, MDM/DOW delegations are active in over 90 countries. Working with local partners around the world where health is diminished or endangered by violations of human rights and civil liberties, DOW projects build long-term solutions focused on TB and HIV prevention and treatment, caring for neglected and abandoned children, women's health, and assistance to torture survivors.

DOW's goal is to support the development of self-sustaining, locally managed care systems in environments where human rights are in jeopardy. DOW projects are developed in close collaboration with local organizations and community groups, and, where possible, host country governments, to ensure that projects meet identified needs and reach at-risk populations in participatory and sustainable ways. In addition to training and health education to build the capacity of local institutions, professionals, and communities, DOW continues to uphold its founding mission of sending volunteer health professionals to partner service sites in underserved areas to provide direct health care.

In addition to work in the United States, DOW has operated programs in over 30 countries. In the United States, DOW's volunteer physicians work directly with survivors of torture and human rights abuses seeking safe haven and with a wide range of advocacy organizations seeking to protect the civil rights of vulnerable people. Many DOW programs around the world bridge health assistance with other sectors, including social and legal services, civil society strengthening, human rights advocacy, infrastructure development, income generation, agronomy and food security, and literacy.

APPENDIX II: Workplan

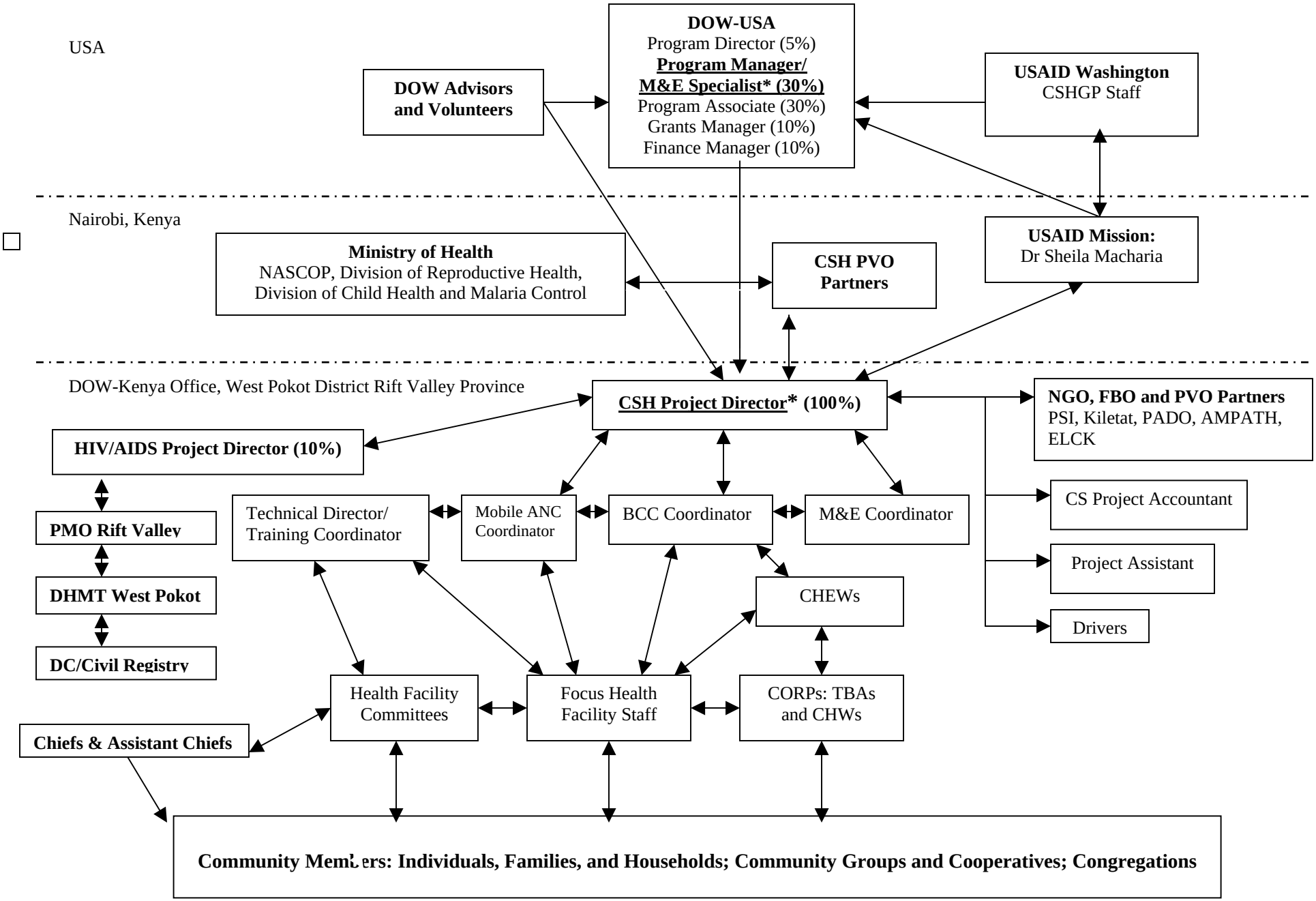
** Note that both target numbers and time frame are subject to change, depending on resource availability.

GOAL 1: To reduce HIV transmission in the West Pokot District ***(all timeframes for objectives are from: April 2005 to March 2009; activities are scheduled for January-December 2007)***			
Objective 1: *To increase testing throughout the district.*			
Activities	**Timeframe**	**Notes/Collaborators**	**Materials Needed**
1.1.1 Assist with supervision of ongoing PMTCT and DTC services at 20 health facilities around the district, including in the wards and TB clinics of KDH, health centers, and Ortum MH. • Ensure the consistent implementation of PMTCT testing at all sites. • Ensure the integration of DTC activities in all inpatient and outpatient services, particularly those pertaining to TB and STIs.	- Ongoing	- With: DASCO and DPHN	- Rapid test kits and appropriate reporting forms at all PMTCT/DTC sites (to be provided by NASCOP through the WP DHMT).
1.1.2 Expansion of PMTCT/DTC sites to include 10 remaining MOH facilities in the district. • Training of nurses in each of the 10 MOH sites not already included in this program.	- TBD	- With: DHMT, PASCO	- Same as above.
1.1.2 Increased PMTCT Referrals • Provide refresher trainings to TBAs in the remaining 12 dispensaries. • Implementation of referral card program among TBAs. • Ensure that monthly TBA meetings at each site are held. • QA of TBA reporting at each site.	- Ongoing	- With: health facility staff, DASCO and DPHN	- Appropriate reporting forms for nurses as well as TBAs (to be provided DOW)
Objective 2: *To improve awareness within communities around the health centers and dispensaries of the means of transmission and prevention of HIV.*			
Activities	**Timeframe**	**Notes/Collaborators**	**Materials Needed**
1.2.1 Education through TBAs	- Ongoing		

1.2.2 Education through community mobilization sessions held around the district, including through community groups such as women's or farmers cooperatives	- Ongoing	- With: health facility/clinic staff and CBOs	- megaphone (DPHN), condoms (DASCO), test kits (DMLT)
GOAL 2: To provide comprehensive care and support to HIV+ individuals and their families in the West Pokot District. ***(all timeframes for objectives are from: April 2005 to March 2009; activities focus on, but are not restricted to January-December 2006)***			
Objective 1: *To increase local capacity to provide necessary treatment (including ARVs and OI meds) to all HIV+ individuals*			
Activities	**Time frame**	**Notes/Collaborators**	**Materials Needed**
2.1.1 Continuation of ART services at KDH • Project Coordinator to continue supervisory activities in Kapenguria (including mentorship of COs) • Ensure trained, alternate staff for all positions of clinic.	- Ongoing	- With: clinic staff	
2.1.2. Continuation and expansion of ART services at health centers • Continue to provide mentorship to HC staff in HIV/AIDS treatment. • Begin providing ART services at health facility in Amakuriat.	- Ongoing - January	- With: clinic staff, HC staff, Catholic Diocese	
Objective 2: *To increase local capacity to provide adequate nutritional support to all HIV+ individuals.*			
Activities	**Time frame**	**Notes/Collaborators**	**Materials Needed**
2.2.1 Maintenance of demonstration plots in Kapenguria, Sigor, Kacheliba • Utilization of plots as educational tools for patients and other stakeholders/collaborators.	- Ongoing	- With: WWFA, VI Agroforestry, and others	- Land: in Kacheliba and Kapenguria, this is to be provided by MOH.
2.2.2 Continuation of home visits by agricultural program manager to provide on-site technical guidance.	- Ongoing		
2.2.3 Expansion of program to include livestock: goats and chickens.	- TBD		

Objective 3: *To increase local capacity to provide emotional support to all HIV+ individuals.*			
Activities	**Time frame**	**Notes/Collaborators**	**Materials Needed**
2.3.1 Continue to strengthen counseling skills of clinic staff by sending staff to appropriate trainings.	- Ongoing	- With: AMPATH and others.	
2.3.2 Continue outreach services to all patients in need.	- Ongoing	- With: DOW/clinic staff	
2.3.3 Continue support group/s for HIV+ individuals and their families.	- Ongoing	- With: DOW staff	
2.3.4 Continue monthly educational seminars for patients (and, sometimes, their families)	- Ongoing	- With: DOW/clinic staff	
2.3.5 Expand network of patient volunteers • Begin network of HIV+ community mobilizers.	- Ongoing	- With DOW/clinic staff, patients	

Annex 4: Organizational Chart/Management Plan



* The Program Manager/M&E Specialist is responsible for technically backstopping this program at DOW's U.S. HQ offices. The Project Director is responsible for managing this project in Kenya.

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 5a:
JDs of Key Project Staff

Annex 5: CVs and JDs of Key Personnel

I. Child Survival Project Director, West Pokot District - Kenya

PRIMARY RESPONSIBILITIES

- Work closely with District Health Management Team to develop agreements and workplans for the project.
- Oversee all gathering of baseline data, working closely with HQ-based Program Manager/M&E Specialist, Baseline Assessment Consultant, and M& Coordinator, through activities such as KPC surveys, Health Facilities Assessment and use of checklists and structured interview tools developed by PVOs and the CORE Group.
- With support from HQ-based Program Manager/M&E Specialist and in cooperation with M&E Coordinator, develop monitoring and evaluation (M&E) tools.
- Lead development of Detailed Implementation Plan, including convening stakeholders workshop and meeting of other PVOs conducting Child Survival and Health (CSH) programs in Kenya.
- In cooperation with the DOW HQ in New York, hire project staff and supervise their work.
- Plan, implement, and supervise BCC, training, and other project activities to fulfil DIP objectives, providing technical leadership and support to field project staff.
- Maintain working relationships with project partners, including local CBOs and FBOs, MOH, and PVOs.
- Maintain regular communication with USAID mission in Kenya.
- Draft narrative reports in accordance with USAID requirements.
- Maintain compliance with all USAID and DOW policies.
- Travel as needed within Kenya for sharing of lessons learned and networking with PVOs addressing similar populations.
- Other duties as requested by Regional Director and DOW HQ staff.

QUALIFICATIONS, KNOWLEDGE, SKILLS AND ABILITIES

- Experience and training in developing health education and behaviour change interventions in Kenya.
- Experience working with PVOs or other international organizations
- Experience in maternal and neonatal health interventions required; experience with HIV/AIDS and/or malaria interventions preferred.
- Experience working with USAID or other governmental donor.
- Experience working with marginalized populations.
- Strong organizational and reporting skills, attention to detail, and ability to meet deadlines.
- MPH strongly preferred.

II. BCC Coordinator, West Pokot District - Kenya

PRIMARY RESPONSIBILITIES

- Review baseline findings to develop BCC framework that reflect community beliefs, behaviours, and needs.
- Gather and adapt BCC materials created by other PVOs and NGOs in Kenya.
- Work with Project Director and Technical Director/Training Coordinator to develop a BCC plan for the project, including key messages and BCC skills to incorporate into all training curricula.
- Work with partner CBOs and FBOs to plan trainings and community mobilization activities.
- Work with nurses, HFCs, CBO/FBO managers, and the M&E Coordinator to plan supervision and evaluation of BCC activities and their impact on demand for and use of MNC, HIV/AIDS and malaria services.

QUALIFICATIONS

- Previous experience working with a health sector PVO or NGO in Kenya
- Experience in designing health education and/or community mobilization interventions; direct experience with BCC framework and tools preferred.
- Familiarity with the Rift Valley and/or pastoralist populations preferred
- Experience and comfort working with community-based networks and associations required.
- Good ability to organize and report on work

III. Technical Director/Training Coordinator, West Pokot District - Kenya

PRIMARY RESPONSIBILITIES

- Review baseline findings to develop training workplan that addresses identified gaps in knowledge, attitudes, behaviors, and practices, particularly of health providers.
- Gather and adapt MNC training curricula developed by the MOH or other PVOs active in Kenya; work with HIV/AIDS and malaria partners (AMPATH, DOW's HIV/AIDS project, PSI) to coordination with their curricula and trainings.
- Working with Project Director and other technical project staff in the field and at HQ, finalize curricula and pre- and post-test assessments for all project trainings.
- Work with the Project Director, DHMT, focus health facility staff, and key staff at partner CBOs and FBO to develop and implement a training schedule.
- Work with Project Director, M&E Coordinator, and Program Manager/M&E Specialist to develop plans for QA/QI.
- Work with Project Director, M&E Coordinator, and Mid-Term Evaluation Consultant, plan and assist evaluation of impact of training and needs for refresher and continuing training in Years 3 and 4.

QUALIFICATIONS, KNOWLEDGE, SKILLS AND ABILITIES

- Previous experience working with the MOH or a health sector PVO or NGO in Kenya
- Experience in developing and conducting health-related trainings.

- Direct experience in MNC issues preferred.
- Familiarity with the Rift Valley and/or pastoralist populations preferred. Experience and comfort working with MOH providers and good knowledge of MOH structure and policies.

IV. M&E Coordinator, West Pokot District - Kenya

PRIMARY RESPONSIBILITIES

- Work with Project Director, HQ Program Manager/M&E Specialist and Baseline Assessment Consultant to design and implement baseline assessments and surveys.
- Assist in gathering and analyzing baseline data to be used in developing DIP.
- Work with BCC Coordinator and Technical Director/Training Coordinator to ensure that their workplans reflect key needs and gap identified through baseline assessment.
- Work with Project Director, HQ Program Manager/M&E Specialist to develop implement processes for ongoing collection of project process and outcome indicators, including gathering and adapting M&E tools developed by the MOH and other PVOs active in Kenya.
- Lead, in close cooperation with the DHMT, development and implementation of activities to strengthen the District's HMIS system, including data collection and reporting tools at facilities and in the community.
- Work with Project Director, HQ Program Manager/M&E Specialist, and Midterm- and Endline-Evaluation Consultants to develop and implement plans for midterm and endline evaluations.
- Assist Project Director in incorporating project data into reporting to HQ, USAID and other donors.

QUALIFICATIONS, KNOWLEDGE, SKILLS AND ABILITIES

- Previous experience working with a PVO or NGO in Kenya.
- Experience in project M&E, preferably in the health sector.
- Familiarity with the Rift Valley and/or pastoralist populations preferred.
- Knowledge of Child Survival and other PVO M&E tools, such as KPC and KABP surveys, preferred.

Other field project staff will include the Project Assistant, Accountant, and Drivers. Job Descriptions for these staff can be provided upon request.

V. Program Manager and M&E Specialist, HQ - New York

RESPONSIBILITIES & DUTIES

- Participate in and/or lead all stages of the project design and approval process: conceptualization, researching, workplan writing, negotiation and budgeting for the designated program area(s) and/or region(s).

- Seek additional funding sources within the region of the project, and act as interface to USAID and other government and bilateral donors.
- Stay abreast of developments in the designated program area(s) through frequent review of donor portfolios, scientific journals, other NGOs' portfolios, donor meetings and participation in relevant working groups.
- Travel to project sites for monitoring and evaluation purposes. Keep abreast of pertinent developments in the country/region of operation as well as the program area. Communicate such developments with field staff.
- Lead the recruitment of any international field staff for the field office.
- Provide direct line management of international, and in some cases, national field staff, including review of monthly reports and annual performance evaluations
- Maintain frequent, regular communication with field staff and overseas contacts.
- Provide the necessary HQ backstopping and management support to field office.
- Maintain electronic and hard copy organizational system to track project documents, donor communications, etc.
- Provide direction and supervision to the Program Associate and field staff on program needs, including those related to administration and reporting.
- Consult closely with the Program Director and, when appropriate, other members of the senior staff on all major project management issues.
- Prepare spending projections, review and approve advance funds requests from the field , and compare actual spending against projections on a regular basis.
- Ensure compliance, among field and other project staff, with DOW and donor policies including those for personnel and related to travel.
- Ensure the timely submission of project and financial reports from the field. Screen reports and follow-up on additional information or clarification needed from the field.
- Review financial data and prepare and review reports and consult with Finance and Administration.
- Oversee the process of baseline survey design, including the selection of indicators and KPC/KAPB survey modules.
- Work with Program Director to create package of detailed project indicators and performance monitoring tools.
- Provide assistance to field staff in developing or adapting tools from CSHGP, CSTS+, The CORE Group, and other PVOs to be appropriate to DOW projects and target groups.
- Support training/orienting of project M&E staff.
- Work closely with field staff and the Program Director in designing databases to record data from baseline and endline assessments as well as from ongoing project monitoring.
- Ensure that qualitative assessments and partner evaluations of projects are adequately integrated into project evaluations.

QUALIFICATIONS, KNOWLEDGE, SKILLS AND ABILITIES

- MPH or equivalent degree.
- At least 5-8 years of international public health experience, with training and experience in M&E.
- Prior field level experience in the developing world.

- Prior experience in survey and other quantitative and qualitative evaluation system design.
- Prior supervisory and programmatic oversight responsibility.
- Experience in grant writing, grants management and reporting.
- Understanding of participatory development models and methodology.
- Proficiency in PC based software systems: MS Word, Excel, Power Point, Outlook.
- Technical knowledge in MCH and HIV/AIDS issues.

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 5b:
CVs of Key Personnel

KAVITA BALI
201 East 37th Street #3D, New York, NY 10016 • (917) 518-0622 • e-mail: kavita_bali2@yahoo.com

EDUCATION

October 2001-December 2004 & January 2006-Present
LONDON SCHOOL OF ECONOMICS **London, England**
PhD Candidate, Development Studies Institute (DESTIN)
Topic: Impact of Political and Social Violence Among Sri Lankan Tamil Refugees
Awarded Rotary International Ambassadorial Scholarship

February 2001
COLUMBIA UNIVERSITY, DUAL-DEGREE PROGRAM **New York, NY**
Master of International Affairs, School of International and Public Affairs
Master of Public Health, Program in Forced Migration, School of Public Health
Awarded Foreign Language Area Studies (FLAS) Fellowship, Academic Fellowship, and Population Fellows Program Summer Scholarship

Relevant Course Work: Cost-Benefit Analysis, Program Evaluation, International Economic Analysis, Accounting, and Management of Health Care Organizations

May 1997
BROWN UNIVERSITY **Providence, RI**
Bachelor of Arts in Human Biology
Awarded Joslin Prize for Excellence in Leadership and Gabriela Mistral Prize for Spanish

SELECTED WORK EXPERIENCE

October 2004-Present
StatMD PHYSICIANS, PLLC URGENT CARE CENTER **New York, NY**
Marketing and Business Development Consultant
- Assisted in development of business plan and five year projections for new business's growth
- Assessed local and regional market for health care services and implemented a comprehensive advertising campaign that reflected community needs
- Implemented management information system to track daily sales and yearly expenditures

January 2001-September 2001
AVERTING MATERNAL DEATH AND DISABILITY PROGRAM **New York, NY**
Program Coordinator
- Managed quarterly progress reporting of 40 country programs with a total budget of $50 million
- Streamlined India project's Management Information System (MIS), resulting in state-level health service delivery reforms and improved data collection methods
- Drafted peer-reviewed journal articles and annual reports for publication

Summer 2000
INTERNATIONAL CENTRE FOR MIGRATION AND HEALTH **Geneva, Switzerland**
Public Health Advisor
- Analyzed quantitative data and prepared working paper from multi-country study on causes of violence among refugee/displaced populations
- Formulated short/long term recommendations after evaluating organization's 5-year strategic plan
- Appointed as country representative to Tanzania and directed development of new health initiatives

September 1998-May 2000
COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH **New York, NY**
Graduate Research Assistant, Center for Population and Family Health
- Designed graduate health curricula and assisted various program directors in independent research
- Created databases to improve accessibility of published research on a variety of public health topics

Summer 1999 — **RELIEF INTERNATIONAL** — **Prizren, Kosovo**
Health — *Program Officer*

- Authored and successfully negotiated a $450,000 grant for reproductive health programs in Kosovo
- Initiated and supervised a country-wide reproductive health assessment, which led to establishment of training programs for over 200 health care professionals, refurbishment of war-damaged medical facilities, and creation of other post-conflict reconstruction projects
- Directed research and implementation team of 20, including local and international staff
- Produced and presented budget analysis and biweekly progress reports to lead UN agencies

January-July 1998 — **THE BASICS PROJECT** — **Arlington, VA**
Program Assistant, Child Survival Programs

- Led team to develop technical conferences for international health experts
- Standardized public-private sector program data reporting and oversaw various project budgets

October-December 1997 — **BAKER & BOTTS, L.L.P.** — **Washington, DC**
Legal Assistant

- Conducted research, including extensive legal writing and editing, for international arbitration
- Counseled ambassadors and other senior country officials in constructing legal arguments

SKILLS AND INTERESTS

Computer: Microsoft Office—Word, Excel, PowerPoint; database (SPSS) and network applications
Language: Proficiency in Spanish, working knowledge of Hindi, Basic Kiswahili

PROFESSIONAL ACTIVITIES

Member, Global Health Council
Member, The Academic Council on the United Nations System (ACUNS)

ALICE N. SHITAMBASI

PERSONAL PARTICULARS

Date of Birth: [redacted]

Marital Status: [redacted]

Contact Address: [redacted]

Mobile: [redacted]

Nationality: Kenyan

Email Address: [redacted]

QUALIFICATIONS

1999 - 2001 **MSc Health Information Science for Health Services Management**
WARWICK UNIVERSITY, UK.
Acquired knowledge on Data Analysis and Interpretation using SPSS. Also on problem solving techniques. Acquired advanced knowledge in health information management.

1990 - 1993 **Diploma In Applied Statistics,**
THE KENYA POLYTECHNIC, NAIROBI
Approach to solving problems using statistical methods. Data analysis techniques. How to communicate effectively. Use of spread sheets to prepare statistical tables.

1981 – 1983 **Certificate in Medical Records Technology (*Health Records and Information Technology*)**
MEDICAL TRAINING COLLEGE.
Provided me with a base to pursue further training in health information and statistics as shown above. It provided me with knowledge about health issues. This is where I developed the interest in Medical Statistics

1983 – 1977 **East African Certificate of Education (EACE) - Division II (2) score**
Mombasa Baptist High School.

Short courses and Seminars

July 2005	Three weeks course on Monitoring & Evaluation, AMREF Training Centre.
February 2005	One week course on Quality Assurance, World Vision,Kenya/Ministry of Health.
September 2004	One week course on PRA/PLA, World Vision, Kenya/Ministry of Health
November 2002	Two weeks course on Training of Facilitators (TOF), Aga Khan Health Services.
September 1996	Six weeks course on Tools for Health Managers, University of Nairobi.
August 1995	Two weeks course on General Management, Ministry of Health.
November 1995	course on Teaching methods, Ministry of Health.
April 1994	One week Seminar on Records management, Kenya National Archives & Documentation Service
November 1993	Three weeks course on Advanced Records Management, ESAMI, Arusha.

October 1993 Two weeks course on Kepi Operational Level Training, Ministry of Health.

EXPERIENCE

I have over eighteen years of work experience in managing health information both at national and district levels. Also I have four years working experience in Monitoring and Evaluation of project implementation activities.

Areas/ Sections worked are as outlined:

August 2002 to Present - Child Survival Project, Teso – World Vision

Job Title: Health Management and Information Systems Coordinator

Key Responsibilities and Tasks:

- Development of an M&E framework for child survival project.
- Strengthening the District Health Information System in Consultation with Ministry of Health.
- Development of M&E tools.
- Participate in Capacity Building of Field staff on HMIS design and Implementation and M&E issues.
- Facilitate the establishment of a Community based information system.
- Ensure that quality improvement principles and sustainability are adhered to by both community and health workers.
- Train Community Own Resource Persons on Community HMIS (Proper data collection methods and use).
- Development of a database on key health indicators.
- Review where necessary data collection tools for Ministry of Health at district level.
- Other duties involve monitoring of programme activities, follow up on implementation of activities in the community, and preparation of health management information reports.

January 2001- July 2002 - Division of Health Information Systems – Ministry of Health

Job Title: Health Records and Information Officer

Key Responsibilities and Tasks:

- Maintenance and management of epidemiological and other health data from the districts
- Coordinate the collection of quality health data from the districts and various sections of the department that should be timely, accurate and relevant, for use by stakeholders.
- Liaise with other departments on matters related to health information and other health issues.
- Design of data collection tools and development of Questionnaires.

Other duties included data collection and management, questionnaire design and participated in baseline surveys. Prepare of statistical reports among other reports.

April 1994 – September 1999 - Division of Continuing Education – Ministry of Health

Job Title: Trainer

- Duties involved organizing and training of refresher courses for health care workers on selected health topics.
- Conducted Training Needs Assessment for health care workers in selected districts.
- Assisted in the development of health learning materials for health care workers
- Assisted in development of training curriculum.

January 1989 – March 1994 - Nairobi Provincial Medical Office – Ministry of Health

Job Title: Health Records & Information Assistant

Duties involved collection, compiling and analysis of data on mortality and morbidity, Maternal and Child Health and Family Planning, Immunizations, Nutrition, and other health services indicators. Design of data collection tools. Coding and Indexing of diseases according to International Classification of Diseases (ICD)

July 1983 – December 1988 - Machakos District Hospital – Ministry of Health

Job Title: Health Records & Information Assistant
Duties involved collection, compiling and analysis of data on morbidity and mortality, Immunizations, Family Planning and other health services indicators. Admission and discharge of patients.. Coding and Indexing of diseases according to International Classification of Diseases (ICD)

OTHER WORK EXPERIENCE

Through working in a health sector, I have acquired insight knowledge and approach solving various health issues such as in Maternal and child health, Family Planning (MCH/FP), HIV/Aids, Communicable and Non Communicable diseases and Nutrition.

CAREER DEVELOPMENT

Trained at Medical Training College for a two – year course in Medical Records Technology. After which I was posted to Ministry of Health in 1983, initially, as a Medical Records Assistant. In 1990, I was sponsored for a three year Diploma course in Applied Statistics at the Kenya Polytechnic, which I completed in 1993. In 1999, I was sponsored for a one – year Masters Degree Course in Health Information Science at the University of Warwick in United Kingdom, which I completed in 2000.

RELEVANT SKILLS

- ✓ Analytical skills - Skills in Statistical analysis techniques -
- ✓ Excellent Communication skills – I communicate effectively with other team members, when sharing information.
- ✓ Report writing and presentation skills – Assisted in the preparation of quarterly reports. I have delivered presentations at various forums such as stakeholders meeting and quarterly review meetings.
- ✓ Facilitation skills – Facilitated at workshops and trainings for health care workers, staff members on HMIS, and Community Own Resource Persons.
- ✓ Database development skills – I developed a database using EPI Info for inputting of data gathered from community and health facilities.
- ✓ Language – Fluent in both English and Kiswahili, verbal and written

OTHER SKILLS

- ❑ Team building - Experience in working within a team based culture. Sharing of lessons learned, planning and implementing activities together in a team.
- ❑ Supervision skills - Supervised a team in an office in Machakos Hospital
- ❑ Adaptability and flexibility - Ability to adapt to any work environment and changes in the Organizational structure.
- ❑ Also have skills in organization and time management.

COMPUTER SKILLS

I have good working knowledge of Windows Operating System, Microsoft Office tools, EPI Info, SPSS and the Internet.

AUMA EUNICE OKOTH

PERSONAL INFORMATION
Date of Birth. [redacted]
Marital Status [redacted]
Nationality: **Kenyan.**
Telephone [redacted]
E-mail [redacted]

SUMMARY OF EXPERIENCE

1. *Twenty years experience in designing, managing, implementating and evaluating health training and service delivery programs*
2. *Demonstrated experience in building the capacity of public and non-public health trainers and service providers in diversified health skill areas, life-planning skills, adolescent Reproductive Health, Child Survival, quality improvement, and over the past five years, performance improvement.*
3. Trained in IMCI case management, facilitation, Supervision and Community IMCI.
4. *A very strong team player and works well even under pressure of work*
5. *Have strong professional initiative, self-confidence and very good oral and written communication and interpersonal skills.*
6. Demonstrated experience in materials development and Periodic review of the curricula, training manuals, service delivery guidelines
7. *Familiar with the policies, priorities and procedures of donors.*
8. *Have demonstrated ability to produce desired results by meeting the AMKENI training target.*
9. *Competent in the use and application of Word, Excel and PowerPoint packages.*
10. Conversant with sustainable training approaches.

Primary areas of expertise are as follows:

- Training, Service Delivery and behaviour change community level.
- Planning, implementation and evaluation of health service delivery and training programs.
- Training needs assessment,
- Performance Improvement Approach application.
- QOC management and use of QI tools
- Reproductive health service provision and skills training (including implants and PAC)
- Adolescent health and development, and life skills.
- Emergency response, first aid and advance life support..
- Training of health workers of all levels including community Lay and Health workers.
- Trauma, grief and loss counselling including Obstetric Fistula counselling.

Professional Experience

JULY 2006 –TO DATE -ENGENDERHEALTH-APHIA 2 Bridging Project-Western Province

Service Delivery and BCC Coordinator – Western Province, Kenya.

- Plans and budgets for service delivery activities.
- Responsible for field supervision in the province.
- Coordinates client mobilization for service utilization in target facilities
- Develops and maintains close relationships with the District Public Health Nurse (DPHN), the District Medical Officer of Health (DMOH)
- Works closely with health providers and community health workers in the supported districts
- Works closely with service providers, and monitoring the goings-on at the facilities related to project implementation
- Takes leadership in implementation, monitoring and coordinating action plans for strengthening service delivery for FP/RH/CS services in the province
- Provides leadership in planning and implementing skills development interventions
- Collaborates with other team members for joint planning and implementation activities
- Coordinates procurement and distribution of relevant equipment
- Monitors and reports monthly on project achievements, facility performance including data collection, challenges and way forwards

2001-June 2006 INTRAH Health International – AMKENI Project
Training & Supervision Coordinator – Western Province, Kenya

Responsibilities include

- Utilise the PNA results to identify training and supervision needs in developing training plans and mobilisation of resources for health facilities in the AMKENI districts in Western province
- Take leadership in implementation, monitoring and co-ordinating actions for strengthening Training and supervisory systems for FP/RH/CS services in Western province
- Provide leadership in planning and implementing skill development interventions in western province.
- Collaborate with other team members for joint planning and implementation of activities aimed at FP/RH/CS serviced delivery improvements
- Liase with the Area Manager to ensure project training and supervision activities are on course
- Monitor and report quarterly on project achievements and challenges.
- Strengthen the DHMTs, RH training and supervision through the application of Performance Improvement Approach(PIA)
- Assist DHMT in planning and implementing Performance Needs Assessment (PNA)
- Contribute to material development (integrated Reproductive Health curriculum, facilitative supervision curriculum)

Selected achievements

- Helped in building the capacity of the DHMTs in AMKENI districts in western province by training trainers and service providers in performance improvement approach, selected productive health skills,
- Contributed to the development of comprehensive national training curricula and manuals in *Reproductive Health, Facilitative Supervision and Post-abortion Care*. Both pre-service and in-service trainees will use these.
- Helped to establish structured on job training process in six districts of Western Province and the first group of trainees have been certified.
- Has worked closely with the DHMTs to planned implement training activities and hence meeting the organisational target.
- Evaluated transfer of learning and the impact of training through trainee follow up.

- Helped six Districts of western Province in adopting sustainable training approaches, which included, on job training, onsite training, whole site training and cost sharing.
- Provided technical assistance in training of trainers in and implementation of quality improvement tools &approaches (facilitative supervision and COPE) to CARE Ethiopia.
- Provided technical assistance to AQUIRE Uganda designing and implementing training program for obstetric fistula counsellors.

1999-2001: Care International (K) - Kisumu, Kenya

Training Officer: Operated as a Project Training Officer in a reproductive health project.

- Responsible for overall Design, Planning, Implementation and Evaluation of the Training Component of the "Strengthening Population Programming" in Nyanza Project.
- Prepared and implemented annual training implementation plan.
- Conducted periodic training needs assessment to establish types and kinds of training needed by the project.
- Evaluated the impact of training on staff/volunteers through trainee follow up.
- Trained service delivery point staff on continuous quality improvement tools.
- Trained and supervised community health workers in reproductive health and child survival skills.
- Conducted facilitative supervision.

1996-1999 – Family Planning Association of Kenya Nairobi, Kenya

Assistant Program Officer (Service Delivery)

- Attached to an integrated Reproductive Health and training Clinic, responsible for planning, coordination, implementation and evaluation of reproductive health services.
- Prepared and implemented annual training implementation plan, periodical training needs assessment and evaluated the impact of training on staff performance.
- Periodically reviewed of the curricula, training manuals, services delivery guidelines and assisted in writing project proposals.
- Helped develop Reproductive Health IEC materials, Audio tape on infection prevention, video cassettes, target brochures.
- Contributed institutionalisation of COPE, Facilitative Supervision in the FPAK clinics
- Trained service managers from **Mbeya Tanzania** in clinic management, COPE and Facilitative Supervision, Service providers on counselling and Norplant insertion and removal.
- Co-Trained providers from Ethiopia and Egypt in IUCD, implant insertion and removal.
- Contributed to the development of the Reproductive Health guidelines and standards for service providers.
- Conducted Training Needs Assessment with INTRAH.

Achievement

- Institutionalised use of quality improvement tools in FPAK clinics.
- Institutionalised PIA.
- Coordinated and supervised RH services at the service delivery points.
- Provided RH services.
- Planned and implemented training activities based on the needs assessment results
- Ensured transfer of learning through trainee follow up of the FPAK service providers.
- Provided technical assistance during the design and development of IEC materials and audio-visual aids.
- Trained community health care providers in various reproductive health fields.
- Consultant trainer in Terminal care,
- Trained providers in grief and loss counselling in consultancy for British council and Nairobi Hospice

1987 – 1995 Kenya Medical Training College, Faculty of Nursing Nairobi, Kenya

Tutor General Nursing Department

- Trained basic Nursing students and other paramedics conducted clinical instruction for skill mastery,
- Evaluated patient care to ensure quality of care.
- Coached and supported students as they went through the training programme
- Coordinated the college and national examinations for three years.
- Counselled the students to help them cope with the problems of growing up and make informed choices.
- Planned and implemented training evaluation activities.

1989-1999-Volunteer St. Johm Abulance services.
1992-1996-Volunteer.Nairobi Hospice.
Care of the terminally ill cancer Patients and Home-based care.

1978 – 1985 Ministry of Health, Kenya
Ward Clinic In-charge

Kisii District Hospital
Kenyatta National Hospital Nairobi
Nanyuki District Hospital

- Planned, coordinated the implementation and evaluation of patient care
- Areas covered were Paediatric Nursing Obstetric and Gynaecological
- Medical and Surgical Nursing.
- Maternal Child Health /Family Planning
- Identified training needs, Organised and conducted continuing education sessions for staff and students

Educational Background

- MCHD- Great Lakes University of Kisumu-ongoing (2006/2007)
- Diploma in Advanced Nursing, University of Nairobi, Faculty of Medicine, 1987.
- Registered Community Health Course Certificate -University Of Nairobi 1987
- Registered Midwife Diploma -Kenya Medical Training College, Nairobi Faculty of Nursing 1980
- Registered Nurse Diploma KMTC Nairobi Faculty of Nursing 1978.

Other Short Courses

- StigmaReduction. -2005
- Logistic Management and MIS-2005
- PMTCT-2004
- IMCI, case management facilitation , Supervision and community IMCI-2002
- PIA 2001
- Basic Counselling Skills 2001
- TOT Advanced Life Support Course, Kenyatta National Hospital Nairobi 1998
- Clinical training Skills.1997
- STI Syndromic Management.
- Quality of Care Management 1997
- Facilitative Supervision 1996
- Norplant Insertion and removal 1996
- Family Planning skills-1995.
- Hospice Care (care of the terminally ill including Home Based Care.
- Lay Lecturers and Examiner course in First Aid St. Johns Ambulance Brigade (K) 1989

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 6:
Training and Technical Guidelines

The direct causes of maternal mortality are: • Hemorrhage: APH and PPH • Sepsis • Pre-eclampsia and eclampsia • Ruptured uterus • Complications of induced abortion	INDIRECT causes of maternal deaths in Kenya are… • Malaria • Anaemia • HIV/AIDS • TB Note: As providers, brainstorm about what you can do to change these statistics; these indirect causes can be prevented and/or detected during ANC
The actions that improve the women's and newborn's chances of survival during pregnancy and childbirth are: • Being attended by a skilled birth attendant. • Prepared clients – who understand danger signs and are ready for complications. • Functional referral systems which include communication, transportation and financial issues. Note: a skilled birth attendant is a trained doctor, clinical officer, nurse or midwife. A trained TBA is NOT a skilled birth attendant.	Four comprehensive, personalized antenatal visits. 1st visit: <16 weeks 2nd visit: 16 – 28 weeks 3rd visit: 28-32 weeks 4th visit: >32 weeks

Focused Antenatal Care

- This type of antenatal care focuses on ensuring, supporting and maintaining maternal and foetal well-being throughout normal pregnancy and childbirth
- It is goal oriented that is timely, friendly and simple

Goals of Focused Antenatal Care

- Early detection and treatment of problems
- Prevention of complications, using safe, simple and cost-effective interventions
- Birth preparedness and complication readiness
- Health promotion using health messages and counseling
- Provision of care by a skilled attendant

During FANC visits, ensure that the following have been accomplished:

History taking:
- Current complaints/ identify danger signs
- Dietary History
- Tetanus vaccination status
- Reproductive history

Physical exam:
- Physical assessment of general health
- Genital inspection, including sexually transmitted infections
- Check for blood pressure, oedema and protenuria to rule out pre-eclampsia
- Check for anaemia
- Check baby's growth

Provide:
- Iron, folate, ITP* (SP is the currently recommended) tetanus toxoid and Nevarapin if recommended

Counseling on:
- Danger signs
Individual birth plans (IBP)
- Complication readiness
- Nutrition, breastfeeding, family planning, safer sex, hygiene etc…
- Return date

Lab:
Most of the lab work should be done during the first visit
- Hb, grouping and Rh factor
- VDRL/RPR, sickle cell (if indicated) Hepatitis B (if indicated)
- HIV (if indicated)

15% of all pregnant women develop life-threatening complications requiring obstetric care*

These women could die if:
- Nobody id there to make timely decisions at home and in the health facility.
- No plans for referral or transport have been made.
- No plans on how to meet the new financial demands are made.

*Yuster 1995, Fortney 1995 Antenatal Care: Overview

Specific transport questions for the patient • Where will you **deliver?** • Where will you go in case of **an emergency?** • **Where** is it located? • **How** will you get there? • **How far** is it from your home? • **How long** will it take to get there? • Have you made this **journey before**? • **How much** will it cost to arrange this transport? • **How** will you raise the funds for this transport?	**Mother – Baby Package** • One pair of sterile rubber gloves (or clean plastic bags that can be worn over the hands where gloves are not available) • Soap • Cotton wool • Clean, unused razor blades • Thread or string • Clothing for the baby and mother • Money to pay for transport, hospital fees, etc… • Sanitary towels, napkins Family members can help purchase these items in the mother baby package and can help pay for transport, or the delivery costs.
Danger signs in pregnancy • Any vaginal **bleeding** • Severe **headache** or blurred vision • **Swelling** of the face and hands • Convulsions or **fits** • High **fever** • **Laboured** breathing • **Premature** labour pains • Noticed that the **baby** is moving less or **not moving** at all	**Other danger signs in pregnancy** • Feeling weak or tired • Vaginal discharge • Abdominal pain • Genital ulcers • Painful urination • Persistent vomiting

Danger signs during labour and delivery • **Severe headache/ visual disturbances** • **Severe abdominal pain** • **Convulsions or fits during labour** • **High fever with or without chills** • **Foul vaginal discharge** • **Labour pains for more than 12 hours** • **Ruptured membranes without labour for more than 12 hours** • **Excessive bleeding during delivery** • **Cord, arm or leg prolapse**	Danger signs after delivery • Placenta not delivered within 30 minutes of the baby's birth • Excessive bleeding after delivery • Severe abdominal pain • Convulsions or fits • High fever with or without chills • Foul vaginal discharge due to infections
Pregnant women get malaria more easily than women who are not pregnant • Many pregnant women have malaria, but have **no symptoms** at all. • When a woman is pregnant she loses some of the ability to fight infection. • Blood test for peripheral parasitaemia is often negative, **despite malaria parasites** in the **placenta**	Signs and symptoms of simple malaria • Fever with or without shivering • Headaches • Weakness • Loss of appetite • Nausea and vomiting • Joint pains • Backache and muscle pains • False labour (uterine contractions • Symptoms of severe anaemia may include: dizziness, awareness of fast heartbeats (palpitations), breathlessness and tiredness

What happens when a pregnant woman gets malaria? • The malaria parasites in the blood of the mother hide in the placenta and so malaria parasites may not be found when you take a finger blood sample. • The mother may have no signs/ symptoms of malaria • The parasites may still be present and cause damage to the baby • Malaria parasites obstruct the passage of food and oxygen to the unborn baby, slowing down its normal growth.	Malaria may cause up to 30% of preventable low birth weight and 3-5% of neonatal deaths* • Low birth weight babies have a higher chance of dying than babies who are born with a good weight. • Malaria increases the risk of premature labour, spontaneous abortion and stillbirths. *Yuster 1995, Fortney 1995 Antenatal Care: Overview
The major health effect of malaria on the mother is anaemia • Malaria destroys the red blood cells of the mother • Any woman form a malaria endemic area with severe anaemia (Hb<7g/dl) should be assumed to have malaria and treated for it even if she has a negative smear	What is Sulfadoxine Pyrimethamine (SP)? • SP is a combination of two different drugs • One tablet of SP contains 500 mg of Sulfadoxine and 25 mg of Pyrathamine • A single dose consists of 3 tablets of SP taken at one time. • Fansidar is the most common brand name but there are many other names that contain the same drugs, like maladox.

Summary Key steps for providing SP to pregnant women • Ask client about gestational age. Determine that the client is at least 16 weeks pregnant. If she is not certain of her dates, ask her if and when she felt the baby move. "Quickening" is a rough estimate of the onset of the second trimester. • Ask about a history if severe skin rash or mucous membrane ulceration with sulpha drugs (If she has had a severe reaction to sulpha drug, do not give SP and make sure allergy is clearly marked on her antenatal card.) • Ask about the use of SP in the past month. • Give client 3 tablets of SP with clean and safe drinking water (not on an empty stomach). • Tell client to return for the second dose between 4 and 6 weeks from today. • She should also come back if she has side effects.	**SP and HIV+ women** • Women who are HIV+ might require additional doses of SP • **After quickening (>16 weeks),** HIV+ women can receive 3 doses of SP at monthly intervals, up to birth. • As with all women, determine first that she **is not allergic sulpha-** containing drugs and discontinue SP if she develops any signs or symptoms of allergy. Note: However research on this is still going on.
We can protect pregnant women from mosquito bites • **All women of childbearing age** should sleep under insecticide treated nets (ITNs) • Insecticide treated nets are much more effective than untreated nets. • **Pregnant women and children,** especially, should sleep under ITNs. These groups are the most vulnerable!	Use a NET! (Insecticide Treated Net or ITN) • Use and ITN form a social marketing vendor. • These vendors can provide nets at a reasonable **standardized cost.** The nets have been correctly dipped in a specially formulated treatment called the K-O TAB. • Sellers involved in social marketing can also re-dip your tent in **6 months. Nets must be re-dipped every 6 months to be effective.** • Supporting these vendors provides them with and you with protection from malaria at the same time!

Preventing Mother to Child Transmission (PMTCT) of HIV

- What is mother-to-child transmission of HIV?
- Mother to Child transmission occurs when the HIV virus is passed from the mother to the baby.
  - This happens during pregnancy, during labour and delivery or when the mother is breastfeeding her baby.
  - Not every baby born to an HIV infected mother will be infected: without intervention about 1 out of 3 babies born to mothers with HIV will get the virus.
- Simple interventions can reduce the chance of getting the HIV virus by virus by about half.

When does the virus pass from the mother to the baby?

- During pregnancy (5 –10%)
- During labour and delivery (10-20%)
- During breastfeeding (5-20%)

What are the main risk factors for MTCT?

- **Viral factors:**
  - Clinical stage of infection: new and advanced infections
  - Low maternal CD4 count* (the number of cells per cubic millimeter of the blood)
  - High viral load in blood and genital tract
- **Maternal Factors:**
  - Unprotected sex with multiple partners
  - Substance abuse
  - Smoking
  - STI's and other co-infections
  - Vitamin A deficiency
  - Mother not taking ARV agents
  - Unprotected sex with an infected partner
  - HIV Infections during pregnant
  - Malaria infection in pregnant women

* The lower the maternal CD4 count he more sick the mother is likely to be

What are the main risk factors for MTCT? (continued)

- **Obstetric factors:**
  - Invasive fetal monitoring
  - Duration of membrane rupture
  - Routine episiotomy
  - Placental disruption
  - Vaginal delivery
- **Infant factors:**
  - Breastfeeding
  - Preterm delivery
  - Neonatal birth injuries
  - Vigorous noso-gastric tube suction

What can you do to prevent MTCT? • Don't discriminate against HIV+ people! • Encourage every pregnant woman to get an HIV test. • Encourage every pregnant woman to get antenatal care. • Encourage every pregnant woman to plan to deliver her baby at a hospital or clinic with PMTCT services. • Provide counseling about infant feeding choices. • Counseling on family planning (dual method) to prevent pregnancy in HIV+ women	Benefits of PMTCT include: • Improved child health and child survival • Decreased burden to the health care system • Increased public understanding of the HIV/AIDS epidemic • Help increase acceptance of people living with HIV/AIDS (PLWHA) by reducing stigma.
Remember the Four Pillars of WHO to Reduce MTCT 1. Prevention of unintended pregnancy in HIV+ women through family planning services 2. Prevention of HIV infection in women through use of ABCD (abstinence, be faithful, condom and dual protection) 3. PMTCT in pregnancy: testing and counseling to identify HIV+ women; provide ARV's to mother and baby; use of infection prevention practices 4. Care and support of those living with HIV/AIDS	

Sample Curricula:

Prevention of Mother to Child Transmission (PMTCT) Refresher Course for Traditional Birth Attendants (TBA)[1]
West Pokot District, Kenya

I. BRIEF REVIEW OF HIV/AIDS

Routes of transmission include contact between three types of fluid:

1. **Sexual (semen, vaginal juices)**
2. **Blood**
3. **Breastmilk**

Means of prevention for each mode of transmission:

1. **Sexual:**
   - abstinence
   - proper use of condoms
2. **Blood:**
   - Testing of blood for transfusions
   - Sterilization of surgical instruments (both in the health facility and in the community; these therefore include everything from syringes to knives used for female genital mutilation)
3. **Breastmilk:**
   - PMTCT! This is to be discussed in greater length during this seminar…

HIV/AIDS cannot be cured. However, it can be treated, or managed, through the use of certain drugs called Anti-retrovirals, or ARVs. Because a person should not stop taking these drugs once they have begun, and because they can have some undesirable side effects, doctors do not prescribe these drugs unless the HIV+ person fits certain criteria determined through other tests.

All of these drugs and tests are provided FREE OF CHARGE at the HIV/AIDS treatment clinic at the Kapenguria District Hospital every TUESDAY and WEDNESDAY as well as at each health center once per month (see posted calendar at each facility for actual dates).

II. WHAT IS PMTCT?

Mother to child transmission (MTCT) of HIV is the vertical transmission of HIV from a mother who is HIV infected to her infant. MTCT is the main route for HIV infection in infants and children. Transmission occurs during pregnancy, labor and delivery and breastfeeding. While precise transmission rates are difficult to capture, the Center for Disease Control notes that during pregnancy a 5-10% rate of transmission exists, there is a 10-20% transmission rate during labor and delivery and a 10-20% transmission rate during breastfeeding (up to 24 months). The transmission rates are dependent upon the mother's viral load, labor procedures and length of breast feeding. It is known, however, that greatest risk of transmission occurs during labor and delivery.

[1] Lessons II, IV-VIII of this curriculum is adapted from the AMPATH PMTCT sensitization curriculum.

Current Statistics

- 38 million people world wide are living with HIV two-thirds of whom are located in Sub- Sahara Africa (*UNAIDS 2004*)
- All sectors of the economy are heavily hit since 50% of infected individuals are between the ages of 15-49 and make up the workforce in sectors such as education, health, security and agriculture
- 40% of HIV infected Kenyans live in the urban areas and HIV prevalence among Kenyan women is nearly twice that of Kenyan men, 15% and 9% respectively
- 2.1 million children under the age of 15 years are living with HIV, 90% of whom are located in Sub- Saharan Africa
- 25% percent of infected babies die within the first 6 months of life while 50% percent will die within 2 years
- MTCT is responsible for more than 90% of childhood HIV infection

PMTCT in Kenya

- In Kenya, Prevention of Mother to Child Transmission of HIV/AIDS guidelines were introduced in 2001. Since then, the ministry of Health (MOH) has facilitated its review and updates and by 2005 nearly 600 facilities were offering PMTCT.
- In 2001 the estimated prevalence rate of HIV in pregnant women was 13% and by 2005 the prevalence rate continued to drop to about 8%. This is translated to 60,000 children infected under the age of 5 years, hence something must be done.
- MOH recognizes the magnitude and adverse toll of HIV/AIDS in pregnancy and particularly MTCT.
- In 2000, 10% of the reported AIDS cases in children were under 5 years of age.
- In Kenya most people contract the HIV through heterosexual contact.

III. PMTCT and risk of transmission to health workers[2]

In the health care setting, HIV can be transmitted in the following ways:

To patients through:

- Contaminated instruments that are re-used without adequate disinfection and sterilization
- Transfusion of HIV-infected blood
- Skin grafts
- Organ transplants
- HIV-infected donated semen
- Contact with blood or other body fluids from an HIV-infected health care worker

To health care workers through:

- Skin piercing with a needle or any other sharp instrument which has been contaminated with blood or other body fluids from an HIV infected person
- Exposure of broken skin, open cuts or wounds to blood or other body fluids from an HIV infected person

[2] Adapted from Factsheet 11 of the WHO. This series of fact sheets can be found at: http://library.unesco-iicba.org/English/HIV_AIDS/cdrom%20materials/navigation%20pages/WHO%20navigaition%20page.htm

- Splashes from infected blood or body fluids onto the mucous membranes (mouth or eyes).

Prevention of occupational exposure to HIV also includes risk assessment and risk reduction activities such as:

- Using Universal Precautions
- Wearing heavy-duty gloves when disposing of "sharps"
- Assessing protective and other equipment for risk and safety
- Adopting safe techniques and procedures, such as disposing of needles without recapping, or recapping using the single-handed method, using sterile nasal catheters and other resuscitation equipment, using a separate delivery pack for each delivery, and **not using episiotomy scissors to cut the umbilical cord**.
- Making appropriate disinfectants and cleaning materials available
- Sterilizing equipment properly
- Eliminating unnecessary injections, episiotomies, and laboratory tests; avoiding, or covering, breaks in the skin, especially the hands.

Universal Precautions: are protective measures taken to ensure that no pathogens are transmitted through the body fluids from patients to patient, patient to health worker or health worker to patient. The precautions are applied universally to all patients. All body fluid and discharge should be treated with the assumption that it is infected. They include:

- **Careful handling and disposal of "sharps"**
- **Hand washing with soap and water before and after all procedures**
- **Use of protective barriers such as gloves, gowns, aprons, masks, goggles for direct contact with blood and other body fluids**
- **Safe disposal of waste contaminated with blood or body fluids**
- **Proper disinfection of instruments and other contaminated equipment**
- **Proper handling of soiled fabrics/sheets**

Safe decontamination of equipment

Efficient cleaning with soap and hot water removes a high proportion of any microorganisms. All equipment should be dismantled before cleaning. Heavy gloves should be worn for cleaning equipment and if contact with body fluid is likely, then additional protective clothing should be worn. The following table helps in selecting the method for decontamination:

Level of Risk	Items	Decontamination Method
High risk	Instruments which penetrate the skin/body	Sterilization, of single use of disposables
Moderate risk	Instruments which come in contact with non-intact skin or mucous membrane	Sterilization, boiling, or chemical disinfection
Low risk	Equipment which comes in contact with intact skin	Thorough washing with soap and hot water

Disinfection of equipment

When available, sterilization through the use of machines such as an autoclave is the most effective means of killing micro-organisms, including HIV, on medical equipment. However, when those are not available, particularly outside of the health facility, disinfection of equipment can be done through boiling or the use of chemicals, such as bleach (*jik*) or spirit. Equipment should be cleaned and boiled for 20 minutes at sea level, and longer at higher altitudes. Disinfection through the use of chemicals is not as reliable as boiling. However, it can be used on heat sensitive equipment, or when other methods of decontamination are not available. In both cases, equipment should be dismantled, thoroughly cleaned and rinsed after disinfection.

Cleaning

Detergents and hot water are adequate for the routine cleaning of floors, beds, toilets, walls, and rubber draw sheets. Following a spillage of body fluids, heavy-duty rubber gloves should be worn and as much body fluid removed with an absorbent material. This can then be discarded in a leak proof container and later incinerated or buried in a deep pit. The area of spillage should be cleaned with a chlorine-based disinfectant and the area thoroughly washed with hot soap and water.

All soiled linen should be handled as little as possible, bagged at the point of collection and not sorted or rinsed in patient care areas. If possible, linen with large amounts of body fluid should be transported in leakproof bags. If leakproof bags are not available, the fabrics should be folded with the soiled parts inside and handled carefully, with gloves.

Safe disposal of waste contaminated with body fluids

Solid waste that is contaminated with blood, body fluids, laboratory specimens or body tissue all should be placed in leak proof containers and incinerated, or buried in a 7 foot deep pit, at least 30 feet away from a water source. Liquid waste such as blood or body fluid should be poured down a drain connected to an adequately treated sewer or pit latrine.

Developing creative strategies

When certain materials are not available, what are some alternatives? For example, can plastic bags or condoms be used instead of gloves? Can cooking utensils be used for boiling equipment? Are there herbal and traditional alternatives to detergents and soaps? Can leaves, thimbles, or plastic wrap be used instead of bandaids to protect cuts? Are the resources that are available being used appropriately? For example, if gloves are in short supply, prioritize -- they are less necessary for giving routine injections and making beds than for deliveries and suturing.

One way to assign priorities is to classify the commonly performed procedures into low, medium and high risk, and allocate resources accordingly. Consideration should be given to cost effectiveness as opposed to cost containment noting that the cheapest equipment is not always the safest or most cost effective in the long run. In home care settings, nurses/midwives will need to be even more creative in finding solutions to infection control. Wherever possible, a home care kit should be available to all health care personnel working in the community and in homes. This kit should include disinfectants, soap, utensils for boiling, gloves, protective garments, and containers for safe disposal of equipment and waste.

Setting and maintaining standards, and political action

Nurses and midwives should be active in developing and maintaining quality assurance programs, and in developing and participating in infection control committees. Nurses and midwives must also develop, maintain, and evaluate standards, procedures and protocols for safe, adequate and effective control of infections. In addition, nurse managers should exert political pressure upon employers and upon national and international agencies to provide funds for essential supplies and equipment for providing safe quality care.

IV. PMTCT AT THE HEALTH FACILITY

PMTCT testing within ANC services

- **Opt Out Strategy**
  - HIV test offered as a routine part of a standard package of care. However, the client is given the opportunity to decline testing or 'opt out'.
  - The Process:
    - Client receives information about HIV testing in PMTCT as part of a group, or on an individual basis.
    - Client is given opportunity to ask questions and the health care provider ensures client understands HIV testing in the PMTCT context.
    - Unless the client declines, the HIV test is performed on the client.

Strategies in Counseling in the ANC Clinic

Share Information

- Address HIV prevalence in pregnant women
- Discuss ways that HIV is transmitted
- Discuss STI, STD, HIV/AIDS Prevention
- Discuss PMTCT Risk Factors During Pregnancy
- Discuss PMTCT Interventions During Pregnancy

If positive:

- Referred to HIV/AIDS treatment clinic in Kapenguria (Tuesday/Wednesday), or to the nearest health center (see calendar posted at health facility for clinic dates).
- Asked to deliver baby in the nearest health center.

If negative:

- Provided with counseling for continued prevention – and periodic re-testing.

For the woman who is HIV+, PMTCT risk factors during [regnancy:

- High maternal viral load/ low CD4 (new or advanced HIV/AIDS)
- Viral, bacterial and parasitic placental infection (especially malaria)
- Vitamin A deficiency
- Sexually transmitted infections
- Maternal malnutrition (indirectly)
- Injecting drugs

PMTCT interventions during pregnancy

- Focused ANC

- Offer information on safer sex practices and HIV infection
- Improve nutritional status during pregnancy
- Screening and treatment
- ARV therapy to reduce maternal viral load
- NVP to mothers and baby who come in late stage of pregnancy
- Educate on infant feeding options
- Link counseling and testing services in ANC
  - Family planning
  - Disclosure counseling
  - Couple counseling
- Ensure adequate supervision for counseling and testing using quality assurance methods
- Promote PMTCT awareness and support in the community (community mobilization, home-based care, training TBAs, CHWs)

V. BENEFITS OF ANC and PMTCT-testing

1. Reduction of MTCT of HIV

- Reduced number of infected children
- Increased child health and survival
- Reduced burden on the health systems
- Reduce risk of transmission to TBAs during delivery

2. HIV Counseling and Testing

- Promotes behavioural change
- Reduces risky behaviour
- Identifies HIV discordant couples
- Increases dual family planning methods and prevention of STIs
- Improves ANC care
- Guiding infants feeding

3. Preventive Therapy

- Malaria chemo prophylaxis
- Opportunistic infections, pneumocystis carinae pneumonia
- TB

4. Promotes Access to Early Medical Care

- Obstetric care
- TB therapy
- Malaria treatment
- STI treatment
- ARV therapy to mothers and family (MTCT plus)

5. Helps Plan for the Future

- Infant feeding support system
- Family planning
- Personal and financial decisions

VI. MANAGEMENT OF LABOR AND DELIVERY IN WOMEN WHO ARE HIV INFECTED AND WOMEN OF UNKNOWN HIV STATUS

For HIV+ woman, MTCT risk factors during labor and delivery:

- High maternal viral load / low CD4 (new or advanced HIV/AIDS)
- HIV infection during pregnancy and breastfeeding
- Rupture of membranes more than four hours before labour begins
- Invasive delivery procedures
- First infant in multiple birth
- Chorioamnionitis (inflammation of membranes covering the foetus)
- Premature infants
- Genetic skin lesions or lesions on mucous membranes

Strategies to Reduce MTCT Risk in Women with Unknown HIV Status: (Another reason why it is important for women to give birth at the health center!)

Counselling and testing should be conducted in labour ward: confirm HIV status of all women who come to labour ward. In early labour provide counseling and testing services otherwise provide counseling and testing services post-delivery.

Also, clinicians in the labor ward should:

- Adhere to standard practice for delivery interventions
- Provide NVP dose within 4 hours before delivery and give baby syrup within 72 hours if not on TPMTCT
- Follow universal precautions
- Use partographs in monitoring labour
- Use invasive procedures minimally and judicially
    - Minimal use of VEs
    - Avoid unnecessary trauma e.g. episiotomy, foetal scalp monitoring
- Avoid prolonged labour
- Avoid premature ROM
- Minimize risk of post natal haemorrhage
- Conduct safe transfusion practices
- Conduct vaginal cleaning with Hibitane 0.25% (reduce puerperal and neonatal sepsis)
- Clamp cord immediately after birth and avoid milking the cord
- Use gauze to avoid spurting of blood while cutting the cord
- Critical Activities related to the baby include:
    - On delivery of the head, wipe baby's nostrils and mouth with gauze
    - Keep the baby warm
    - Wipe with Hibitane (0.25% warm) plus gauze
    - No suction unless very necessary
    - TEO 1%
    - Avoid breastfeeding if the mother is positive unless decision was made before hand

Summary of Interventions:

- Offer counselling and testing (Opt out) in labour ward
- Provide post test counseling
- Safe delivery practices
- ARV prophylaxis to mother and infant appropriately

VII. POST PARTUM CARE OF WOMEN WHO ARE HIV INFECTED AND WOMEN OF UNKNOWN HIV STATUS

Immediate Care of the Infants

- Clamp cord immediately after birth
- Do not milk cord
- Cover cord with gauze before cutting
- Wipe infants mouth and nostrils with gauze on delivery of the head
- Use suction minimally-only when meconum stained liquid is present
- Dry the infant and keep warm
- Determine the mother's feeding choice and act appropriately
- Administer VIT K, TEO
- Provide ARV prophylaxis according to protocol
- Encourage routine follow up for assessment PCP prophylaxis, testing and immunization

HIV infected women

- Postnatal examination
- Monitor status of postnatal infections i.e. fever, foul smelling lochia, cough, shortness of breath
- Monitoring and treatment of opportunistic infections, malaria and TB
- Refer to clinic for appropriate ARV treatment
- Counsel on infant feeding options and care
  - Support proper breastfeeding techniques (proper baby latching on oreolea)
  - If not breastfeeding-bind the breast firmly to limit milk production (give bromocriptine)
  - Demonstrate infant feeding with formula milk to those who opt not to breastfeed
- Reinforce couple counseling
- Reinforce safer sex practices and condom use
- Avoid sit baths use clean clothes soaked in saline
- Family planning counseling is vital (contraception use should be initiated 2-4 weeks postpartum)
  - HIV positive women can use all contraceptive methods
  - Dual method approach is recommended when on hormonal contraceptive
  - IUDs are not contraindicated in HIV positive women, however when the woman is immuno-suppressed, IUDs increases the risk of infection
- Schedule postnatal visits

Unknown status

- Counselling and testing
- Providing information on HIV and a known status will assist the woman to choose safer infant feeding options
- Initiate ARV prophylaxis for infant
- Provide access to HIV treatment and care for mother

VIII. INFANT FEEDING OPTIONS FOR MOTHERS WHO ARE HIV INFECTED

For HIV+ mother, MTCT risk factors during breastfeeding

- High maternal viral load (new or advanced HIV/AIDS)
- Duration of breastfeeding
- Early mixed feeding of infant (breast milk with replacement feeding)
- Breast abscesses/ inflammation or cracked nipples
- Maternal malnutrition
- Infant oral diseases e.g. thrush, mouth sores

Her options include:

1. **Exclusive Breast Feeding with early Cessation (3 months)**

   Exclusive breastfeeding is a safe feeding option when replacement feeding is *not*

   - Acceptable
   - Feasible
   - Affordable
   - Sustainable
   - Safe

   Advantages

   - Easily digestible
   - Nutritious, complete
   - Always available
   - No special preparation needed
   - Reduces mother's risk of breast cancer
   - Increases birth spacing
   - Protects from diarrhoea, pneumonia, other infections/diseases
   - Promotes bonding

   Disadvantages

   - Risk of passing HIV to baby
   - Increased risk if mother has breast infection
   - Increases risk of death in immuno-suppressed women
   - Mother requires additional calories to support breastfeeding
   - Requires feeding on demand

2. **Replacement Feeding (6 months)**

   Replacement feeding is defined as feeding infants who would otherwise receive breast milk with a diet that provides most of the nutrients that infants need until the age at which they can be fully fed on family foods.

   Advantages

   - Poses no risk of transmitting HIV to the infant
   - Made specially for infants
   - Other family members can help feed infants
   - Has all nutrients that an infant needs.
   - If mother falls ill, others can feed her infant while she recovers

Disadvantages

- Does not contain anti-bodies which protect infant from infection
- Expensive
- Likely-hood of diarrhea diseases and pneumonia
- Continuous reliable formula supply needed to prevent malnutrition
- Soap, clean water needed
- Boil vigorously for 1-2 seconds thus requires fuel
- Each feeding may need to made at night
- Cup feeding takes time to learn
- Must stop breastfeeding completely or risk of HIV transmission will continue
- A mother who does not BF may be questioned about her HIV status
- Formula feeding offers the mother no protection from pregnancy

***NB:* Nan Pelargon formula is the preferred replacement feed in the AMPATH PMTCT which is given as an option for infant feeding. It is free and provided for up to 6 months.**

3. Home modified animal milk

Advantages

- Presents no risk of HIV transmission
- Less expensive than commercial and readily available
- Can be used when commercial formula is not available
- Other family members may help fed the infant
- If mother is sick others can help feed as she recovers

Disadvantages

- No antibodies
- Lack of all nutrients, micronutrients that infants need in the first 6months of life
- Must be diluted with clean water, boiled vigorously and sugar added in correct amounts
- Day and night feed preparations
- More difficult for infant to digest
- Likelihood of diarrhoea and pneumonia-malnutrition
- Frequent supply of animal milk, sugar, multivitamins, fuel for boiling water, soap and utensils
- Cup feeding takes time to learn
- Mother may be questioned of HIV status
- Offers no protection from pregnancy

***NB*: Infants need15 litres of modified animal milk per month for the first 6 months**

IX. THE ROLE OF TBAs IN PMTCT

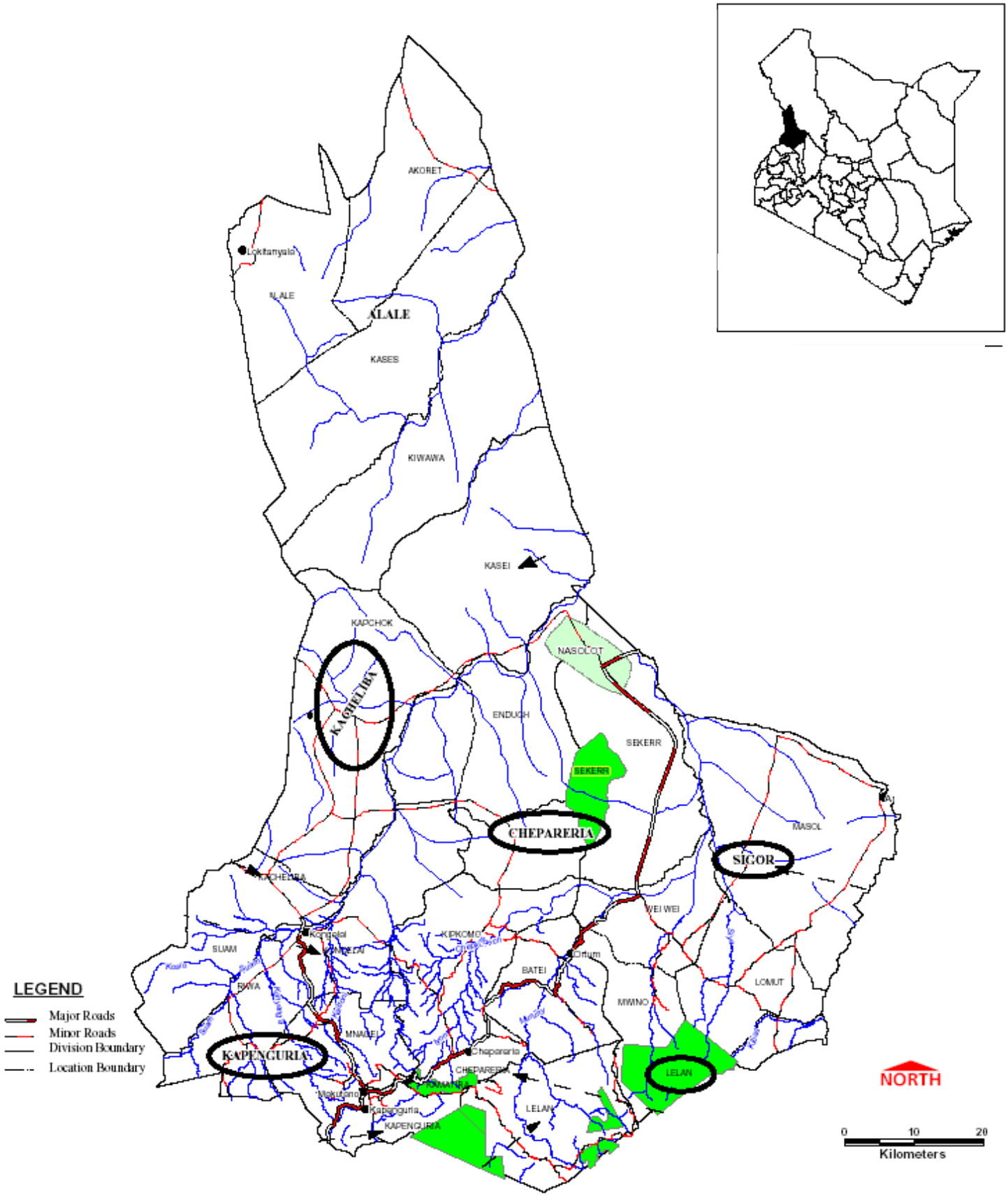
- Health education in the community
- Referral of women and encourage support from men for ANC/PMTCT
- Referral of women and encourage support from men for delivery in the health facility
- Referral of men for HIV counseling and testing; couple counseling
- Role model in accepting HIV+ individuals in the community: reduction of stigma

Sample Training Agenda:

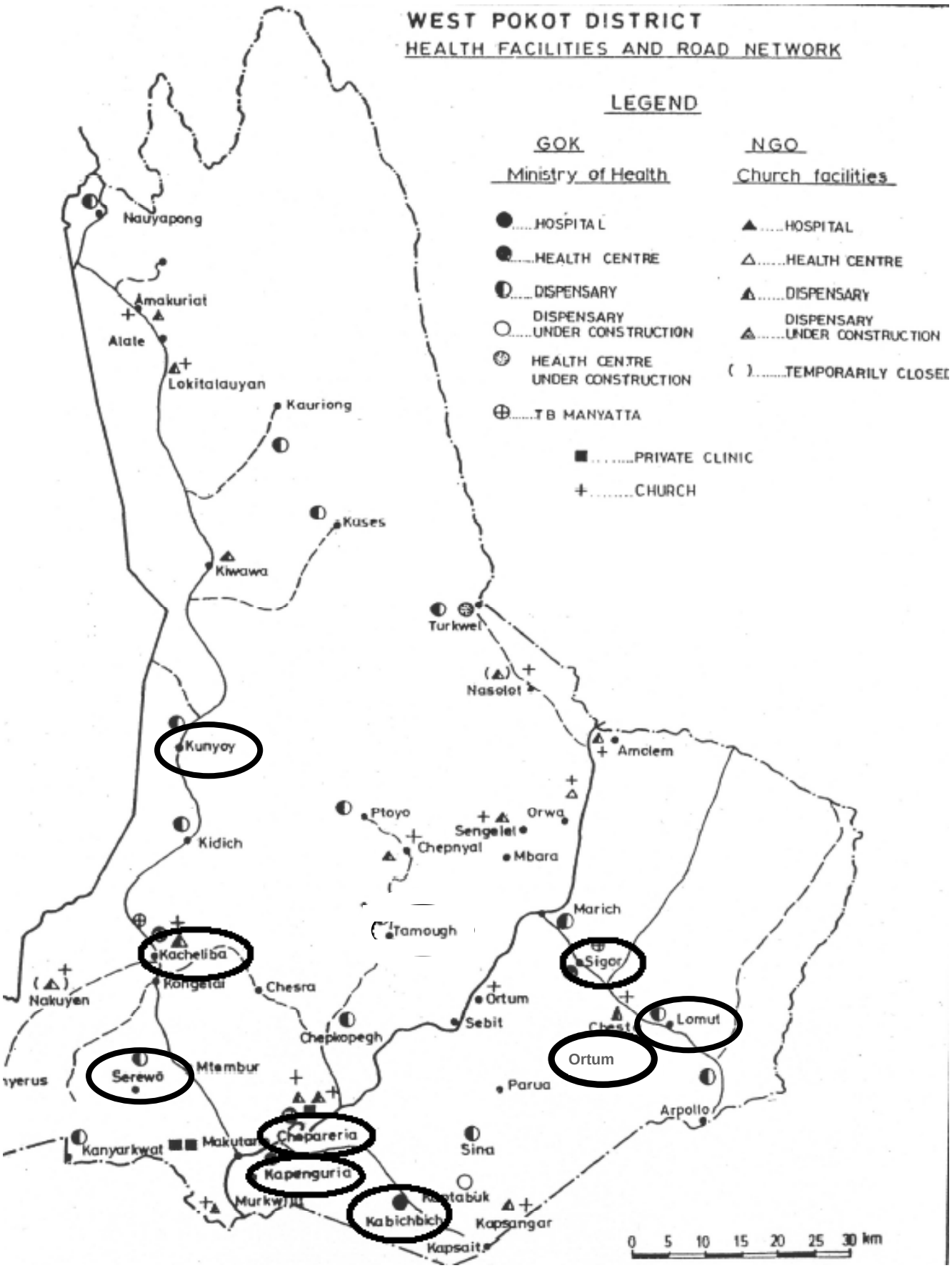
PMTCT Refresher Course

TIME	TOPIC/SESSION
8:30 - 9:00 AM	Introductions
9:00 - 9:30 AM	Review of HIV/AIDS: General Knowledge
9:30 -10:30 AM	• What is PMTCT – Review • PMTCT and risk of transmission to health care workers
10:30 - 11:30 AM	• PMTCT at the health facility: testing and treatment • Benefits OF ANC and PMTCT-testing
11:30 - 11:45 AM	Tea Break
11:45 AM - 12:45 PM	Management of labor and delivery in women who are HIV-infected and women of unknown HIV status
12:45 - 1:45 PM	Post-partum care of women who are HIV-infected and women of unkonown HIV status
1:45 - 2:45 PM	Infant feeding options for mothers who are HIV-infected
2:45 - 3:15 PM	The role of TBAs in PMTCT
3:15 PM	Closing; departure

WEST POKOT DISTRICT



Annex 7: Maps of Program Area



NOTE: Divisions and Focus Health Facilities in the proposed program location are circled.

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 8:
Project Budget and Budget Narrative

Doctors of the World-USA
Partnership for Maternal and Neonatal Health -
West Pokot District Child Survival and Health Program

BUDGET NARRATIVE

The following narrative is an explanation of line items in the project budget. An inflation factor of 3.0% has been added for Years 2, 3 and 4 of the project.

Headquarters Staff $259,401 $172,911 USAID funds $86,490 Cost Share

Program Director/HQ Technical Backstop: 0.05 FTE for all years of the project; oversees program activities and development; provides MCH and HIV/AIDS technical assistance to the CSH Project Director; serves as technical support to the CSH staff; and liaises with USAID/CSHGP. DOW is seeking outside funding for these costs.

Program Manager/M&E Specialist: 0.30 FTE for all years of the project; will provide headquarters project support and oversee project management staff in the field including the CSH Project Director. Liaises with donors and other PVOs implementing programs in similar technical/regional areas. DOW is seeking USAID support for 100% of this cost.

Program Associate: 0.30 FTE for all years of the project; undertakes research related to program development, supervises interns, handles travel arrangements and other logistics. DOW is seeking USAID support for 100% of this cost.

Grants Manager: 0.10 FTE for all years; responsible for ensuring compliance of grant activities with approved DIP and USAID cooperative agreement regulations; coordinates resource mobilization for cost share and grant activities; and assists with all reporting. DOW is seeking outside funding for these costs.

Finance Manager: 0.10 FTE for all years; provides direct support to the field Accountant regarding budget management and reporting, procurement policies and procedures, and banking and funds management. DOW is seeking outside funding for these costs.

Headquarters Staff Benefits: calculated at 21% of total salary expense. Fringe benefits include health insurance, employer contributions to social security and retirement plans, employment taxes, life insurance, workers compensation, and medical evacuation coverage while abroad. DOW is seeking USAID funding to cover 50% of these costs.

International Staff $29,427 $0 USAID funds $29,427 Cost Share

HIV/AIDS Project Director - Kenya: 0.10 FTE for all years; will provide management and oversight of PMTCT and HIV/AIDS trainings and coordination of local partner relations. Will build project capacity and offer M&E support and guidance. Builds project human

resource capacity, including training staff working on HIV/AIDS issues. DOW has secured outside funding for the allocated portion of this position.

International Staff Benefits: Benefits are estimated at 28% of International Staff Salaries. Fringe benefits include health insurance, employer contributions to social security and retirement plans, employment taxes, life insurance, workers compensation, and medical evacuation coverage. DOW is seeking outside funding for these expenses.

National Staff $465,605 $349,204 USAID funds $116,401 Cost Share

CSH Project Director - Kenya: 0.75 FTE for year one and 1.0 FTE for years 2, 3, and 4; will provide management of the entire project including regional and local donor and partner relations; relations with pertinent government agencies; in-country budget and expense management; new project planning; ongoing M&E; local human resources management and performance evaluations; and maintenance of project timelines and schedules. Builds project human resources capacity, including training of key staff. Serves as liaison with governmental agencies and other partners. DOW is seeking 75% support from USAID for this position.

Technical Director/Training Coordinator: 0.50 FTE for Year 1 and 1.00 FTE for Years 2, 3 and 4; will provide oversight for the development of curricula and coordination and implementation of all training for the project. The Technical Director/Training Coordinator is responsible for overall management of all Doctors of the World trainings and workshops in the region. DOW is seeking 75% support from USAID for the allocated portion of this position.

BCC Coordinator: 0.50 FTE for Year 1 and 1.00 FTE for Years 2, 3 and 4; will design and implement all BCC trainings and activities. Will liaise directly with partner CBOs and CHWs to coordinate BCC meetings in constituent communities. DOW is seeking 75% support from USAID for the allocated portion of this position.

M&E Coordinator: 0.75 FTE for year one and 1.0 FTE for years 2, 3, and 4; will oversee all monitoring and evaluation of DOW and partner organizations' projects; will manage the development of improved M&E protocols at focus health facilities; will help to design the baseline study; and is responsible for implementing new systems of M&E in accordance with the CSH work plan. DOW is seeking 75% support from USAID for the allocated portion of this position.

Mobile ANC Coordinator: 1.00 FTE for years 2, 3, and 4; will supervise the clinical ANC staff working to expand the coverage of ANC services throughout the district. This position will be filled by a clinician who can oversee other ANC staff providers and offer on-site QA/QI to health facility staff working on the mobile ANC units. DOW is seeking 75% support from USAID for the allocated portion of this position.

Project Assistant: 1.00 FTE for all years; is responsible for assistance to the Project Director and other project staff. Oversees day-to-day logistics, planning, and data

coordination with local public and NGO partners; manages logistics for DIP development and trainings; provides translation if necessary. DOW is requesting 75% support from USAID for the allocated portion of this position.

Community Health Extension Workers (CHEWs): Five positions at .5 FTE will begin the second half of year 2. Each CHEW will be responsible for coordinating the project's activities with CORPs(TBAs and CHWs) including organizing monthly meetings in collaboration with the DHMT where CORPs will report community health data (i.e. # of deliveries, malaria incidence, etc.) in his/her assigned district. DOW is seeking USAID support for 75% of the cost of this position.

Accountant: 0.50 FTE for all years of the project; will provide project-related bookkeeping and financial support to the project team; ensure financial and procurement procedures are followed, and manage payroll and tax filings related to the project. DOW is seeking USAID support for 75% of the cost of this position.

Drivers: Two drivers (1.00 FTE all years; and the other at 0.05 FTE in Year 1, and 1.0 FTE in years 2,3, and 4), to drive vehicles used for program development and community outreach; maintain vehicles and provide transportation for focus health facilities and consultants as needed. DOW is seeking USAID support for 75% of these costs.

National Staff Benefits: benefits are budgeted at 25% of yearly salaries. Benefits include housing, risk differential, medical and overtime allowances. DOW is seeking USAID support for 75% of the total costs of national staff benefits.

Consulting/Contractors $76,970 $38,485 USAID funds $38,485 Cost Share

Consultant Fees and Insurance: Local IT Support and Consulting: Six months in Year 1 and 12 months in Years 2, 3, and 4. This consultant will periodically come to the CSH office in Kapenguria to work on issues of networking, data collection, and other IT backstopping assistance. This service will cost $80/month. DOW is requesting 50% from USAID to cover these costs.

The Baseline Assessment consultant will be an International consultant responsible for managing and directing the baseline assessment done in Q2 of Year 1. Consultant fees of $350 per day for 25 days, and includes a $972 for international insurance, for a total cost of $9,722 are budgeted. DOW is requesting 50% from USAID to cover these costs.

A expert in Quality Improvement/Quality Assurance strategies will be contracted to conduct to provide expert advice on the implementation of the QI/QA systems at the project's targeted facilities. The QI/QA consultant will make one trip a year beginning Year 2, each for 15 days at a cost of $350 per day, totaling $15,750.

The Midterm and Endline Evaluation consultants will be International consultants responsible for managing and directing the Mid-term Evaluation to be done at the end of Year 2, and the Endline Evaluation to be conducted in Q3-4 of Year 4. The projected

budget consists of $500 per day for 15 days for the Midterm Evaluation consultant, and $500 per day for 25 days for the Final Evaluation Consultant plus an additional $486 per consultant for international insurance, for a total cost of $20,972 for both consultants. DOW is requesting 50% from USAID to cover these costs.

The Endline Health Facility Assessment (HFA) consultant will manage and direct the HFA to be done Year 4, Quarter 3-4. The consultant fees are budgeted at $500 per day for 10 days plus an additional $486 for international insurance, for a total cost of $5, 486. DOW is requesting 50% from USAID to cover these costs.

Baseline KPC and KAPB Surveys: conducted during the Quarter 2 of Year 1 at a cost of $8,000 to establish baseline data and information through survey and data collection from focus health facilities, the Department of Health, constituent communities and local CBOs. DOW is requesting 50% from USAID to cover these costs.

Midterm and End line KPC and KAPB Surveys: conducted during Quarter 3 of Year 2 and Quarters 3-4 of Year 4 at a cost of $4,000 in Year 2, and $6,000 in Year 4 to collect information to determine the midterm and end line status of program indicators in order to measure the impact of the project upon constituent communities and focus health facilities. DOW is requesting 50% from USAID to cover these costs.

Professional Fees $25,498 $12,749 USAID funds $12,749 Cost Share

Legal: Consultants will provide assistance to the organization in finalizing contracts and MOUs and advising on taxation issues. Costs for Legal services have been budgeted at $600 per year. DOW seeks funding from USAID to cover 50% of these costs.

Audit: Professional services have been budgeted at $5,500 per year. DOW seeks funding from USAID to cover 50% of these costs.

Rent/Utilities/Maintenance $15,335 $11,501 USAID funds $3,834 Cost Share

Office Rent and Security: Rent is budgeted to accommodate the office staff and provide a location for project meetings and a base for consultants to work. Rent costs are budgeted at $1,800 for years 1 & 2 and $2,400 for years 3 and 4. DOW seeks funding from USAID to cover 75% of these costs.

Cleaning/Maintenance/Utilities: This line item has been budgeted at $1,560 per year for cleaning, maintenance, security, and utilities for the office space. DOW seeks funding from USAID to cover 75% of these costs.

Materials/Supplies $50,420 $25,210 USAID funds $25,210 Cost Share

Printing and photocopying: General office printing and photocopying is budgeted at $266 per month, or $3,200 per year, including copies of training materials. DOW seeks funding from USAID to cover 50% of these costs.

Office Supplies: Office supplies are budgeted at $100 per month, or $1,200 per year; this amount covers paper, filing folders, pens, pencils, printer cartridges, and other general office supplies. DOW seeks funding from USAID to cover 50% of these costs.

Medical Supplies and Pharmaceuticals: This line item includes equipment to outfit two Mobile Outreach vehicles, sterilizers, oxygen cylinders, face masks, delivery beds, suction pumps, safe delivery packs, gloves, exam tables and medical furniture and replacement of various equipment, for a total of $21,668 in Medical Supplies. DOW seeks funding from USAID to cover 50% of these costs.

Renovation/Rehabilitation Materials: Renovation materials needed to rehabilitate focus health facilities, including hospital, health centers, and dispensaries at a total cost of $12,360. The work will consist of painting and repairs and simple renovation. DOW seeks funding from USAID to cover 50% of these costs.

Equipment/Furniture $209,316 $121,316 USAID funds $88,000 Cost Share

Equipment, Furniture Under $5,000: This line item includes two fax / printer combinations for office at a total cost of $1,000; six desktop computers for the office staff at $1,000 each; one digital camera at a cost of $500; installation of three landlines at $150 each, for a total of $450; software for the new computers and renewal of antivirus software at a total of $3,600; and office furnishing at a total budgeted cost of $2,800. USAID funding is sought for 100% of these costs.

Vehicle Purchase – Cost Share: DOW will purchase one 4x4 vehicles in Year 1 for $38,000. This vehicle will be used for staff and consultant transportation. DOW will use cost share funds for the purchase of this vehicle.

Vehicle Purchase – USAID funds: Three 4x4 vehicles capable of transporting several CHEWs and patients will be purchased at a cost of $50,000 each, two in year 2 and one in year 3. DOW seeks USAID funding for two of these vehicles.

Vehicle Fuel/Maintenance/Fees $51,426 $51,426 USAID funds $0 Cost Share

Vehicle fuel: Based on costs provided by our Kenya program staff, fuel costs are estimated at $136 per vehicle per month. DOW will pay fuel for three vehicles for the life of the project, and for the two additional vehicles through the first half of Year 4. In the second half of Year 4, it is expected that the Kenya Ministry of Health will pay for the fuel for two of the vehicles that will be transitioned to the local health authorities for continued project work. USAID funding is requested for 100% of this cost.

Vehicle Maintenance: Based on costs provided by our Kenya program staff, DOW has estimated maintenance costs at $47 per month per. DOW will pay maintenance for three vehicles for the life of the project, and the two additional vehicles through the first half of Year 4. In the second half of Year 4, it is expected that the Kenya Ministry of Health will

pay for the fuel for two of the vehicles that will be transitioned to the local health authorities for continued project work. USAID funding is requested for 100% of this cost.

Vehicle Fees/Taxes: Total vehicle insurance have been budgeted at $1,000 per vehicle per year, in accordance with estimates made by local PVO partners in Kenya. Initial registration of the vehicles is budgeted at $66 per vehicle. USAID funding is requested for 100% of these costs.

Travel: $122,816 $92,112 USAID funds $30,704 Cost Share

In-Country Regional Travel: This budget item is for travel of Kenya staff to meetings in Nairobi with USAID and other partners – six trips per year for one traveler, of four days each ($350 for travel, $150 per diem for lodging and meals). The budget also includes a yearly exchange trip for one person to visit other Kenya PVO CSH Projects budgeted at $850 per trip per year. Additional regional travel is planned for the DOW HQ Program Manager to attend meetings in Washington DC twice each year in years 2, 3, and 4 for two days each trip ($1,340 per trip). In Year 1, two DC trips are planned for the HQ Program Manager to attend the backstop institute and the mini-university/DIP review ($1,000 for each trip). DOW is seeking USAID funding to cover 75% of these travel costs.

International Travel: This line item includes one visit in year 1, three visits in year 2 and 4 and two visits in year 3 for monitoring by the HQ Program Manager and/or Program Director ($3,850 per trip); bi-yearly Management and Oversight trips in Years 1 and 3 ($3,850 per trip); one Baseline Research Consultant visit in Year 1 at a total cost of $7,900); Midterm and Final Evaluation Consultant visits in Years 2 and 4 ($4,530 per trip); one trip for the Endline Health Facility Assessment consultant and the HQ Program Manager who will be accompanying him/her at $9500; two trips in Year 1 for the CSH Project Director to attend the backstop institute and the mini-university/DIP review and meetings in NY ($5,725 per trip); and one trip for international staff to HQ in New York (at $5,850). Travel costs include International airfare from the US to Kenya ($2,000-$2,400 per trip), Lodging and meals (average $100/night in Kenya), Visas ($50 per visit in Kenya), and local travel ($400 within Kenya and to/from airports). DOW is seeking USAID funding to cover 75% of these travel costs.

Communications/Postage $37,620 $28,,604 USAID funds $9,405 Cost Share

Postage and Delivery: Postage and courier charges for operations are budgeted at $1,200 per year. This includes the cost of courier charges incurred from DOW's NY headquarters for materials sent to Kenya and back, as well as project-related materials exchanged with Consultants, partners, and funders. DOW requests USAID funding for 75% of these costs.

Telephone: Project-related telephone charges are estimated at $350 per month, including national and international calls and cellular phone charges, for a total of $4,200 per year. DOW requests USAID funding for 75% of these costs.

Internet Service/Email: Internet and email service is budgeted at $300 per month. DOW requests USAID funding for 75% of these costs.

Trainings/Workshops $289,515 $274,192 USAID funds $15,323 Cost Share

Details of Training/Workshops appear in the budget details showing the individual cost of each training included in the project work plan (number of projected attendees, number of trainings per year, number of days, costs for materials, stipends, supplies, etc.).

Travel including Lodging/Per Diems: This will cover the regional transport costs associated with the trainings of staff at focus health facilities, dispensaries and outreach clinics, as well as local community health workers, traditional birth attendants, chiefs and other constituents. Costs include travel costs for participants and trainers and all lodging during multi-day training classes. USAID funding is requested for 100% of these costs.

Meals and Refreshments Provided: This line item will cover the costs of meals and refreshments associated with all trainings for the health workers, nurses, hospital and clinic staff, traditional birth attendants, community health workers, chiefs and other constituents. USAID funding is requested for 100% of these costs.

Training/Conference Space: Space will be rented for many of the training programs and workshops. Whenever possible, local clinics will be used as venues for training ($4,087). USAID funding is requested for 100% of these costs.

Fees/Stipends: This line item covers stipends for health workers, nurses, hospital and clinic staff, traditional birth attendants, community health workers, chiefs, local trainers and other constituents. DOW is requesting USAID funding for 100% of these costs.

Supplies and Materials: This line item will cover the cost of KPC reports and final evaluations to be distributed to project stakeholders as well as all curricula developed and distributed to trainees. USAID funding is requested for 75% of these costs.

Additional Training Resources and Materials: This line item covers one time training supplies such as anatomical models, easels and other unforeseen expenses. USAID funding is requested for 75% of these costs.

Other Program Expenses $76, 603 $34,121 USAID funds $42,481 Cost Share

Meeting Coordination and Supplies: This line item ($30,083 after adjusting for inflation) includes all supplies and logistical support needed to facilitate monthly and quarterly monitoring meetings for TBAs and CHWs. Also covered under this line item will be an event held in Year 1 to officially announce the launch of the project to the target community and stakeholders. The cost of this event is budgeted at $2,500. USAID funding is requested for 50% of these costs.

Vouchers for Safe Delivery: A system will be set up to supply community-Health Workers traveling to monitoring meetings and pregnant women with travel stipends and vouchers to cover the cost of transit to and from health facilities. $38,160 is budgeted (after accounting for inflation). DOW is requesting USAID funding for 50% of these costs.

Insecticide-Treated Bednet Distribution Program: This line item ($8,360) will cover the costs of purchasing supplies and implementing a program for ITN distribution to pregnant women. DOW will utilize cost share funding for 100% of this cost.

Other Expenses	**$4,445**	**$0 USAID funds**	**$4,445 Cost Share**

Recruiting for Field Positions: Recruiting expenses will be incurred at a rate of $3,000 in Year 1 and 1,445 in Year 2. DOW will utilize cost share funding for 100% of this cost.

Fees, Charges, Taxes	**$2,508**	**$349 USAID funds**	**$2,160 Cost Share**

Bank Charges: Bank charges associated with financial transactions relating to the project are budgeted at approximately $50 per month at a total of $600 per year. This covers the cost of transferring funds from DOW in New York to Kenyan bank accounts and the cost of maintaining accounts in Kenya. DOW is seeking USAID support for 66% of these expenses.

INDIRECT COSTS

Total Indirect	**$404,514**	**$286,898 USAID funds**	**$117,616 Cost Share**

Our current NICRA is 23.65%.

COST SHARE

Total Costs	**$2,114,933**	**$1,500,000 USAID funds**	**$614,933 Cost Share**

DOW will seek support in addition to the USAID award amount to secure the funds necessary for the implementation of the project as outlined. This is a 29% cost share for this project.

PROCUREMENT PLAN

DOW is attentive to the need for strict compliance with the guidelines, rules, policies, and contractual requirements established by each of our donor institutions. For procurements with USAID financing, we strictly adhere to the source and supply guidelines stated in 22 CFR 228.

When a procurement request is made, DOW obtains the necessary price quotations and any additional information required for USAID financing. Our internal policy is to request at least three (3) competitive bids, in writing, for all items over US$2,500. For items under US$2,500, DOW requests a written price quotation from an experienced and

qualified vendor, in good standing, from our vendors list. These vendors are rotated and routine price analyses of their bids are performed to ensure best value for money.

All purchases require at least two levels of approval at the field level, and purchases of $2,500 or more require the further approval of the DOW Program Manager or Director of Finance and Administration.

In all instances, procurement and logistics services performed by DOW take into consideration adequate quantities, reasonable prices, timely delivery, desired specifications, and best value.

Doctors of the World-USA

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

Four-Year Project Budget in USAID Categories

Program Budget by USAID Budget Categories

	Year 1	Year 2	Year 3	Year 4	Total
Personnel	$ 102,200	$ 165,135	$ 169,150	$ 173,528	$ 610,012
Fringe Benefits	23,616	39,292	40,238	41,274	144,420
Travel	50,950	24,401	20,553	26,912	122,816
Equipment	47,700	107,326	53,636	654	209,316
Supplies and Materials	2,400	30,480	11,055	6,486	50,420
Contractual	18,202	18,742	6,583	33,443	76,970
Training	62,580	111,621	113,134	2,180	289,515
Other Direct Costs	29,412	58,816	65,247	59,959	213,434
Indirect Costs	79,715	131,450	113,424	81,459	406,048
Total Program Costs	**$ 416,775**	**$ 687,262**	**$ 593,019**	**$ 425,895**	**$ 2,122,951**
USAID Share	$ 295,791	$ 483,162	$ 434,619	$ 286,428	$ 1,500,000
Non Federal Share	$ 120,985	$ 204,100	$ 158,400	$ 139,467	$ 622,951
Total	**$ 416,775**	**$ 687,262**	**$ 593,019**	**$ 425,895**	**$ 2,122,951**

Doctors of the World-USA

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

Four Year Budget: Oct. 2006 - Sept. 2010

			Inflation 3%		Inflation 3%		Inflation 3%			ALLOCATIONS BY FUNDER		
	Year 1	Year 2	Year 2 Adjusted	Year 3	Year 3 Adjusted	Year 4	Year 4 Adjusted	TOTAL	Inflation Adjusted Total	USAID	Cost Share	
Headquarters Staff												
Program Director @ 0.05 FTE	$ 4,725	$ 4,725	$ 4,867	$ 4,725	$ 5,009	$ 4,725	$ 5,150	$ 18,900	$ 19,751	$ -	$ 19,751	0%
Program Manager/M&E Specialist @ 0.30 FTE	22,500	22,500	23,175	22,500	23,850	22,500	24,525	90,000	94,050	94,050	-	100%
Program Associate @ 0.25 FTE	13,500	13,500	13,905	13,500	14,310	13,500	14,715	54,000	56,430	56,430	-	100%
Grants Manager @ 0.1 FTE	5,600	5,600	5,768	5,600	5,936	5,600	6,104	22,400	23,408	-	23,408	0%
Finance Manager @ 0.1 FTE	5,000	5,000	5,150	5,000	5,300	5,000	5,450	20,000	20,900	-	20,900	0%
HQ Staff Benefits @ 21% of salaries	10,733	10,733	11,055	10,733	11,377	10,733	11,699	42,930	44,862	22,431	22,431	50%
TOTAL HQ STAFF	**$ 62,058**	**$ 62,058**	**$ 63,919**	**$ 62,058**	**$ 65,781**	**$ 62,058**	**$ 67,643**	**$ 248,230**	**$ 259,401**	**$ 172,911**	**$ 86,490**	
International Staff												
HIV AIDS Project Director - Kenya @ .1 FTE	5,500	5,500	5,665	5,500	5,830	5,500	5,995	22,000	22,990	-	22,990	0%
International Staff Benefits @ 30% of salaries	1,540	1,540	1,586	1,540	1,632	1,540	1,679	6,160	6,437	-	6,437	0%
TOTAL INTERNATIONAL STAFF	**$ 7,040**	**$ 7,040**	**$ 7,251**	**$ 7,040**	**$ 7,462**	**$ 7,040**	**$ 7,674**	**$ 28,160**	**$ 29,427**	**$ -**	**$ 29,427**	
National Staff - Kenya			-									
CSH Project Director - Kenya @ 1.0 FTE	16,875	30,000	30,900	30,000	31,800	30,000	32,700	106,875	112,275	$ 84,206	$ 28,069	75%
Training Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	5,000	20,000	20,600	20,000	21,200	20,000	21,800	65,000	68,600	51,450	17,150	75%
BCC Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	4,000	8,000	8,240	8,000	8,480	8,000	8,720	28,000	29,440	22,080	7,360	75%
M&E Coordinator @.75 FTE Y1, 1.0 FTE Yrs 2-4	9,000	16,000	16,480	16,000	16,960	16,000	17,440	57,000	59,880	44,910	14,970	75%
Mobile ANC Coodinator @ 1.0 FTE	-	8,000	8,240	8,000	8,480	8,000	8,720	24,000	25,440	19,080	6,360	75%
Project Assistant @ 1.0 FTE	4,000	4,000	4,120	4,000	4,240	4,000	4,360	16,000	16,720	12,540	4,180	75%
Accountant @ .5 FTE	-	1,500	1,545	750	795	375	409	2,625	2,749	2,062	687	75%
Driver @ 1.0 FTE	1,500	4,000	4,120	4,000	4,240	4,000	4,360	13,500	14,220	10,665	3,555	75%
Driver @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	4,000	4,000	4,120	4,000	4,240	4,000	4,360	16,000	16,720	12,540	4,180	75%
Community Health Extension Worker (5) .5 FTE	1,000	8,000	8,240	8,000	8,480	8,000	8,720	25,000	26,440	19,830	6,610	75%
National Staff Benefits @ 25% of salaries	11,344	25,875	26,651	25,688	27,229	25,594	27,897	88,500	93,121	69,841	23,280	75%
TOTAL NATIONAL STAFF	**$ 56,719**	**$ 129,375**	**$ 133,256**	**$ 128,438**	**$ 136,144**	**$ 127,969**	**$ 139,486**	**$ 442,500**	**$ 465,605**	**$ 349,204**	**$ 116,401**	
Consulting/Contractors												
Local IT Support and Consulting	480	960	989	960	1,018	960	1,046	3,360	3,533	1,766	1,766	50%
Program Consultants stipends/fees	8,750	12,750	13,133	5,250	5,565	22,750	24,798	49,500	52,245	26,123	26,123	50%
Insurance for Consultants/Volunteers	972	486	501	-	-	972	1,059	2,430	2,532	1,266	1,266	50%
Other Consulting/Contracting												
Baseline KPC and KAPB Surveys	8,000		-	-	-		-	8,000	8,000	4,000	4,000	50%
Midterm / Endline KPC and KAPB Surveys		4,000	4,120	-	-	6,000	6,540	10,000	10,660	5,330	5,330	50%
TOTAL CONSULTING / CONTRACTORS	**$ 18,202**	**$ 18,196**	**$ 18,742**	**$ 6,210**	**$ 6,583**	**$ 30,682**	**$ 33,443**	**$ 73,290**	**$ 76,970**	**$ 38,485**	**$ 38,485**	

Doctors of the World-USA

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

Four Year Budget: Oct. 2006 - Sept. 2010

	Year 1	Year 2	Year 2 Adjusted	Year 3	Year 3 Adjusted	Year 4	Year 4 Adjusted	TOTAL	Inflation Adjusted Total	USAID	Cost Share	
Professional Fees												
Legal	$ 600	$ 600	$ 618	$ 600	$ 636	$ 600	$ 654	$ 2,400	$ 2,508	$ 1,254	$ 1,254	50%
Audit (local and international)	5,500	5,500	5,665	5,500	5,830	5,500	5,995	22,000	22,990	11,495	11,495	50%
TOTAL PROFESSIONAL FEES	**$ 6,100**	**$ 6,100**	**$ 6,283**	**$ 6,100**	**$ 6,466**	**$ 6,100**	**$ 6,649**	**$ 24,400**	**$ 25,498**	**$ 12,749**	**$ 12,749**	
Rent, Utilities, Cleaning, Maintenance, etc.												
Office Rent	$ 1,800	$ 1,800	$ 1,854	$ 2,400	$ 2,544	$ 2,400	$ 2,616	$ 8,400	$ 8,814	$ 6,611	$ 2,204	75%
Cleaning/Maintenance/Utilities/Security	1,560	1,560	1,607	1,560	1,654	1,560	1,700	6,240	6,521	4,891	1,630	75%
TOTAL RENT, CLEANING, MAINT.	**$ 3,360**	**$ 3,360**	**$ 3,461**	**$ 3,960**	**$ 4,198**	**$ 3,960**	**$ 4,316**	**$ 14,640**	**$ 15,335**	**$ 11,501**	**$ 3,834**	
Materials and Supplies												
Printing and Photocopying	1,200	$ 3,200	$ 3,296	$ 3,200	$ 3,392	$ 3,200	$ 3,488	$ 10,800	$ 11,376	$ 5,688	$ 5,688	50%
Office Supplies	1,200	1,200	1,236	1,200	1,272	1,200	1,308	4,800	5,016	2,508	2,508	50%
Medical Supplies/Pharmaceuticals	-	13,192	13,588	6,029	6,391	1,550	1,690	20,771	21,668	10,834	10,834	50%
Renovation/Rehabilitation Materials		12,000	12,360		-		-	12,000	12,360	6,180	6,180	50%
TOTAL MATERIALS/SUPPLIES	**$ 2,400**	**$ 29,592**	**$ 30,480**	**$ 10,429**	**$ 11,055**	**$ 5,950**	**$ 6,486**	**$ 48,371**	**$ 50,420**	**$ 25,210**	**$ 25,210**	
Equipment, Furniture, Vehicles												
Equipment, Furniture Under $5,000	9,700	4,200	4,326	600	636	600	654	15,100	15,316	$ 15,316	$ -	100%
Vehicles	38,000	100,000	103,000	50,000	53,000	-	-	188,000	194,000	106,000	88,000	55%
TOTAL EQUIPMENT, FURNITURE, VEHICLES	**$ 47,700**	**$ 104,200**	**$ 107,326**	**$ 50,600**	**$ 53,636**	**$ 600**	**$ 654**	**$ 203,100**	**$ 209,316**	**$ 121,316**	**$ 88,000**	
Vehicle Fuel and Maintenance		3		4		2.5						
Vehicle Fuel	$ 1,120	$ 7,360	$ 7,581	$ 10,480	$ 11,109	$ 5,800	$ 6,322	$ 24,760	$ 26,132	$ 26,132	$ -	100%
Vehicle Maintenance	200	2,600	2,678	3,800	4,028	2,000	2,180	8,600	9,086	9,086	-	100%
Vehicle Fees / Taxes / Insurance	1,132	4,132	4,256	5,066	5,370	5,000	5,450	15,330	16,208	16,208	-	100%
TOTAL VEHICLE FUEL AND MAINTENANCE	**$ 2,452**	**$ 14,092**	**$ 14,515**	**$ 19,346**	**$ 20,507**	**$ 12,800**	**$ 13,952**	**$ 48,690**	**$ 51,426**	**$ 51,426**	**$ -**	
Travel for Staff and Consultants												
In-Country/Regional Travel	8,550	7,890	8,127	7,890	8,363	7,890	8,600	32,220	33,640	25,230	8,410	75%
International Travel	42,400	15,800	16,274	11,500	12,190	16,800	18,312	86,500	89,176	66,882	22,294	75%
TOTAL TRAVEL - STAFF AND CONSULTANTS	**$ 50,950**	**$ 23,690**	**$ 24,401**	**$ 19,390**	**$ 20,553**	**$ 24,690**	**$ 26,912**	**$ 118,720**	**$ 122,816**	**$ 92,112**	**$ 30,704**	
Communications & Postage												
Postage & Delivery	$ 1,200	$ 1,200	$ 1,236	$ 1,200	$ 1,272	$ 1,200	$ 1,308	$ 4,800	$ 5,016	$ 3,762	$ 1,254	75%
Telephone	4,200	4,200	4,326	4,200	4,452	4,200	4,578	16,800	17,556	13,167	4,389	75%
Internet Service/Email	3,600	3,600	3,708	3,600	3,816	3,600	3,924	14,400	15,048	11,286	3,762	75%
TOTAL COMMUNICATIONS	**$ 9,000**	**$ 9,000**	**$ 9,270**	**$ 9,000**	**$ 9,540**	**$ 9,000**	**$ 9,810**	**$ 36,000**	**$ 37,620**	**$ 28,215**	**$ 9,405**	

Doctors of the World-USA

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

Four Year Budget: Oct. 2006 - Sept. 2010

	Year 1	Year 2	Year 2 Adjusted	Year 3	Year 3 Adjusted	Year 4	Year 4 Adjusted	TOTAL	Inflation Adjusted Total	USAID	Cost Share	
Training / Conferences organized by DOW												
Travel including Lodging/Per Diems	$ 13,360	$ 22,130	22,794	$ 24,970	26,468	-	-	60,460	62,622	62,622	-	100%
Meals and Refreshments Provided	18,920	36,150	37,235	24,630	26,108	-	-	79,700	82,262	82,262	-	100%
Conference / Training Space	1,040	2,520	2,596	1,040	1,102	-	-	4,600	4,738	4,738	-	100%
Fees / Stipends	17,800	27,640	28,469	30,500	32,330	-	-	75,940	78,599	78,599	-	100%
Supplies and Materials	9,460	12,930	13,318	18,590	19,705	-	-	40,980	42,483	31,862	10,621	75%
Add'l training resources and materials	2,000	7,000	7,210	7,000	7,420	2,000	2,180	18,000	18,810	14,108	4,703	75%
TOTAL TRAINING	**$ 62,580**	**$ 108,370**	**$ 111,621**	**$ 106,730**	**$ 113,134**	**$ 2,000**	**$ 2,180**	**$ 279,680**	**$ 289,515**	**$ 274,192**	**$ 15,323**	
Other Program Expenses												
Meeting Coordination and Supplies	$ 2,900	$ 8,548	$ 8,804	$ 8,548	$ 9,061	$ 8,548	$ 9,317	$ 28,544	$ 30,083	$ 15,041	$ 15,041	50%
Vouchers for Safe Delivery		12,000	12,360	12,000	12,720	12,000	13,080	36,000	38,160	19,080	19,080	50%
Insecticide-Treated Bednet Distribution Program	2,000	2,000	2,060	2,000	2,120	2,000	2,180	8,000	8,360	-	8,360	0%
TOTAL OTHER PROGRAM EXPENSES	**$ 4,900**	**$ 22,548**	**$ 23,224**	**$ 22,548**	**$ 23,901**	**$ 22,548**	**$ 24,577**	**$ 72,544**	**$ 76,603**	**$ 34,121**	**$ 42,481**	
Other Expenses												
Recruiting for Field positions	3,000	1,403	1,445		-		-	4,403	4,445	-	4,445	0%
TOTAL OTHER EXPENSES	**$ 3,000**	**$ 1,403**	**$ 1,445**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,403**	**$ 4,445**	**$ -**	**$ 4,445**	
Fees, Charges, Taxes												
Bank Charges	600	600	618	600	636	600	654	2,400	2,508	1,660	848	66%
TOTAL FEES, CHARGES, TAXES	**$ 600**	**$ 600**	**$ 618**	**$ 600**	**$ 636**	**$ 600**	**$ 654**	**$ 2,400**	**$ 2,508**	**$ 1,660**	**$ 848**	
TOTAL DIRECT COSTS	**$ 337,060**	**$ 539,624**	**$ 555,812**	**$ 452,448**	**$ 479,595**	**$ 315,996**	**$ 344,436**	**$ 1,645,128**	**$ 1,716,904**	**$ 1,213,101**	**$ 503,802**	**71%**
INDIRECT RATE - 23.65%	**$ 79,715**	**$ 127,621**	**$ 131,450**	**$ 107,004**	**$ 113,424**	**$ 74,733**	**$ 81,459**	**$ 389,073**	**$ 406,048**	**$ 286,898**	**$ 119,149**	**23.65%**
TOTAL BUDGET	**$ 416,775**	**$ 667,245**	**$ 687,262**	**$ 559,452**	**$ 593,019**	**$ 390,729**	**$ 425,895**	**$ 2,034,201**	**$ 2,122,951**	**$ 1,500,000**	**$ 622,951**	
									Funder Percentage	71%	29%	

Doctors of the World-USA

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

Staffing Budget*

	Employee and/or Position			Annual Sal per FTE	Annual Salary Adjustment	% on Project Year 1	% on Project Year 2	% on Project Year 3	% on Project Year 4		Year 1	Year 2	Year 3	Year 4	Year 5	Total All Years
	Headquarters Staff															
5101	Program Director @ 0.05 FTE			94,500		5%	5%	5%	5%		4,725	4,725	4,725	4,725	-	18,900
5101	Program Manager/M&E Specialist @ 0.30 FTE			75,000		30%	30%	30%	30%		22,500	22,500	22,500	22,500	-	90,000
5101	Program Associate @ 0.25 FTE			45,000		30%	30%	30%	30%		13,500	13,500	13,500	13,500	-	54,000
5101	Grants Manager @ 0.1 FTE			56,000		10%	10%	10%	10%		5,600	5,600	5,600	5,600	-	22,400
5101	Finance Manager @ 0.1 FTE			50,000		10%	10%	10%	10%		5,000	5,000	5,000	5,000	-	20,000
5101	**Total HQ Staff Salaries**										**51,325**	**51,325**	**51,325**	**51,325**	**-**	**205,300**
5150	**Benefit Allocation Amoun**	**Benefit Rate =**	**21%**		$ -						10,733	10,733	10,733	10,733	-	**42,930**
	Total HQ Staff Benefits				**$ -**						**10,733**	**10,733**	**10,733**	**10,733**	**-**	**42,930**
	Total HQ Salaries + Benefits				**$ -**						**$ 62,058**	**$ 62,058**	**$ 62,058**	**$ 62,058**	**$ -**	**$ 248,230**
	International Staff				0											
	HIV AIDS Project Director - Kenya @ .1 FTE			55,000		10%	10%	10%	10%		5,500	5,500	5,500	5,500		22,000
	Total International Staff Benefits			28%							1,540	1,540	1,540	1,540	-	6,160
	Total International Staff Salaries + Benefits				**$ -**						**$ 7,040**	**$ 7,040**	**$ 7,040**	**$ 7,040**	**$ -**	**$ 28,160**
	National Staff															
5301	CSH Project Director - Kenya @ 1.0 FTE			30,000		75%	100%	100%	100%		16,875	30,000	30,000	30,000		106,875
5301	Training Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4		Q3	20,000		50%	100%	100%	100%		5,000	20,000	20,000	20,000		65,000
5301	BCC Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4		Q3	12,000		50%	100%	100%	100%		4,000	8,000	8,000	8,000		28,000
5301	M&E Coordinator @.75 FTE Y1, 1.0 FTE Yrs 2-4		Q1	16,000		75%	100%	100%	100%		9,000	16,000	16,000	16,000		57,000
5301	Mobile ANC Coodinator @ 1.0 FTE		Q1 Yr 2	8,000		0%	100%	100%	100%		-	8,000	8,000	8,000		24,000
5301	Project Assistant @ 1.0 FTE		Q1	4,000		100%	100%	100%	100%		4,000	4,000	4,000	4,000		16,000
5301	Accountant @ .5 FTE		Q1	3,000		50%	50%	50%	50%		-	1,500	750	375		2,625
5301	Driver @ 1.0 FTE		Q1	4,000		100%	100%	100%	100%		1,500	4,000	4,000	4,000		13,500
5301	Driver @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4		Q3	4,000		50%	100%	100%	100%		4,000	4,000	4,000	4,000		16,000
5301	Community Health Extension Workers (5) @ .5 FTE			1,600		0%	100%	100%	100%		1,000	8,000	8,000	8,000		25,000
5301	**Total National Salaries**				**-**						45,375	103,500	102,750	102,375	-	354,000
5350	**National Staff Benefits**															
5355	**Social Security/National Health**															
	Benefit Allocation Amoun	**Benefit Rate =**	**25%**		-						11,344	25,875	25,688	25,594	-	88,500
	Total National Staff Benefits			**-**	**-**						**11,344**	**25,875**	**25,688**	**25,594**	**-**	**88,500**
	Total National Staff Salaries + Benefits			**$ -**	**$ -**						**56,719**	**129,375**	**128,438**	**127,969**	**-**	**442,500**
	TOTAL PERSONNEL			**$ 0**	**$ -**						**$ 125,816**	**$ 198,473**	**$ 197,535**	**$ 197,066**	**$ -**	**$ 718,890**

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Doctors of the World-USA

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

Program Consultants*

Program Consultants (do not use for Consultants running specific Training Conferences - see Training/Conf Page)

Consultant 1									
Name >									
Position >	**Baseline Assessment Consultant**	**Number of Days**	**Daily Rate**	**Number of times per year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
6150	Consultant Stipend or Fee	25	350	1	8,750		-		8,750
6184	Workers Comp. Insurance				800		-		800
6186	Medical Evacuation Insurance				172				172
	Total Consultant 1				**$ 9,722**	**$ -**	**$ -**	**$ -**	**$ 9,722**

Consultant 2									
Name >									
Position >	**Mid-Term and Endline Evaluation Consultants**	**Number of Days**	**Daily Rate**	**Number of times per year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
6150	Consultant Stipend or Fee	15 mid term and 25 endline	500	1		7,500	-	12,500	20,000
6184	Workers Comp. Insurance				-	400	-	400	800
6186	Medical Evacuation Insurance					86		86	172
	Total Consultant 2				**$ -**	**$ 7,986**	**$ -**	**$ 12,986**	**$ 20,972**

Consultant 3									
Position >	**QA/QI Consultant**	**Number of Days**	**Daily Rate**	**Number of times per year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
6150	Consultant Stipend or Fee	15	350			5,250	5,250	5,250	15,750
6184	Workers Comp. Insurance								-
6186	Medical Evacuation Insurance								-
	Total Consultant 3				**$ -**	**$ 5,250**	**$ 5,250**	**$ 5,250**	**$ 15,750**

Consultant 4									
Position >	**End-line HFA Consultant**	**Number of Days**	**Daily Rate**	**Number of times per year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
6150	Consultant Stipend or Fee		500					5,000	5,000
6184	Workers Comp. Insurance							400	400
6186	Medical Evacuation Insurance							86	86
	Total Consultant 3				**$ -**	**$ -**	**$ -**	**$ 5,486**	**$ 5,486**

TOTAL CONSULTANTS									
					Year 1	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
6150	Consultant Stipend or Fee				8,750	12,750	5,250	22,750	49,500
6184	Workers Comp. Insurance				800	400	-	800	2,000
6186	Medical Evacuation Insurance				172	86	-	172	430
	TOTAL BENEFITS				972	486	-	972	2,430
	Total Consultants				**$ 9,722**	**$ 13,236**	**$ 5,250**	**$ 23,722**	**$ 51,930**

*direct costs only - inflation applied on master budget page

Doctors of the World-USA

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

Rent, Utilities, Maintenance, Security, Cleaning*

7110	Rent	Item Cost	Number / Quantity	Times per Month	Year 1	Year 2	Year 3	Year 4	TOTAL
7111	Office 1 rent	$150	12	1	$ 1,800	$ 1,800	$ 2,400	$ 2,400	$ 8,400
7111	Rent for Years 3&4	$200							$ -
7111	Housing for training/monitoring HQ staff, transportation, miscellaneous for DOW staff								$ -
7113	Service center 2								$ -
7113	Service center 3								$ -
									$ -
TOTAL office rent					**$ 1,800**	**$ 1,800**	**$ 2,400**	**$ 2,400**	**$ 8,400**

7120	Maintenance/Utilities/Cleaning Services	Item Cost	Number / Quantity	Times per Month	Year 1	Year 2	Year 3	Year 4	TOTAL
7120	Cleaning and Maintenance Office 1	$80	12	1	$ 960	$ 960	$ 960	$ 960	3840
7120	Cleaning and Maintenance Office 2		12	1	$ -	$ -	$ -	$ -	0
7120	Cleaning and Maintenance Service center 1		12	1	$ -	$ -	$ -	$ -	0
7120	Cleaning and Maintenance Service center 2		12	1	$ -	$ -	$ -	$ -	0
7120	Utilities Office 1	$50	12	1	$ 600	$ 600	$ 600	$ 600	2400
7120	Utilities Office 2		12	1	$ -	$ -	$ -	$ -	0
7120	Utilities Service Center 1		12	1	$ -	$ -	$ -	$ -	0
7120	Utilities Service Center 2		12	1	$ -	$ -	$ -	$ -	0
7120	Security Service Office 1		12	1	$ -	$ -	$ -	$ -	0
7120	Security Service Office 2		12	1	$ -	$ -	$ -	$ -	0
7120	Security Service Service Center 1		12	1	$ -	$ -	$ -	$ -	0
7120	Security Service Service Center 2		12	1	$ -	$ -	$ -	$ -	0
			12	1	$ -	$ -	$ -	$ -	0
TOTAL Maintenance/UtilitiesCeaning Services					**$ 1,560**	**$ 1,560**	**$ 1,560**	**$ 1,560**	**$ 6,240**

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Doctors of the World-USA

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

Supplies, Materials, Equipment*

Medical Supplies and Pharmaceuticals		**cost**	**number**		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
	Mobile Outreach Vehicle Supplies	$ 340	2			$ 680				$ 680
	Sterilizers	100	6			$ 600				$ 600
	Oxygen Cylinders	25	6			$ 150	$ 150	$ 150		$ 450
	Face Mask	32	6			$ 96	$ 96			$ 192
	Delivery Bed	216	9			$ 1,296	$ 648			$ 1,944
	Suction Pump	100	9			$ 600	$ 300			$ 900
	Delivery Pack	145	9			$ 870	$ 435			$ 1,305
	Gloves	100	9			$ 900	$ 900	$ 900		$ 2,700
	Exam Tables and Medical Furniture	1,000	9			$ 6,000	$ 3,000			$ 9,000
	Various equipment replacement	500	6			$ 2,000	$ 500	$ 500		$ 3,000
TOTAL Other Suplies					**$ -**	**$ 13,192**	**$ 6,029**	**$ 1,550**	**$ -**	**$ 20,771**

Equipment / Furniture Under $5,000		**cost**	**number**		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
	Fax/Printer	$ 500	2		$ 1,000					$ 1,000
	Copier	2,000	1							$ -
	Desktop computers for office	1,000	6		$ 3,000	$ 3,000				$ 6,000
	Digital Camera	500	1		$ 500					$ 500
	Install landlines at health centers + office	150	3		$ 450					$ 450
	Telephones	150	5		$ 750					$ 750
	Software	300	4		$ 1,200	$ 1,200	$ 600	$ 600		$ 3,600
	Office furnishing	2,800	1		$ 2,800					$ 2,800
TOTAL Equipment / Furniture / Equip Maint Under $5,000					**$ 9,700**	**$ 4,200**	**$ 600**	**$ 600**	**$ -**	**$ 15,100**

Equipment over $5000		**cost**	**number**		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
	Vehicles - Staff and Office	$ 38,000	1		$ 38,000					$ 38,000
	Vehicles for Transport of Healthworkers/Patients	50,000	3			$ 100,000	$ 50,000			$ 150,000
TOTAL Other Suplies					**$ 38,000**	**$ 100,000**	**$ 50,000**	**$ -**	**$ -**	**$ 209,500**

Meeting Coordination and Supplies		**Item Cost**	**Number / Quantity**	**Times per Year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
	TBA Monitoring Meetings	25	7	12		2,100	2,100	2,100		6,300
	CHW Monitoring Meetings	72	7	12		6,048	6,048	6,048		18,144
	Quarterly CSH partners Meetings	100	1	4	400	400	400	400		1,600
	Project launch and community awareness event	2500	1	1	2,500					2,500
	Total Refreshments and Meeting Coordination				**2,900**	**8,548**	**8,548**	**8,548**	**-**	**28,544**

*direct costs only - inflation applied on master budget page

Doctors of the World-USA

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

Travel Budget*

Travel - Staff, Consultants - includes attendance at conferences and meetings

International Travel			Year 1	Year 2	Year 3	Year 4	Total
Trip Description	**Enter Number of Trips in each Year > >**		1	3	2	3	
Monitoring /Evaluation - HQ staff	**Enter Number of Travellers > >**		1	1	1	1	
	Enter Number of Days per Trip in each Year > >		14	14	14	14	
	Air Fare > >	$2,000	$2,000	$6,000	$4,000	$6,000	**$18,000**
Total Local Travel per Trip per Person > >		$400	$400	$1,200	$800	$1,200	**$3,600**
	Visas and other Costs > >	$50	$50	$50	$50	$50	**$200**
	Per Deim > >	$100	$1,400	$4,200	$2,800	$4,200	**$12,600**
TOTAL TRAVEL			**$3,850**	**$11,450**	**$7,650**	**$11,450**	**$34,400**

International Travel			Year 1	Year 2	Year 3	Year 4	Total
Trip Description	**Enter Number of Trips in each Year > >**		1				
Baseline HFA Research Consultant	**Enter Number of Travellers > >**		2				
	Enter Number of Days per Trip in each Year > >		25				
	Air Fare > >	$1,200	$2,400	$0	$0	$0	**$2,400**
Total Local Travel per Trip per Person > >		$200	$400	$0	$0	$0	**$400**
	Visas and other Costs > >	$50	$100	$0	$0	$0	**$100**
	Per Deim > >	$100	$5,000	$0	$0	$0	**$5,000**
TOTAL TRAVEL			**$7,900**	**$0**	**$0**	**$0**	**$7,900**

International Travel			Year 1	Year 2	Year 3	Year 4	Total
Trip Description	**Enter Number of Trips in each Year > >**			1		1	
KPC Mid-Term & Final Eval Consultants	**Enter Number of Travellers > >**			1		1	
	Enter Number of Days per Trip in each Year > >			15		25	
	Air Fare > >	$2,400	$0	$2,400	$0	$2,400	**$4,800**
Total Local Travel per Trip per Person > >		$400	$0	$400	$0	$400	**$800**
	Visas and other Costs > >	$50	$0	$50	$0	$50	**$100**
	Per Deim > >	$100	$0	$1,500	$0	$2,500	**$4,000**
TOTAL TRAVEL			**$0**	**$4,350**	**$0**	**$5,350**	**$9,700**

International Travel			Year 1	Year 2	Year 3	Year 4	Total
Trip Description	**Enter Number of Trips in each Year > >**		1				
Final HFA Research Consultant	**Enter Number of Travellers > >**		2				
	Enter Number of Days per Trip in each Year > >		25				
	Air Fare > >	$2,000	$4,000	$0	$0	$0	**$4,000**
Total Local Travel per Trip per Person > >		$200	$400	$0	$0	$0	**$400**
	Visas and other Costs > >	$50	$100	$0	$0	$0	**$100**
	Per Deim > >	$100	$5,000	$0	$0	$0	**$5,000**
TOTAL TRAVEL			**$9,500**	**$0**	**$0**	**$0**	**$9,500**

International Travel			Year 1	Year 2	Year 3	Year 4	Total
Trip Description	**Enter Number of Trips in each Year > >**						
HMIS Consultant	**Enter Number of Travellers > >**						
	Enter Number of Days per Trip in each Year > >						

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Doctors of the World-USA

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

Travel Budget*

	Air Fare > >	$1,000	$0	$0	$0	$0	**$0**
Total Local Travel per Trip per Person > >		$400	$0	$0	$0	$0	**$0**
	Visas and other Costs > >	$50	$0	$0	$0	$0	**$0**
	Per Deim > >	$100	$0	$0	$0	$0	**$0**
TOTAL TRAVEL			**$0**	**$0**	**$0**	**$0**	**$0**

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International Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		1		1		
Management and Oversight	**Enter Number of Travellers > >**		1		1		
	Enter Number of Days per Trip in each Year > >		14		14		
	Air Fare > >	$2,000	$2,000	$0	$2,000	$0	**$4,000**
Total Local Travel per Trip per Person > >		$400	$400	$0	$400	$0	**$800**
	Visas and other Costs > >	$50	$50	$0	$50	$0	**$100**
	Per Deim > >	$100	$1,400	$0	$1,400	$0	**$2,800**
TOTAL TRAVEL			**$3,850**	**$0**	**$3,850**	**$0**	**$7,700**

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International Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		2				
Backstop Institute and Mini University - CHS Project Director	**Enter Number of Travellers > >**		1				
	Enter Number of Days per Trip in each Year > >		14				
	Air Fare > >	$2,400	$4,800	$0	$0	$0	**$4,800**
Total Local Travel per Trip per Person > >		$400	$800	$0	$0	$0	**$800**
	Visas and other Costs > >	$250	$250	$0	$0	$0	**$250**
	Per Deim > >	$200	$5,600	$0	$0	$0	**$5,600**
TOTAL TRAVEL			**$11,450**	**$0**	**$0**	**$0**	**$11,450**

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International Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		1				
Int'l Trip for Field staff	**Enter Number of Travellers > >**		1				
	Enter Number of Days per Trip in each Year > >		14				
	Air Fare > >	$2,400	$2,400	$0	$0	$0	**$2,400**
Total Local Travel per Trip per Person > >		$400	$400	$0	$0	$0	**$400**
	Visas and other Costs > >	$250	$250	$0	$0	$0	**$250**
	Per Deim > >	$200	$2,800	$0	$0	$0	**$2,800**
TOTAL TRAVEL			**$5,850**	**$0**	**$0**	**$0**	**$5,850**

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Regional Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**			2	2	2	
DC Trips for Program Manager	**Enter Number of Travellers > >**			1	1	1	
	Enter Number of Days per Trip in each Year > >			2	2	2	
	Air Fare > >	$250	$0	$500	$500	$500	**$1,500**
Total Local Travel per Trip per Person > >		$20	$0	$40	$40	$40	**$120**
	Per Deim > >	$200	$0	$800	$800	$800	**$2,400**

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Doctors of the World-USA

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

Travel Budget*

TOTAL TRAVEL			**$0**	**$1,340**	**$1,340**	**$1,340**	**$4,020**

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Regional Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		2				
Backstop Institute and Mini-University for PM	**Enter Number of Travellers > >**		1				
	Enter Number of Days per Trip in each Year > >		5				
	Air Fare > >	$250	$500	$0	$0	$0	**$500**
Total Local Travel per Trip per Person > >		$0	$0	$0	$0	$0	**$0**
	Per Deim > >	$150	$1,500	$0	$0	$0	**$1,500**
TOTAL TRAVEL			**$2,000**	**$0**	**$0**	**$0**	**$2,000**

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Regional Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		6	6	6	6	
Nairobi for meetings, etc.	**Enter Number of Travellers > >**		1	1	1	1	
	Enter Number of Days per Trip in each Year > >		4	4	4	4	
	Air Fare > >	$300	$1,800	$1,800	$1,800	$1,800	**$7,200**
Total Local Travel per Trip per Person > >		$50	$300	$300	$300	$300	**$1,200**
	Per Deim > >	$150	$3,600	$3,600	$3,600	$3,600	**$14,400**
TOTAL TRAVEL			**$5,700**	**$5,700**	**$5,700**	**$5,700**	**$22,800**

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Regional Travel			Year 1	Year 2	Year 3	Year 4	**Total**
Trip Description	**Enter Number of Trips in each Year > >**		1	1	1	1	
Exchange Visit to other Kenya PVO CSH Projects	**Enter Number of Travellers > >**		1	1	1	1	
	Enter Number of Days per Trip in each Year > >		5	5	5	5	
	Air Fare > >	$300	$300	$300	$300	$300	**$1,200**
Total Local Travel per Trip per Person > >		$50	$50	$50	$50	$50	**$200**
	Per Deim > >	$100	$500	$500	$500	$500	**$2,000**
TOTAL TRAVEL			**$850**	**$850**	**$850**	**$850**	**$3,400**

Total Local Travel			**$0**	**$0**	**$0**	**$0**	**$0**
Total Regional Travel			**$8,550**	**$7,890**	**$7,890**	**$7,890**	**$32,220**
Total International Travel			**$42,400**	**$15,800**	**$11,500**	**$16,800**	**$86,500**

Total TRAVEL			**$50,950**	**$23,690**	**$19,390**	**$24,690**	**$118,720**

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Focused Antenatal Care (FANC) Including MIP & PMTCT		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Yr 1, Q4					
Enter Number of Conferences/Training per year > >		4	0			
Enter Number of Days per Training/Conference > >		3	0		0	
Cost of Conference / Training Space Rental per day > >	$20	$240	$0	$0	$0	$240
Meals / Refrestments - daily cost per Attendee > >	$10	$3,240	$0	$0	$0	$3,240
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25				
Housing costs per day per Trainee > >	$0	$240	$0	$0	$0	**$240**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2				
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$1,200	$0	$0	$0	**$1,200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$8,080**	**$0**	**$0**	**$0**	**$8,080**

Normal Delivery (Partographs, AVD, AMSTL)		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Yr 1, Q4					
Enter Number of Conferences/Training per year > >		4	0		0	
Enter Number of Days per Training/Conference > >		3	0		0	
Cost of Conference / Training Space Rental per day > >	$20	$240	$0	$0	$0	$240
Meals / Refrestments - daily cost per Attendee > >	$10	$3,240	$0	$0	$0	$3,240
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	6	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2	0	3	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$1,200	$0	$0	$0	**$1,200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$7,840**	**$0**	**$0**	**$0**	**$7,840**

Emergency Obstetric and Newonatal Care (EmONC) incl. FGM		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y1, Q4					
Enter Number of Conferences/Training per year > >		4	0	0	0	
Enter Number of Days per Training/Conference > >		3	0	0	0	
Cost of Conference / Training Space Rental per day > >	$20	$240	$0	$0	$0	$240
Meals / Refrestments - daily cost per Attendee > >	$10	$3,480	$0	$0	$0	$3,480
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	19	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		4	0	0	0	
Housing costs per day per Trainer > >	$20	$960	$0	$0	$0	**$960**
Local Travel per Trainer > >	$10	$160	$0	$0	$0	**$160**
Regional Travel per Trainer > >	$20	$320	$0	$0	$0	**$320**
Supplies - Training Materials - cost per Trainer >>	$10	$160	$0	$0	$0	**$160**
Stipend or Fee per Trainer > >	$50	$2,400	$0	$0	$0	**$2,400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$10,720**	**$0**	**$0**	**$0**	**$10,720**

Postpartum and Newborn Care		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y1, Q4					
Enter Number of Conferences/Training per year > >		4	0	0	0	
Enter Number of Days per Training/Conference > >		3	0	0	0	
Cost of Conference / Training Space Rental per day > >	$20	$240	$0	$0	$0	$240
Meals / Refrestments - daily cost per Attendee > >	$10	$3,240	$0	$0	$0	$3,240
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	0	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$0	$0	$0	**$0**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2	0	0	0	
Housing costs per day per Trainer > >	$20	$480	$0	$0	$0	**$480**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$20	$160	$0	$0	$0	**$160**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$1,200	$0	$0	$0	**$1,200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$7,480**	**$0**	**$0**	**$0**	**$7,480**

Post Abortion Care (PAC)		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >		0	2	0		
Enter Number of Days per Training/Conference > >		0	10	0		
Cost of Conference / Training Space Rental per day > >	$20	$0	$400	$0	$0	$400
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$2,800	$0	$0	$2,800
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	12	0		
Housing costs per day per Trainee > >	$20	$0	$2,400	$0	$0	**$2,400**
Local Travel per Trainee > >	$10	$0	$120	$0	$0	**$120**
Regional Travel per Trainee > >	$20	$0	$480	$0	$0	**$480**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$120	$0	$0	**$120**
Stipend or Incentive per Trainee > >	$10	$0	$240	$0	$0	**$240**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	2	0		
Housing costs per day per Trainer > >	$20	$0	$800	$0	$0	**$800**
Local Travel per Trainer > >	$10	$0	$40	$0	$0	**$40**
Regional Travel per Trainer > >	$20	$0	$80	$0	$0	**$80**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$40	$0	$0	**$40**
Stipend or Fee per Trainer > >	$50	$0	$200	$0	$0	**$200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$7,720**	**$0**	**$0**	**$7,720**

Malaria Prevention and Control Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y1, Q4					
Enter Number of Conferences/Training per year > >		4	0		0	
Enter Number of Days per Training/Conference > >		1	0		0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$1,080	$0	$0	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	0	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2	0	0	0	
Housing costs per day per Trainer > >	$20	$160	$0	$0	$0	**$160**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$20	$160	$0	$0	$0	**$160**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$400	$0	$0	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$4,960**	**$0**	**$0**	**$0**	**$4,960**

General HIV/AIDS Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y1, Q4					
Enter Number of Conferences/Training per year > >		4	0	0	0	
Enter Number of Days per Training/Conference > >		1	0	0	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$1,080	$0	$0	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	0	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2	0	0	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$500	$0	$0	$0	**$500**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$2,500	$0	$0	$0	**$2,500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$7,160**	**$0**	**$0**	**$0**	**$7,160**

Focused Antenatal Care (FANC) Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >			0	4	0	
Enter Number of Days per Training/Conference > >			0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >			0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,640**	**$0**	**$4,640**

Normal Delivery Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >			0	4	0	
Enter Number of Days per Training/Conference > >			0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >			0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS GROUP 1 (with same/fee stipend)						
Trainer Names/De	PS and MOH Staff					
Enter Number of Trainers/Staff per Conference / Training > >			0	2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,640**	**$0**	**$4,640**

EmONC/FGM Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >			0	4	0	
Enter Number of Days per Training/Conference > >			0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >			0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS GROUP 1 (with same/fee stipend)						
Trainer Names/De	PS and District MOH					
Enter Number of Trainers/Staff per Conference / Training > >			0	2	0	
Housing costs per day per Trainer > >	$20	$0	$0	$160	$0	**$160**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$20	$0	$0	$160	$0	**$160**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,960**	**$0**	**$4,960**

Postpartum and Newborn Care Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >			0	4	0	
Enter Number of Days per Training/Conference > >			0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >			0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			0	2	0	
Housing costs per day per Trainer > >	$20	$0	$0	$160	$0	**$160**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$20	$0	$0	$160	$0	**$160**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,210**	**$0**	**$4,210**

PAC Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q2					
Enter Number of Conferences/Training per year > >		0	0	4	0	
Enter Number of Days per Training/Conference > >		0	0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >			0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			0	2	0	
Housing costs per day per Trainer > >	$20	$0	$0	$160	$0	**$160**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$20	$0	$0	$160	$0	**$160**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,210**	**$0**	**$4,210**

Onsite QA/QI - Focus on COPE		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >			4		0	
Enter Number of Days per Training/Conference > >			3		0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$3,240	$0	$0	$3,240
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,000	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,000	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$1,000	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2	0	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$80	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$80	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$1,200	$0	$0	**$1,200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$7,600**	**$0**	**$0**	**$7,600**

Data Collection of MNH Activities and Use (HMIS)		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >		0	4	0	0	
Enter Number of Days per Training/Conference > >		0	3	0	0	
Cost of Conference / Training Space Rental per day > >	$20	$0	$240	$0	$0	$240
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$3,240	$0	$0	$3,240
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25	0	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,000	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$250	$0	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$1,000	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	2	0	0	
Housing costs per day per Trainer > >	$0	$0		$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$80	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$80	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$400	$0	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$6,290**	**$0**	**$0**	**$6,290**

MNH Supply Chain		Year 1	Year 2	Year 3	Year 4	Total
Enter Number of Conferences/Training per year > >		0	1	0	0	
Enter Number of Days per Training/Conference > >		0	3	0	0	
Cost of Conference / Training Space Rental per day > >	$20	$0	$60	$0	$0	$60
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$960	$0	$0	$960
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	30	0	20	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$300	$0	$0	**$300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$300	$0	$0	**$300**
Stipend or Incentive per Trainee > >	$10	$0	$300	$0	$0	**$300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	2	0	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$20	$0	$0	**$20**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$20	$0	$0	**$20**
Stipend or Fee per Trainer > >	$50	$0	$100	$0	$0	**$100**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$2,060**	**$0**	**$0**	**$2,060**

COPE Follow-up/ Refresher (entire site)		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q2					
Enter Number of Conferences/Training per year > >		0	0	4	0	
Enter Number of Days per Training/Conference > >		0	0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	0	2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$3,890**	**$0**	**$3,890**

Data Collection Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3 Q2					
Enter Number of Conferences/Training per year > >		0	0	4	0	
Enter Number of Days per Training/Conference > >		0	0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	0	2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$3,890**	**$0**	**$3,890**

MNH Supply Chain Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q2					
Enter Number of Conferences/Training per year > >		0	0	4	0	
Enter Number of Days per Training/Conference > >		0	0	1	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,080	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	0	25	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,000	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	0	2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$80	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$80	$0	**$80**
Stipend or Fee per Trainer > >	$50	$0	$0	$400	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,640**	**$0**	**$4,640**

Facility Infection Prevention		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y1, Q4					
Enter Number of Conferences/Training per year > >		4	0	0	0	
Enter Number of Days per Training/Conference > >		1	0	0	0	
Cost of Conference / Training Space Rental per day > >		$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$1,080	$0	$0	$0	$1,080
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	0	0	
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2	0	0	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer > >	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$400	$0	$0	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$4,640**	**$0**	**$0**	**$0**	**$4,640**

Facility Infection Prevention Refresher		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q4					
Enter Number of Conferences/Training per year > >		4	0	0	0	
Enter Number of Days per Training/Conference > >		1	0	0	0	
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$1,000	$0	$0	$0	$1,000
TRAINEES						
Enter Number of Trainees per Conference/Training > >		25	0	0	0	**0**
Housing costs per day per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Local Travel per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Stipend or Incentive per Trainee > >	$10	$1,000	$0	$0	$0	**$1,000**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS GROUP 1 (with same/fee stipend)						
Trainer Names/De	PS and MOH Staff					
Enter Number of Trainers/Staff per Conference / Training > >		2	0	0		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$80	$0	$0	$0	**$80**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$80	$0	$0	$0	**$80**
Stipend or Fee per Trainer > >	$50	$400	$0	$0	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$5,560**	**$0**	**$0**	**$0**	**$5,560**

TOTALS					
Cost of Conference / Training Space > >	$960	$700	$0	$0	$1,660
Meals / Refrestments - daily cost per Attendee > >	$17,440	$10,240	$8,640	$0	$36,320
TRAINEES					
Housing costs for Trainees > >	$1,240	$2,400	$0	$0	$3,640
Local Travel for Trainees > >	$8,000	$2,420	$8,000	$0	$18,420
Regional Travel for Trainees > >	$0	$480	$0	$0	$480
Supplies - Training Materials - cost for Trainee > >	$8,000	$1,670	$5,000	$0	$14,670
Stipend or Incentive for Trainees > >	$7,000	$2,540	$8,000	$0	$17,540
Additional Per Diem for Trainee > >	$0	$0	$0	$0	$0
TRAINERS					
Housing costs for Trainers Group 1 > >	$1,600	$800	$480	$0	$2,880
Local Travel for Trainers Group 1 > >	$1,140	$220	$640	$0	$2,000
Regional Travel forTrainers Group 1 > >	$640	$80	$480	$0	$1,200
Supplies - Training Materials - cost for Trainers Group 1 > >	$720	$220	$640	$0	$1,580
Stipend or Fee for Trainers Group 1 > >	$9,700	$1,900	$3,200	$0	$14,800
Additional Per Diem for Trainers Group 1 > >	$0	$0	$0	$0	$0
Total Conference Costs	**$56,440**	**$23,670**	**$35,080**	**$0**	**$115,190**

GRAND TOTALS					
Travel including Lodging/Per Diems	$12,620	$6,400	$9,600	$0	**$28,620**
Meals and Refreshments Provided	$17,440	$10,240	$8,640	$0	**$36,320**
Conference / Training Space	$960	$700	$0	$0	**$1,660**
Fees / Stipends	$16,700	$4,440	$11,200	$0	**$32,340**
Supplies and Materials	$8,720	$1,890	$5,640	$0	**$16,250**
	$56,440	**$23,670**	**$35,080**	**$0**	**$ 115,190**

Doctors of the World-USA

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

Training / Workshops Organized by DOW*

Kenya National Community Strategy		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >			1			
Enter Number of Days per Training/Conference > >			3			
Cost of Conference / Training Space Rental per day > >	$20	$0	$60	$0	$0	$60
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$960	$0	$0	$960
TRAINEES						
Enter Number of Trainees per Conference/Training > >			30			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$300	$0	$0	**$300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$300	$0	$0	**$300**
Stipend or Incentive per Trainee > >	$10	$0	$300	$0	$0	**$300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$20	$0	$0	**$20**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$0	$0	**$0**
Stipend or Fee per Trainer > >	$50	$0	$300	$0	$0	**$300**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$2,240**	**$0**	**$0**	**$2,240**

General MNH, HIV/AIDS & Malaria Prev. for Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >		2				
Enter Number of Days per Training/Conference > >		2				
Cost of Conference / Training Space Rental per day > >	$20	$80	$0	$0	$0	$80
Meals / Refrestments - daily cost per Attendee > >	$10	$1,480	$0	$0	$0	$1,480
TRAINEES						
Enter Number of Trainees per Conference/Training > >		35				
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$700	$0	$0	$0	**$700**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$700	$0	$0	$0	**$700**
Stipend or Incentive per Trainee > >	$10	$700	$0	$0	$0	**$700**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		2				
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$40	$0	$0	$0	**$40**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$40	$0	$0	$0	**$40**
Stipend or Fee per Trainer > >	$50	$400	$0	$0	$0	**$400**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$4,140**	**$0**	**$0**	**$0**	**$4,140**

*direct costs only - inflation applied on master budget page

General MNH, HIV/AIDS & Malaria Prev. for Chiefs & Asst Chiefs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >		0	5			
Enter Number of Days per Training/Conference > >		0	1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,400	$0	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	26			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Stipend or Incentive per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$6,100**	**$0**	**$0**	**$6,100**

General MNH, HIV/AIDS & Malaria Prev. for CORPs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q1					
Enter Number of Conferences/Training per year > >		0	5			
Enter Number of Days per Training/Conference > >		0	3			
Cost of Conference / Training Space Rental per day > >	$20	$0	$300	$0	$0	$300
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$4,050	$0	$0	$4,050
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$0	$0	**$0**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$300	$0	$0	**$300**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$300	$0	$0	**$300**
Stipend or Fee per Trainer > >	$50	$0	$1,500	$0	$0	**$1,500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$8,950**	**$0**	**$0**	**$8,950**

*direct costs only - inflation applied on master budget page

Doctors of the World-USA

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

Training / Workshops Organized by DOW*

Birthplanning, FANC including MIP and PMTCT for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >		0	5			
Enter Number of Days per Training/Conference > >		0	3			
Cost of Conference / Training Space Rental per day > >	$20	$0	$300	$0	$0	$300
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$4,050	$0	$0	$4,050
TRAINEES						
Enter Number of Trainees per Conference/Training > >		0	25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$250	$0	$0	**$250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$250	$0	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$6,800**	**$0**	**$0**	**$6,800**

MNH, HIV/AIDS & Malaria Prev. Refresher for Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				2		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$40	$0	$40
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$740	$0	$740
TRAINEES						
Enter Number of Trainees per Conference/Training > >				35		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$700	$0	**$700**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$700	$0	**$700**
Stipend or Incentive per Trainee > >	$10	$0	$0	$700	$0	**$700**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$40	$0	**$40**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$40	$0	**$40**
Stipend or Fee per Trainer > >	$50	$0	$0	$200	$0	**$200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$3,160**	**$0**	**$3,160**

*direct costs only - inflation applied on master budget page

MNH, HIV/AIDS & Malaria Prev. Refresher for Chiefs & Asst Chiefs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,400	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >				26		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$520	$0	**$520**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$6,520**	**$0**	**$6,520**

MNH, HIV/AIDS & Malaria Prev. Refresher for CORPs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$5,900**	**$0**	**$5,900**

*direct costs only - inflation applied on master budget page

Birthplanning, FANC including MIP and PMTCT for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$5,900**	**$0**	**$5,900**

BCC Advocacy Messaging for HFC and Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			2			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$40	$0	$0	$40
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$740	$0	$0	$740
TRAINEES						
Enter Number of Trainees per Conference/Training > >			35			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$700	$0	$0	**$700**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$700	$0	$0	**$700**
Stipend or Incentive per Trainee > >	$10	$0	$700	$0	$0	**$700**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$40	$0	$0	**$40**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$40	$0	$0	**$40**
Stipend or Fee per Trainer > >	$50	$0	$200	$0	$0	**$200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$3,160**	**$0**	**$0**	**$3,160**

*direct costs only - inflation applied on master budget page

BCC Advocacy Messaging for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,350	$0	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$0	$0	**$0**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$4,650**	**$0**	**$0**	**$4,650**

On Site Training in MNH Referral for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			3			
Cost of Conference / Training Space Rental per day > >	$20	$0	$300	$0	$0	$300
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$4,050	$0	$0	$4,050
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$250	$0	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$1,500	$0	$0	**$1,500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$8,800**	**$0**	**$0**	**$8,800**

*direct costs only - inflation applied on master budget page

FGM Sensitization for Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q3					
Enter Number of Conferences/Training per year > >			2			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$40	$0	$0	$40
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$740	$0	$0	$740
TRAINEES						
Enter Number of Trainees per Conference/Training > >			35			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$700	$0	$0	**$700**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$700	$0	$0	**$700**
Stipend or Incentive per Trainee > >	$10	$0	$700	$0	$0	**$700**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$40	$0	$0	**$40**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$40	$0	$0	**$40**
Stipend or Fee per Trainer > >	$50	$0	$200	$0	$0	**$200**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$3,160**	**$0**	**$0**	**$3,160**

FGM Sensitization for Chiefs & Asst. Chiefs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,400	$0	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >			26			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$260	$0	$0	**$260**
Stipend or Incentive per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$5,060**	**$0**	**$0**	**$5,060**

*direct costs only - inflation applied on master budget page

FGM Sensitization for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,350	$0	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$250	$0	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$100	$0	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$4,900**	**$0**	**$0**	**$4,900**

On-site MNH Referral Refresher for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$0	$0	$0	$0	$0	$0
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >		0	0	2	0	
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,800**	**$0**	**$4,800**

*direct costs only - inflation applied on master budget page

FGM Sensitization Refresher for Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q4					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$250	$0	**$250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,900**	**$0**	**$4,900**

FGM Sensitization Refresher for Chiefs & Asst. Chiefs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q4					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,600	$0	$1,600
TRAINEES						
Enter Number of Trainees per Conference/Training > >				30		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,500	$0	**$1,500**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,500	$0	**$1,500**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,500	$0	**$1,500**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$6,900**	**$0**	**$6,900**

*direct costs only - inflation applied on master budget page

FGM Sensitization Refresher for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y3, Q4					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer > >	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$5,900**	**$0**	**$5,900**

Community Based Postpartum & Newborn Care for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,350	$0	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$0	$0	**$0**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$5,800**	**$0**	**$0**	**$5,800**

*direct costs only - inflation applied on master budget page

Doctors of the World-USA

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

Training / Workshops Organized by DOW*

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Data Monitoring and Reporting for CHEWs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			1			
Enter Number of Days per Training/Conference > >			2			
Cost of Conference / Training Space Rental per day > >	$0		$0			$0
Meals / Refrestments - daily cost per Attendee > >	$10		$140			$140
TRAINEES						
Enter Number of Trainees per Conference/Training > >			5			
Housing costs per day per Trainee > >	$0		$0			**$0**
Local Travel per Trainee > >	$10		$50			**$50**
Regional Travel per Trainee > >	$0		$0			**$0**
Supplies - Training Materials - cost per Trainee > >	$10		$50			**$50**
Stipend or Incentive per Trainee > >	$10		$50			**$50**
Additional Per Diem per Trainee > >	$0		$0			**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0		$0			**$0**
Local Travel per Trainer > >	$10		$20			**$20**
Regional Travel per Trainer > >	$0		$0			**$0**
Supplies - Training Materials - cost per Trainer > >	$10		$0			**$0**
Stipend or Fee per Trainer > >	$50		$200			**$200**
Additional Per Diem per Trainer > >	$0		$0			**$0**
Total Conference Costs		**$0**	**$510**	**$0**	**$0**	**$510**

*direct costs only - inflation applied on master budget page

Data Collection and Use: CBHIS for Community Partners		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			2			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20		$40			$40
Meals / Refrestments - daily cost per Attendee > >	$10		$740			$740
TRAINEES						
Enter Number of Trainees per Conference/Training > >			35			
Housing costs per day per Trainee > >	$0		$0			**$0**
Local Travel per Trainee > >	$10		$700			**$700**
Regional Travel per Trainee > >	$0		$0			**$0**
Supplies - Training Materials - cost per Trainee > >	$10		$700			**$700**
Stipend or Incentive per Trainee > >	$10		$700			**$700**
Additional Per Diem per Trainee > >	$0		$0			**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0		$0			**$0**
Local Travel per Trainer > >	$10		$40			**$40**
Regional Travel per Trainer > >	$0		$0			**$0**
Supplies - Training Materials - cost per Trainer > >	$10		$0			**$0**
Stipend or Fee per Trainer > >	$50		$200			**$200**
Additional Per Diem per Trainer > >	$0		$0			**$0**
Total Conference Costs		**$0**	**$3,120**	**$0**	**$0**	**$3,120**

Data Collection and Use: CBHIS for Chiefs & Asst. Chiefs		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			
Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,400	$0	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >			26			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Stipend or Incentive per Trainee > >	$10	$0	$1,300	$0	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			2			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$100	$0	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$0	$0	**$0**
Stipend or Fee per Trainer > >	$50	$0	$500	$0	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$6,000**	**$0**	**$0**	**$6,000**

Data Collection and Use: CBHIS for CORPS		Year 1	Year 2	Year 3	Year 4	Total
Approx Dates	Y2, Q2					
Enter Number of Conferences/Training per year > >			5			

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Enter Number of Days per Training/Conference > >			1			
Cost of Conference / Training Space Rental per day > >	$20	$0	$100	$0	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$1,450	$0	$0	$1,450
TRAINEES						
Enter Number of Trainees per Conference/Training > >			25			
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$1,250	$0	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >			4			
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$200	$0	$0	**$200**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$200	$0	$0	**$200**
Stipend or Fee per Trainer > >	$50	$0	$1,000	$0	$0	**$1,000**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$6,700**	**$0**	**$0**	**$6,700**

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Postpartum and Newborn Care Refresher for CORPS		Year 1	Year 2	Year 3	Year 4	**Total**
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						
Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$5,900**	**$0**	**$5,900**

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Data Monitoring and Reporting Refresher for CORPS		Year 1	Year 2	Year 3	Year 4	**Total**
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,350	$0	$1,350
TRAINEES						

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Enter Number of Trainees per Conference/Training > >				25		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,250	$0	**$1,250**
Stipend or Incentive per Trainee > >	$10	$0	$0	$0	$0	**$0**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,650**	**$0**	**$4,650**

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Data Collection and Use Refresher for Chiefs & Asst. Chiefs		Year 1	Year 2	Year 3	Year 4	**Total**
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,400	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >				26		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$260	$0	**$260**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$260	$0	**$260**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$4,020**	**$0**	**$4,020**

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Data Collection and Use Refresher for CHEWs/CORPS		Year 1	Year 2	Year 3	Year 4	**Total**
Approx Dates	Y3, Q1					
Enter Number of Conferences/Training per year > >				5		
Enter Number of Days per Training/Conference > >				1		
Cost of Conference / Training Space Rental per day > >	$20	$0	$0	$100	$0	$100
Meals / Refrestments - daily cost per Attendee > >	$10	$0	$0	$1,400	$0	$1,400
TRAINEES						
Enter Number of Trainees per Conference/Training > >				26		
Housing costs per day per Trainee > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Regional Travel per Trainee > >	$0	$0	$0	$0	$0	**$0**

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Doctors of the World-USA

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

Training / Workshops Organized by DOW*

Supplies - Training Materials - cost per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Stipend or Incentive per Trainee > >	$10	$0	$0	$1,300	$0	**$1,300**
Additional Per Diem per Trainee > >	$0	$0	$0	$0	$0	**$0**
TRAINERS						
Enter Number of Trainers/Staff per Conference / Training > >				2		
Housing costs per day per Trainer > >	$0	$0	$0	$0	$0	**$0**
Local Travel per Trainer > >	$10	$0	$0	$100	$0	**$100**
Regional Travel per Trainer > >	$0	$0	$0	$0	$0	**$0**
Supplies - Training Materials - cost per Trainer >>	$10	$0	$0	$100	$0	**$100**
Stipend or Fee per Trainer > >	$50	$0	$0	$500	$0	**$500**
Additional Per Diem per Trainer > >	$0	$0	$0	$0	$0	**$0**
Total Conference Costs		**$0**	**$0**	**$6,100**	**$0**	**$6,100**

TOTALS					
Cost of Conference / Training Space > >	$80	$1,820	$1,040	$0	$2,940
Meals / Refrestments - daily cost per Attendee > >	$1,480	$25,910	$15,990	$0	$43,380
TRAINEES					
Housing costs for Trainees > >	$0	$0	$0	$0	$0
Local Travel for Trainees > >	$700	$14,250	$13,810	$0	$28,760
Regional Travel for Trainees > >	$0	$0	$0	$0	$0
Supplies - Training Materials - cost for Trainee > >	$700	$9,860	$11,810	$0	$22,370
Stipend or Incentive for Trainees > >	$700	$14,400	$13,600	$0	$28,700
Additional Per Diem for Trainee > >	$0	$0	$0	$0	$0
TRAINERS GROUP 1 (with same/fee stipend)					
Housing costs for Trainers Group 1 > >	$0	$0	$0	$0	$0
Local Travel for Trainers Group 1 > >	$40	$1,480	$1,560	$0	$3,080
Regional Travel forTrainers Group 1 > >	$0	$0	$0	$0	$0
Supplies - Training Materials - cost for Trainers Group 1 > >	$40	$1,180	$1,140	$0	$2,360
Stipend or Fee for Trainers Group 1 > >	$400	$8,800	$5,700	$0	$14,900
Additional Per Diem for Trainers Group 1 > >	$0	$0	$0	$0	$0
Total Conference Costs	**$4,140**	**$77,700**	**$64,650**	**$0**	**$146,490**

GRAND TOTALS					
Travel including Lodging/Per Diems	$740	$15,730	$15,370	$0	**$31,840**
Meals and Refreshments Provided	$1,480	$25,910	$15,990	$0	**$43,380**
Conference / Training Space	$80	$1,820	$1,040	$0	**$2,940**
Fees / Stipends	$1,100	$23,200	$19,300	$0	**$43,600**
Supplies and Materials	$740	$11,040	$12,950	$0	**$24,730**
	$4,140	**$77,700**	**$64,650**	**$0**	**$ 146,490**

GRAND TOTALS Q3 YEAR 1	
Travel including Lodging/Per Diems	$0
Meals and Refreshments Provided	$0
Conference / Training Space	$0
Fees / Stipends	$0
Supplies and Materials	$0
	$0

GRAND TOTALS Q4 YEAR 1

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Doctors of the World-USA

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

Training / Workshops Organized by DOW*

Travel including Lodging/Per Diems	$740
Meals and Refreshments Provided	$1,480
Conference / Training Space	$80
Fees / Stipends	$1,100
Supplies and Materials	$740
	$4,140

*direct costs only - inflation applied on master budget page

Doctors of the World-USA

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

Year 1 Cash Projections

As of July 2007

	Year 1	Year 2 Adjusted	Year 3 Adjusted	Year 4 Adjusted	Year 5 Adjusted	Inflation Adjusted Total	TOTAL USAID Funds	TOTAL Cost Share	Year 1 Cost-Share USAID Funds	Year 1 Cost-Share Cost Share	Year 1 Q1 USAID Funds	Year 1 Q1 Cost Share	Year 1 Q2 USAID Funds	Year 1 Q2 Cost Share	Year 1 Q3 USAID Funds	Year 1 Q3 Cost Share	Year 1 Q4 USAID Funds	Year 1 Q4 Cost Share	Total Year 1 USAID Funds	Total Year 1 Cost Share	Total Year 1 All Funding	Year 1
Headquarters Staff																						
Program Director @ 0.05 FTE	$ 4,725	$ 4,867	$ 5,009	$ 5,150	$ -	$ 19,751	$ -	$ 19,751	$ -	$ 4,725	$ -	$ 1,181	$ -	$ 1,181	$ -	$ 1,181	$ -	$ 1,181	$ -	$ 4,725	$ 4,725	$ 4,725
Program Manager/M&E Specialist @ 0.30 FTE	22,500	23,175	23,850	24,525	-	94,050	94,050	-	22,500	-	5,625	-	5,625	-	5,625	-	5,625	-	22,500	-	22,500	$ 22,500
Program Associate @ 0.25 FTE	13,500	13,905	14,310	14,715	-	56,430	56,430	-	13,500	-	3,375	-	3,375	-	3,375	-	3,375	-	13,500	-	13,500	$ 13,500
Grants Manager @ 0.1 FTE	5,600	5,768	5,936	6,104	-	23,408	-	23,408	-	5,600	-	1,400	-	1,400	-	1,400	-	1,400	-	5,600	5,600	$ 5,600
Finance Manager @ 0.1 FTE	5,000	5,150	5,300	5,450	-	20,900	-	20,900	-	5,000	-	1,250	-	1,250	-	1,250	-	1,250	-	5,000	5,000	$ 5,000
HQ Staff Benefits @ 21% of salaries	10,733	11,055	11,377	11,699	-	44,862	22,431	22,431	5,366	5,366	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	5,366	5,366	10,733	$ 10,733
TOTAL HQ STAFF	**$ 62,058**	**$ 63,919**	**$ 65,781**	**$ 67,643**	**$ -**	**$ 259,401**	**$ 172,911**	**$ 86,490**	0 **$ 41,366**	**$ 20,691**	**$ 10,342**	**$ 5,173**	**$ 10,342**	**$ 5,173**	**$ 10,342**	**$ 5,173**	**$ 10,342**	**$ 5,173**	**$ 41,366**	**$ 20,691**	**$ 62,058**	**$ 62,058**
International Staff																						
HIV AIDS Project Director - Kenya @ .1 FTE	5,500	5,665	5,830	5,995	-	22,990	-	22,990	-	5,500	-	1,375	-	1,375	-	1,375	-	1,375	-	5,500	5,500	$ 5,500
International Staff Benefits @ 30% of salaries	1,540	1,586	1,632	1,679	-	6,437	-	6,437	-	1,540	-	385	-	385	-	385	-	385	-	1,540	1,540	$ 1,540
TOTAL INTERNATIONAL STAFF	**$ 7,040**	**$ 7,251**	**$ 7,462**	**$ 7,674**	**$ -**	**$ 29,427**	**$ -**	**$ 29,427**	0 **$ -**	**$ 7,040**	**$ -**	**$ 1,760**	**$ -**	**$ 1,760**	**$ -**	**$ 1,760**	**$ -**	**$ 1,760**	**$ -**	**$ 7,040**	**$ 7,040**	**$ 7,040**
National Staff - Kenya																						
CSH Project Director - Kenya @ 1.0 FTE	$ 16,875	$ 30,900	$ 31,800	$ 32,700	$ -	$ 112,275	$ 84,206	$ 28,069	$ 12,656	$ 4,219	$ -	$ -	$ -	$ -	$ 6,328	$ 2,109	$ 6,328	$ 2,109	$ 12,656	$ 4,219	$ 16,875	$ 16,875
Training Coordinator @ 0.5 FTE Yr 1, 1.0 FTE	$ 5,000	$ 20,600	$ 21,200	$ 21,800	$ -	$ 68,600	$ 51,450	$ 17,150	$ 3,750	$ 1,250	$ -	$ -	$ -	$ -	$ 1,875	$ 625	$ 1,875	$ 625	$ 3,750	$ 1,250	$ 5,000	$ 5,000
BCC Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs	4,000	8,240	8,480	8,720	-	29,440	22,080	7,360	3,000	1,000	-	-	-	-	1,500	500	1,500	500	3,000	1,000	4,000	$ 4,000
M&E Coordinator @.75 FTE Y1, 1.0 FTE Yrs 2	9,000	16,480	16,960	17,440	-	59,880	44,910	14,970	6,750	2,250	1,688	563	1,688	563	1,688	563	1,688	563	6,750	2,250	9,000	$ 9,000
Mobile ANC Coodinator @ 1.0 FTE	-	8,240	8,480	8,720	-	25,440	19,080	6,360	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
Project Assistant @ 1.0 FTE	4,000	4,120	4,240	4,360	-	16,720	12,540	4,180	3,000	1,000	750	250	750	250	750	250	750	250	3,000	1,000	4,000	$ 4,000
Accountant @ .5 FTE	-	1,545	795	409	-	2,749	2,062	687	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
Driver @ 1.0 FTE	1,500	4,120	4,240	4,360	-	14,220	10,665	3,555	1,125	375	281	94	281	94	281	94	281	94	1,125	375	1,500	$ 1,500
Driver @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	4,000	4,120	4,240	4,360	-	16,720	12,540	4,180	3,000	1,000	-	-	-	-	1,500	500	1,500	500	3,000	1,000	4,000	$ 4,000
Community Health Extension Worker (5) .5 FT	1,000	8,240	8,480	8,720		26,440 #	19,830	6,610	750	250	-	-	-	-	375	125	375	125	750	250	1,000	$ 1,000
National Staff Benefits @ 25% of salaries	11,344	26,651	27,229	27,897	-	93,121	69,841	23,280	8,508	2,836	680	227	680	227	3,574	1,191	3,574	1,191	8,508	2,836	11,344	$ 11,344
TOTAL NATIONAL STAFF	**$ 56,719**	**$ 133,256**	**$ 136,144**	**$ 139,486**	**$ -**	**$ 465,605**	**$ 349,204**	**$ 116,401**	**$ 42,539**	**$ 14,180**	**$ 3,398**	**$ 1,133**	**$ 3,398**	**$ 1,133**	**$ 17,871**	**$ 5,957**	**$ 17,871**	**$ 5,957**	**$ 42,539**	**$ 14,180**	**$ 56,719**	**$ 56,719**
Consulting/Contractors																						
Local IT Support and Consulting	$ 480	$ 989	$ 1,018	$ 1,046	$ -	$ 3,533	$ 1,766	$ 1,766	$ 240	$ 240	$ 240	$ 240	$ -	$ -	$ -	$ -	$ -	$ -	$ 240	$ 240	$ 480	$ 480
Program Consultants stipends/fees	$ 8,750	$ 13,133	$ 5,565	$ 24,798	$ -	$ 52,245	$ 26,123	$ 26,123	$ 4,375	$ 4,375	$ 4,375	$ 4,375	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,375	$ 4,375	$ 8,750	$ 8,750
Insurance for Consultants/Volunteers	972	501	-	1,059	-	2,532	1,266	1,266	486	486	486	486	-	-	-	-	-	-	486	486	972	$ 972
Other Consulting/Contracting											0	0										
Baseline KPC and KAPB Surveys	8,000	-	-	-	-	8,000	4,000	4,000	4,000	4,000	4,000	4,000	-	-	-	-	-	-	4,000	4,000	8,000	$ 8,000
Midterm / Endline KPC and KAPB Surveys	-	4,120	-	6,540	-	10,660	5,330	5,330	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
TOTAL CONSULTING / CONTRACTORS	**$ 18,202**	**$ 18,742**	**$ 6,583**	**$ 33,443**	**$ -**	**$ 76,970**	**$ 38,485**	**$ 38,485**	**$ 9,101**	**$ 9,101**	**$ 9,101**	**$ 9,101**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 9,101**	**$ 9,101**	**$ 18,202**	**$ 18,202**
Professional Fees																						
Legal	$ 600	$ 618	$ 636	$ 654	$ -	$ 2,508	$ 1,254	$ 1,254	$ 300	$ 300	$ 75	$ 75	$ 75	$ 75	$ 75	$ 75	$ 75	$ 75	$ 300	$ 300	$ 600	$ 600
Audit (local and international)	5,500	5,665	5,830	5,995	-	22,990	11,495	11,495	2,750	2,750	688	688	688	688	688	688	688	688	2,750	2,750	5,500	$ 5,500
TOTAL PROFESSIONAL FEES	**$ 6,100**	**$ 6,283**	**$ 6,466**	**$ 6,649**	**$ -**	**$ 25,498**	**$ 12,749**	**$ 12,749**	0 **$ 3,050**	**$ 3,050**	**$ 763**	**$ 763**	**$ 763**	**$ 763**	**$ 763**	**$ 763**	**$ 763**	**$ 763**	**$ 3,050**	**$ 3,050**	**$ 6,100**	**$ 6,100**
Rent, Utilities, Cleaning, Maintenance, etc.																						
Office Rent	$ 1,800	$ 1,854	$ 2,544	$ 2,616	$ -	$ 8,814	$ 6,611	$ 2,204	$ 1,350	$ 450	$ 338	$ 113	$ 338	$ 113	$ 338	$ 113	$ 338	$ 113	$ 1,350	$ 450	$ 1,800	$ 1,800
Cleaning/Maintenance/Utilities/Security	1,560	1,607	1,654	1,700	-	6,521	4,891	1,630	1,170	390	293	98	293	98	293	98	293	98	1,170	390	1,560	$ 1,560
TOTAL RENT, CLEANING, MAINT.	**$ 3,360**	**$ 3,461**	**$ 4,198**	**$ 4,316**	**$ -**	**$ 15,335**	**$ 11,501**	**$ 3,834**	0 **$ 2,520**	**$ 840**	**$ 630**	**$ 210**	**$ 630**	**$ 210**	**$ 630**	**$ 210**	**$ 630**	**$ 210**	**$ 2,520**	**$ 840**	**$ 3,360**	**$ 3,360**
Materials and Supplies																						
Printing and Photocopying	$ 1,200	$ 3,296	$ 3,392	$ 3,488	$ -	$ 11,376	$ 5,688	$ 5,688	$ 600	$ 600	$ 150	$ 150	$ 150	$ 150	$ 150	$ 150	$ 150	$ 150	$ 600	$ 600	$ 1,200	$ 1,200
Office Supplies	1,200	1,236	1,272	1,308	-	5,016	2,508	2,508	600	600	150	150	150	150	150	150	150	150	600	600	1,200	$ 1,200
Medical Supplies/Pharmaceuticals	-	13,588	6,391	1,690	-	21,668	10,834	10,834	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
Renovation/Rehabilitation Materials	-	12,360	-	-	-	12,360	6,180	6,180	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
TOTAL MATERIALS/SUPPLIES	**$ 2,400**	**$ 30,480**	**$ 11,055**	**$ 6,486**	**$ -**	**$ 50,420**	**$ 25,210**	**$ 25,210**	0 **$ 1,200**	**$ 1,200**	**$ 300**	**$ 300**	**$ 300**	**$ 300**	**$ 300**	**$ 300**	**$ 300**	**$ 300**	**$ 1,200**	**$ 1,200**	**$ 2,400**	**$ 2,400**
Equipment, Furniture, Vehicles																						
Equipment, Furniture Under $5,000	$ 9,700	$ 4,326	$ 636	$ 654	$ -	$ 15,316	$ 15,316	$ -	$ 9,700	$ -	$ 9,700	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,700	$ -	$ 9,700	$ 9,700
Vehicles	38,000	103,000	53,000	-	-	194,000	106,000	88,000	20,763	17,237	20,763	17,237	-	-	-	-	-	-	20,763	17,237	38,000	$ 38,000
TOTAL EQUIPMENT, FURNITURE, VEHICLE	**$ 47,700**	**$ 107,326**	**$ 53,636**	**$ 654**	**$ -**	**$ 209,316**	**$ 121,316**	**$ 88,000**	0 **$ 30,463**	**$ 17,237**	**$ 30,463**	**$ 17,237**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 30,463**	**$ 17,237**	**$ 47,700**	**$ 47,700**
Vehicle Fuel and Maintenance																						**2**
Vehicle Fuel	$ 1,120	$ 7,581	$ 11,109	$ 6,322	$ -	$ 26,132	$ 26,132	$ -	$ 1,120	$ -	$ 280	$ -	$ 280	$ -	$ 280	$ -	$ 280	$ -	$ 1,120	$ -	$ 1,120	$ 1,120
Vehicle Maintenance	200	2,678	4,028	2,180	-	9,086	9,086	-	200	-	50	-	50	-	50	-	50	-	200	-	200	$ 200
Vehicle Fees / Taxes / Insurance	1,132	4,256	5,370	5,450	-	16,208	16,208	-	1,132	-	283	-	283	-	283	-	283	-	1,132	-	1,132	$ 1,132
TOTAL VEHICLE FUEL AND MAINTENANC	**$ 2,452**	**$ 14,515**	**$ 20,507**	**$ 13,952**	**$ -**	**$ 51,426**	**$ 51,426**	**$ -**	0 **$ 2,452**	**$ -**	**$ 613**	**$ -**	**$ 613**	**$ -**	**$ 613**	**$ -**	**$ 613**	**$ -**	**$ 2,452**	**$ -**	**$ 2,452**	**$ 2,452**
Travel for Staff and Consultants																						
In-Country/Regional Travel	$ 8,550	$ 8,127	$ 8,363	$ 8,600	$ -	$ 33,640	$ 25,230	$ 8,410	$ 6,413	$ 2,138	$ 3,206	$ 1,069	$ 962	$ 321	$ 962	$ 321	$ 1,283	$ 428	$ 6,413	$ 2,138	$ 8,550	$ 8,550
International Travel	42,400	16,274	12,190	18,312	-	89,176	66,882	22,294	31,800	10,600	15,900	5,300	4,770	1,590	4,770	1,590	6,360	2,120	31,800	10,600	42,400	$ 42,400
TOTAL TRAVEL - STAFF AND CONSULTAN	**$ 50,950**	**$ 24,401**	**$ 20,553**	**$ 26,912**	**$ -**	**$ 122,816**	**$ 92,112**	**$ 30,704**	0 **$ 38,213**	**$ 12,738**	**$ 19,106**	**$ 6,369**	**$ 5,732**	**$ 1,911**	**$ 5,732**	**$ 1,911**	**$ 7,643**	**$ 2,548**	**$ 38,213**	**$ 12,738**	**$ 50,950**	**$ 50,950**
Communications & Postage																						
Postage & Delivery	$ 1,200	$ 1,236	$ 1,272	$ 1,308	$ -	$ 5,016	$ 3,762	$ 1,254	$ 900	$ 300	$ 225	$ 75	$ 225	$ 75	$ 225	$ 75	$ 225	$ 75	$ 900	$ 300	$ 1,200	$ 1,200
Telephone	4,200	4,326	4,452	4,578	-	17,556	13,167	4,389	3,150	1,050	788	263	788	263	788	263	788	263	3,150	1,050	4,200	$ 4,200
Internet Service/Email	3,600	3,708	3,816	3,924	-	15,048	11,286	3,762	2,700	900	675	225	675	225	675	225	675	225	2,700	900	3,600	$ 3,600
TOTAL COMMUNICATIONS	**$ 9,000**	**$ 9,270**	**$ 9,540**	**$ 9,810**	**$ -**	**$ 37,620**	**$ 28,215**	**$ 9,405**	0 **$ 6,750**	**$ 2,250**	**$ 1,688**	**$ 563**	**$ 1,688**	**$ 563**	**$ 1,688**	**$ 563**	**$ 1,688**	**$ 563**	**$ 6,750**	**$ 2,250**	**$ 9,000**	**$ 9,000**
Training / Conferences organized by DOW																						
Travel including Lodging/Per Diems	$ 13,360	$ 22,794	$ 26,468	$ -	$ -	$ 62,622	$ 62,622	$ -	$ 13,360	$ -	$ -	$ -	$ -	$ -			$ 13,360	$ -	$ 13,360	$ -	$ 13,360	$ 13,360
Meals and Refreshments Provided	18,920	37,235	26,108	-	-	82,262	$ 82,262	$ -	$ 18,920	$ -	-	-	-	-			$ 18,920	$ -	18,920	-	18,920	$ 18,920
Conference / Training Space	1,040	2,596	1,102	-	-	4,738	$ 4,738	$ -	$ 1,040	$ -	-	-	-	-			$ 1,040	$ -	1,040	-	1,040	$ 1,040
Fees / Stipends	17,800	28,469	32,330	-	-	78,599	$ 78,599	$ -	$ 17,800	$ -	-	-	-	-			$ 17,800	$ -	17,800	-	17,800	$ 17,800
Supplies and Materials	9,460	13,318	19,705	-	-	42,483	$ 31,862	$ 10,621	$ 7,095	$ 2,365	-	-	-	-			$ 7,095	$ 2,365	7,095	2,365	9,460	$ 9,460
Add'l training resources and materials	2000	7,210	7,420	2,180		18,810	$ 14,108	$ 4,703	$ 1,500	$ 500	-	-	-	-			$ 1,500	$ 500	1,500	500	2,000	$ 2,000
TOTAL TRAINING	**$ 62,580**	**$ 111,621**	**$ 113,134**	**$ 2,180**	**$ -**	**$ 289,515**	**$ 274,192**	**$ 15,323**	0 **$ 59,715**	**$ 2,865**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 59,715**	**$ 2,865**	**$ 59,715**	**$ 2,865**	**$ 62,580**	**$ 62,580**
Other Program Expenses																						
Meeting Coordination and Supplies	$ 2,900	$ 8,804	$ 9,061	$ 9,317	$ -	$ 30,083	$ 15,041	$ 15,041	$ 1,450	$ 1,450	$ 363	$ 363	$ 363	$ 363	$ 363	$ 363	$ 363	$ 363	$ 1,450	$ 1,450	$ 2,900	$ 2,900
Vouchers for Safe Delivery	-	12,360	12,720	13,080	-	38,160	19,080	19,080	-	-	-	-	-	-	-	-	-	-	-	-	-	$ -
Insecticide-Treated Bednet Distribution Progra	2,000	2,060	2,120	2,180	-	8,360	-	8,360	-	2,000	-	500	-	500	-	500	-	500	-	2,000	2,000	$ 2,000
TOTAL OTHER PROGRAM EXPENSES	**$ 4,900**	**$ 23,224**	**$ 23,901**	**$ 24,577**	**$ -**	**$ 76,603**	**$ 34,121**	**$ 42,481**	0 **$ 1,450**	**$ 3,450**	**$ 363**	**$ 863**	**$ 363**	**$ 863**	**$ 363**	**$ 863**	**$ 363**	**$ 863**	**$ 1,450**	**$ 3,450**	**$ 4,900**	**$ 4,900**
Other Expenses																						
Recruiting for Field positions	$ 3,000	$ 1,445	$ -	$ -	$ -	$ 4,445	$ -	$ 4,445	$ -	$ 3,000	-	750	-	750	-	750	-	750	$ -	$ 3,000	$ 3,000	$ 3,000
TOTAL OTHER EXPENSES	**$ 3,000**	**$ 1,445**	**$ -**	**$ -**	**$ -**	**$ 4,445**	**$ -**	**$ 4,445**	0 **$ -**	**$ 3,000**	**$ -**	**$ 750**	**$ -**	**$ 750**	**$ -**	**$ 750**	**$ -**	**$ 750**	**$ -**	**$ 3,000**	**$ 3,000**	**$ 3,000**
Fees, Charges, Taxes																						
Bank Charges	$ 600	$ 618	$ 636	$ 654	$ -	$ 2,508	$ 1,660	$ 848	$ 397	$ 203	99	51	99	51	99	51	99	51	$ 397	$ 203	$ 600	$ 600
TOTAL FEES, CHARGES, TAXES	**$ 600**	**$ 618**	**$ 636**	**$ 654**	**$ -**	**$ 2,508**	**$ 1,660**	**$ 848**	0 **$ 397**	**$ 203**	**$ 99**	**$ 51**	**$ 99**	**$ 51**	**$ 99**	**$ 51**	**$ 99**	**$ 51**	**$ 397**	**$ 203**	**$ 600**	**$ 600**
TOTAL DIRECT COSTS	**$ 337,060**	**$ 555,812**	**$ 479,595**	**$ 344,436**	**$ -**	**$ 1,716,904**	**$ 1,213,101**	**$ 503,802**	0 **$ 239,216**	**$ 97,844**	**$ 76,865**	**$ 44,271**	**$ 23,927**	**$ 13,474**	**$ 38,399**	**$ 18,299**	**$ 100,025**	**$ 21,801**	**$ 239,216**	**$ 97,844**	**$ 337,060**	**$ 337,060**
INDIRECT RATE - 23.65%	**$ 79,715**	**$ 131,450**	**$ 113,424**	**$ 81,459**	**$ -**	**$ 406,048**	**$ 286,898**	**$ 119,149**	0 **$ 56,575**	**$ 23,140**	**$ 18,179**	**$ 10,470**	**$ 5,659**	**$ 3,187**	**$ 9,081**	**$ 4,328**	**$ 23,656**	**$ 5,156**	**$ 56,575**	**$ 23,140**	**$ 79,715**	**$ 79,715**

Doctors of the World-USA

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

Year 1 Cash Projections

As of July 2007

							TOTAL		Year 1 Cost-Share		Year 1 Q1		Year 1 Q2		Year 1 Q3		Year 1 Q4		Total Year 1			
	Year 1	Year 2 Adjusted	Year 3 Adjusted	Year 4 Adjusted	Year 5 Adjusted	Inflation Adjusted Total	USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	All Funding	Year 1
TOTAL BUDGET	$ 416,775	$ 687,262	$ 593,019	$ 425,895	$ -	$ 2,122,951	$ 1,500,000	$ 622,951	0 $ 295,791	$ 120,985	$ 95,044	$ 54,741	$ 29,585	$ 16,661	$ 47,481	$ 22,626	$ 123,681	$ 26,956	$ 295,791	$ 120,985	$ 416,775	$ 416,775

Doctors of the World-USA

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

4 Year Cash Projections

As of July 2007

	Year 1	Year 2 Adjusted	Year 3 Adjusted	Year 4 Adjusted	Year 5 Adjusted	Inflation Adjusted Total		YEAR 1 SPENDING		YEAR 2 SPENDING	
							USAID Funds	USAID Funds	Cost Share	USAID Funds	Cost Share
Headquarters Staff											
Program Director @ 0.05 FTE	$ 4,725	$ 4,867	$ 5,009	$ 5,150	$ -	$ 19,751	$ -	$ -	$ 4,725	$ -	$ 4,867
Program Manager/M&E Specialist @ 0.30 FTE	22,500	23,175	23,850	24,525	-	94,050	$ 94,050	22,500	-	23,175	-
Program Associate @ 0.25 FTE	13,500	13,905	14,310	14,715	-	56,430	$ 56,430	13,500	-	13,905	-
Grants Manager @ 0.1 FTE	5,600	5,768	5,936	6,104	-	23,408	$ -	-	5,600	-	5,768
Finance Manager @ 0.1 FTE	5,000	5,150	5,300	5,450	-	20,900	$ -	-	5,000	-	5,150
HQ Staff Benefits @ 21% of salaries	10,733	11,055	11,377	11,699	-	44,862	$ 22,431	5,366	5,366	5,527	5,527
TOTAL HQ STAFF	**$ 62,058**	**$ 63,919**	**$ 65,781**	**$ 67,643**	**$ -**	**$ 259,401**	**$ 172,911**	**$ 41,366**	**$ 20,691**	**$ 42,607**	**$ 21,312**
International Staff											
HIV AIDS Project Director - Kenya @ .1 FTE	5,500	5,665	5,830	5,995	-	22,990	$ -	-	5,500	-	5,665
International Staff Benefits @ 30% of salaries	1,540	1,586	1,632	1,679	-	6,437	$ -	-	1,540	-	1,586
TOTAL INTERNATIONAL STAFF	**$ 7,040**	**$ 7,251**	**$ 7,462**	**$ 7,674**	**$ -**	**$ 29,427**	**$ -**	**$ -**	**$ 7,040**	**$ -**	**$ 7,251**
National Staff - Kenya											
CSH Project Director - Kenya @ 1.0 FTE	$ 16,875	$ 30,900	$ 31,800	$ 32,700	$ -	$ 112,275	$ 84,206	$ 12,656	$ 4,219	$ 23,175	$ 7,725
Training Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	$ 5,000	$ 20,600	$ 21,200	$ 21,800	$ -	$ 68,600	$ 51,450	$ 3,750	$ 1,250	$ 15,450	$ 5,150
BCC Coordinator @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	4,000	8,240	8,480	8,720	-	29,440	$ 22,080	3,000	1,000	6,180	2,060
M&E Coordinator @.75 FTE Y1, 1.0 FTE Yrs 2-4	9,000	16,480	16,960	17,440	-	59,880	$ 44,910	6,750	2,250	12,360	4,120
Mobile ANC Coodinator @ 1.0 FTE	-	8,240	8,480	8,720	-	25,440	$ 19,080	-	-	6,180	2,060
Project Assistant @ 1.0 FTE	4,000	4,120	4,240	4,360	-	16,720	$ 12,540	3,000	1,000	3,090	1,030
Accountant @ .5 FTE	-	1,545	795	409	-	2,749	$ 2,062	-	-	1,159	386
Driver @ 1.0 FTE	1,500	4,120	4,240	4,360	-	14,220	$ 10,665	1,125	375	3,090	1,030
Driver @ 0.5 FTE Yr 1, 1.0 FTE Yrs 2-4	4,000	4,120	4,240	4,360	-	16,720	$ 12,540	3,000	1,000	3,090	1,030
Community Health Extension Worker (5) .5 FTE	1,000	8,240	8,480	8,720	-	26,440	$ 19,830	750	250	6,180	2,060
National Staff Benefits @ 25% of salaries	11,344	26,651	27,229	27,897	-	93,121	$ 69,841	8,508	2,836	19,988	6,663
TOTAL NATIONAL STAFF	**$ 56,719**	**$ 133,256**	**$ 136,144**	**$ 139,486**	**$ -**	**$ 465,605**	**$ 349,204**	**$ 42,539**	**$ 14,180**	**$ 99,942**	**$ 33,314**
Consulting/Contractors											
Local IT Support and Consulting	$ 480	$ 989	$ 1,018	$ 1,046	$ -	$ 3,533	$ 1,766	$ 240	$ 240	$ 494	$ 494
Program Consultants stipends/fees	$ 8,750	$ 13,133	$ 5,565	$ 24,798	$ -	$ 52,245	$ 26,123	$ 4,375	$ 4,375	$ 6,566	$ 6,566
Insurance for Consultants/Volunteers	972	501	-	1,059	-	2,532	$ 1,266	486	486	250	250
Other Consulting/Contracting	-	-	-	-	-	-	$ -	-	-	-	-
Baseline KPC and KAPB Surveys	8,000	-	-	-	-	8,000	$ 4,000	4,000	4,000	-	-
Midterm / Endline KPC and KAPB Surveys	-	4,120	-	6,540	-	10,660	$ 5,330	-	-	2,060	2,060
TOTAL CONSULTING / CONTRACTORS	**$ 18,202**	**$ 18,742**	**$ 6,583**	**$ 33,443**	**$ -**	**$ 76,970**	**$ 38,485**	**$ 9,101**	**$ 9,101**	**$ 9,371**	**$ 9,371**
Professional Fees											
Legal	$ 600	$ 618	$ 636	$ 654	$ -	$ 2,508	$ 1,254	$ 300	$ 300	$ 309	$ 309
Audit (local and international)	5,500	5,665	5,830	5,995	-	22,990	$ 11,495	2,750	2,750	2,833	2,833
TOTAL PROFESSIONAL FEES	**$ 6,100**	**$ 6,283**	**$ 6,466**	**$ 6,649**	**$ -**	**$ 25,498**	**$ 12,749**	**$ 3,050**	**$ 3,050**	**$ 3,142**	**$ 3,142**
Rent, Utilities, Cleaning, Maintenance, etc.											
Office Rent	$ 1,800	$ 1,854	$ 2,544	$ 2,616	$ -	$ 8,814	$ 6,611	$ 1,350	$ 450	$ 1,391	$ 464
Cleaning/Maintenance/Utilities/Security	1,560	1,607	1,654	1,700	-	6,521	$ 4,891	1,170	390	1,205	402
TOTAL RENT, CLEANING, MAINT.	**$ 3,360**	**$ 3,461**	**$ 4,198**	**$ 4,316**	**$ -**	**$ 15,335**	**$ 11,501**	**$ 2,520**	**$ 840**	**$ 2,596**	**$ 865**
Materials and Supplies											
Printing and Photocopying	$ 1,200	$ 3,296	$ 3,392	$ 3,488	$ -	$ 11,376	$ 5,688	$ 600	$ 600	$ 1,648	$ 1,648
Office Supplies	1,200	1,236	1,272	1,308	-	5,016	$ 2,508	600	600	618	618
Medical Supplies/Pharmaceuticals	-	13,588	6,391	1,690	-	21,668	$ 10,834	-	-	6,794	6,794
Renovation/Rehabilitation Materials	-	12,360	-	-	-	12,360	$ 6,180	-	-	6,180	6,180
TOTAL MATERIALS/SUPPLIES	**$ 2,400**	**$ 30,480**	**$ 11,055**	**$ 6,486**	**$ -**	**$ 50,420**	**$ 25,210**	**$ 1,200**	**$ 1,200**	**$ 15,240**	**$ 15,240**
Equipment, Furniture, Vehicles											

Doctors of the World-USA

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

4 Year Cash Projections

As of July 2007

	Year 1	Year 2 Adjusted	Year 3 Adjusted	Year 4 Adjusted	Year 5 Adjusted	Inflation Adjusted Total	USAID Funds	YEAR 1 SPENDING USAID Funds	YEAR 1 SPENDING Cost Share	YEAR 2 SPENDING USAID Funds	YEAR 2 SPENDING Cost Share
Equipment, Furniture Under $5,000	$ 9,700	$ 4,326	$ 636	$ 654	$ -	$ 15,316	$ 15,316	$ 9,700	$ -	$ 4,326	$ -
Vehicles	38,000	103,000	53,000	-	-	194,000	$ 106,000	$ 20,763	$ 17,237	$ 56,278	$ 46,722
TOTAL EQUIPMENT, FURNITURE, VEHICLES	**$ 47,700**	**$ 107,326**	**$ 53,636**	**$ 654**	**$ -**	**$ 209,316**	**$ 121,316**	**$ 30,463**	**$ 17,237**	**$ 60,604**	**$ 46,722**
Vehicle Fuel and Maintenance											
Vehicle Fuel	$ 1,120	$ 7,581	$ 11,109	$ 6,322	$ -	$ 26,132	$ 26,132	$ 1,120	$ -	$ 7,581	$ -
Vehicle Maintenance	200	2,678	4,028	2,180	-	9,086	$ 9,086	200	-	2,678	-
Vehicle Fees / Taxes / Insurance	1,132	4,256	5,370	5,450	-	16,208	$ 16,208	1,132	-	4,256	-
TOTAL VEHICLE FUEL AND MAINTENANCE	**$ 2,452**	**$ 14,515**	**$ 20,507**	**$ 13,952**	**$ -**	**$ 51,426**	**$ 51,426**	**$ 2,452**	**$ -**	**$ 14,515**	**$ -**
Travel for Staff and Consultants											
In-Country/Regional Travel	$ 8,550	$ 8,127	$ 8,363	$ 8,600	$ -	$ 33,640	$ 25,230	$ 6,413	$ 2,138	$ 6,095	$ 2,032
International Travel	42,400	16,274	12,190	18,312	-	89,176	$ 66,882	31,800	10,600	12,206	4,069
TOTAL TRAVEL - STAFF AND CONSULTANTS	**$ 50,950**	**$ 24,401**	**$ 20,553**	**$ 26,912**	**$ -**	**$ 122,816**	**$ 92,112**	**$ 38,213**	**$ 12,738**	**$ 18,301**	**$ 6,100**
Communications & Postage											
Postage & Delivery	$ 1,200	$ 1,236	$ 1,272	$ 1,308	$ -	$ 5,016	$ 3,762	$ 900	$ 300	$ 927	$ 309
Telephone	4,200	4,326	4,452	4,578	-	17,556	$ 13,167	3,150	1,050	3,245	1,082
Internet Service/Email	3,600	3,708	3,816	3,924	-	15,048	$ 11,286	2,700	900	2,781	927
TOTAL COMMUNICATIONS	**$ 9,000**	**$ 9,270**	**$ 9,540**	**$ 9,810**	**$ -**	**$ 37,620**	**$ 28,215**	**$ 6,750**	**$ 2,250**	**$ 6,953**	**$ 2,318**
Training / Conferences organized by DOW											
Travel including Lodging/Per Diems	$ 13,360	$ 22,794	$ 26,468	$ -	$ -	$ 62,622	$ 62,622	$ 13,360	$ -	$ 22,794	$ -
Meals and Refreshments Provided	18,920	37,235	26,108	-	-	82,262	$ 82,262	18,920	-	37,235	-
Conference / Training Space	1,040	2,596	1,102	-	-	4,738	$ 4,738	1,040	-	2,596	-
Fees / Stipends	17,800	28,469	32,330	-	-	78,599	$ 78,599	17,800	-	28,469	-
Supplies and Materials	9,460	13,318	19,705	-	-	42,483	$ 31,862	7,095	2,365	9,988	3,329
Add'l training resources and materials	2,000	7,210	7,420	2,180	-	18,810	$ 14,108	1,500	500	5,408	1,803
TOTAL TRAINING	**$ 62,580**	**$ 111,621**	**$ 113,134**	**$ 2,180**	**$ -**	**$ 289,515**	**$ 274,192**	**$ 59,715**	**$ 2,865**	**$ 106,489**	**$ 5,132**
Other Program Expenses											
Meeting Coordination and Supplies	$ 2,900	$ 8,804	$ 9,061	$ 9,317	$ -	$ 30,083	$ 15,041	$ 1,450	$ 1,450	$ 4,402	$ 4,402
Vouchers for Safe Delivery	-	12,360	12,720	13,080	-	38,160	$ 19,080	-	-	6,180	6,180
Insecticide-Treated Bednet Distribution Program	2,000	2,060	2,120	2,180	-	8,360	$ -	-	2,000	-	2,060
TOTAL OTHER PROGRAM EXPENSES	**$ 4,900**	**$ 23,224**	**$ 23,901**	**$ 24,577**	**$ -**	**$ 76,603**	**$ 34,121**	**$ 1,450**	**$ 3,450**	**$ 10,582**	**$ 12,642**
Other Expenses											
Recruiting for Field positions	$ 3,000	$ 1,445	$ -	$ -	$ -	$ 4,445	$ -	$ -	$ 3,000	$ -	$ 1,445
TOTAL OTHER EXPENSES	**$ 3,000**	**$ 1,445**	**$ -**	**$ -**	**$ -**	**$ 4,445**	**$ -**	**$ -**	**$ 3,000**	**$ -**	**$ 1,445**
Fees, Charges, Taxes											
Bank Charges	$ 600	$ 618	$ 636	$ 654	$ -	$ 2,508	$ 1,660	$ 397	$ 203	$ 409	$ 209
TOTAL FEES, CHARGES, TAXES	**$ 600**	**$ 618**	**$ 636**	**$ 654**	**$ -**	**$ 2,508**	**$ 1,660**	**$ 397**	**$ 203**	**$ 409**	**$ 209**
TOTAL DIRECT COSTS	**$ 337,060**	**$ 555,812**	**$ 479,595**	**$ 344,436**	**$ -**	**$ 1,716,904**	**$ 1,213,101**	**$ 239,216**	**$ 97,844**	**$ 390,750**	**$ 165,062**
INDIRECT RATE - 23.65%	**$ 79,715**	**$ 131,450**	**$ 113,424**	**$ 81,459**	**$ -**	**$ 406,048**	**$ 286,898**	**$ 56,575**	**$ 23,140**	**$ 92,412**	**$ 39,037**
TOTAL BUDGET	**$ 416,775**	**$ 687,262**	**$ 593,019**	**$ 425,895**	**$ -**	**$ 2,122,951**	**$ 1,500,000**	**$ 295,791**	**$ 120,985**	**$ 483,162**	**$ 204,100**

Doctors of the World-USA

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

4 Year Cash Projections

YEAR 3 SPENDING		YEAR 4 SPENDING		Total		
USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	All Funding
$ -	$ 5,009	$ -	$ 5,150	$ -	$ 19,751	$ 19,751
23,850	-	24,525	-	94,050	-	94,050
14,310	-	14,715	-	56,430	-	56,430
-	5,936	-	6,104	-	23,408	23,408
-	5,300	-	5,450	-	20,900	20,900
5,688	5,688	5,849	5,849	22,431	22,431	44,862
$ 43,848	**$ 21,933**	**$ 45,089**	**$ 22,554**	**$ 172,911**	**$ 86,490**	**$ 259,401**
-	5,830	-	5,995	-	22,990	22,990
-	1,632	-	1,679	-	6,437	6,437
$ -	**$ 7,462**	**$ -**	**$ 7,674**	**$ -**	**$ 29,427**	**$ 29,427**
$ 23,850	$ 7,950	$ 24,525	$ 8,175	$ 84,206	$ 28,069	$ 112,275
$ 15,900	$ 5,300	$ 16,350	$ 5,450	$ 51,450	$ 17,150	$ 68,600
6,360	2,120	6,540	2,180	22,080	7,360	29,440
12,720	4,240	13,080	4,360	44,910	14,970	59,880
6,360	2,120	6,540	2,180	19,080	6,360	25,440
3,180	1,060	3,270	1,090	12,540	4,180	16,720
596	199	307	102	2,062	687	2,749
3,180	1,060	3,270	1,090	10,665	3,555	14,220
3,180	1,060	3,270	1,090	12,540	4,180	16,720
6,360	2,120	6,540	2,180	19,830	6,610	26,440
20,422	6,807	20,923	6,974	69,841	23,280	93,121
$ 102,108	**$ 34,036**	**$ 104,614**	**$ 34,871**	**$ 349,204**	**$ 116,401**	**$ 465,605**
$ 509	$ 509	$ 523	$ 523	1,766	1,766	3,533
$ 2,783	$ 2,783	$ 12,399	$ 12,399	26,123	26,123	52,245
-	-	530	530	1,266	1,266	2,532
-	-	-	-	-	-	-
-	-	-	-	4,000	4,000	8,000
-	-	3,270	3,270	5,330	5,330	10,660
$ 3,291	**$ 3,291**	**$ 16,722**	**$ 16,722**	**$ 38,485**	**$ 38,485**	**$ 76,970**
$ 318	$ 318	$ 327	$ 327	1,254	1,254	2,508
2,915	2,915	2,998	2,998	11,495	11,495	22,990
$ 3,233	**$ 3,233**	**$ 3,325**	**$ 3,325**	**$ 12,749**	**$ 12,749**	**$ 25,498**
$ 1,908	$ 636	$ 1,962	$ 654	6,611	2,204	8,814
1,240	413	1,275	425	4,891	1,630	6,521
$ 3,148	**$ 1,049**	**$ 3,237**	**$ 1,079**	**$ 11,501**	**$ 3,834**	**$ 15,335**
$ 1,696	$ 1,696	$ 1,744	$ 1,744	5,688	5,688	11,376
636	636	654	654	2,508	2,508	5,016
3,195	3,195	845	845	10,834	10,834	21,668
-	-	-	-	6,180	6,180	12,360
$ 5,527	**$ 5,527**	**$ 3,243**	**$ 3,243**	**$ 25,210**	**$ 25,210**	**$ 50,420**

Doctors of the World-USA

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

4 Year Cash Projections

YEAR 3 SPENDING		YEAR 4 SPENDING		Total		
USAID Funds	Cost Share	USAID Funds	Cost Share	USAID Funds	Cost Share	All Funding
$ 636	$ -	$ 654	$ -	15,316	-	15,316
$ 28,959	$ 24,041	$ -	$ -	106,000	88,000	194,000
$ 29,595	**$ 24,041**	**$ 654**	**$ -**	**$ 121,316**	**$ 88,000**	**$ 209,316**
$ 11,109	$ -	$ 6,322	$ -	26,132	-	26,132
4,028	-	2,180	-	9,086	-	9,086
5,370	-	5,450	-	16,208	-	16,208
$ 20,507	**$ -**	**$ 13,952**	**$ -**	**$ 51,426**	**$ -**	**$ 51,426**
$ 6,273	$ 2,091	$ 6,450	$ 2,150	25,230	8,410	33,640
9,143	3,048	13,734	4,578	66,882	22,294	89,176
$ 15,415	**$ 5,138**	**$ 20,184**	**$ 6,728**	**$ 92,112**	**$ 30,704**	**$ 122,816**
$ 954	$ 318	$ 981	$ 327	3,762	1,254	5,016
3,339	1,113	3,434	1,145	13,167	4,389	17,556
2,862	954	2,943	981	11,286	3,762	15,048
$ 7,155	**$ 2,385**	**$ 7,358**	**$ 2,453**	**$ 28,215**	**$ 9,405**	**$ 37,620**
$ 26,468	$ -	$ -	$ -	62,622	-	62,622
26,108	-	-	-	82,262	-	82,262
1,102	-	-	-	4,738	-	4,738
32,330	-	-	-	78,599	-	78,599
14,779	4,926	-	-	31,862	10,621	42,483
5,565	1,855	1,635	545	14,108	4,703	18,810
$ 106,352	**$ 6,781**	**$ 1,635**	**$ 545**	**$ 274,192**	**$ 15,323**	**$ 289,515**
$ 4,530	$ 4,530	$ 4,659	$ 4,659	15,041	15,041	30,083
6,360	6,360	6,540	6,540	19,080	19,080	38,160
-	2,120	-	2,180	-	8,360	8,360
$ 10,890	**$ 13,010**	**$ 11,199**	**$ 13,379**	**$ 34,121**	**$ 42,481**	**$ 76,603**
$ -	$ -	$ -	$ -	-	4,445	4,445
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,445**	**$ 4,445**
$ 421	$ 215	$ 433	$ 221	1,660	848	2,508
$ 421	**$ 215**	**$ 433**	**$ 221**	**$ 1,660**	**$ 848**	**$ 2,508**
$ 351,491	**$ 128,104**	**$ 231,644**	**$ 112,792**	**$ 1,213,101**	**$ 503,802**	**$ 1,716,904**
$ 83,128	**$ 30,296**	**$ 54,784**	**$ 26,675**	**$ 286,898**	**$ 119,149**	**$ 406,048**
$ 434,619	**$ 158,400**	**$ 286,428**	**$ 139,467**	**$ 1,500,000**	**$ 622,951**	**$ 2,122,951**

OMB Approval No. 0348-0043

Application For Federal Assistance

2. DATE SUBMITTED
July 16, 2007

Applicant Identifier
NA

1. TYPE OF SUBMISSION

Application
- [ ] **Construction**
- [x] **Non-Construction**

Preapplication NA
- [ ] **Construction**
- [ ] **Non-Construction**

3. DATE RECEIVED BY STATE
NA

State Application Identifier
NA

4. DATE RECEIVED BY FEDERAL AGENCY

Federal Identifier
NA

5. APPLICANT INFORMATION

Legal Name:
Doctors of the World-USA, Inc.

Organizational Unit:
N/A

Address (give city, county, state, and zip code)
80 Maiden Lane
New York, NY 10038

Name and telephone number of person to be contacted on matters involving this application *(give area code)*.
Thomas Dougherty, 212-226-9890 x4820

6. EMPLOYER IDENTIFICATION NUMBER:
1 3 - 3 7 9 1 3 9 1

7.TYPE OF APPLICANT *(enter appropriate letter in box)* [N]

A. State
B County
C. Municipal
D. Township
E, Interstate
F. Intermunicipal
G. Special District
H. Independent School District
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify) **Non-profit -Private Voluntary Organization**

8. TYPE OF APPLICATION:
- [ ] New
- [ ] Continuation
- [x] Revision

If Revision, enter appropriate letter(s) in box(s):

A. Increase Award
B. Decrease Award
C. Increase Duration
D. Decrease Duration
Other (specify):

9. NAME OF FEDERAL AGENCY:
USAID

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
9 8 0 0 1

TITLE: **FY-2006 Child Survival and Health Grants Program**
RFA No. M/OAA/GH/HSR-06-001

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Partnership for Maternal and Neonatal Health
West Pokot District Child Survival and Health Program

12. AREAS AFFECTED BY PROJECT *(cities, counties, states, etc.):*
KENYA

13. PROPOSED PROJECT:

Start Date	Ending Date
10/01/06	**09/30/10**

14. CONGRESSIONAL DISTRICT OF: **Manhattan**

a. Applicant **8th District**

b. Project

15. ESTIMATED FUNDING:

a. Federal	$1,500,000
b. Applicant	$622,951
c. State	$0
d. Local	$0
e. Other	$0
f. Program Income	$0
g. TOTAL	$2,122,951

16. IS APPLICANT SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE: _____

b. No. [x] PROGRAM IS NOT COVERED BY E.O. 12372

[ ] OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

[ ] **Yes if "Yes", attach an explanation.** [X] **No**

18. **TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.**

a Typed Name of Authorized Representative
Thomas J. Dougherty

b Title
Executive Director

c Telephone Number
212-226-9890 x4820

d Signature of Authorized Representative
TDougherty

e Date Signed
7/16/2007

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds Federal (c)	Estimated Unobligated Funds Non-Federal (d)	New or Revised Budget Federal (e)	New or Revised Budget Non-Federal (f)	New or Revised Budget Total (g)
1. Partnership for Maternal & Neonatal Health - West Pokot District Child Survival & Health Program	98-001	$1,500,000	$622,951			$2,122,951
2.						$0
3.						$0
4.						$0
5. TOTALS		$1,500,000	$622,951	$0	$0	$2,122,951

SECTION B - BUDGET CATEGORIES

6. OBJECT CLASS CATEGORIES	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) USAID Funds	(2) Matching Funds	(3) 0	(4) 0	Total (5)
a. Personnel	$429,843	$180,169			$610,012
b. Fringe Benefits	$92,272	$52,149			$144,420
c. Travel	$92,112	$30,704			$122,816
d. Equipment	$121,316	$88,000			$209,316
e. Supplies	$25,210	$25,210			$50,420
f. Contractual	$38,485	$38,485			$76,970
g. Construction	$0	$0			$0
h. Other	$413,864	$89,085			$502,949
i. Total Direct Charges (sum of 6a-6h)	$1,213,101	$503,802			$1,716,904
j. Indirect Charges	$286,898	$119,149			$406,048
k. TOTALS (sum of 6i and 6j)	$1,500,000	$622,951			$2,122,951
7. PROGRAM INCOME	$0	$0	$0	$0	$0

Standard Form 424A (Rev. 7-97)

Previous Edition Usable

Authorized for Local Reproduction

Prescribed by OMB Circular A-102

SECTION C - NON FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other sources	(e) TOTALS
8. Partnership for Maternal & Neonatal Health - West Pokot District Child Survival & Health Program	$622,951	$0	$0	$622,951
9.				$0
10.				$0
11.				$0
12. TOTALS (sum of lines 8 and 11)	$622,951	$0	$0	$622,951

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$295,791	$95,044	$29,585	$47,481	$123,681
14. NonFederal	$120,985	$54,741	$16,661	$22,626	$26,956
15. TOTAL (sum of lines 13 and 14)	$416,775	$149,784	$46,247	$70,107	$150,637

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b) First	(c)Second	(d) Third	(e) Fourth
16. Partnership for Maternal & Neonatal Health - West Pokot District Child Survival & Health Program	$483,162	$434,619	$286,428	
17.				
18.				
19.				
20. TOTALS (sum of lines 16 - 19)	$483,162	$434,619	$286,428	$0

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: $1,716,904

22. Indirect Charges: $406,048

23. Remarks: Per NICRA agreement - indirect charges calculated 23.65% of direct costs

Authorized for Local Reproduction

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

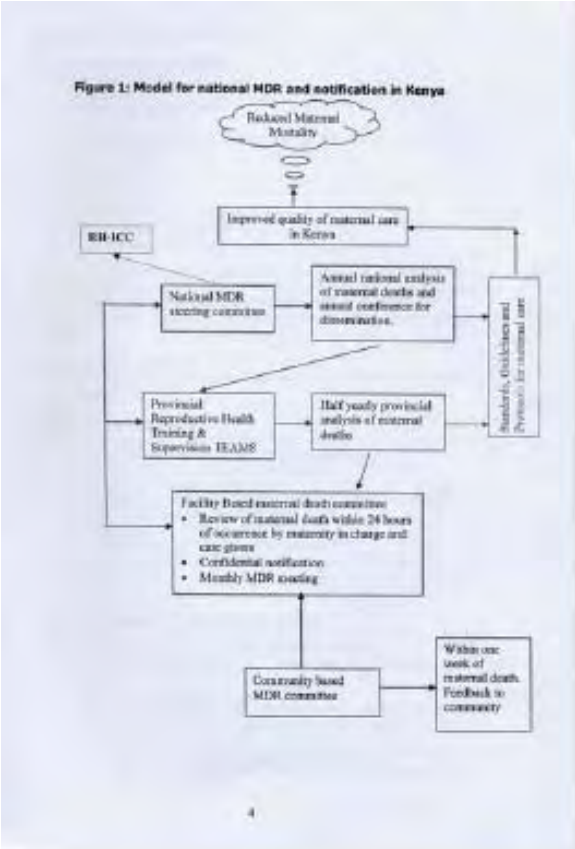
ANNEX 9:
Monitoring and Evaluation Materials

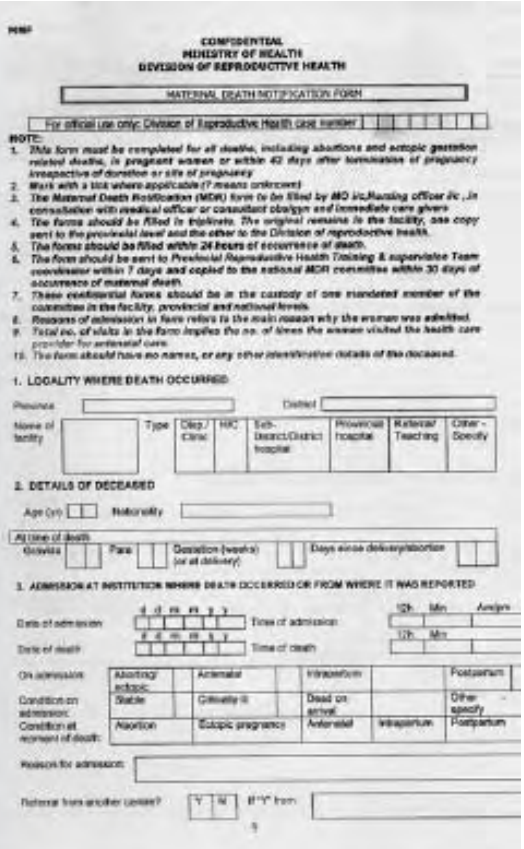
TBA Monthly Report

Location: _____
Date: _____

			Delivered Clients						Expectant Clients				Counsel	
				HIV Status			HIV Status				HIV Status			
	Name	**Location/Village**	TBA Deliveries	Positive	Unknown	Escorted Deliveries	Positive	Unknown	Expectant Clients	Referred to pMTCT counseling /ANC	Positive	Unknown	Community Members Counseled	**Comments**
1														
2														
3														
4														
5														
6														
7														
8														
9														
	TOTAL Number													
	AVG #/TBA													

Annex 9: Monitoring and Evaluation Materials





MMF

CONFIDENTIAL
MINISTRY OF HEALTH
DIVISION OF REPRODUCTIVE HEALTH

MATERNAL DEATH NOTIFICATION FORM

For official use only: Division of Reproductive Health case number

NOTE:
1. *This form must be completed for all deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy*
2. *Mark with a tick where applicable (? means unknown)*
3. *The Maternal Death Notification (MDN) form to be filled by MO in/Nursing officer in/, in consultation with medical officer or consultant obs/gyn and immediate care giver*
4. *The forms should be filled in triplicate. The original remains in the facility, one copy sent to the provincial level and the other to the Division of reproductive health.*
5. *The forms should be filled within 24 hours of occurrence of death.*
6. *The form should be sent to Provincial Reproductive Health Training & supervision Team coordinator within 7 days and copied to the national MDR committee within 30 days of occurrence of maternal death.*
7. *These confidential forms should be in the custody of one mandated member of the committee in the facility, provincial and national levels.*
8. *Reasons of admission in form refers to the main reason why the woman was admitted.*
9. *Total no. of visits in the form implies the no. of times the woman visited the health care provider for antenatal care.*
10. *The form should have no names, or any other identification details of the deceased.*

1. LOCALITY WHERE DEATH OCCURRED

Province | District

Name of facility | Type: Dep./Clinic | HIC | Sub-District/District hospital | Provincial hospital | National/Teaching | Other - Specify

2. DETAILS OF DECEASED

Age (yr) | Nationality

At time of death: Gravida | Para | Gestation (weeks) (or at delivery) | Days since delivery/abortion

3. ADMISSION AT INSTITUTION WHERE DEATH OCCURRED OR FROM WHERE IT WAS REPORTED

Date of admission (d d m m y y) | Time of admission (Hr Min Am/pm)

Date of death (d d m m y y) | Time of death (Hr Min)

On admission: Abortion/ectopic | Antenatal | Intrapartum | Postpartum

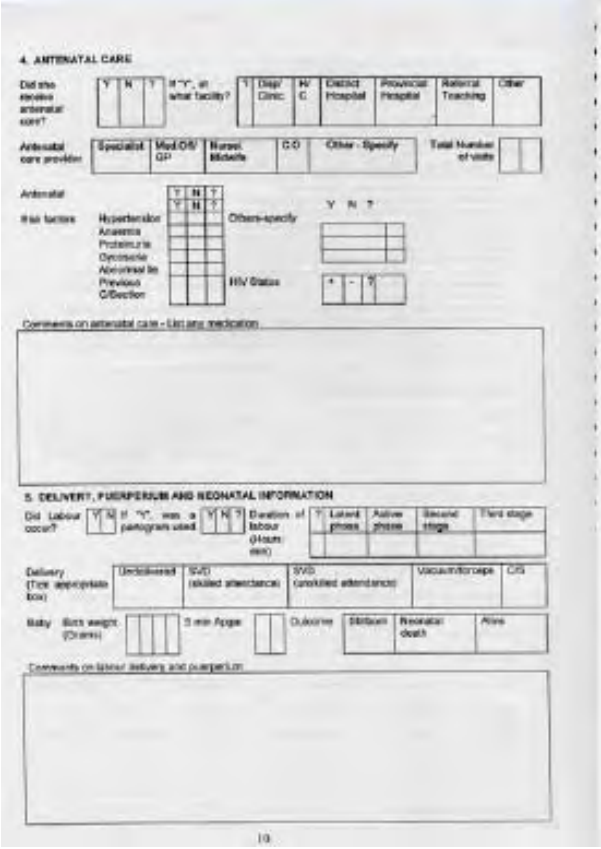
Condition on admission: Stable | Critically ill | Dead on arrival | Other - specify

Condition at moment of death: Abortion | Ectopic pregnancy | Antenatal | Intrapartum | Postpartum

Reason for admission

Referral from another center? Y | N | If "Y" from

5



4. ANTENATAL CARE

Did she receive antenatal care? Y | N | ? | If "Y", at what facility? ? | Dep/Clinic | HC | District Hospital | Provincial Hospital | Referral Teaching | Other

Antenatal care provider: Specialist | Med OS/GP | Nurse/Midwife | CO | Other - Specify | Total Number of visits

Antenatal risk factors: Hypertension, Anaemia, Proteinuria, Glycosuria, Abnormal lie, Previous C/Section | Others-specify | HIV Status

Comments on antenatal care - list any medication

5. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

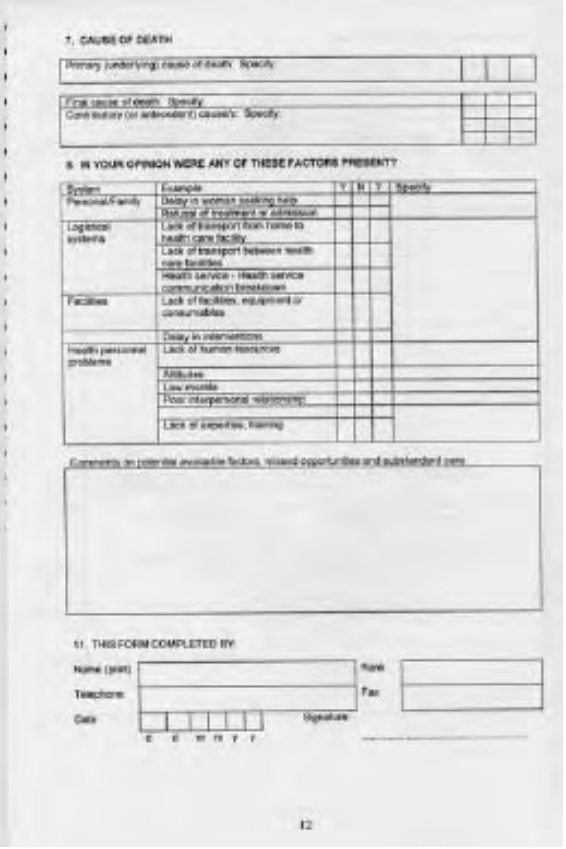
Did Labour occur? Y | N | If "Y", was a partogram used? Y | N | ? | Duration of labour (Hours min): Latent phase | Active phase | Second stage | Third stage

Delivery (Tick appropriate box): Undelivered | SVD (skilled attendance) | SVD (unskilled attendance) | Vacuum/forceps | C/S

Baby: Birth weight (Grams) | 5 min Apgar | Outcome: Stillbirth | Neonatal death | Alive

Comments on labour delivery and puerperium

10



7. CAUSE OF DEATH

Primary (underlying) cause of death: Specify

Final cause of death: Specify

Contributory (or antecedent) cause/s: Specify

8. IN YOUR OPINION WERE ANY OF THESE FACTORS PRESENT?

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Risk/cost of treatment or admission				
Logistical systems	Lack of transport from home to health care facility				
	Lack of transport between health care facilities				
	Health service - Health service communication breakdown				
Facilities	Lack of facilities, equipment or consumables				
	Delay in interventions				
Health personnel problems	Lack of human resources				
	Attitudes				
	Low morale				
	Poor interpersonal relationship				
	Lack of expertise, training				

Comments on potential avoidable factors, missed opportunities and substandard care

11. THIS FORM COMPLETED BY:

Name (print) | Rank

Telephone | Fax

Date (d d m m y y) | Signature

12

Rural Health Facility PMTCT Monthly Report

Date: _____ Facility: _____ Clinician/Title: _____

Antenatal Clinic

No. of pregnant women visited:	
First visit:	
Return visits:	
Of first visits:	
Number of pregnant women counseled:	
Number of pregnant women tested:	
Of those tested, no. tested positive:	
Of return visits:	
Number of pregnant women counseled:	
Number of pregnant women tested:	
Of those tested, no. tested positive:	

Couples at Antenatal Clinic

No. of couples registered	
No. of couples counseled	
No. of couples tested	
Of those tested, no. concordant positive (+,+)	
Of those tested, no. concordant negative (-,-)	
Of those tested, no. discordant (+,-)	

Labor Ward

No. of deliveries (known HIV status)	
No. of mothers registered	
No. of mothers positive	
Of positive mothers, number attending HAART	
No. of deliveries (unknown HIV status)	
No. of mothers counseled	
No. of mothers tested	
Of those tested, no. positive	
Number of mothers given nevirapine	
Number of babies given nevirapine syrup	

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 10:
Kenya Ministry of Health Registers

2006 Kenyan MOH In-Patient Register Format:

IN-PATIENT REGISTER

MOH 301

Date of Admission	In-patient Number	Name and Address	Age (yrs)	Sex	Diagnosis	Condition on Discharge	Date Discharged Died or Transferred To other Hospital	FOR FEE RECORD PURPOSES			
								Fixed Cash Receipt Number	Fees Waived by Medical Officer (Amount)	Official (G.P.68 A) Number	Bill Number

2006 Kenyan MOH Maternity Register Format:

Annex 10: Kenya Ministry of Health Registers

Facility Name | Facility Code | District | Province

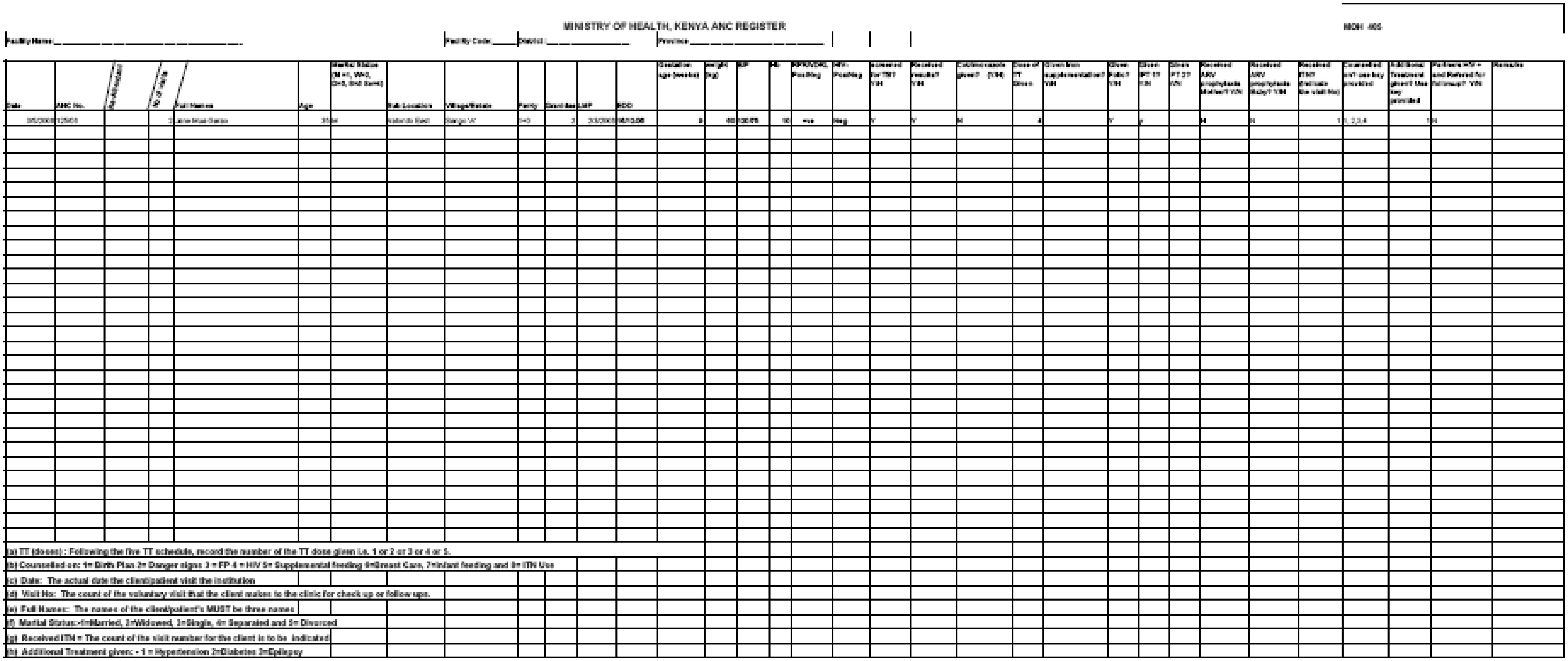
	Date DD/MM/YY	ANC. No.	IP/No	Name	Residence	Date of Admission DD/MM/YY	Mother knows serology status 1=Yes 0=No	Counseled and tested 0=No, 1=Yes, 8=on ARVs		Serology (HIV) 0=Non-Reactive, 1=Reactive, 8=Not tested	Date of Delivery DD/MM/YY	Parity	Mode of delivery 1=SVD, 2=AVD 3=CS	APGAR score	Baby condition 1=Alive, 2-Dead	Baby sex 1=Male 2=Female	Baby weight (grams)	Mother condition after delivery 1=Alive, 2=Dead	Drug taken		Choice of infant feeding 0= BF, 1=Alternative	Birth notification number	Comments
								Mother	Partner										Nevirapine Mother dose 0=No, 1=Yes, 8=N/A	Nevirapine Baby dose 0=No, 1=Yes, 8=N/A			
KEY	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	17	18		19	20	21
1																							
2																							
3																							
4																							

MATERNITY REGISTER

Supervisor's signature: _____ Date: / /

Copy of New Kenyan ANC Register:

Annex 10: Kenya Ministry of Health Registers



MINISTRY OF HEALTH, KENYA ANC REGISTER

MOH 405

Facility Name:________________________ Facility Code:_____ District :_____________ Province ____________________

Date	ANC No.	[illegible]	[illegible]	Full Names	Age	Marital Status (M=1, W=2, [illegible])	Sub Location	Village/Estate	Parity	Gravidae	LMP	EDD	Gestation age (weeks)	weight (kg)	BP	Hb	RPR/VDRL Pos/Neg	HIV: Pos/Neg	Screened for TB? Y/N	Received results? Y/N	Cotrimoxazole given? (Y/N)	Dose of TT Given	Given iron supplementation? Y/N	Given Folic? Y/N	Given IPT 1? Y/N	Given IPT 2? Y/N	Received ARV prophylaxis Mother? Y/N	Received ARV prophylaxis Baby? Y/N	Received ITN? (indicate the visit No)	Counselled on? use key provided	Additional Treatment given? Use key provided	Partners HIV + and Referred for followup? Y/N	Remarks

(a) TT (doses) : Following the five TT schedule, record the number of the TT dose given i.e. 1 or 2 or 3 or 4 or 5.

(b) Counselled on: 1= Birth Plan 2= Danger signs 3 = FP 4 = HIV 5= Supplemental feeding 6=Breast Care, 7=Infant feeding and 8= ITN Use

(c) Date: The actual date the client/patient visit the institution

(d) Visit No: The count of the voluntary visit that the client makes to the clinic for check up or follow ups.

(e) Full Names: The names of the client/patient's MUST be three names

(f) Marital Status:-1=Married, 2=Widowed, 3=Single, 4= Separated and 5= Divorced

(g) Received ITN = The count of the visit number for the client is to be indicated

(h) Additional Treatment given: - 1 = Hypertension 2=Diabetes 3=Epilepsy

Copy of New Kenyan Child Register:

Annex 10: Kenya Ministry of Health Registers

MINISTRY OF HEALTH - KENYA PERMANENT REGISTER FOR CHILDREN

MOH 510

Facility Name:_____ Facility Code:____ District :_____ Province _____

										DATE WHEN IMMUNISATION WAS GIVEN MUST BE INDICATED. TICKS OR CHECKS ARE NOT ACCEPTABLE														
Date	Serial Number	Child's Number	Children's Name	Sex	Date of Birth	Date First Seen	Father's Name	Mother's Name	Location	Sub-location/ Village/ Estate	BCG	Revaccination	Polio birth Dose	1st Polio	2nd Polio	3rd Polio	DPT/Hep.B/ Hib 1	DPT/Hep.B/ Hib 2	DPT/Hep.B/ Hib 3	Measles	Yellow Fever	Vitamin A	Fully Immunised	Remarks

Annex 10: Kenya Ministry of Health Registers

Copy of New Kenyan Child Welfare Clinic Register:

MINISTRY OF HEALTH KENYA

CWC REGISTER

MOH 511

District :

Facility Name:

Province

Facility Code:

CLIENT's CONTACT

Date	CWC NO	Re-visit	Full Names	Age	sex	Sub Location	Village/Estate	Address	Weight in Kgm	Any Danger signs this visit	Issued with a net this visit? (Y/N)	Type of Follow up	Referral	Remarks
[illegible]	[illegible]		[illegible]	[illegible]	F	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Y		[illegible]	

The register is used at the MCH for clients/children less than 5yrs (0 - 59 Months) who attend Child Welfare Clinic (CWC)

(a) Date: The actual date the child attends the CWC
(b) CWC
(c) Revisit: - Indicated the number from the CWC Card
(d) Full Names: - The three names MUST be given and written under this column
(e) Address: The physical address or landmarks, telephone numbers will be required to be put in this column for trace or followups
(f) Weight in Kgm- Weight in Kilogrammes after growth monitoring and indicating on the card, the actual weight MUST be indicated in the register too.
(g) Any danger signs: - The Health Worker should indicate any danger signs identified such as Blood Diarrhoea, severe Malnutrition, sunken eyes or any signs that require urgent interventions
(f) Type of follow up - The child may be having Marasmus and need nutritional follow-up or other danger signs and need follow-ups. Specific types of follow-ups should be indicated
(j) Referral: In the first place within hospital may indicate referred for what purpose but referral to other levels of care outside Health facility should also be indicated

Annex 10: Kenya Ministry of Health Registers

Copy of New Kenyan General Register:

MINISTRY OF HEALTH - KENYA

GENERAL OPD REGISTER

MOH 204 B

Facility Name:_____ Facility Code:_____

District :_____ Province _____

						PATIENT CONTACT							
Date	OPD No.	Re-visit	Full Names	Age in Years	sex	Sub Location	Village/Estate	Address	Visual Acuity **RE / LE **	Diagnosis	Treatment	Referral	Amount charged
4/5/2006	1905/06		Erick Juma Boy	30	M	Kaiserani	Mwiki	Sentori Stage (0721857585)	RE 6/36, LE 6/12	Pneumonia/ malaria			

The register will be used for both Male and Female above 5 years (60+ months) who are sick and visit the Health Facility for treatment

(a) Date: The actual date the patient is seen at the Health Facility

(b) OPD No. - The Outpatient Number usual given to patients that are first visit/ attendant at the Health Facility in the Calendar Year

(c) Revisit: The OPD Number of the patient who returns to the Health Facility for the services during the calender year.

(d) Full Names;_ The three names of the patient must be written under this column

(e) Address: The physical Address, Land marks, Telephone Numbers will be required here for the follow-up or trace of patient

(f) Diagnosis: The impression or final diagnosis from the clinician must be indicated in this column

(g) Treatment: The recommendation is to indicate the prescription items

(h) Referral - The patients will be referred from one level to another for specialised services and different levels MUST be indicated (Level 1 - 6 of ADP II)

(i) Amount Charged: - Total service charged should be indicated for easy of accountability and able to appreciate the contributions made from government, private and individuals

Note: It is not for Auditing the Health Worker or Institution

Annex 10: Kenya Ministry of Health Registers

Copy of New Kenyan In-Patient Register:

MINISTRY OF HEALTH - KENYA IN-PATIENT REGISTER

MOH 501

District : _____ Facility Name: _____ Facility Code: _____

Province _____

					PATIENT CONTACT								
Date of Adm	In-patient No	Full Name	Age in Years	Sex	Sub Location	Village/Estate	Address	Diagnosis	Treatment	Date of Discharge	Outcome (A = Alive D = Dead)	Referral	Amount charged
4/4/2006	2006/06	Ben Jagi Nyarerua	23	M	Borabu South	Ngumo Estate	Box 110005 KNH 0723587785	Tuberculosis		4/5/2006	A	Mmosa Disp	

The register is for all patients to be admitted to the hospital/hospitalized for tretament care regardless of age.

(a) Date of ADM - Date when the patient is admitted

(b) In-patient No. - The number issued to patients that are being hospitilized for in-patient services

(c) Address: The physical Address, Land marks, Telephone Numbers will be required here for the follow-up or trace of patient

(d) Age in years - A child (infant, neonate) should indicate months, weeks or days

(e) Date of Discharge - The date when the patient leaves the hospital for home or for other specialized care elsewhere

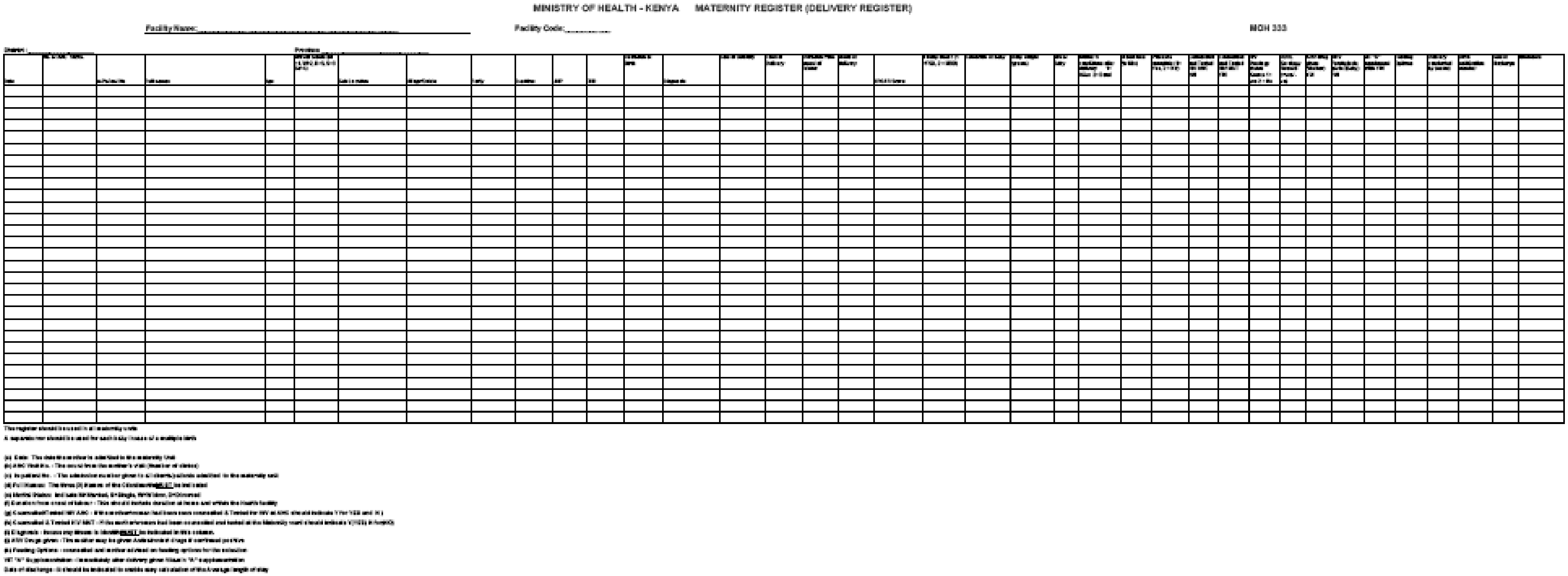
(f) Outcome - The result of illness - eighter alive = A dead = D

(g) Referral - Indicate different levels of referral for service delivery

(h) Amount Charged: - Total service charged should be indicated for easy of accountabilully and able to appreciate the contributions made from government, private and individuals

Annex 10: Kenya Ministry of Health Registers

Copy of New Kenyan Maternity Register:



MINISTRY OF HEALTH - KENYA MATERNITY REGISTER (DELIVERY REGISTER)

Facility Name:________________ Facility Code:________ MOH 333

Copy of New Kenyan Postnatal Register:

MINISTRY OF HEALTH - KENYA POST-NATAL REGISTER

Facility Name:_____ Facility Code:_____ District :_____ Province _____

CONTACT

(a) PNC NO. Post-natal clinic number

(b) Where appropriate use the key provided

Copy of New Kenya Under Five Register:

MINISTRY OF HEALTH - KENYA - UNDER 5 OPD REGISTER

MOH 204 A

District : _____ Facility Name: _____ Facility Code: _____

Province: _____

						PATIENT's CONTACT											
Date	OPD No.	Revisit	Full Names	Age	sex	Sub Location	Village/ Estate	Address	Danger signs	Final Acute *RDT LE **	Duration of Illness	Diagnosis classification	Treatment	Follow up (Y/N)	Referral (Y/N)	Amount charged
20/09/05		005/2006	Ibrahim Juma Omo	2.5	M	Kenyenya	Marambee	Marambee primary school	Blood diarrhoea Diarrhoea	RDT 4/30, LE 8/12	2 days	Ayourty		Y	Man Comm	

The register is to be used for children less than 5 years (0-59months) who are sick and visit the facility for care. The register also covers the IMCI component and should not have any other register for districts implementing IMCI strategy.

(a) Date: The actual date the sick child attends the clinic or Health Facility to seek treatment

(b) OPD Number - The outpatient number usually given to the patient that are attending the health facility for the first visit within the calendar year.

(c) Revisit - The OPD number of the patient who return to the Health Facility for service or follow ups in the case of IMCI.

(d) Full Names: - Record these names in this column

(e) Address: - The physical Address, Landmarks, Telephone of parent or caretaker should be entered in this column for follow up or trace of patient.

(f) Danger Signs: - Using the IMCI guidelines Clinician should indicate the danger signs identified from the child.

(g) Duration of Illness: - Number of days the illness has taken since its onset

(h) Diagnosis classification - The districts with IMCI strategy MUST indicate the final classification of the illness e.g severe pneumonia. While districts not started IMCI strategy will indicate the diagnosis PNEUMONIA

(i) Treatment: indicate the number from the prescription

(j) Follow up - Active trace of patient for identifying further changes after treatment started or trace of defaulters from treatment

(k) Referral Referral for further management from different levels of care.

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 11:
Table of Process Indicators

Annex 11: Table of Process Indicators

Objective	Indicator	Frequency of Measurement
Increased % of pregnant women receiving quality focused antenatal care (FANC)	Number of pregnant women receiving FANC	Quarterly
Improved availability of essential medicines and supplies at all DOW-supported sites	Number of focus health facilities experiencing no stock-outs of medicines and supplies for MNC for at least six continuous months	Quarterly
Improved capacity of health centers to provide BEmOC	Number of focus health centers providing coverage of BEmOC signal functions	Quarterly
Percent of focus health facilities that provide basic-level HIV testing and HIV/AIDS clinical management	Number of focus facilities able to provide HIV testing and HIV/AIDS clinical management	Quarterly
Consistent provision of ANC/post-partum/neonatal care through mobile/outreach services in project Divisions	Number of mobile service sites receiving monthly outreach team visits for at least six continuous months	Quarterly
Improved integration of MNC services with HIV/AIDS and malaria control services with all focus health care facilities	Number of women using MNC services at focus health facilities counseled in, referred for, and/or receiving appropriate HIV/AIDS and malaria interventions	Quarterly
Improved ongoing QA/QI activities conducted at focus health facilities	Number of regular monitoring visits by DHMT and District medical officers to focus health facilities	Quarterly
Increased exposure of community members to MNC, HIV/AIDS and malaria issues through CHW *barazas*	Number of *barazas* held	Quarterly
Increased exposure of community members to MNC, HIV/AIDS, and malaria issues through local NGO- and FBO-conducted education and mobilization activities	Number of community education events held by partner NGOs and FBOs	Quarterly
Improved monitoring of CHWs by HFCs	Number of monthly CHW monitoring meetings held by HFCs in the focus program area	Quarterly
Improved data collection for facility-based and community-based MNC activities	Number of facilities and communities accurately and consistently filling out data collection forms	Quarterly
Increased use of maternal death review mechanisms	Number of focus health facilities submitting maternal death review forms according to MOH/DRH guidelines	Quarterly
Improved integration of community-based MNC data in aggregate District statistics and reporting	Number of completed community-reported MNC data forms included in District health records	Quarterly

Detailed Implementation Plan
Partnership for Maternal and Neonatal Health
West Pokot, Kenya

ANNEX 12:
Planned Activities by Strategic Objectives

Annex 12: Planned Activities by Strategic Objective

Strategic Objective	Planned Activities
Strategic Objective 1: Strengthen the capacity of nine focus West Pokot District health facilities to provide quality Maternal and Newborn Care (MNC) services	• Train indicated District health staff, and selected Health Facility Committees in essentials of MNC, as well as monitoring, supervision, and management skills. • Incorporate curricula and policies developed by MOH and key PVOs active in Kenya, train facility-based providers (nurses, clinical officers, and medical officers at focus health facilities as they are phased in) in MNC interventions, including: o Focused antenatal care, including intermittent preventive therapy for malaria and the promotion of ITNs; tetanus toxoid injections, STI/HIV screening and care, and the creation of birth preparedness and complication readiness plans; o Current intrapartum and postpartum/newborn care protocols; o Counseling on postpartum family planning and exclusive breastfeeding; o Emergency obstetric care (and comprehensive emergency obstetric care for hospital-based staff); o Post-abortion care; o Management of MNC in the context of extremely high local prevalence of type-III female genital mutilation (infibulation); o Responding to community perceptions about facility-based health services. • Provide refresher and continuing training to facility-based health providers in HIV/AIDS services (including HIV testing and counseling and ART as appropriate, in partnership with AMPATH) and in management of malaria (in partnership with PSI). • In partnership with PSI, assist focus health facilities in purchasing ITNs for pregnant women, including through provision of seed money to program sites for purchase of ITNs, and through supervision of focus facility clinicians in the purchase and distribution of ITNs. • Ensure implementation of improved MNC services at focus health care facilities (all of which are DOW-supported PMTCT sites) as they are phased in, including by on-site workshops with health facility staff and HFCs to plan for implementation and monitoring of improved MNC services and integration of these with HIV/AIDS and malaria control services. • In partnership with DMHT, assess gaps in current procurement chain for MNC medicines and supplies and develop and implement sustainable solutions to identified gaps at focus health facilities. • Renovate and equip four health centers to provide improved antenatal care, safe delivery and emergency obstetric care services, postpartum/newborn health care services, and referral of appropriate cases to hospital. • Support three dispensaries in providing antenatal care, vaginal delivery services, postpartum/newborn health care services, and referral of appropriate cases to health centers and/or hospital for indicated care.

Strategic Objective	Planned Activities
Strategic Objective 2: Strengthen community awareness of and demand for quality MNC services	• In partnership with HFCs and partner local non-governmental organizations (NGOs) and faith-based organization (FBOs), identify community mobilization strategies to increase awareness and utilization of facility-based MNC services as well as HIV/AIDS services and related malaria control interventions such as ITNs. • Provide further training to DOW-supported traditional birth attendants (TBAs) in the program area (who already refer women for HIV testing and PMTCT) in danger signs during delivery; educating community members about MNC, HIV/AIDS, and malaria (including demonstrating ITN treatment and maintenance, with PSI); and referral for facility-based MNC services. • Provide refresher training to nurses at focus health centers and dispensaries (all DOW-supported PMTCT sites where monthly TBA monitoring already occurs), to incorporate monitoring of and data collection from TBAs' MNC activities into monthly meetings. • Identify existing female community health workers (CHWs) in the program area and train and support them to conduct community education through barazas related to MNC, HIV/AIDS prevention and care, and related malaria control interventions (including ITN treatment and maintenance with PSI), as well as to refer community members to facility-based MNC services. • Identify existing male CHWs in the program area and train and support them in topics above, as well as promoting male involvement in MNC and educating male community members about causes of and responses to maternal and newborn mortality and morbidity, and in supporting use of facility-based MNC services and related HIV/AIDS services and malaria control interventions (e.g., encouraging pregnant women and young children to use ITNs). • Support HFCs at focus health facilities to conduct monthly monitoring meetings of CHWs in their catchment areas, including review of service and education activities as well as collection of data from CHWs. • Conduct a sensitization workshop for chiefs and assistant chiefs about MNC issues, the importance of mobilizing communities to use facility-based services, and relate HIV/AIDS and malaria interventions (including, in partnership with PSI, promoting the use of ITNs. • Train key staff at two partner local NGOs and partner FBO in MNC, HIV/AIDS, and malaria issues and in implementing and monitoring community education and mobilization activities through their existing networks and community groups. • Conduct regular monitoring meetings with LOCAL NGO and FBO representatives to gather data on community education and mobilization activities.

Annex 12: Planned Activities by Strategic Objective

Strategic Objective	Planned Activities
Strategic Objective 3: Improve access for local communities in the district to quality MNC services	• Reduce barriers to facility-based delivery through use of a voucher scheme provided during birth planning and provision of two vehicles to health centers for emergency transfers. • Implement outreach antenatal and postpartum/neonatal care and education through DOW/MOH-trained mobile teams. • Convene meetings between MOH focus health facilities and DOW's HIV/AIDS clinic at the Kapenguria District Hospital to identify mechanisms for enrolling HIV-positive in full ART, starting with referral and potentially progressing to mobile HIV management team conducting monthly visits to health centers to monitor and treat patients in line with AMPATH and NASCOP guidelines.
Strategic Objective 4: Strengthen the District Health Management Information System (DHMIS), with particular attention to maternal and newborn health.	• Train DHMT in essentials of MNC, as well as monitoring, supervision, and management skills. • In partnership with DHMT, review and improve data collection forms relevant to MNC, HIV/AIDS, and malaria services, and establish priorities for strengthening data collection and management to capture essential information, including services provided at the health center/dispensary level, disaggregated causes of maternal and neonatal mortality and morbidity, and services provided via outreach teams. • Train facility-based providers in appropriate use of improved data collection tools. • Improve data forms used by DOW-supported TBAs and supervising nurses, and work with HFCs and CHWs to create data forms to capture CHW activities; implement use of new and improved data collection for activities of these community-based health resource persons. • Work with health facilities to improve reporting of MNC data to the DHMT. • Train chiefs and assistant chiefs to improve reporting of births as well as maternal and newborn deaths in the community to the Civil Registry. • Support DHMT to implement consistent use of MOH maternal death review form and establish regular maternal death review meetings. • Work with DHMT, particularly DHRIMO, to incorporate data collected from community-based health resource persons into District health data systems. • Facilitate regular meetings between the DHMT and the District Civil Registry Monitoring Committee, to ensure improved reporting and sharing of facility-based and community-based maternal and newborn health data between the MOH and the Civil Registry.