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End of Project Evaluation of DFID Support to the Delivery of Essential Health Services (EHS), Kenya

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List of Abbreviations

Acronyms

ANC	Antenatal Care
AOP	Annual Operational Plan
APHIA	USAID health programme
BEmOC	Basic Emergency Obstetric Care
CBO	Community Based Organisation
CEmOC	Comprehensive Emergency Obstetric Care
CHEW	Community Health Extension Worker
CHW	Community Health Worker
CSO	Civil society organisation
DANIDA	Danish International Development Organisation
DFID	Department for International Development
DHMT	District Health Management Team
DP	Development Partners
DPHK	Development Partners in Health Kenya
DRH	Division of Reproductive Health
EHS	Essential Health Services
EmOC	Emergency Obstetric Care
GOK	Government of Kenya
GIZ	German Technical Cooperation
GFATM	Global Fund for AIDS, TB and Malaria
HC	Health Centre
HENNET	Non governmental organisations network group
HMIS	Health Management Information System
ICC	Interagency Co-ordinating Committee
IHP+	International Health Partnership
ITO	infrastructure Technical Officer
JICA	Japan Development Co-operation Agency
KEPH	Kenya Essential Package for Health
KIA	Kenya Institute of Administration
LSS	Life Saving Skills
LATH	Liverpool Associates in Tropical Health
MVA	Manual Vacuum Aspiration
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MoPW	Ministry of Public Works
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
NHSSP	National Health Sector Strategic Plan
PCR	Project Completion Report
PE	Personal Emolument
PHMT	Provincial Health Management Team
PMO	Provincial Medical Officer
PNO	Provincial Nursing Officer
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SIDA	Swedish International Development Agency
SWAp	Sector Wide Approach

TA	Technical Advisor / Assistance
TBA	Traditional Birth Attendant
TOR	Terms of Reference
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

Executive summary

The EHS programme of support has been successful in largely achieving its objectives and also in the way it has worked in a fully integrated way at central, provincial and district level. There is an EHS esprit de corps which is palpable from the national level to Community Units. This is a feat achieved by few programmes funded by donor partners. Both DFID and EHS staff are to be congratulated; DFID for designing a programme that anticipated integration into national programmes and EHS for implementing the approach to a degree which was unlikely to have been anticipated by those who initially designed the programme.

In summary the achievements of the EHS programme against the agreed logframe are as follows

Output 1

Central MOPHS/MOMS effectively supported in strengthening health systems policy development and planning for the delivery of the Kenya EPH

Indicator 1: Extent of Health Sector Joint Planning

At the commencement of the programme in 2005, co-ordinated sector planning did not exist. The 1999-2005 first Health Sector Strategic plan is reported to have resulted in vertical programmes with little cross dialogue or co-ordination. The second HSSP provided an opportunity for a change, both in strategic direction but also in the methodologies for undertaking planning in line with the desire to move towards greater devolvement and increased harmonisation. AOPs have improved in their scope and their role in co-ordinating activities around the Ministries plan. The EHS has actively supported capacity building and the development of tools and guidelines. **EHS has fully delivered on this objective.**

Indicator 2: Extent of Establishment of Joint Performance Monitoring for the Health Sector

There is commitment to using a single monitoring process and common data at national, provincial and local level. **EHS has fully delivered on this objective**.

Indicator 3: Extent of development of national MNH strategic documents

The last three years have seen an impressive output in terms of strategy and policy relating to Reproductive Health but particularly maternal and neonatal health. **EHS has fully delivered on this objective**

1.1 Output 2: Health Systems in Nyanza Support KEPH

Health Systems in Nyanza province to support delivery of KEPH especially the maternal and neonatal health component

Indicator 1: Extent to which mechanisms for co-ordination of partnerships are established in Nyanza and target districts

The processes relating to annual planning and monitoring have been established in Nyanza with support from EHS and are perceived as working well with good collaboration with DPs, including DFID, JICA, INICEF and shortly USAID. **EHS has fully delivered on this objective.**

Indicator 2: Extent to which referral system is strengthened in Nyanza and target districts

EHS has strengthened telephone communication and provided transport. Considerable sensitisation on the need for referral has been carried out. The motor cycle ambulances have not proved as successful as in other locations and this review makes a number of recommendations before further roll out. **This objective has been largely achieved.**

Indicator 3: Extent to which the inventory system is operational at Provincial and District level

Whilst EHS has undertaken training and provided documentation. **This objective has not been achieved.**

Indicator 4: Extent to which the RH data management is functioning in Nyanza and target districts) There were no specific indicators specified for this indicator and objective assessment is therefore not possible

1.2 Output 3 Strengthening of KEPH

Indicator	Baseline (2006 unless indicated)	2011 milestone	Achievement
Districts with minimum coverage EOC	0	5 CEOC 20 BEOC	5 CEOC & 7 BEOC fully functional
Births by skilled birth attendant	7-12%	35%	35% average (range 23-45%)
4 ANC visits by women	16-24%	35%	Achieved in 3/7 districts (range 24.7-39.7%)

District population based C/S rates	0.8%	2.5%	3 reached 2.5% 5/6 reached 2.2% (range 1.4-4.1%)
Health workers trained in EOC/LSS	0	220	242 HWs and 27 master trainers trained in province
Health facilities increasing EOC signal functions		100%	All facilities increased EOC functions

1.3 Output 4 Increased Community Level Demand

Indicator	Baseline (2006 unless indicated)	2011 milestone	Achievement
Extent to which quality of care (QoC) is institutionalized	No QoC process in place	QoC committee in all facilities Facility based maternal death reviews	24/25 (96%) of facilities have a committee 22/25 (88%) operational
Community midwives trained in EOC	None	50	50 midwives trained (100%)
No functioning community units (CU)	None	24	24 established
CU with functioning emergency referral systems	None	10	7 established (70%)
Communities with established verbal autopsy process	None	12 per district or 72	63 VA committees established of which 16 have conducted a VA

1.4 Output 5. Management of EHS Support

DFID support to delivery of EHS programme effectively managed to promoted MOPHS and MOMS ownership

Indicator 1: Number of project workplans and budgets approved by the Programme Steering Committee

All plans and budgets have been agreed by the PSC which has also monitored progress. **This objective has been fully achieved.**

Indicator 2: Extent to which lessons learned have been shared with MOPHS/MOMS

The level of integration between programme staff and ministry staff has ensured ongoing sharing of lessons learnt. The dissemination meeting of the end line survey and end of programme review had good attendance from the Ministries and the debate demonstrated the depth of comprehension of the lessons from the programme. **This objective has been fully achieved.**

Summary of Conclusions

The contributions of Dr Pendame and Dr Dielemans at both national and local level have been outstanding. The support they have given to the development of co-operation architecture, strategic and operational planning and monitoring has clearly been much appreciated by colleagues in MOMS/ MOPHS and other development partners.

It will be important that continuing support is given to planning processes over the next few years during the transition to the new Kenyan constitution. There is a real risk of a loss of capacity and institutional memory due to the reintegration of the two ministries, the creation of new teams at county level and the delegation of responsibility for the totality of the budget including staffing. Both Dr Pendame and Dr Dielemans have provided continuity during significant Ministerial changes and, if there is any way that their personal contribution can be extended, this would prove hugely beneficial to the successful development of the programme nationally.

It is of the utmost importance that planning and monitoring become routine, recurrently funded GOK activities. Both should be an integral part of the work of all managers. Currently the AOP is more an instrument for capturing development partner support. It needs to develop into a tool that encompasses the totality of activity, change and development to be undertaken in the coming year. In this form, it should drive individual performance contracts for Ministry staff at all levels.

In identifying priorities for support and improvement, it is essential that the concept of the sector wide approach is built on and that the “whole care pathway” is studied for bottlenecks. The EHS has put significant effort and resources into staff capacity building and on increasing demand for skilled birth attendants. However for significant periods there were shortages of essential supplies, particularly oxytocin, which meant that the investment in staff training could not be fully realised. Whilst the problem has been widely acknowledged, there does not seem to be a current commitment through the AOP to the analysis and delivery of system strengthening and processes which would provide long term and sustainable solutions to the supply side issues identified.

This programme has worked to improve maternal and neonatal health care. Particular emphasis has been given to increase the proportion of women who deliver with skilled birth attendants and who access emergency obstetric care, via a broad array of programme activities designed to strengthen both the demand and supply side of service use. With existing reporting practices and systems, it is difficult to reach conclusions regarding the programme’s impact on health outcomes. There is, however, a strong feeling on the part of those involved, that the overall impact of EHS activities has been greater than the sum of their individual parts. Certainly there is considerable synergy between the various activity strands and it will be difficult, if not impossible, to disaggregate their individual impacts or in the case of the community-based interventions, to rigorously establish value for money.

Table 1: An integrated and multi level approach to system strengthening

Policies and Management Structures Strengthened to Support Improvements in Demand and Supply at the Central, Provincial, District Levels with Improved Leadership and Management Skills	
Supply Interventions	**Demand Interventions**
▪ Improve clinical skills of midwives through Life Saving Skills, Emergency Obstetric Care, etc. ▪ Use of protocols and standards Infrastructure improvements (construction & renovation of maternity units and theatres) ▪ Improve enabling environment ▪ Essential equipment, medications & supplies ▪ Supportive supervision & Quality Improvement ▪ Management strengthening (District Health Management Teams, Facility Management Teams, Community Health Management Teams) ▪ Maternal Death Reviews (MDRs) ▪ Health Management Information System & use of data for decision making ▪ Improved referral and communication systems ▪ Increase capacity to do Basic and Comprehensive Emergency Obstetric Care	▪ Community strategy ▪ Community Units (CUs) ▪ Community Health Extension Workers ▪ Community Health Workers ▪ Community Midwives ▪ Traditional Birth Attendants (transition to Traditional Birth Companions or birth companions) ▪ Verbal Autopsies ▪ Improved referral system ▪ Improved knowledge and awareness about danger signs, complications, Skilled Birth Attendants ▪ Community Dialogue Days ▪ Increased involvement of communities

Building community demand has been pursued through the education of both prospective mothers and the community as a whole. This was done by establishing Community Health Committees, identifying and supporting Community Health Workers to reach out and maintain contact with a number of households, sharing community data during Community Dialogue Days, sensitizing community members about the benefits of skilled attendance at birth and the dangers in delaying to seek health care in an emergency, "marketing" new maternity facilities/infrastructure to women during antenatal care with tours of health facilities, and encouraging the use of community-based verbal autopsies following a maternal death. Retired midwives were asked to support and deliver women who opted for a home-based birth. The overall impression given is that no stone was left unturned when seeking ways to sensitise and mobilise the community regarding safe delivery.

The EHS approach to district and community support has already delivered promising results and there are indications of the potential to achieve more. The

simultaneous strengthening of both the demand and supply side appears to have delivered improved services to mothers. However, it is difficult to measure or attribute the contribution of the demand side activities. This is perhaps inevitable; it is not unique to Kenya and it provides no reason not to continue to roll these activities out. To a large extent they will rely on the sustainability of the CHWs and CHEWs. There has already been some drop out and sustainability will be hard to achieve without some recognition being given for the services provided at the community level.

Any future programme incorporating long term TA at District level should consider basing a single TA in each district to work with both demand and supply side interventions. The existing staff have these competences and feel it would work better.

Infrastructure improvement has been delivered to a good standard and the partnership with MOPW has resulted in serendipitous capacity strengthening. The facilities are not currently being used to capacity and there are some suggestions that they may be larger than necessary. However some have only just been opened and it is too soon to judge. It is suggested that consideration is given to GOK adopting standard design modules to reduce future design costs to include furniture and equipment standards based on function and projected activity levels. Such standards should not be restricted to the clinical domain, but should also include elements such as document storage.

Motor cycle ambulances and maternity waiting homes are two initiatives which have been implemented successfully elsewhere. However, they have been less well utilised in Nyanza and there seem a range of reasons why this is so. It is difficult to recommend further investment in them without undertaking a further comparative study with locations where they have been better used.

Key recommendations for Future MNH Programming

Future programming in Maternal and Newborn health should:

- pursue simultaneous strengthening of systems of demand, supply and policy;
- ensure that the whole care pathway is addressed through the AOP process to prevent bottlenecks
- incorporate planning and monitoring as an expectation of all ministry staff , with appropriate budgets to support the key events etc. ;
- include indicators of process and health outcomes; for example: health facility-based case fatality rate (maternal deaths among women with obstetric complications) and intrapartum/early neonatal death rate;
- increase attention on both specific interventions for and data pertaining to the perinate;
- appropriate Ministry staff review and revised the training materials for use with the VA committees. In preparation for these revisions, it would be beneficial to identify well-functioning VA committees, particularly if there is evidence of verbal autopsies that have led to specific corrective actions in the community, and to seek their input on improving training materials. It is also

recommended that verbal autopsy committees be continually supported where they have been established and that this activity be rolled out more widely following revision of training materials.

- use EHS Endline Survey data to target the health facilities which are still missing certain signal functions at the close of the EHS programme.

- include interventions to assist the poorest women to access life-saving care for herself or her foetus .

- assure collaborative efforts between Ministries and DP partners to finalise the Comprehensive MNH training package which could be used for Pre- or In-Service training. Such a programme should also focus on developing means to maintain an updated pre-service curriculum for physicians, nurse/midwives and clinical officers in the area of maternal and neonatal health.

- assure collaborative efforts between donor partners and the Ministry to strive to shift away from such heavy reliance on in-service training toward a more balanced program encompassing pre-service and in-service training.

- Develop new interventions to promote day to day supportive supervision in the workplace to supplement the occasional visits from district and provincial level MOMS staff.

- It is recommended that at least once annually, health facilities report to the Ministry of Medical Services their number of maternal deaths, the number of maternal death reviews completed and summaries of recommendations resulting from these death reviews and corrective actions that have been undertaken in response to the reviews. The purpose of this additional reporting requirement is to establish expectations among health care providers and health facility administrators regarding responsiveness to the maternal death reviews.

- Use training modules already developed rather than design new and potentially duplicative courses.

- Provide continuity by using long term TA integrated within the ministry structure.

Future Research

- Undertake a small study to explore barriers to access to caesarean delivery.

- Undertake a short comparative study of sites where motorcycle ambulances are being used successfully before further roll out of this intervention.

- Undertake a follow-up study to identify whether the demand trajectory for the new build units was realistic and whether the calculations of required capacity were accurate

The review has identified a number of detailed recommendations and conclusions. These are incorporated in the text and there is a summary at Annex 2.

1.5 Methodology

The PCR incorporates information obtained from an endline survey implemented by LATH who designed the data collection tools and undertook data collection and analysis together with health staff from Nyanza. The PCR team had the task of overseeing and quality assuring the methodology for the survey, the data analysis and the subsequent summary report and survey report. The PCR team were satisfied that the methodology and tools were rigorous and the reports accurately reflected the data collected. Both the endline survey and the evaluation were undertaken in compliance with DFID's Ethical Principles for Research and Evaluation.

The PCR team examined project documentation, including previous internal and external reviews, as well as other contextual material. (see Annex 3) In addition they spent a week in Kenya (January 16th to 24th) when they had the opportunity to meet staff from both ministries in Nairobi, representatives of development partners (DPs) provincial and district level staff in Nyanza, community workers and service users. They undertook short field visits to Migori, Kuria, Rongo, Homa Bay and Suba and were able to attend the Nyanza provincial review meeting.

1.6 Background

In 2004, DFID agreed to provide up to £7.5 million over five years to the Government of Kenya to support the delivery of essential health services, through increasing its capacity to deliver services for women and children with a particular focus on reproductive health and immunisation. In line with the emerging sector-wide approach (SWAp) for health in Kenya, it was agreed that DFID support would be provided in a flexible and responsive way and integrated with multi-partner efforts to develop and implement essential health services in Kenya, now defined as the Kenya Essential Package for Health (KEPH).

The **goal** of the Essential Health Services (EHS) programme is to contribute to achieving the health-related Millennium Development Goals (MDGs) in Kenya and, in particular, to a reduction in infant and maternal mortality. The **purpose** of the programme is to support the Government of Kenya and the Ministries of Public Health and Sanitation and of Medical Services (MOPHS and MOMS), under the auspices of the Second National Health Sector Strategic Plan (NHSSPII), to provide integrated effective health services in Kenya, particularly for poor women and infants.

The programme **outputs** are:

1 Central Ministries of Public Health and Sanitation and of Medical Services effectively supported in strengthening health systems, policy development and stewardship for delivery of the Kenya Essential Package for Health (KEPH).

2 Health systems strengthened in Nyanza Province to support delivery of Kenya Essential Package for Health (KEPH), especially the maternal and neonatal health component.

3 Delivery of the Kenya Essential Package for Health (KEPH) significantly strengthened in selected districts in Nyanza Province, especially to address poor women's' and infants' health needs.

4 Increased community level demand for Kenya Essential Package for Health (KEPH), especially for poor women and infants in selected districts of Nyanza Province.

5 DFID support to the delivery of Essential Health Services programme effectively managed to promote Ministries of Public Health and Sanitation and of Medical Services ownership.

By programme inception a proportion of the original allocation had already been used for emergency response leaving only £5 million. At one stage there was a suggestion that the programme should only run for two years and this caused considerable uncertainty.

DFID support to the delivery of EHS (Essential Health Services) began in July 2005 with a 10.5 month Inception Phase. The programme began in June 2006 with a revised logframe, a detailed work plan and budget for the first year of activities, and a budget forecast for the four-year implementation phase. Following the recommendations of the first external Output to Purpose Review (OPR), DFID approved a cost extension for EHS from £7.5 million to £14.2 million in October 2008. The period of implementation was also extended and the number of districts benefiting from the programme increased from four to six (using original district boundaries). The selected districts for the programme are now Suba, Homa Bay, Migori, Kuria, Siaya and Kisumu West.

Selected districts in Nyanza province were chosen for programme interventions based on need. Reportedly, 25% of all maternal deaths occur in Nyanza, the province has twice the rate of HIV of the rest of Kenya (RH in Nyanza Situational Analysis), and, in 2004, only 10% of health facilities were able to provide 24 hour delivery services (Kenya Service Provision Assessment Survey). The population covered by the EHS is 2, 230,814. Nyanza has been shown in successive attempts at poverty mapping to be a province with a high level of poverty as well as a significant poverty gap.

An important element of the Essential Health Services programme has been the provision of long term technical assistance (TA) and support to Ministries of Health planning and review processes. Technical assistance to the Ministries of Health Technical Planning and Monitoring Departments was provided by the Programme Manager Dr Pendame. Full-time technical assistance was also provided to the Ministry of Health Division of Reproductive Health (DRH) by a reproductive health specialist, Dr Dieleman, who was initially based in Nairobi, but later transferred to the Nyanza programme office in May 2009. This enabled more direct ongoing technical assistance and support to the province and six Essential Health Services target districts through the three district offices based in the District Health Management offices in Siaya, Migori and Homa Bay. Essential Health Services staffing has evolved over the course of the programme and its personnel are integrated into the management and technical groups at the central, provincial and district levels.

The Essential Health Services programme staffing is comprised of:

- Programme Manager/Health Systems Adviser
- Maternal and Neonatal Health (MNH) Technical Adviser
- Maternal and Neonatal Health (MNH) Technical Officers (district based)
- Community Health Development Technical Officers (district based)
- Infrastructure Technical Officer (Nyanza)

- Finance and Administration Officers
- Drivers

The activities implemented under the five outputs of the Essential Health Services programme directly or indirectly support the overall strengthening of the policy and strategic framework of the health sector, and are broadly in line with priorities identified in the National Health Sector Strategic Plan II and in the Annual Operational Plans.

The Essential Health Services Logical Framework was revised after the second Output to Purpose Review in December 2008. Essential Health Services Technical Advisors worked with their public sector counterparts to develop the new logframe, milestones and targets and the new output indicators which are in line with February 2009 DFID global directives.

1.7 Programme Principles

The basic principles followed by the Essential Health Services in its programme approach to implementation are:

- Alignment to sector priorities and key policy objectives of the National Health Sector Strategic Plan II
- Government of Kenya/Health Ministries ownership of the programme
- Linkage between policy and reform strategies; service delivery and technical focus on maternal and neonatal health targeting underserved and vulnerable populations
- Use of existing Government of Kenya/Health Ministries systems and structures
- Programme management to ensure Government of Kenya/Health Ministries ownership.

2. Programme Progress – Purpose Level

GOK/MOPHS/MOMS supported under the auspices of the NHSSPII to provide integrated effective health services in Kenya particularly for poor women and orphans

Indicator 1: Extent to which health sector stakeholder partnership is strengthened

2.1.1 Development Partners

In moving towards a Sector Wide Approach, the Development Partners in Health (DPHK) donor group continues to be active and to meet monthly at national level. It has membership from eighteen organisations including seven multi-laterals, seven individual bi-laterals, together with the EU, Clinton Foundation and GFATM LFA. There is a secretariat together with a technical support facility funded, in turn, by its partners. There are likely to be additional members in the near future including the Bill and Melinda Gates Foundation and the Government of the Netherlands. There is additional support to the health sector provided outside the co–operation mechanisms by China, Saudi Arabia and other bodies based in the Middle East. In general, their support is focused on infrastructure and they work directly with the Ministries but outside joint planning mechanisms.

2.1.2 Implementing Partners

NGO co-ordination is undertaken through HENNET (Health NGOs Network) who represent approximately 77 CSOs/ NGOs. They are invited to the monthly meetings of the health donor group but do not always attend. They are represented at the Health Sector Co-ordinating Committee. Their secretariat is active and co-ordination meetings are held quarterly. However HENNET membership does not reflect the very large number of small local CSOs nor the large international NGOS who undertake major projects in country. There is a need recognised for a mapping exercise to identify the extent of NGO service provision.

There continue to be issues concerning the willingness and ability of some NGOs, CSOs and FBOs to disclose information on proposed financial investments. These figures do not appear in the AOPs unless the NGO is a grantee of one of the development partners.

There is little evidence of involvement of the private sector in planning and co-ordination activities and given that an estimated 14% of service delivery is provided through private facilities and practitioners, this represents a significant lack.

2.1.3 Health Sector Co-ordinating Committee

The Health Sector Co-ordinating Committee consists of the MOMS & MOPHS together with membership from DPHK representing development partners and HENNET representing implementing partners. The committee meets quarterly and attendance is reportedly good. In principle there should be information fed to this committee by the Interagency co-ordinating Committees (ICCs) but this is not operating universally yet.

There remain some difficulties in obtaining financial information from some individual DPs and co-ordination of DP funded activity remains problematic. There is currently a proposal that GIZ may set up a DP website identifying support, although it is acknowledged that this ideally should be co-ordinated by the Ministries.

2.1.4 Interagency Co-ordinating Committees

Eight system support ICCs and ten technical ICCs have been established. It is reported that some are more functional than others and this is partially consequent on the ability of the Ministries to provide input and the degree of interest by DPs and others. Each ICC has a lead DP which, in many cases (March 2010), is a multi-lateral agency. There is an inequity of involvement of DPs, with the ICCs relating to sector financing, procurement/ supply, malaria and HIV/AIDs having greater number of members, whilst WHO is the sole DP on the ICC for non communicable disease. This would suggest that DPs may be continuing to work in areas chosen by themselves rather than identified as being of particular need by the Ministries. There is a proposal to set up an ICC for public private partnerships (PPP) with membership to include representatives of PPPs who have signed the code of conduct.

2.1.5 Shadow budget

Financial co-operation and co-ordination mechanisms are still being undertaken using the mechanism of the shadow budget which captures off budget investment.
Planning within the health sector has continued in part to be undertaken separately from budgeting. This in part reflects the problems associated with GOK health sector budgeting. There is no total agreed budget for either Ministry at District and Provincial level due to problems of disaggregation, particularly of Personal Emoluments (PE). Financial tracking exercises have been undertaken with support from EHS and formulae for resource allocation to District level are available in draft form but formal reallocation of budgets has not yet taken place. This will form one of the challenges in implementing the new Constitution.

The AOP 6 identifies that there is an increase in public resources allocated to the health sector. This may well be true, but information about any increase was not made available to Provinces and Districts and their planning was based on MTEF information from the previous year. This has been a recurring theme throughout the recent AOP cycles.

Despite the agreement to share information on proposed expenditure and actual disbursement, it has been difficult to obtain this information from some development partners concerning their off budget contribution. In the last financial year (2010/11) the AOP lacked specificity because although total investment on and off budget was documented, it was not possible to disaggregate this by level of service. The information required to do this was not available from a number of partners including the US government who contributes 61.5% of total DP funds.

The proposed DP commitments for financial year 2011/12 are due to be submitted by end of January 2011. There are good indications that this will occur on time, albeit that a lack of synchronicity of financial planning cycles will inevitably mean that some partners will submit estimates rather than their final investment figures.

2.1.6 Code of conduct

At the commencement of 2010/11 financial year there were sixteen signatories to the code of conduct and, of these, eight have on-budget resources and seven have off-budget resources. An additional thirteen partners who are not signatories are, never

the less providing on-budget resource. The majority of this resource is tied to specific earmarked investments.

2.1.7 Joint Financing Agreement

At the present time, the World Bank and DANIDA remain the only two development partners to have signed the current Joint Financing Agreement. However, this does not appear to represent a loss of support to the principles established at the 2007 Mombasa meeting. There is a perception that development partners are more likely to commit once the health structures, roles and responsibilities, as laid down in the new Constitution, have been further clarified. Once the next election in 2012 has been undertaken, and as long as no conflict results, it seems likely that there will be a number of development partners who will be prepared to commit.

2.1.8 International Health Partnership+

Kenya is a partner of IHP+ but no separate compact has been developed on the basis that the existing Code of Conduct was felt to cover the principles and undertaking a format change would be a distraction. Not all DPs are IHP+ partners and, even where they are, local support is not necessarily strong. However, IHP+ principles are felt to be supported and the recent monitoring of the code of conduct commitments was in line with IHP+ processes.

The strong link between Dr Pendame and EHS with Dr Humphrey Karamagi of WHO has facilitated the use of IHP+ principles and tools in the development of Kenyan planning and co-ordination systems.

2.1.9 Co-ordination Functions at District and Province

The 2010-2011 AOP demonstrates that all Provincial Ministries are submitting provincial priorities, service delivery baselines, targets and proposals for Provincial Health Management Support. The level of detail appears to vary but Nyanza has one of the more comprehensive plans. Nyanza can demonstrate involvement of major development partners in the planning process but implementing partners are less well represented It is disappointing that managers interviewed almost all felt that planning and joint monitoring was not fully sustainable without DP funding. Indeed, district level staff in the EHS supported districts felt there was a risk that future planning activities would be dramatically scaled back.

The sustainability plan drawn up by the EHS for local level planning acknowledges that, without resources, lower level planning processes could cease. Efforts are being made for funding to be picked up by JICA or USAID through APHIA plus. Whilst this provides short term continuity, it does not provide long term sustainability. Planning is an integral part of the job of being a manager and should be a recognised part of normal role delivery and revenue funding.

2.1.10 New Kenyan Constitution

The implementation of the new Kenyan constitution has the potential to achieve more locally owned and locally sensitive planning but also to cause a disruption to planning, budgeting and monitoring systems which are just coming to maturity. In order to operationalize the revised county structures, provision will need to be made in the new Health Policy, some of the existing health laws will need to be revised or rewritten and new tools will need to be designed. The EHS has already provided support in identifying some of the issues.

Robust planning and budgeting will need to be established based on the existing national systems and guided by agreed national strategies. This will require orientation and support to both the county assembly, the county executive and health officers. The role at ministry level will change substantially and there will need to be significant capacity building in line with their changed roles. In addition, in line with delegation of financial responsibility, budget apportionment will need to be undertaken and this will have significant implications, particularly for PE. The envisaged time scale is very short and there is a real risk that the reorganisation could result in a temporary diversion in focus which could affect performance management to achieve agreed health objectives and reduce supervision.

Recommendations
There are no specific recommendations related to this indicator

Indicator 2: Number of targeted districts which have a minimum acceptable coverage for EMOC

2.1.11 Emergency Obstetric Care Coverage

To better monitor services for women who experience obstetric complications, WHO has defined two levels of obstetric care, Basic and Comprehensive Emergency Obstetric Care. A health facility providing Basic Emergency Obstetric Care (BEmOC) should be capable of managing all obstetric complications except for those requiring surgery or blood transfusion. Thus, a facility which meets the criteria for BEmOC is one in which there is documentation that the following procedures, referred to as signal functions, have been performed within the last three months: injectable antibiotics, injectable oxytocics, injectable anti-convulsants, manual vacuum aspiration, manual removal of the placenta, vacuum extraction, newborn resuscitation. A Comprehensive Emergency Obstetric Care (CEmOC) facility is one which offers all of the BEOC signal functions, as well as caesarean and blood transfusion. To assure adequate coverage, WHO recommends five BEmOC facilities per 500,000 population, with at least one CEmOC facility. WHO coverage recommendations are not evidence-based and in settings with documented declines in maternal mortality, coverage per population is substantially higher than WHO recommendations.

At the inception of the EHS programme, minimum requirements (following WHO recommendations) and programme goals for the coverage of BEmOC and CEmOC facilities per district were established. For every district, the goals established for the EHS programme either met or, in most cases, exceeded WHO requirements for the minimum number of BEmOC facilities relative to the population. Due to weak record-keeping, particularly evident at baseline assessment, the EHS team replaced the WHO definition of “performance” of signal functions with “readiness” to perform signal functions (trained personnel, equipment, drugs). Thus, the data presented in Table 2 below do not reflect performance within three months prior to data collection.

At baseline measurement, none of the facilities met all the criteria for a CEmOC or a BEmOC facility; Siaya District Hospital came the closest, lacking only one signal function: vacuum extraction. Results from the Endline survey show that four of the five health facilities targeted to be upgraded to meet CEmOC facilities met all nine CEmOC criteria in late 2010, plus one facility originally targeted as a BEOC. Seven of the 20 facilities targeted to meet BEmOC criteria did in the end meet the seven BEmOC signal functions by the endline survey. All 20 targeted BEmOC facilities

showed readiness to provide at least 5 signal functions and 13 of them showed readiness to provide six of the signal functions. More detailed information on the specific constellation of services offered at Baseline and Endline is provided in Section 3. Thus, although the EHS programme did not fully achieve its targeted goals for EmOC health facility readiness by late 2010, very substantial progress was made. However, it should be remembered that these data on readiness do not necessarily imply that the full array of BEmOC and CEmOC functions were recently performed.

Table 2: Numbers of BEOC and CEOC facilities recommended by WHO, targeted by EHS and achieved by EHS

District	Minimum number of BEOC facilities *RECOMMENDED* for District population given WHO recommendations	Number of facilities TARGETED for upgrading to BEOC at inception of EHS program	Number of facilities ACHIEVING BEOC status, BEOC-1, BEOC-2		Minimum number of CEOC facilities RECOMMENDED for District population given WHO recommend-dations	Number of facilities TARGETED for upgrading to CEOC at inception of EHS program	Number of facilities ACHIEVING CEOC status, CEOC-1, CEOC-2
Homa Bay	2	3	1 BEOC 2 BEOC-1		1	1	1 CEOC-1
Kisumu West	1	2	1 BEOC-2		0	0	1 CEOC-2
Kuria	2	2	1 BEOC 1 BEOC-2		0	1	1 CEOC
Migori	5	5	4 BEOC 1 BEOC-1		1	1	1 CEOC
Siaya	4	5	5 BEOC-2		1	1	1 CEOC
Suba	2	3	2 BEOC-1		0	1	2 CEOC
Total	13	20	7* BEOC		4	5	5 CEOC

* Includes one facility targeted as BEOC which became a CEOC

2.1.12 Recommendation

Given the very substantial contribution the EHS programme has made toward expanding and upgrading infrastructure for safe delivery, efforts in EHS supported districts should continue to focus on increasing use of these facilities. Lessons learnt in the planning and construction of new structures should be shared with the Ministries and other donor partners for expanded infrastructure in districts which were not reached by EHS activities from 2005-2010.

Indicator 3: Proportion of births attended by skilled health staff in Nyanza Target Districts

2.1.13 Skilled Birth Attendance

A key policy goal, both nationally and for EHS targeted districts, is increasing skilled attendance at birth. 2006 data from the Kenya Demographic and Health Survey suggest that the percent of births with a medically trained attendant (doctor, nurse, midwife) in Nyanza Province is in line with the national average, at approximately 45%. DHS trend data suggest that the percent of births with a medically trained

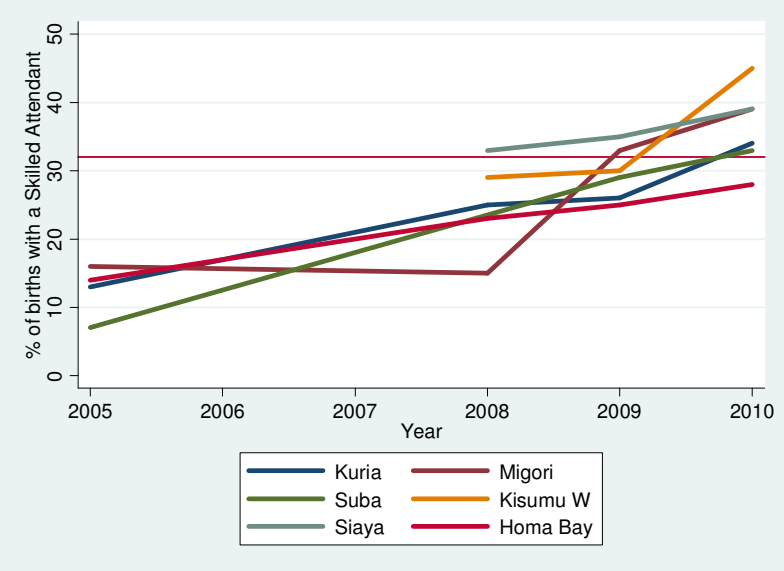
attendant in this province remained quite stagnant at around 38% from approximately 1992-2002, then rose to its current level. In 2006, nine percent of births took place in a private health facility in Nyanza Province.

For this evaluation, two types of data are presented on skilled attendance at birth; the percent of births attended by a skilled attendant reported by the HMIS at baseline and endline, and the baseline and endline numbers of births occurring in EHS targeted health facilities or at home with a trained community midwife. The EHS programme goal was to achieve 32% of births with a skilled attendant in EHS targeted districts.

Figure 1 shows trends in skilled attendance at birth from 2005 through 2010, based on HMIS data. It should be noted that although all public and private facilities should report data to the HMIS, it is rare to have complete (or in some cases, any) reporting by the private sector. We assume that discrepancies between the higher rates reported in the DHS and the rates shown here are due to a) general under-reporting often associated with HMIS data; b) some private sector use which is not captured in the HMIS data; and c) the fact that EHS targeted districts were selected based on need and therefore are likely to have lower rates of use of health services.

Very impressive increases in the percent of births with a skilled attendant are shown in five of the six EHS target districts. In Homa Bay, the rate doubled from 14% to 28%, in Migori rates increased by a factor of 2.4 (16% to 39%), in Kuria rates increased by a factor of 2.6 (13% to 34%) and in Suba, the rate increased nearly five times, from 7% to 39%. The district of Siaya showed the smallest increase at 15% (from 33% to 39%), but this covered only a two year period between 2008 and 2010. Thus, the programme goal of 32% skilled attendance rate was reached in five of the six EHS target districts. Homa Bay did not reach the goal, but came close at 28%.

Figure 1: Percent of births with a skilled attendant in EHS-supported districts ; 2005-2010



Source: Kenya HMIS data

Figures 2 and 3 show the average number of deliveries per month attended by a skilled provider within the 25 EHS-supported health facilities. In 21 facilities, the mean number of deliveries increased, in some cases by a large number. In two

facilities the mean remained approximately constant (Karungu sub-District Hospital and Siaya District Hospital) and in two facilities (Dienya and Ligega Health Centres) the mean decreased from baseline to endline (from 11 to 8 and 9 to 7, respectively). Thus, care seeking at birth improved throughout EHS districts and was not restricted to a few popular health facilities. Still, it should be noted that in half (13) of the 25 health facilities, staff were delivering, on average, fewer than one birth per day. Except for Homa Bay and Siaya Hospitals which managed around three deliveries per day, all the other facilities were managing fewer than two.

Figure 2: Mean number of deliveries in Hospitals at baseline and endline for EHS-supported facilities

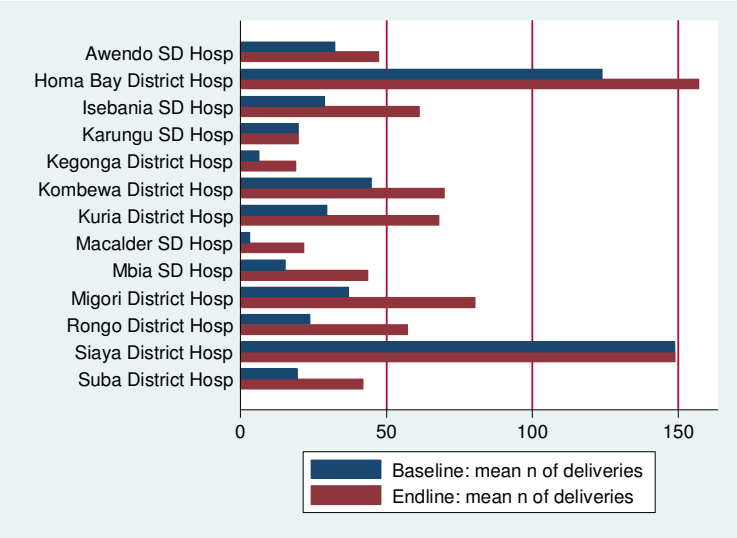
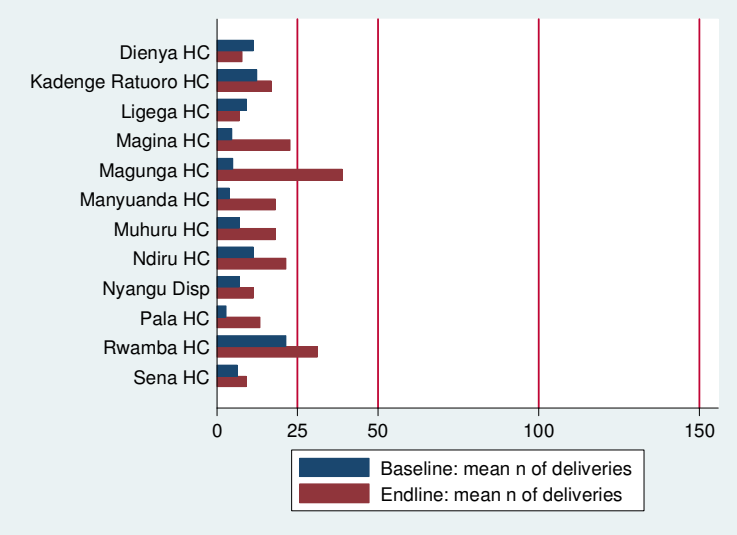


Figure 3: Mean number of deliveries in Health Centres at baseline and endline for EHS-supported facilities



2.1.14 Recommendation

Continuation of programming to support both the supply and demand side for skilled attendance at birth is recommended. Trend data shown here on skilled attendance at birth suggest steady increases during this period of intense programme activity. Conclusions from the Value for Money assessment is required to determine if there are some supply or demand side activities that are less efficient than others.

Indicator 4: Proportion of pregnant women receiving 4 ANC visits in Nyanza Target Districts

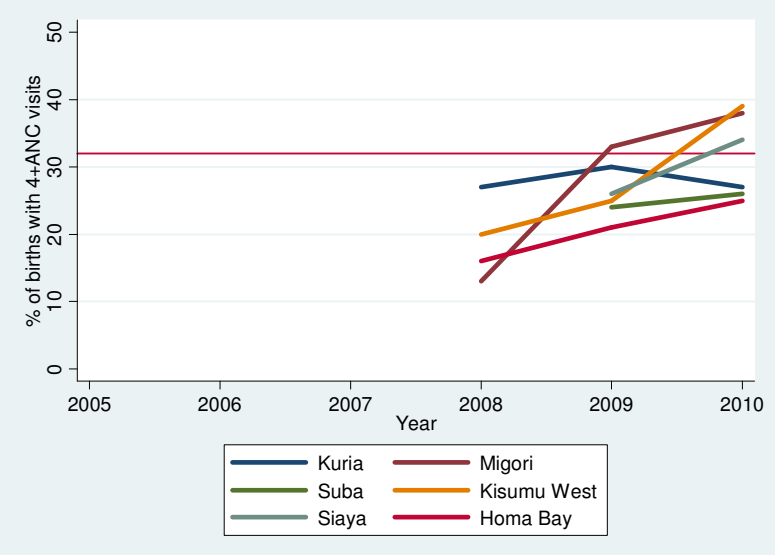
2.1.15 Antenatal Visits

As with skilled attendance, the EHS programme goal was to increase the percentage of pregnant women receiving four or more antenatal care visits to 32% in target districts. This information was not collected at baseline and was only added to the Kenya HMIS in 2007. Thus, HMIS results are presented from 2008 – 2010. As above, it is assumed that antenatal care from the private sector is probably under-represented here. Increases in the percentage of women receiving four or more antenatal care visits are shown for all six districts, even over this short period of time (see Figure 4). Rates in 2010 range from 25% to 39%. Three of the six districts reached the goal of 32% by the last quarter of 2010.

2.1.16 Recommendation

Detailed data from the endline survey report, however, indicate that in 12 of 25 EHS-supported facilities, the number of *first* antenatal care visits decreased between baseline and endline surveys. This is a worrying trend particularly given the extensive EHS efforts at community mobilisation for maternal health care in general, and one that should be closely monitored in the months following the end of EHS-supported activities.

Figure 4: Percent of births for which the woman received four or more antenatal care visits; EHS targeted districts



Source: Kenya HMIS data

3. Programme Progress – Output Level

3.1 Output 1: Central Ministries Strengthened

Central MOPHS/MOMS effectively supported in strengthening health systems policy development and planning for the delivery of the Kenya EPH

Indicator 1: Extent of Health Sector Joint Planning

3.1.1 Background

At the commencement of the programme in 2005, co-ordinated sector planning did not exist. The 1999-2005 first Health Sector Strategic plan is reported to have resulted in vertical programmes with little cross dialogue or co-ordination. The second HSSP provided an opportunity for a change, both in strategic direction but also in the methodologies for undertaking planning in line with the desire to move towards greater devolvement and increased harmonisation. AOPs have improved in their scope and their role in co-ordinating activities around the Ministries plan. The EHS has actively supported capacity building and the development of tools and guidelines

3.1.2 Central MOPHS/MOMS support

Both Dr Richard Pendame and Dr Paul Dielemans have provided long term technical assistance (LTTA) to the two Ministries. Colleagues have expressed their appreciation of their technical knowledge, professionalism and enthusiasm. It is clear that they have given considerable support in the development of the institutional framework for the SWAp and also supported the Reproductive Health Division in establishing strategic direction. Dr Dielemans made a substantive contribution to the roadmap for Maternal Health and the Reproductive Health Strategy.

It is unfortunate that there have been so many senior personnel changes in the Reproductive Health Division at Ministry level. Such turn-over will continue to undermine the sustainability of any capacity building efforts by government or development partners. It is particularly concerning that systems for retention and retrieval of documentation in the Ministries are not well developed. There are plans to ensure that all materials produced with the support of EHS are assembled and archived but there appears to be a major issue concerning the management of documentation and access to supporting information within both Ministries.

Some short term TA was also used. Feedback suggests that this was most helpful to colleagues in the respective ministries when the consultants had country knowledge and hands on management experience.

"EHS short term consultants were well informed in local systems. They were not just academics who knew the theory". Head of Planning Division

3.1.3 Overview of National planning and budgeting processes.

There has been a steady improvement in the processes and outcomes of the national planning, budgeting and monitoring processes. There is general agreement that EHS has contributed significantly to this. However, the planning process is still in great part an exercise for co-ordinating development partner support around a plan. It does not drive changes in the way GOK staff work nor initiate new pieces of work for them to carry out as part of their routine responsibilities. There remains a culture that all but basic and routine "maintenance " functions need additional funding support and this needs to originate from DPs. The Performance Contract process provides an opportunity for public sector staff down to the level of departmental head to be set objectives relating to service change or development but it is reported that the system is not yet fulfilling its potential

The AOP process has considerably increased the transparency relating to the totality of funding but there remain problems relating to timeliness and breakdown of forward projections both from GOK and from DPs.

EHS has made significant contribution to building in house technical capacity at central level, developing tools and guidelines and ensuring the process is institutionalised. The basic problem remains however that there is no GOK recurring funding for planning or review. Whilst several DPs support this process (currently DFID, WHO, WB) it is entirely reliant on external funding.

3.1.4 Identifying bottlenecks

An integrated approach to planning has the aim of ensuring that the all support and development initiatives work together to achieve a nationally agreed priority. No single support programme can tackle all the issues for a particular client group, certainly not one as big as Maternal and Child Health. However, if the complete "whole care pathway" is not analysed for bottlenecks there is a risk that some of the investment cannot be capitalised on, nor the objectives in terms of patient outcome be achieved. This must clearly be a responsibility of the ministries.

Whilst EHS has delivered significant demand side strengthening and built both capacity and infrastructure, this cannot be exploited to the full unless other parts of the pathway are in place. The most significant issue identified has been the lack of drugs, particularly oxytocin/ iron/ folic acid and antibiotics. This was acknowledged by interviewees at all levels yet there seemed no plans to rectify the situation in a sustainable way and it was not identified in the AOP (although availability of drugs was an assumption in the logframe). It was, however, remarked that oxytocin had very recently been suggested as an addition to the list of "tracer" drugs in Kenya, a promising step and one that should be pursued. The lack of oxytocin is not a criticism of EHS, and indeed the programme procured emergency supplies, but it undermines the investment. This "whole pathway" approach should be one of the strengths of a sector wide approach to planning yet, in this case, it is not being demonstrated. This could be a consequence of inadequate resources rather than lack of planning but the current situation would appear to merit more demonstrable action.

3.1.5 Impact of Constitutional Change

Proposals are in place for major constitutional changes which will result in the creation of forty seven counties with considerable devolved autonomy. This will be accompanied by the disbandment of the provincial and regional tiers and a significant change of role at the centre. Whilst this has the potential to strengthen both planning

and management locally, there are significant risks during the transition period, not least a loss of institutional memory. There is a recognition that this constitutional change will require significant technical support, particularly as governors will be elected politicians rather than technocrats.

Likewise, the changes at ministry level have the potential to divert the focus from supporting and providing supervision of agreed strategy and policy. There is no agreed co-ordination mechanism to ensure harmonisation of planning for DPs as yet with the potential of them operating at individual county level with consequent high transaction costs. The National Commission to implement the new constitution had just been appointed at the time of the review.

3.1.6 Recommendations

The support provided through long term TA has demonstrated the value of embedding senior level specialists with managerial experience as well as technical skills in ministry structures. Whilst some short term TA is perceived as useful for very specialist tasks**, it is recommended that every effort is made to maximise the use of long term TA in future initiatives involving support to system development and management of change.**

As the planning system matures it is important that it increasingly reflects the totality of investment both from DPs but also from GOK. This must include the budgets relating to personnel. This is planned under the new constitution but **it is recommended that specific support is given to implementing this allocation exercise**. The apportionment of funds (particularly those relating to staff) will be informed by some of the work already undertaken (e.g. the finance tracking exercise supported by EHS) at county level Only when this is achieved will it be possible to jointly assess whether allocation reflects need, to hold partners to account and to guard against fungibility.

It is recommended that significant support will be needed during the implementation of the new constitution to ensure that the transition to counties takes place smoothly and that established mechanisms for identifying national priorities are in place and progress can be monitored.. New infrastructure will need to be developed not only for planning, budgeting and monitoring but also for implementation. The current performance contracts need to be further embedded and given “teeth” (recognition of achievement/ penalties for poor performance) as greater levels of responsibility (including financial responsibility) are delegated.

Indicator 2: Extent of Establishment of Joint Performance Monitoring for the Health Sector

There is commitment to using a single monitoring process and common data but this continues to be hampered by the quality of data from HMIS. It has become necessary to incorporate internal data quality review processes. Whilst there are national, provincial and district joint reviews of progress against the AOP, individual support programmes (including EHS) continue to have separate review processes, albeit that ministry staff are involved in both data collection and dissemination events. This is transaction heavy but it is recognised that in the current economic climate it will continue to be necessary in order to demonstrate impact (and thus future funding) to DP national bodies.

3.1.7 Recommendation

The endline survey highlighted the continuing problems with poor data collection and recording and there are reported to be issues relating to timeliness of quality of HMIS information. Any future initiatives must continue to incorporate support activities relating to data recording, collection, interpretation and health information use in order for effective monitoring and evaluation to be feasible.

Indicator 3: Extent of development of national MNH strategic documents

3.1.8 Policy and Strategy

The last three years have seen an impressive output in terms of strategy and policy relating to Reproductive Health but particularly maternal and neonatal health. See Table 3 below.

Table 3: RH Policy and Strategy - key documents

National RH monitoring and evaluation plan	February 2007
National Contraceptive Commodities Security Strategy 2007 - 2012	
National RH policy	October 2007
National RH training plan 2007 - 2012	May 2008
Strategy for improving the uptake of long-acting and permanent methods of contraception in the FP program 2008 - 2010	2008
Child survival and development strategy 2008 - 2015	
Best practices in RH in Kenya	August 2009
National guidelines for Maternal and Perinatal Death Notification and Review	August 2009
National RH Strategy 2009 - 2015	August 2009
Review of the 04-08 RH research agenda and proposed 2010-2014 research agenda	January 2010
Road Map for accelerating the attainment of MDGs 4 and 5	August 2010
Community based Maternal and Newborn Care: training course for community health workers	2010
MNH guidelines and comprehensive training package	Still in draft

A revised Kenya Strategic Reproductive Health Strategy was produced in 2009 to cover the period 2009-15. Part of its aim was to provide guidance and alignment with the National Reproductive Health Policy produced in 2007.The document also built on the Road Map for Accelerating Attainment of MDG5 which was supported by EHS.

The Strategy was supported by the RH strategy task force of which Paul Dielemans was a member. The Strategy documented a change in emphasis in respect of maternal health with a focus on skilled birth attendance as well as system strengthening, increased functionality of facilities and appropriate care of newborns.

The development of the strategy reflected the changes in planning and consultation in health services as a whole and appears to have involved both “bottom up “ consultation with district health teams and the involvement of development partners.

It integrates relevant priorities from HSSPII, including the implementation of the Community Strategy

Considerable emphasis was put on a review of available evidence. Whilst the impact and experience obtained through the EHS cannot be demonstrated as an influencing factor, it is clear that many priorities within the strategy in respect of MNH reflect the EHS approach, including both supply and demand side strengthening.

There has been considerable activity during the period that the EHS has provided support including the development of Maternal and Neonatal Health guidelines and the revision and circulation of revised national Maternal and Perinatal Death Review guidelines and tools

Rapid turnover of staff has particularly affected the Reproductive Health Division (RHD) where the current acting incumbent as lead for Maternal Health is the fifth person in two years to hold this position. There has clearly been a significant issue with institutional memory, openly acknowledged by those in RH and this has substantially eroded the significant contribution made by Dr Dielemans . There is a perception that the Road Map is not on track, due to lack of central capacity.

3.1.9 Recommendation

The value of excellent long term technical assistance supported by appropriate short term specialist TA has been proven. A relationship of trust can be established and Dr Dielemans was perceived as part of the Ministry MNH “team”. A number of senior staff identified that having continuity of support was preferable to short term “visits” which have high transaction costs, particularly if significant orientation is needed However, the impact of such support cannot be sustained without a degree of senior level stability within the Ministries.

3.1.10 Comprehensive MNH training package for pre-and in- service

To date, there has been discussion at the national level regarding the development of a comprehensive maternal/neonatal health training manual. What is envisioned is one manual, which would include, but not be limited to, the existing manuals for Emergency Obstetric Care (EmOC) and Life Saving Skills (LSS) training and from which chapters could be pulled, as needed, for in-service training, as well as for pre-service instruction for a variety of health care cadres (nurse-midwives, clinical officers, etc), thus standardizing MOMS and/or development partner clinical training activities. Interviews conducted for this report suggest that substantial progress was made in drafting chapters via collaboration between EHS, WHO and the Intra Capacity Project, but that this process has stalled and that it may be pursued during the next AOP planning discussions.

During the EHS project (2005-2010), much greater effort has been directed at provincial and district levels to in-service clinical training using the EOC and LSS manuals than to pre-service education in maternal and neonatal health. This is likely to be true for GoK and donor partner efforts nation-wide and is generally true across low-income countries. Section 3.3.2 documents the impressive number of health care providers who received EmOC/LSS training with EHS support in Nyanza Province.

The duration of EmOC training is two weeks, with the first week focused more on theoretical content and the second week, offering trainees the opportunity to practice skills on patients at a health facility. The difficulties associated with EmOC training is its duration, and the fact that trainees often do not have the opportunity to practice

their skills during the second week due to a) the small number of patients at the health facilities, and b) lack of exposure to patients with obstetric complications. LSS training which should be preceded by EmOC training, has been reduced to three days and is focused entirely on skills acquisition by working with anatomical models. LSS training is often conducted in hotels, with their associated costs. It was suggested by several informants for this report, that with appropriate planning, up-to-date EmOC training materials could be incorporated into pre-service training, thus alleviating the need to call health care personnel away from their jobs for extended periods of time and at greatly reduced costs.

However, pre-service MNH education was never cited as a priority among those interviewed for this report either from MOMS/MOPHS personnel nor among donor partners at national, provincial or district levels. This includes JHPIEGO which has a large pre-service division which is predominantly focused on family planning and HIV.

Thus, updating pre-service education in maternal and neonatal health does not appear to have been a priority for the GoK, and, not surprisingly therefore, does not figure among the activities of the EHS project. It should be noted that there has been discussion of adding the EmOC/LSS training module just following completion of pre-service training for nurse-midwives (following exams and prior to receipt of results). This idea was proposed so as not to disturb the content of the pre-service curriculum. On one hand, this is a creative solution to an urgent problem. On the other hand, it reflects resignation and acceptance that the content of pre-service education in maternal/neonatal health will not be current. This issue is not unique to Kenya. However, ultimately, updated, evidence-based instruction during pre-service training will be more cost-effective than continuous in-service training programs.

3.1.11 Recommendation:

Planning efforts at national level should focus on developing means to maintain an updated pre-service curriculum for physicians, nurse/midwives and clinical officers in the area of maternal and neonatal health.

Collaborative efforts between donor partners and the Ministry should strive to shift away from such heavy reliance on in-service training toward a more balanced program encompassing pre-service and in-service training.

3.1.12 National Level Management Development

Dr Pendame has worked closely with Dr Karamjagi (WHO) and others to develop a national management development programme delivered by four institutions. In phase 1, 650 managers have been trained in teams to increase continuity. The training includes a strong emphasis on planning and monitoring.

3.1.13 Recommendation

Considerable DP resources continue to be used in designing a variety of management development courses. Most of them cover the same topics and in some cases they are delivered by the same institutions (e.g. Great Lakes University is delivering both this course and a similar JICA design)

It is strongly recommended that the GOK adopts a single curriculum and delivery model and that future DP support to management development, uses this single modality.

3.2 Output 2: Health Systems in Nyanza Support KEPH

Health Systems in Nyanza province to support delivery of KEPH especially the maternal and neonatal health component

Indicator 1: Extent to which mechanisms for co-ordination of partnerships are established in Nyanza and target districts

3.2.1 Mechanisms for the co-ordination of partnerships

The processes relating to annual planning are established in the Province and appear to be working in all Districts. In the six Districts supported by EHS, senior staff are working in accordance with the agreed schedules for key meetings. There is clearly a very productive working relationship with EHS particularly in respect of agreeing support packages.

"EHS is very different. We sit together to make plans and they pick up areas where they can support. We can see ahead and know they will do it with us. Other partners are different. We don't know what is in their basket and anyway they implement what they decide and we end up having to support them. EHS is the other way round" **DMT member**

At Provincial level, there is active involvement and support to the process from DFID (EHS), JICA and UNICEF and it is anticipated that USAID in the form of APHIA plus will be involved shortly. Some faith-based organisations have accepted the invitation to be involved but there is little involvement of international NGOs (who tend to work in individual Districts) and virtually none from the private sector.

Attendance at the review meeting held on January 20th was impressive and the quality of the service delivery monitoring material was good. Information on financial disbursement by partners is provided although it is understood that this can be challenging to co-ordinate. Financial information from the Ministries is less developed given that national data are not easily disaggregated. For instance, there is no agreed staffing establishment at District or facility level and the Personal Emolument (PE) system is held nationally. Given that salaries are estimated to account for up to 80% of budget this means that the totality of input from GOK cannot be accounted for. This also hinders any cost comparisons as there is no personnel cost breakdown nor apportionment of facility costs using a cost accounts system. Likewise the cost of drugs and consumables is not easy to obtain and cannot be disaggregated by patient group except where a drug is only used for a single illness/ condition.

The new constitutional arrangements whereby there will be local financial management, including local employment of staff, will provide an opportunity to obtain cost information but only if management accounting systems use a single national code book across all Districts. Without the ability to cost services Districts will find it difficult to plan and budget and, by comparison, to identify where there are opportunities for efficiencies.

A further issue between development partners and the Provincial Ministries relates to co-ordination of logistics relating to agreed activities. Many activities (training sessions/ workshops/ review meetings) involve senior staff. Yet, on many occasions events are planned concurrently and often at short notice. This results in problems of attendance and, on occasions, one partner supported activity being hampered because Ministry staff are involved in another activity supported by a different partner at the same time. This highlights the need for Ministry staff at both District and Provincial level to establish and manage scheduling systems.

Whilst planning and review activities are well established, there appear to be some issues in relation to serial duplication. Over a period of time, several management development programmes have been developed locally and nationally, targeted at senior staff and teams at Provincial and District level. This includes the current national programme supported by WHO and EHS and a previous initiative delivered by MSH. Given that each of the programmes have been newly written at substantial cost and some are running concurrently (e.g. the JICA programme in Nyanza and the national programme) there appears a need for some consideration by Government of Kenya whether further resources (both design, delivery and attendance costs) should be expended. All the courses are credible and the curricula are remarkably similar.

3.2.2 Recommendation

Planning and monitoring are not “additional” or optional activities and thus they need to be incorporated in normal work activities of all ministry staff and there should be budgets to support the key events etc. Relying on DP support is not sustainable for such a core function. This should be the long term strategy incorporated in the planning goals. In the short term it will be important that there is continuity of support to ensure no dislocation

Indicator 2: Extent to which referral system is strengthened in Nyanza and target districts

3.2.3 Access to functioning transport and communication

EHS has provided telephone communication to strengthen referral. Reports on the distribution of mobile phones are mixed. In some locations this was seen to be operating very effectively with prior notice of arrival being given to the Level 4 facility. However, in another location, the mobile telephone was observed to be in a cupboard in an office not permanently occupied. It is not clear whether this was because alternative means of communication were available. In interviews at the health centre level, some respondents expressed frustration that their air time for the mobile phones was insufficient. No data on mobile phone utilisation was available.

3.2.4 Motorcycle ambulances

The mid term review of the use of motorcycle ambulances was carried out in March 2010. The report was modified in July 2010 and the end line survey updated utilisation data and identified little progress in terms of appropriate utilisation. These reports suggest that the introduction of the motorcycles has not had a significant impact on strengthening emergency referral systems although they are accepted as an alternative means of transport from the community to the health centre.

There is little accurate quantitative data on use of the motorcycles due to incomplete record-keeping. However, the mid-term review compiled existing data related to use between February 2009 and January 2010. The picture that emerges is that the five motorcycles purchased by EHS are infrequently used for referral as a means of transport from one health facility to a higher level of care for obstetric cases. Data

from the five health Centres housing the motorcycles showed 47 cases of obstetric referral of which only four were transported by motorcycle, suggesting that other means of transport were located and preferred over 90% of the time. Motorcycles were used, however, for 18 non-obstetric referral cases. Motorcycles were used even less frequently to transport patients from the community to the health Centre. Data show a total of 31 motorcycle trips during that year, of which 13 were obstetric, and these were not necessarily for obstetric emergencies.

Interviews with EHS staff also raised the question of whether the availability of the motorcycle ambulances actually decreased the likelihood that women would seek a facility delivery, since they know that should they experience a problem at home, emergency transport would be available. The qualitative data compiled for the mid term review and endline survey, as well as interviews conducted for this PCR, paint a mixed picture. To generalize, one is left with the impression that people like the idea of the motorcycles more than they like to use the motorcycles. Interviews on this subject tended to elicit quite positive responses. For example, no one interviewed would recount any experiences when a request for referral could not be accommodated and the motorcycles were considered an innovative solution to referral transport. On the other hand, investigation into use of the motorcycles revealed this intervention to be quite complicated, requiring substantial record-keeping and accounting (requests for service, collection of charges, maintenance and fuel for the motorcycles, funds for expenses required by the riders), and training and retention of community riders.

Ultimately, this intervention needs to be considered as one of the experimental approaches that EHS used in their endeavours to mobilise the community for safe delivery. Although the utilization of the motorcycles was low, there were no expectations *a priori* about what level of use would justify the cost and effort.

3.2.5 Lessons Learnt

There appear to be a number of lessons which can be learnt from this initiative including:

- The need for clarity about the envisaged role of the ambulances (i.e. whether they should transport patients between facilities or from the community to a facility)
- Whether the motorcycles are for emergencies only, or a general source of transportation to the facility for delivery when other means are unavailable)
- The need to locate the ambulances where there is most potential for their use
- The need to ensure that the vehicles are sufficiently robust to be functional
- The need to undertake a survey of alternative provision (taxis etc) and the cost of this before introducing motorcycles and fixing a cost for their use.
- The need for comprehensive and consistent community mobilisation and information giving
- The need for agreed operating procedures including
    - Responsibility for ensuring roadworthiness (routine maintenance and cleaning)
    - Responsibility for ensuring fuel is available
    - Responsibility for documentation of use, expenses and income
    - Responsibility and systems for obtaining cost sharing contributions

- The need for handover of the above responsibilities as staff move/ change.
- Consideration whether there should be a common reward package for drivers (payment/ lunch allowance/ protective clothing etc)

Motor cycle ambulances have been successfully introduced elsewhere and it is difficult to identify why this initiative has, so far, had less impact. There is a real danger that motorcycles may become unroadworthy due to lack of use which would preclude staff's ability to mobilise them sufficiently quickly. Failed attempts at using them could easily result in increasingly negative public perception of the motorcycles.

3.2.6 Recommendation

Before committing to further roll out it, would seem sensible to undertake a short comparative study of sites where they are being used successfully, and to determine if the definition of success is appropriate across different settings.

3.2.7 Indicator 3: Extent to which the inventory system is operational at Provincial and District level

EHS has supported the districts by procuring inventory registers and orientation was provided to the health facility senior manager ("in charge") in entering and maintenance. This has been followed up with both the managers and DHMT members on two occasions in the past six months. It was disappointing that, despite this, the evaluation team were not able to obtain sight of any registers to assess their completeness. It is understood that there have been some problems with the registers being seen as part of EHS and therefore only EHS equipment being entered. This underlines the need for the ministry to be fully involved in both provision of equipment and its documentation. There is a risk that "project equipment" is treated differently if it is not incorporated into the AOP and also that new systems likewise need ownership.

This activity did not feature in AOP 6 and it would seem that there has not been as much ownership by Provincial and district staff. However it is understood that MOMS have recently issued guidelines to hospitals which may revitalise the initiative

although it is not possible to verify if the operational policy is the same as that supported by EHS. The Provincial RH lead has been undertaking an audit of MNH equipment in order to undertake a gap analysis prior to the next planning round.

3.2.8 Recommendation

Without both provincial and district ownership, this sort of initiative has little potential sustainability and time invested in both establishment and ongoing limited term supervision is unlikely to be capitalised on.

Indicator 4: Extent to which the RH data management is functioning in Nyanza and target districts)

3.2.9 RH data management

Whilst there have been identifiable improvements nationally in the HMIS, partially attributable to support from DANIDA, the annual reports continue not to be complete or timely. There has been a problem with synchronisation of HMIS data (which works to a calendar year) and AOP data (based on a financial year). Data collection is only computerised to district level and below this it is collected manually.

In the EHS logframe there are no specific indicators related to HMIS improvement. This suggests that HMIS data collection, compilation, analysis and interpretation were not as high a priority as other components of the programme for which the EHS vision was clearly articulated. Thus said, it was apparent during the preparation for the endline survey that the EHS has developed good and close working relations with HMIS staff at the provincial level and that the EHS greatly valued their knowledge and input. However, without specific goals or indicators, it is difficult to assess progress made in HMIS processes or products between 2005 and 2010. To note, HMIS staff were integrally involved in the data processing for the endline survey.

Reproductive health data go beyond the few variables captured by the HMIS. For some indicators in this report, a fall back plan of using HMIS data over health facility-based data was needed due to data quality issues at health facilities. The data collected from health facilities also focused narrowly on the mother; for example, there are no indicators at all on perinatal health care or outcomes despite resuscitation figuring in EmOC and LSS training and the distribution of ambu bags among EHS-supported equipment. There are also no useable data on actual use of EmOC among women with complications despite the EHS focus on EmOC. In discussions with EHS staff for this report, this was often attributed to concerns about existing data quality at health facilities.

3.2.10 Recommendation

Planning is only as good as the data on which it is based. Whilst the HMIS is recognised to have improved, further strengthening will be necessary for the investment in planning processes to be fully realised.

Efforts at strengthening the HMIS should be focused on specific tasks, with articulated goals and timelines which can then be monitored over time. A focus on the quality, breadth and use of data collected at health facilities also merits increased attention.

3.3 Output 3: Strengthening of KEPH

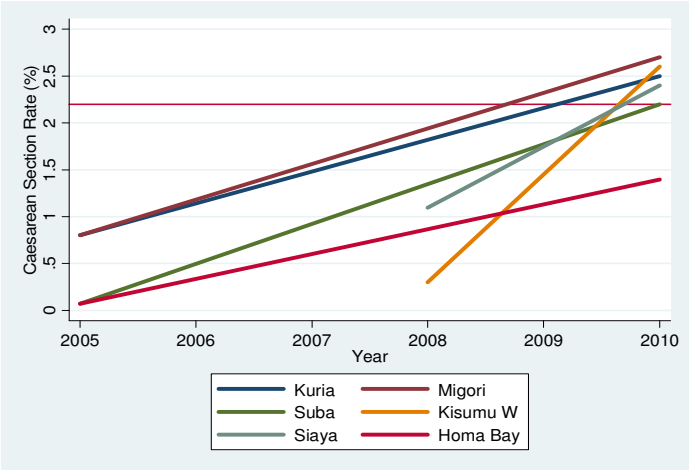
"Delivery of KEPH significantly strengthened in selected districts in Nyanza province especially to address poor women and infant health needs

Indicator 1: Population based Caesarean Section rate for target districts

The population-based caesarean section rate serves as an indicator of access to emergency obstetric care. Although there will never be agreement on an "optimal" caesarean section rate because the concept is context-specific, WHO recommends a minimum caesarean section rate of 5%. The Unmet Obstetric Need Network has determined that a rate below approximately 2% (1.0%-1.6%) is inadequate to cover even absolute maternal indications for obstetric surgery. In other words, caesarean section rates below 2% reflect too few caesareans to keep women with serious obstetric complications alive, much less to prevent major maternal morbidity or perinatal morbidity or mortality. In addition to being a powerful indicator, the caesarean section rate is generally considered to be quite accurate whether measured in women-based or health facility-based surveys. At health facilities, many details about maternal care may be poorly recorded, but surgeries will rarely go undocumented. The methodology for collecting data necessary for the calculation of population-based caesarean section rates for this report are described in detail in the Endline Survey Report.

The caesarean section rates documented from the EHS baseline survey tell a compelling story; in only one district did the caesarean section rate even hit 1%. See Figure 5. These data suggest that women may have been dying due to lack of caesarean in all of these districts. The programme goal for caesarean delivery set a reasonable target of 2.2%. According to results from the endline survey, five of the six districts reached or surpassed this goal. Migori showed the highest rate, increasing from 0.8% to 2.7% between 2005 and 2010. Kisumu West showed the greatest proportional increase, from 0.3% to 2.6%. Five of the districts (including Kisumu West) show caesarean section rates at the endline survey between 2.2 and 3%, and for the case of Kisumu West and Siaya Districts, these results were achieved between the last quarters of 2008 and 2010. Homa Bay was the only district that, although it doubled its rate from 0.7 to 1.4% between 2005 and 2010, did not reach the programme target.

Figure 5: Baseline and Endline Caesarean Section Rates (in %); EHS targeted districts



Three issues should be noted here:

- Even where the target was reached, the number of caesareans performed during a three month period remains extremely small. Existing infrastructure in Nyanza can accommodate a greater number of caesarean deliveries.

- The impact of the substantial EHS investments in infrastructure at the Mbita sub-district Hospital (Suba District), including three surgical bays within the maternity, are not represented in the data shown here as they performed their first caesarean the week before the endline survey, and were still in the process of arranging for fulltime access to an anaesthetist during the survey.

- When population-based caesarean section rates are this low, they usually imply “mass deprivation” of accessible services; that is, rates are so low because care is simply not available for anyone, and not only marginalised groups are deprived of access. It is unusual to see rates this low where care is available, and to some extent, emergency funds (ie, waivers) can be accessed.

Given the stated EHS priority of strengthening health service delivery to the poor, it is surprising that there were no specific activities to assess the importance of financial barriers for skilled care at delivery or during emergencies. Responses to multiple interviews reiterated that the waiver system worked partially at best. It was described as not well publicized and involving “difficult and discouraging paperwork”.

These caesarean section rates raise several questions: To what extent is caesarean delivery available and being used from private sector sources or from sources outside of Nyanza Province? And, what are the barriers that keep women from accessing caesarean delivery (cost, transport, perception of quality of care or treatment at health facilities, stigma associated with a caesarean birth)?

3.3.1 Recommendation

As mentioned above targeted efforts are needed to improve the collection, analysis and review of HMIS data, including the capture of data on caesarean delivery from the public and, if possible, private sectors.

It is also recommended that qualitative interviews be conducted to explore the barriers women face in accessing caesarean delivery and that results of such interviews be shared with Community Units to encourage local problem-solving. To note, data from Nyanza Province in the 2008 Kenya DHS showed that among women who opted to deliver at home, 45% of them did so because of long distances and transport issues. Cost was reported by only 17% of women.

Given the potentially life-saving nature of caesarean delivery for the woman and foetus, it would be important to know if these are the same barriers for caesarean delivery, or if other or additional issues need to be addressed.

In any case, interventions to assist the poorest women to access life-saving care for herself or her foetus should figure in any broad-based program to decrease maternal mortality and morbidity.

Indicator 2: Training in EmOC and LSS in Nyanza province

3.3.2 Training in EmOC and LSS

Facility-based delivery cannot be expected to result in health gains if the staff are not knowledgeable and competent in evidence-based maternal and neonatal health care practices. The EHS project, in collaboration with the Ministries of Health, undertook extensive efforts in the provision of training in Emergency Obstetric Care (EmOC) for nurse-midwives and clinical officers. As described in the Section on Pre and In-Service maternal and neonatal health training above, for most participants this training activity included both theoretical and applied components (EmOC and LSS, respectively), both of which included skills related to immediate newborn care such as resuscitation.

Over the course of the EHS programme, 283 health care providers were trained, of which 242 were based in Nyanza Province, including in districts not targeted by the EHS programme. Training for personnel in non-targeted districts, at the Provincial level and for three persons at the national level was provided in response to requests from the MOPHS and MOMS. The goal was to provide follow up supervision, generally via visits by district or provincial staff a few weeks after training. Quantitative data are not available to assess the frequency with which follow up supervision was achieved. According to the logframe, the goal was to train 220 health care providers in EmOC, thus the programme achievements surpassed the goal by nearly 30%.

To increase the sustainability of these efforts, EHS staff also trained a pool of 34 trainers (including four EHS staff) in LSS, and provided training materials (anatomical models, etc) to permit on-going training. Thus, the capacity for future training and supervision is in place.

Less specific attention seems to have been paid to the softer side of quality of care interventions such as provider/patient interaction. Interviews with EHS staff, who

provided some of the most objective information gathered for this report, expressed their disappointment in some of the interactions they occasionally witnessed between providers and patients despite the efforts invested in clinical training.

"You train them, but when you see them in action it's a different story. It's their time versus the woman's time". EHS staff

3.3.3 Recommendation

Given the pool of trainers developed by EHS, efforts should be made to make sure that these individuals are called upon for future training efforts. In addition, interventions for day-to-day supportive supervision addressing issues of provider/patient interaction should also be explored, particularly given current low institutional delivery rates and broad community mobilisation for skilled care at birth.

Indicator 3: % of EHS targeted facilities that have increased number of EmOC signal functions

The logframe goal regarding the provision of EmOC at health facilities was for 100% of EHS-supported facilities to show increases in the number of signal functions between baseline and the endline surveys. For practical purposes, the EHS team defined readiness of the facility to provide signal functions, versus actual provision of care within the three month period prior to survey, as it is usually defined. This decision was made for two reasons; 1) poor record keeping, particularly for manual procedures such as manual vacuum aspiration, manual removal of placenta and resuscitation, and 2) many of the EHS targeted health facilities have such a low volume of deliveries that one would not expect them to see all complications associated with the signal functions within a three month period. It should also be noted that due to incomplete recording on logs and registers, the survey teams at both baseline and endline resorted to asking facility staff if certain procedures had been conducted within the last three months or whether they had the capacity (ie staff and equipment, drugs) to provide each function.

Results are illustrated in Annex C. The number of health facilities which showed readiness to provide each of the signal functions by the endline survey increased for all signal functions except for injectable antibiotics. Very impressive increases in services are shown even in facilities that did not achieve BEmOC status by the endline survey. For example Dienya, Nyang'u and Rwamba Health Centres were providing none or only one of the signal functions at baseline, as compared to five signal functions at endline. Newborn resuscitation, manual removal of placenta, manual vacuum aspiration and injectable anti-convulsants were recorded in all 25 of the EHS-targeted facilities, and showed large increases between baseline and endline surveys.

The availability of the anti-convulsant, magnesium sulphate, in all EHS facilities merits special mention, as many health facilities across sub-Saharan Africa have been reticent or unable to adopt this evidence-based approach for treating eclampsia/severe pre-eclampsia. Elsewhere, slow adoption of the use of magnesium sulphate is due to provider concerns about the drug or due to a lack of its availability from pharmaceutical distributors. Access to, acceptance and use of this drug are notable achievements among EHS facilities.

A critical contribution of the EHS programme was the increase in the number of facilities capable of providing caesarean, which increased from two to six. The

availability of injectable oxytocics increased from 14 to 24 health facilities. This result was surprising based on interviews conducted for this report during which the inconsistent supply of oxytocin was repeatedly lamented from the health centre to the national level. During the field visit for this report, a KEMSA vehicle was seen to arrive at more than one health facility. Thus, it is possible that the large majority of health facilities were supplied with oxytocin due to the fortuitous timing of that delivery. Given that MOMS policy promotes routine prophylactic use of oxytocin for every delivery (and not just for the treatment of complications), the lack of oxytocics represents an important weakness in the provision of care in Nyanza.

The two signal functions least in practice at the time of the endline survey were injectable antibiotics and vacuum extraction (available in 14 and 16 health facilities, respectively out of the total of 25). The lack of antibiotics and oxytocin was also frequently mentioned in interviews for this evaluation, and seen as a result of the "push" drug distribution system used by KEMSA. A "pull" system in which health facilities or at least provincial or district health authorities determine the quantities and timing of drug distribution was clearly preferred by staff interviewed for this report.

Thus, these data which reflect a mixture of availability of staff and resources and actual utilization, suggest that substantial progress has been made in the readiness and provision of EmOC in Nyanza Province. It should be noted that when monitoring the availability and use of EmOC, it is recommended that all eight of the WHO Process Indicators be used. These eight indicators include: availability of CEmOC and BEmOC facilities per 500,000 population; use of BEmOC and CEmOC facilities; use of BEmOC and CEmOC facilities among those in need (met need for emergency obstetric care); population-based caesarean section rate (intended as an indicator of access to emergency obstetric care), the direct obstetric case fatality rate and the intrapartum and very early neonatal death rate (intended as indicators of quality of of obstetric and perinatal care, respectively.

From its inception the EHS programme selected quantitative indicators of availability and use of care. With the need to alter the definition from use of services to readiness to provide services, (with the exception of caesarean delivery) we are left with an idea of what obstetric care is *potentially* being provided. We do not have data on actual use, use among those in need or any quantitative data on maternal or perinatal health outcomes. Given the restricted set of indicators and the data problems associated with those, it appears that there was insufficient emphasis placed on record-keeping in health facilities, a required element in assuring quality of care. Given the volume of births even in the district hospitals, work-load is not a credible excuse for poor record-keeping. Adequate record-keeping occurs where it is expected behaviour.

3.3.4 Recommendation

It is recommended that Province-wide discussions be held to review the best series of maternal/perinatal indicators for routine collection at the health facility level and (separately) for the HMIS. An alternative approach is for HMIS to introduce data analysis, reporting and feedback on MNH outcome indicators, some of which are already being collected at facility level.

It is also recommended at least at the health facility level, that consideration be given to collection of a broader series of the WHO Process Indicators for EmOC, including the indicators of use of EmOC services and health outcomes (met need for EmOC and direct obstetric and intrapartum/early neonatal case fatality rates, respectively).

Collection of additional data, however, is only justified if it is accompanied by a commitment to data quality and data use.

Indicator 4: Extent to which quality of care has been institutionalised in all target districts

3.3.5 Quality of Care committees

EHS quality assurance activities included the establishment of health facility-based Quality Improvement committees. The goal was to establish such committees in 75% of EHS supported facilities. EHS supported half day orientation trainings for these committees. By late 2010, Quality Improvement committees were established in 24 of 25 EHS-supported facilities, 22 of which were operational as evidenced by documentation of meetings. The QI committees in Mbita sub-district hospital and the Ligega Health were established in October of 2010 and had not convened their first meeting or commenced any activities at the time of the endline survey. The Sena Health Centre had not established a QI committee by the time of the endline survey.

Assessing the effectiveness of the QI committees was beyond the scope of the endline survey, although the endline survey did document their last scheduled meetings and compiled a list of activities reportedly undertaken. Most committees had not been in existence for very long by the endline survey; nine committees were established between September and December 2010 and seven others were established between June and August 2010. Four QI committees have been in existence for a year or more.

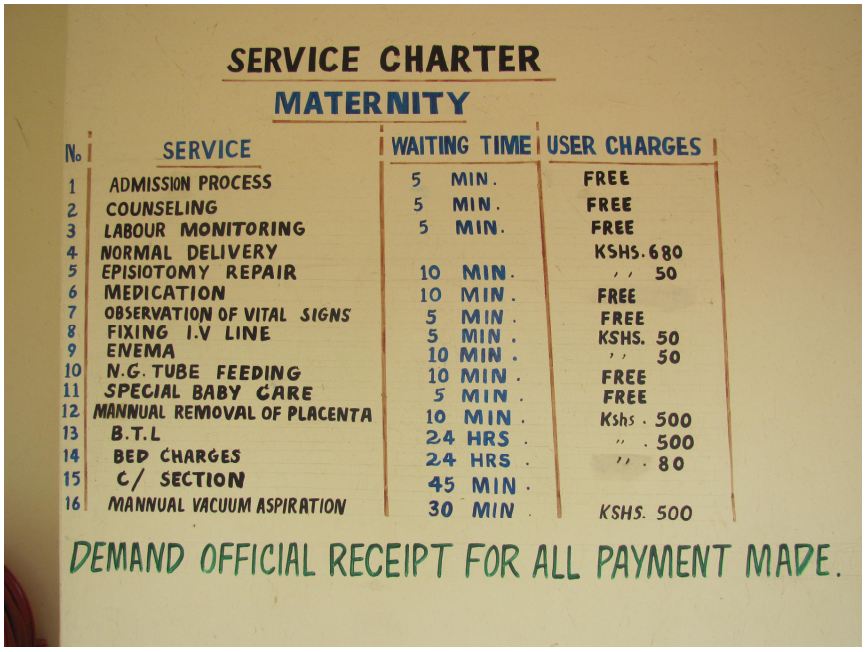
Selected QI committee activities which were reported during the endline survey are summarized in Table 4. The fact that the list of activities is highly varied and that each activity is specific to only a few health facilities is evidence that the committees were functioning independently and presumably looking closely at their own needs. It should also be noted that a) there are rarely articulated expectations about outcomes associated with QI committees and b) the smaller scale efforts shown in Table 4 are generally the type of activity that a QI committee has the means and influence to address. Given the recent establishment of the majority of these committees, one cannot judge how sustainable they will be.

There was a perception that the half day orientation to support establishment of QI committees was not sufficiently detailed and tended to focus on small scale “cosmetic” improvements to enhance the patient experience rather than on ensuring that the quality of clinical care was optimised.

Table 4: Quality Improvement Committee activities reported during the endline survey (and number of facilities in which they were reported)

Services to patients	Staff skills/practice	Infrastructure/supplies
Providing tea to mothers after delivery (2)	Improving record-keeping	Purchase oxytocics (2)
Providing a hot bath to mothers (2)	Training on use of the partograph (and making partographs available)	Improving waste disposal (2)
Providing patients with toilet paper on admission	Improving infection prevention (2)	Establish emergency trays in wards (1)
Improving quality of food served to patients (1)	Staff counselling on bad behaviour (2)	Obtaining referral forms from district hospital (1)
Putting up a suggestion box for patients (4)	Improving internal supervision of staff	Obtaining patient uniforms from KEMSA (1)
		Putting up curtains in the wards (1)
		Improving security – putting a guard at the gate (1); repairing the fence/gate (2)

The evaluation team was able to see some visible demonstrations of the work attributed to the QI committees in improvements made to the patient experience. These included increased privacy (particularly in delivery rooms), showers for the use of women after giving birth and also availability of tea or porridge. At the Magunga Waiting Home, mats were placed on the floor of one room for pregnant women who were more comfortable on the floor than in the beds. These improvements were actively "marketed" by Community Health Workers in order to encourage women to use the facilities. In Isebania the QI committee had established a standard for waiting time and were monitoring for adherence. This practice has also been adopted at some of the hospitals visited for this evaluation, though it is unlikely that close monitoring of waiting times is being routinely conducted at hospitals



SERVICE CHARTER

MATERNITY

No.	SERVICE	WAITING TIME	USER CHARGES
1	ADMISSION PROCESS	5 MIN.	FREE
2	COUNSELING	5 MIN.	FREE
3	LABOUR MONITORING	5 MIN.	FREE
4	NORMAL DELIVERY		KSHS. 680
5	EPISIOTOMY REPAIR	10 MIN.	" 50
6	MEDICATION	10 MIN.	FREE
7	OBSERVATION OF VITAL SIGNS	5 MIN.	FREE
8	FIXING I.V LINE	5 MIN.	KSHS. 50
9	ENEMA	10 MIN.	" 50
10	N.G. TUBE FEEDING	10 MIN.	FREE
11	SPECIAL BABY CARE	5 MIN.	FREE
12	MANNUAL REMOVAL OF PLACENTA	10 MIN.	Kshs. 500
13	B.T.L	24 HRS.	" 500
14	BED CHARGES	24 HRS.	" 80
15	C/ SECTION	45 MIN.	
16	MANNUAL VACUUM ASPIRATION	30 MIN.	KSHS. 500

DEMAND OFFICIAL RECEIPT FOR ALL PAYMENT MADE.

"*We talked to the women and they told us they did not like washing in cold water. Now we give them* warm *water after they give birth. We know they have told their friends*". Nurse

3.3.6 Recommendations

It is recommended that the training/ orientation provided to Quality Improvement committees be reviewed before being rolled out further to ensure that there is greater focus on improvement to the quality of clinical care and staff attitudes as well as enhancing the patient experience.

3.3.7 Maternal Death Reviews

Maternal death reviews constituted another component of the institutionalization of quality of care within EHS-supported heath facilities. Furthermore, the Guidelines for Maternal and Perinatal Death Notification and Review document were developed with EHS support. The goal for this component of the programme was that facility-based maternal deaths in all districts would be reviewed. Based on endline survey results, all six district hospitals have established maternal death review committees, as have three sub-district hospitals (Mbita, Karungu, and Isebania). However, as maternal deaths are rare, not all had conducted reviews during the three month reference period for the endline survey. Results from the Endline survey regarding maternal death reviews are summarized in Table 5 .

In Kuria and in Homa Bay, there is evidence of completed maternal death reviews, but not for all maternal deaths; in Homa Bay only 2 of 9 maternal death cases were reviewed. Thanks to EHS support, it was possible to invite selected staff to attend maternal death reviews from health facilities within the district. It is not known if this will be sustainable without EHS support.

As with QI committees, expected outcomes for maternal death reviews are rarely articulated. Text books describe an audit cycle in which problems are identified, solutions developed and implemented and the outcomes of similar future situations are monitored to see if old problems have been avoided. However, the full audit

cycle is generally only implemented and fully documented in well-resourced settings or for research purposes. Others would argue that the maternal death review serves primarily as a sensitization exercise. As such, one cannot expect to identify specific results associated with the review process. Nonetheless, an open discussion amongst colleagues of a maternal death is likely to draw attention to difficulties that otherwise would pass unnoticed.

The quotes below from interviews while preparing this report attest to this view, awareness is increased, and there is an expectation that behaviours change. Still, another observed that one sees the same recommendations resulting from the maternal death reviews over and over again and these are often recommendations that require government action. For example, referral and fuel allocation are often mentioned as problems, but it was reported that over the last five years fuel allocation has decreased. As local level, control over human and financial resources increase with decentralization of the Ministries of Public Health and Sanitation and of Medical Services, districts will be better able to respond to the specific needs identified from maternal death reviews providing these reviews are made a priority and there is an expectation of appropriate follow up to the results of these reviews.

Recommendation:
It is recommended that at least once annually, health facilities report to the Ministry of Medical Services their number of maternal deaths, the number of maternal death reviews completed and summaries of recommendations resulting from these death reviews and corrective actions that have been undertaken in response to the reviews. The purpose of this additional reporting requirement is to establish expectations among health care providers and health facility administrators regarding responsiveness to the maternal death reviews.

Table 5: Number of reported maternal deaths and number of completed maternal death reviews during the three month reference period for the endline survey.

Health Facility	Reported maternal deaths	Maternal Death Reviews
Homa Bay District Hospital	9	2
Siaya District Hospital	3	3
Migori District Hospital	2	2
Kuria District Hospital	1	0
Kisumu West District – Kombewa Hospital	1	1

"*It was difficult at first. Now we discuss openly. There is no victimisation. We are recognising the problems and that means care is improved.*" Senior nurse
"Maternal death reviews have really helped. It makes people keen on taking care of women. There's guilt. People share experiences during the maternal death reviews." District Public Health Nurse

3.4 Output 4: Increased Community Level Demand

Increased community Level demand for KEPH especially for poor women in selected districts in Nyanza province

Indicator 1: Number of Community midwifes trained in EmOC in target districts

3.4.1 Community midwives trained in EmOC

As a means of making the best use of all available resources, EHS and their Ministry colleagues invited retired nurses/midwives to provide midwifery services for women at the community level. The EHS goal was to train 50 Community Midwives. Over the course of the programme, 50 were trained across all six districts, of which 41 were active at the end of 2010.

Community midwives live in EHS target districts, have participated in EHS-sponsored EmOC and or LSS training and are provided with delivery kits and ad hoc support (for example: autoclaving of equipment at the local health Centre or NGOs, occasional resupply of gloves, oxytocin, bleach, cotton wool, etc). Occasionally, Community Midwives will attend deliveries at the hospital or health Centre when staff are over-stretched, or at their own homes, though most attend deliveries at the woman's home, and some attend deliveries in the presence of traditional birth attendants.

Remuneration of Community Midwives is inconsistent; it appears that most are probably paid in kind (chickens, vegetables, cereals). Where their services were paid, Community Midwives charged between 200-1000 K Sh. Community Midwives

are also involved in provision of antenatal care and family planning services. Although their numbers are small, it appears that they serve as an important liaison between the community and health facilities.

Reporting practices by Community Midwives were inconsistent, with some reporting to the facility officer-in-charge, some to EHS staff, some to the District Health Management Team and some to the district hospital. In 2010, based on documentation provided by the Community Midwives, they were responsible for attending 852 deliveries, representing 2.6% of all deliveries assisted by skilled birth attendants in EHS supported districts. See Table 6. Given that reporting was incomplete, it is likely that their contribution was somewhat higher than this. Thus, Community Midwives reside in the community, most are active, they provide a variety of services, they likely play an important role in sensitisation regarding skilled attendance at delivery and serve as a link between the village and the health system. The percentage of births they attend is probably an insufficient indicator of the role they play, which will render value for money assessments difficult.

Table 6. Number of Community Midwives trained, still practicing and the percent of Community Midwife-assisted births among all births attended by a skilled birth attendant.

District	N of Community Midwives trained	N of Community Midwives still practicing (12/2010)	% of CM-assisted births among all births with a skilled attendant
Homa Bay	12	12	277 (6.6%)
Kisumu West	5	3	15 (0.6%)
Kuria	5	3	120 (3.4%)
Migori/Nyatike	15	13	294 (2.8%)
Siaya	5	3	40 (0.5%)
Suba	8	7	106 (3.6%)
Total	50	41	852 (2.6%)

Case Study; Community Midwife
A male retired enrolled nurse in his early fifties was trained as a community midwife and provided with delivery kits, promotional and IC material. He is based near a community unit and has made extraordinary efforts to involve the whole of the local community in encouraging women to give birth with a skilled attendant. He both performs normal deliveries in women's homes but also in a small clinic set up in his own home. Despite his gender, he appears to be acceptable to women and their families in this capacity. He is married and he and his family are well known in the community.

He has a strong record in appropriate and timely referral to the nearest hospital and has developed considerable rapport with the staff in the maternity unit there. On occasions he *accompanies* women to the hospital and delivers them there. He has established a women's group including older women who have previously acted as TBAs and undertaken considerable sensitisation with them. This group has established a fund to pay for a taxi when necessary to take a mother who needs referral, The midwife has negotiated a rate with a reliable local taxi.

Apart from his professional qualification this midwife appears to have a number of additional competences:-

- Confidence to refer when necessary
- Ability to interface with senior hospital staff as a professional equal
- Outstanding networking and persuasion/ marketing skills
- Ability to analyse the local barriers to increased SBA deliveries and address these

3.4.2 Recommendation

A final recommendation regarding continuation of efforts to train and support Community Midwives should not be drawn until conclusions from the Value for Money assessment are available. The ultimate decision should be based on that quantitative assessment in conjunction with the qualitative assessment presented here. The level of investment required to train and support Community Midwives would be small relative to many of the activities undertaken by the EHS programme. However, the outcome, if measured by number of births attended, should always be expected to be small as well. The goal is not to encourage home-based births, but to provide pregnant women who would otherwise not opt for a health facility-based birth, with a medically skilled attendant.

Indicator 2: Number of functioning community units established

3.4.3 Community units established

Community Units consist of Community Health Committees and two different types of outreach worker, the Community Health Worker(CHW) who is working on a voluntary basis and the Community Health Extension Worker(CHEW). Community Units are designed to increase community demand for health services and to serve as a bridge between the health system and the communities they serve. This approach is part of a national Community Strategy and an important complement to the EHS efforts at increasing skilled attendance at birth by upgrading and or constructing health facilities and improving staff clinical skills.

The EHS goal was to establish 24 functioning Community Units in Nyanza Province. By the end of 2010, 24 Community Units had been established in the six EHS supported districts. This involved providing one week training sessions on community mobilisation and a one week training on reproductive, maternal and child health. Each Community Unit consists of about 50 Community Health Workers who have the responsibility of monthly visits to a block of about 20 households to assess the health of the household and to provide general health education. Community Health Workers report to the Community Health Committee.

In total, the EHS programme trained 1,219 Community Health Workers (of which two-thirds were female) and 263 Community Health Committee members (of which 44% were female). EHS-supported Community Units were provided with a motorcycle and three bicycles to be shared across all of the Community Health Workers. Community Health Workers have been provided with a logbook to document their activities and the health status of their households. This information is passed to the Community Health Extension Workers and it is discussed during Community Dialogue Days. Not surprisingly, the frequency and documentation of meetings by the Community Health Committees and of Community Dialogue Days varied across districts, with some more dynamic and active than others.

In interviews for this report, it was reported that work within an EHS supported district won a national award for best implementation of the Community Strategy. In another interview, it was claimed that EHS had established more Community Units than other donor partners in Nyanza, and that after initially establishing the Community Unit, others often “did not complete the whole process”, presumably referring to EHS on-going support.

Data collected during the endline survey suggest that about 60% of Community Health Workers remain very active and are considered by community members as the face of the Community Unit. Given that these are volunteer positions, it is to be expected that some will be more engaged than others and that there will always be turn-over.

In multiple interviews for this evaluation, sincere gratitude was expressed to EHS for supporting the umbrella of activities undertaken by the Community Unit. This support often took the form of providing contact and dialogue with EHS field staff, or even providing sodas or lunch at a meeting. Small expenditures appeared to have disproportionate benefit. EHS community-based interventions seem to have identified and provided the type of supervision and support that are often lacking in community-based efforts. It is uncertain whether ministry-level programmes could sustain such a wide distribution of small payments, but their importance as incentives at the community level is clear.

3.4.4 Recommendation

Given the increasing but still low rates of skilled attendance at birth and caesarean section, it is our recommendation that demand-side interventions must be pursued even if hard data supporting their effectiveness are scant. It seems more likely that community-based demand-side interventions will encourage service use than dropping these activities and hoping that women will come.

The construction and upgrading of maternity units and operating theatres, supply of equipment and clinical training investments compared against the number of deliveries per day managed at these facilities in EHS supported districts suggest that

"if you build it, they won't necessarily come", or at least not in large numbers and not right way. Whilst improving standards of facilities is highly desirable it is recommended that a standard be established for buildings and equipment and that more effort is made to calculate the likely demand for these facilities so they can be "right sized". This will involve taking into account private and NGO facilities locally.

There has been a degree of dropout of CHWs already and it is recommended that consideration is given to some form of ongoing recognition if their establishment is to be capitalised on.

Indicator 3: Number of CUs with functioning community referral system for Skilled Birth Attendants

In serving as the bridge between the community and the health system, the EHS programme sought to incorporate practical means of referral into the responsibilities of the Community Units. The EHS goal was to establish six functioning community referral systems for accessing skilled attendance at birth. By the endline survey, seven community referral systems were reported by Community Units to have been established, but few data were available to determine the extent of their functioning.

The emergency referral system consisted of different means of transport and communication across Community Units, with some relying on mobile phones to call for an ambulance or a motorcycle ambulance or even a boat. Various registers were kept of trips taken and monies collected, though reporting is sporadic which has made definitive conclusions for this report difficult. Qualitative data from both the internal evaluation and from interviews conducted for this evaluation suggest that health facility personnel, members of Community Units and women in the community perceive that referrals have become more common.

3.4.5 Recommendation:

Given that quantitative data reflecting actual use of referral services are scant, conclusions regarding the continuation of activities to support referral (community to facility and facility to higher level facilities) will need to rely to a great extent on qualitative data. A referral system is not optional in a setting with such a high percentage of home-based births.

Therefore, it is recommended that increased attention be paid to basic record-keeping at all levels of the referral chain to permit better monitoring in the future. Specific recommendations regarding the motorcycle component of the referral activities described previously.

Indicator 4: Number of communities with established verbal autopsy

As further means of sensitising communities about the importance of skilled attendance at birth and health-care seeking in emergencies, the EHS included in their demand-side activities the establishment of community-based verbal autopsy committees. The project discussed with the committees the process and purpose of the verbal autopsies for maternal deaths. These committees were tasked with open discussions of the events leading up to the death and identification of the difficulties that may have prevented the woman from receiving timely and effective care.

The EHS goal was to establish 12 community-based verbal autopsy committees per district, for a total of 72. There were no articulated goals or indicators to document actions taken as a result of these committee discussions. By the end of 2010, 63

such committees had been established, of which 16 had actually reviewed at least one maternal death. A total of 26 verbal autopsy review meetings have been convened. Thus, EHS nearly reached its goals regarding the establishment of verbal autopsy committees. To note, as with other components of the community strategy, record-keeping has been difficult, particularly for community activities. As mentioned above, the District Reproductive Health Coordinator reports having received only 16 of the 26 reported verbal autopsies. It should also be noted that 54 of the 63 committees were established after August 2010, explaining why so few have had the experience of conducting a verbal autopsy.

Results from the qualitative study suggest that the training provided to VA committees needs review and revision. Evidence was provided showing inappropriate timing of the VA interviews with family members, in some cases even before burial of the deceased. The goal of the activity often seemed more focused on succeeding in completing the VA form, than identifying root causes of the events that led to a maternal death. Also, even when conducted in an appropriate manner, as with the facility-based maternal death reviews, discussion of a maternal death, identification of the problems and even identification of solutions do not guarantee that these solutions will be put into place in the future, but it is likely that they do increase the odds. The effect of community sensitisation will always be difficult to assess in concrete terms.

3.4.6 Recommendation

It is recommended that appropriate Ministry staff review and revise the training materials for use with the VA committees. In preparation for these revisions, it would be beneficial to identify well-functioning VA committees, particularly if there is evidence of verbal autopsies that have led to specific corrective actions in the community, and to seek their input on improving training materials. It is also recommended that verbal autopsy committees be continually supported where they have been established and that this activity be rolled out more widely following revision of training materials. Given the infrequent occurrence of a maternal death, this is not a heavy burden on the committees. This activity also supports the idea of maternal deaths being considered a “notifiable” event even at the community-level, as is the expectation at the health facility level.

3.5 Output 5: Management of EHS Support

DFID support to delivery of EHS programme effectively managed to promoted MOPHS and MOMS ownership

Indicator 1: Number of project workplans and budgets approved by the Programme Steering Committee

Programme management has been undertaken by the Programme Steering Committee. There have now been seven meetings and a further meeting was due to be held in January 2011. Attendance at these meetings from the Ministries has varied considerably over time as has the chairmanship. It is concerning that there appears to have been very little continuity which makes achieving ownership difficult. The PSC approves the workplan and projected budget and receives a report on activities and expenditure for the period. In the third year the proposed workplan was

not accepted on the basis it did not fulfil earlier commitments. This indicates that the process was not a mere “rubber stamping “ and resulted in ministry ownership. To an extent this is a parallel (and more detailed) process to the AOP review and should not ultimately be necessary as it creates additional transaction costs and contradicts the principle of single planning and monitoring. The Director of Medical Services currently chairs this PSC and four others relating to the programmes of other partners.

3.5.1 Recommendation

As Kenya moves further towards harmonisation support programmes should not require separate Programme Steering committees. Whilst they continue to exist there is a need for consistency of representation from the Ministry (ies) to ensure that the programme is held to account

Managing the Programme

3.5.2 EHS Infrastructure, Construction and Renovations

Due to time constraints it was not possible for the evaluation team to see all the infrastructure improvements supported by EHS. The following list therefore is based on information received from the ITO and from Dr Dielemans. Those facilities marked with an asterisk were visited.

EHS, the Infrastructure Technical Officer Mr Shadrack Bwana and the Ministry of Public Works Infrastructure Team are to be congratulated on achieving this work under time pressures and logistical difficulties. Whilst a more conventional contract for design and build direct with a commercial contractor might have reduced programme transaction costs it is reported that there has been considerable capacity building for the MoPW team, which adds value.

These design templates are now the property of the MOPW and therefore have the potential to be reused.

Staff at all the units visited expressed their great satisfaction with the work undertaken and particularly with their involvement in design and equipping. In general, the designs appeared appropriate and provided improved privacy for patients and improved facilities for staff. Measures to improve confidentiality of records may need consideration which might include both better storage and increased sensitisation of staff. Furniture (filing cabinets or shelves, etc) are needed for the storage of medical records. The standard of finish was generally reasonably high although it will be important that appropriate cleaning procedures are used to maintain sterility, particularly in operating theatres, where tiling has been undertaken with coarse grouting.

When visited, all the facilities were impeccably clean and in good order.

Phase 1 (all completed and in use)
*Homabay District Hospital (extension)
*Mbita MU and OR (new build) *Mbita DHMT Offices (new build)
Sena Health Centre (HC) (renovation with unit built on existing foundations)
*Magunga HC MU and Maternity Waiting Shelter (new build)
Phase 2
Magina HCMU (new build)
*Ndiru HCMU (new build
Phase 3
Pala HCMU (renovation)
*Migori district Hospital MU and OR (new build) MU in use, OR built but not operational as awaiting delayed delivery of operating lamp
Phase 4
*Rongo district hospital MU (new build) Main structure built but internal fixtures, fittings and decoration awaited. Handover scheduled March 2011
*Kehancha district hospital MU (renovation) open
*Isebania sub district hospital MU (renovation) completed and in use
Suba district hospital MU (renovation) completed and in use. Separate contract for construction of septic tank to be completed by March 2011
Awendo sub District hospital MU (new build) to be handed over March 2011

It is evident that the improved infrastructure is having an impact on utilisation although units were still underutilised. It is difficult to estimate the demand trajectory but a further study in, say, eighteen months' time, would confirm whether the capacity requirements were accurately developed.

It is also impacting on income as shown in Table 7 from the Isebania Sub District Hospital where income, including that related to maternal health services, increased when the new unit opened in October 2010

Table 7: Income – Isebania Sub District Hospital

2010	Income; Isebania Health Centre
July	20,200 Ks
August	21,700 Ks
September	23,900 Ks
October	25,000 Ks
November	40,100 Ks
December	41,650 Ks

There remained some infrastructure issues however, particularly relating to water supply and drainage. Most of the construction initiatives visited incorporated rain water capture (although this was not the case for all the buildings (e.g Migori maternity unit) but this could not necessarily provide for the dry season. Boreholes appear necessary.

Most facilities tied in to existing drainage facilities, some of which appeared to be inappropriate. In Isebania the water supply was not completed and water was being

provided from a shallow well where the pump was broken at the time of the visit. Although tests for e-coli were reported to have been undertaken sometime previously, this had not been repeated and the water source was approximately 30m from pit latrines. Likewise at Rongo the new unit would drain into existing septic tanks but the DPHN expressed concern that there was no funded system for regularly emptying these.

Some of the design features were innovative. The “pass” wall into OR and the “pass” window from recovery at Migori stand out. These will certainly help to ensure that staff do not inadvertently encroach on clean areas but it will be important to undertake training in safe transfer of patients to avoid back injuries to staff given the absence of transfer trollies.

Because of the need to adhere to financial disbursement plans, some equipment was ordered and delivered in advance. This could not easily be examined on receipt and some problems resulted when furniture and equipment was found not to be of an appropriate standard.

These issues should not detract from the considerable contribution that the new buildings and renovations have made.

Most of the units had not been open long but, even those in Phase 1, were not being utilised at high capacity at the time of the visit. There is a suspicion that some units may have more capacity than can reasonably be anticipated, even if there is a major increase in institutional deliveries. The current impact is that facilities have considerable space but with few patients occupying different areas of the unit (admission/ post natal etc) observation is more difficult as the full staff complement cannot be justified by occupancy. Figures 3 and 4 illustrate the mean number of deliveries by month in EHS-supported health facilities, and show half which manage fewer than one birth per day.

3.5.3 Recommendations

The facilities built were all designed using programme funding. There is a strong argument to adopt a “national” design for health centres/ maternity wards etc which could be rolled out wherever infrastructure is being developed. This approach has been used in a number of countries for many years (including the “Best Buy” hospitals in the UK) and has resulted in lower costs. National designs could incorporate eco-friendly features and could be customised cosmetically (tiling/ paint colour etc)

These designs, together with indicative costs, would need to be accepted by the Ministry of Works and, if the designs were to be available nationally, it would be necessary for the planning department of the Ministry of Medical Services to reach agreement that this is the default model to be used in future. It might be appropriate for this to be discussed between the Ministries and DPs so that there is consistent budgeting for any planned infrastructure supported by DPs .

The provision of equipment under EHS was based on ensuring all units had a certain agreed minimum but again did not appear to have used a national standard inventory. Room data sheets specifying both furniture, equipment and fittings are available both commercially and as a global good. It is recommended that the inventory exercise be used as an opportunity to develop standards for equipment and furniture, possibly using the templates developed under EHS.

3.5.4 Finance

The EHS has been challenging to manage due to significant variations in programme funding over time. This has given conflicting messages to staff, partners and even community members and this appears, on occasions, to have encouraged procurement which might have benefited from greater consideration. Variations of the magnitude of this project carry significant commercial risks for the implementing contractor in terms of cash flow.

This review did not include a financial audit but financial record keeping on the part of both DFID and LATH has been less than optimal. This relates to attributing purchases made by DFID against programme funds both before commencement and in the early stages. This has taken significant time and effort to reconcile on two occasions and there is still not final reconciliation although the gap is significantly smaller (£40,000 on January 24th)

Financial and programme management has clearly been challenging given the geographically split location both in country (Nairobi/ Nyanza) and in the contractor.(Nairobi/ Liverpool) . Financial management commitments have been made locally but monthly expenditure reports are produced from Liverpool.

The DFID requirement to have prior approval for expenditure over £2000 value seems unusually stringent given that the PSC approves both a workplan and budget.

DFID financial planning regulations now require detailed and precise financial forward planning. This has to be confirmed monthly based on a six monthly plan. A variation of less than 2% between planned and actual expenditures is mandatory. The EHS is highly valued for its flexibility in supporting the Ministries. Unlike project funding, much expenditure relates to funding activities which are scheduled and delivered by Ministry staff and are thus out of the control of EHS LTTA. It is challenging (and on occasions probably impossible) to support this sort of activity and adhere strictly to such tight work planning. Consideration needs to be given to how this will affect the traditional (and much valued) role that DFID plays in supporting country led initiatives.

It is striking how processes relating to financial planning of DFID support have increased over the life of the EHS. This has an impact on the job content of both DFID advisors and programme managers. If this is a continuing requirement of DFID (which is almost certainly the case) then it will need to be reflected in heavier overheads for any contractor managing programmes of this sort and a skill mix which has greater emphasis on financial management.

3.5.5 Recommendation

There is a need for a small pool of flexible funding which can be utilised to facilitate urgent work and to “unblock” barriers to progress. This has been a feature of DFID funding which has been much appreciated. If there is a continuing requirement of DFID for detailed financial projections and small tolerances on disbursement (which is almost certainly the case) then it will need to be reflected in a skill mix which has greater emphasis on financial management which will inevitably result in heavier overheads for any contractor managing programmes of this sort.

3.5.6 Procurement and Infrastructure

There appears to have been an issue in the original contract for procurement of infrastructure relating to the overhead charge. This was eventually negotiated from

zero to 7.5% which does not compare with the overhead paid to the procurement agent. This suggests that there might have been a case for benchmarking and establishing a realistic "market rate" for both functions.

3.5.7 Staffing

In general LATH is to be congratulated on retaining its long term technical staff both local and international. This reflects well on the team leadership of Dr Pendame and Dr Dielemans.

Dr Pendame and Dr Dielemans provide complementary experience and competences and have clearly worked exceptionally well together. The decision to move the senior manager to a base in Nyanza has had considerable benefits both in terms of programme management but also in building strong relationships, particularly at Provincial level and with other DPs. It has probably reduced the amount of day to day support that can be given at Ministry level however, particularly at a time of considerable turnover in the RH division.

In general the technical officers have been appreciated and have ensured that agreed activities have been completed to time and quality. The decision to have two staff co-located to serve two Districts and strengthen demand and supply side respectively is now considered to have not been ideal. Some of the staff concerned could have covered the full range of activities and having one located full time with a District team would have reduced travelling time and enhanced embedding with the District Management Team.

"*EHS, they are here. They work with us every day. Others (partners) just come occasionally*" DMT member in District where TA located.

3.5.8 Implementing Review Recommendations

The EHS programme has had three reviews, two external and one internal. The most recent was completed in February 2010. Whilst most of the recommendations incorporated in the first report were actioned, not all the most recent recommendations have been completed in full although there is demonstrable progress. This, in part, reflects the short time interval between the third and end of programme reviews.

3.5.9 Sustainability Plan

The EHS senior team have recognised the need for a responsible exit strategy and have developed a sustainability plan. This is good practice and it will be important that the Project Manager has adequate time to complete the scheduled activities. Sustainability at Provincial and District level is heavily dependent on future support from development partners particularly JICA and USAID. Whilst the plan is sensible and comprehensive, the residual risk ratings following mitigation action may be conservative.

3.5.10 Recommendation

The sustainability plan should be monitored monthly by EHS/ DFID/ MOMS/MOPHS until the end of the programme to provide early warning of areas where planned mitigation of risk cannot be delivered.

Indicator 2: Extent to which lessons learned have been shared with MOPHS/MOMS

Given the extent to which the EHS has successfully integrated their team into the MOPHS/MOMS ministries from the national to the district levels, it is assumed that few specific efforts would be required to reach out and share the lessons of EHS with their GoK colleagues as they were all integrally involved in nearly all aspects of the work. This includes the complete integration of ministry colleagues in the design and implementation of the EHS Endline Survey, a task for which many donor partners would likely have hired a private firm. In contrast, there are many lessons for donor partners, should they be open to adopting the EHS approach of truly working in an integrated fashion with the MOPHS/MOMS.
However, as part of the sustainability plan, the EHS project manager plans to disseminate a number of papers. These include:

- EHS achievements, challenges and lessons learnt across all outputs
- EHS supported infrastructure improvements including drawings and BQs
- Specific papers on:
    - Community midwifery approach
    - Maternal death review
    - Skills development (and HR implications)

There is an EHS esprit de corps which is palpable from the national level to Community Units. This is a feat achieved by few donor partners. Both DFID and EHS staff are to be congratulated; DFID for designing a programme that expected integration into national programmes and EHS for implementing the approach to a degree which was likely not anticipated by those who initially designed the programme.

4. Additional Issues

4.1 Poverty Focus

It seems that the EHS claim to focus on service delivery for the poor was incorporated into the programme via the selection of the districts of greatest need within Nyanza Province, a province with well-documented high levels of poverty. There were not, however, any specific interventions to assure service delivery to the poorest within Nyanza. Given that access to a caesarean delivery and a skilled attendant at birth shows much greater socio-economic disparities than other aspects of maternal or child health care use throughout low income countries, context-specific interventions to remove financial barriers, particularly for emergency obstetric care, are warranted. Such interventions could address weaknesses in the implementation of the existing health fee waiver system and or experiment by adapting various schemes for community or health facility-based distribution of emergency loan funds.

4.2 Gender

EHS was not designed to identify gender issues although by the nature of its focus on maternal and newborn health, the needs of women have been paramount. Recognising the importance of men in the decisions which lead to mothers receiving optimal care (ante natal visits, skilled birth attendants) the programme has particularly strived to ensure a gender balance in interventions at community level. Of the community health workers recruited, 67% have been women and 33% male and membership of community Health Committees in the six Districts showed that women constituted 44% of members and men 56%. Whilst no figures were recorded for

participation in verbal autopsies, the evaluation team were told that the involvement of men was actively sought.

It is interesting to note that one of the reasons given for poor utilisation of the maternity waiting home was that men were not happy to take additional responsibility for children to allow women to stay in the facility. This suggests that greater sensitisation is needed as to the risks and benefits.

4.2.1 Recommendations

In order to assess gender impact in future initiatives, documentation of gender relating to the following would be valuable:

- Community Health Workers recruited
- Community Extension Workers recruited
- Community midwives recruited
- Community Health committee members
- Quality Improvement committee Members
- Attendees at Verbal Autopsies

It would further be helpful to examine attrition rates of staff in the first three cadres above by gender.

It is suggested that gender be recorded in respect of staff recruitment and attendance at all training initiatives. Where professional staff registration is in place (e.g. nurses) it should be possible to ensure that participation reflects the gender makeup of the cohort.

5. Annexes

Annex 1: Terms of Reference

Project Completion Report
Essential Health Services Project, DFID Kenya

OBJECTIVE

The overall objective of this consultancy is to conduct an end of project evaluation and complete a Project Completion Report (PCR). This will involve evaluating the project's achievements against its log frame and identifying lessons learnt to inform future programmes in Kenya or elsewhere.

RECIPIENT

The recipient will be DFID Kenya and Somalia

SCOPE OF WORK

The consultants will –

- Guide and quality assure the endline survey (to be conducted by LATH).
- Assess overall progress to date on achievement of project outputs and purpose.
- Assess quality, appropriateness and impact of Technical Assistance (TA) and support to the ministries of health in planning and reviews and policy/strategy development.
- Identify lessons learned from the project that are relevant to successful design and implementation of any future DFID projects on maternal health.
- Pay particular attention to previous annual reviews and Project Steering Committee decisions and implementation of their recommendations.
- Assess the effectiveness of LATH management and execution of EHS in terms of project management, strategic direction, responsiveness, and quality.
- Write a Project Completion Report in standard DFID format.
- Write a Project Evaluation report to accompany the PCR.

METHODOLOGY

The consultants will provide technical leadership, supervision and quality assurance of the whole evaluation process including endline survey, project evaluation, and completion of the PCR. LATH's role will be to conduct the endline survey, producing a stand-alone report, and help to implement the project evaluation, under the guidance of the consultants. The LATH contribution to the PCR is described in the attached TORs for the project endline survey.

The evaluation will include assessments/production of:

- Value for money and cost benefit analysis, including estimation of unit costs. In addition to analyzing VFM for the EHS components (actual and potential), this should involve a VFM comparative analysis on what other interventions/approaches LATH could have used, with reference to VFM assessments internationally.
- Extent to which project activities have contributed to purpose and impact
- Lessons learned/recommendations for the design and implementation of similar projects in the future (design, interventions, management, log frame, M&E system, research component, gender dimensions, etc)
- Recommendations for further research from the EHS that the evaluation was not able to measure but would inform policy/strategy in Kenya and/or

internationally, with initial suggestions on what research questions would be answered and how it might be conducted.

The consultants will need to supervise and monitor the design and implementation of the project endline survey. This will involve quality assuring survey protocols, questionnaires, other data collection/capture, data analysis and report writing. The work of the consultants will supplement the end-line survey in order to complete the PCR by validating survey results, but also assessing appropriateness of approach, management effectiveness as well as evaluating achievement of the outputs that need to be assessed independently. The consultants will review all relevant documents and reports from the project and the sector. (see Annex 1 for a preliminary list of relevant documents).

Initially the consultants will agree with DFID and LATH a detailed plan of activities and outputs including time frame, key activities, consultancy input, LATH deadlines, communication and other arrangements. The consultants will also agree the endline survey TORs before they are finalised. Final write-up of the project endline survey and PCR will be done in April and involve participation in a dissemination meeting soon afterwards.

DFID COORDINATION
The consultants will report to the DFID Senior Health and HIV Advisor Jean-Marion Aitken, supported by Tony Daly, the Regional Maternal Health Adviser. For all in-country arrangements they will liaise with Dr. Richard Pendame of EHS.

REPORTING/DELIVERABLES
The consultants will be responsible for producing a comprehensive evaluation narrative report, together with a summarized PCR in DFID excel format. Parts of the narrative report that cover the LATH report can be summarized and refer to the detailed end-line survey report. A presentation will need to be prepared and made to stakeholders to facilitate comments and to DFID Kenya staff.

TIMEFRAME
The consultancy will be undertaken November 2010 – May 2011. The agreed methodology, plan of activities and timing of outputs will be produced in consultation with LATH and DFID within 2 weeks of starting. Stakeholders will have up to three weeks to comment on the evaluation and PCR reports, after which the consultants will revise and submit within 2 weeks. It is envisaged that the consultancy will total up to 40 days.

CONSULTANCY SKILLS AND REQUIREMENTS
The consultancy team will need to have expertise in the following areas:

- Maternal health programmes, including obstetric care
- SWAp/Health Systems Strengthening
- community health programmes
- conducting project reviews, preferably with some experience of DFID PCRs
- health economics and in particular, approaches to calculating value for money
- maternal health research

BACKGROUND
In 2004, DFID agreed to provide up to £7.5 million over five years to GOK to support the delivery of essential health services, through increasing capacity to deliver services for women and children with a particular focus on reproductive health and immunization. In line with the emerging sector-wide approach (SWAp) for health in

Kenya, it was agreed that DFID support would be provided in a flexible and responsive way and integrated with multi-partner efforts to develop and implement essential health services in Kenya, now defined as the Kenya Essential Package for Health (KEPH).

The **goal** of the Essential Health Services (EHS) project is to contribute to achieving the health related Millennium Development Goals in Kenya and in particular to a reduction in infant and maternal mortality. The **purpose** of the project is to support GOK and the Ministries of Public Health Services and of Medical Services (MOPHS and MOMS), under the auspices of the Second National Health Sector Strategic Plan (NHSSPII), to provide integrated effective health services in Kenya, particularly for poor women and infants. The project **outputs** are:

1. Central MOPHS/MOMS effectively supported in strengthening health systems, policy development and stewardship for delivery of the KEPH.
2. Health systems strengthened in Nyanza Province to support delivery of KEPH, especially safe motherhood and neonatal health.
3. Delivery of the KEPH significantly strengthened in selected districts in Nyanza Province, especially to address poor womens' and infants' health needs.
4. Increased community level demand for KEPH, especially for poor women and infants in selected districts of Nyanza Province.
5. DFID support to the delivery of EHS project effectively managed to promote MOPHS/MOMS ownership.

The project started in July 2005 with a 1 year Inception phase and Implementation phase commencing July 2006. Following the recommendations of the first external Output to Purpose Review, DFID approved a cost extension for EHS from GBP7.5 million to GBP14.2 million in October 2008. The period of implementation was also extended by 14.2 months and the number of districts benefiting from the project increased from four to six (using original district boundaries). The selected districts for the project are now Suba, Homa Bay, Migori, Kuria, Siaya and Kisumu West.
Liverpool Associates in Tropical Health (LATH), in partnership with Liverpool VCT (LVCT) Kenya, Nuffield Centre for International Health and Development (UK), and Health Unlimited, Kenya, was awarded a contract through a competitive tendering process to act as managing agents for the EHS project in July 2005. A 10.5 month Inception Phase for the project that started in July 2005 resulted in a revised project Logframe, a detailed work plan for the first year of implementation, and a budget forecast for the four-year implementation phase. Project implementation began in June 2006.

Technical assistance to the MOH Health Sector Reform Secretariat (HSRS) has been provided by the Project Director. Full-time TA was initially provided to the MOH Department of Reproductive Health (DRH) by a reproductive health specialist who later moved to Kisumu, Nyanza Province.

A project office in Nyanza Province provides technical assistance and support to one provincial and six district health offices and oversees project activities in the six selected project target districts.

An important input of the EHS Project has been provision of TA and support to MOH planning and review processes. As the Kenya health SWAp moves forward, DPs are committed to aligning on-going projects and programmes as much as possible to more explicitly support implementation of the NHSSPII and Joint Programme of Work and Funding. The project plans to implement an endline survey and project evaluation. The PCR will be a process of overseeing and quality assuring the project

evaluation. LATH will implement the endline survey and facilitate data collection and analysis. The PCR process will ensure that the evaluation gathers all the information needed to complete a comprehensive PCR. A number of DFID country offices may need to design new maternal health programmes. The PCR will be critical to develop lessons learned, a judgement on sustainability, value for money and impact and to identify M&E needs and potential modalities for future DFID programmes.

DFID Kenya
November 2010

Annex 2: Summary of Recommendations and Conclusions by Purpose and Output Level

GOK/MOPHS/MOMS supported under the auspices of the NHSSPII to provide integrated effective health services in Kenya particularly for poor women and orphans

Indicator 1; Extent to which health sector stakeholder partnership is strengthened

No specific recommendations

Indicator 2 Number of targeted districts which have a minimum acceptable coverage for EmOC

Given the very substantial contribution the EHS programme has made toward expanding and upgrading infrastructure for safe delivery, efforts in EHS supported districts should continue to focus on increasing use of these facilities. Lessons learnt in the planning and construction of new structures should be shared with the Ministries and other donor partners for expanded infrastructure in districts which were not reached by EHS activities from 2005-2010.

Indicator 3 Proportion of births attended by skilled health staff in Nyanza Target Districts

Continuation of programming to support both the supply and demand side for skilled attendance at birth is recommended. Trend data shown here on skilled attendance at birth suggest steady increases during this period of intense programme activity. Conclusions from the Value For Money assessment is required to determine if there are some supply or demand side activities that are less efficient than others.

Indicator 4 Proportion of pregnant women receiving 4 ANC visits in Nyanza Target Districts

Detailed data from the endline survey report identifies, however, that in 12 of 25 EHS-supported facilities, the number of *first* antenatal care visits decreased between baseline and endline surveys. This is a worrying trend particularly given the extensive EHS efforts at community mobilisation for maternal health care in general, and one that should be closely monitored in the months following the end of EHS-supported activities.

Output 1 Central MOPHS/MOMS effectively supported in strengthening health systems policy development and planning for the delivery of the Kenya EPH

Indicator 1 Extent of Health Sector Joint Planning

The support provided through long term TA has demonstrated the value of embedding senior level specialists with managerial experience as well as technical skills in ministry structures. Whilst some short term TA is perceived as useful for very specialist tasks it is recommended that every effort is made to maximise the use of long term TA in future initiatives involving support to system development and management of change.

AOP process

As the planning system matures it is important that it increasingly reflects the totality of investment both from DPs but also from GOK. This must include the budgets relating to personnel and drugs which are not available at provincial, district or facility levels. Only when this is achieved will it be possible to jointly assess whether allocation reflects need, to hold partners to account and to guard against fungibility.

New constitution
Significant support will be needed during the implementation of the new constitution to ensure that the transition takes place smoothly and that established mechanisms for identifying national priorities are in place and progress can be monitored. The apportionment of funds (particularly those relating to staff) will be informed by some of the work already undertaken (e.g. the finance tracking exercise supported by EHS) at county level new infrastructure will need to be developed not only for planning, budgeting and monitoring but also for implementation. The current performance contracts need to be further embedded and given "teeth" (recognition of achievement/ penalties for poor performance) as greater levels of responsibility (including financial responsibility) are delegated.

Indicator 2 Extent of Establishment of Joint Performance Monitoring for the Health Sector

The endline survey highlighted the continuing problems with assiduous data recording and there are reported to be issues relating to timeliness of quality of HMIS information. Any future initiatives must continue to incorporate support activities relating to data recording, collection, interpretation and data use in order for monitoring and evaluation to be meaningful.

Indicator 3 Extent of development of national MNH strategic documents

Support to RH Division
The value of excellent long term technical assistance supported by appropriate short term specialist TA has been proven. A relationship of trust can be established and Dr Dielemans was perceived as part of the Ministry MNH "team". A number of senior staff identified that having continuity of support was preferable to short term "visits" which have high transaction costs, particularly if significant orientation is needed However, the impact of such support cannot be sustained without a degree of senior level stability.

Planning efforts at national level should focus on developing means to maintain an updated pre-service curriculum for physicians, nurse/midwives and clinical officers in the area of maternal and neonatal health. Collaborative efforts between donor partners and the Ministry should strive to shift away from such heavy reliance on in-service training toward a more balanced program encompassing pre-service and in-service training.

National Level Management Development
Considerable DP resources continue to be used in designing a variety of management development courses. Most of them cover the same topics and in some cases they are delivered by the same institutions (e.g. Great Lakes University is delivering both this course and a similar JICA design) It is strongly recommended that the GOK adopts a single curriculum and delivery model and that future DP support to management development, uses this single modality.

Output 2 Health Systems in Nyanza province to support delivery of KEPH especially the maternal and neonatal health component

Indicator 1 Extent to which mechanisms for co-ordination of partnerships are established in Nyanza and target districts

Planning and monitoring are not "additional" or optional activities and thus they need to be incorporated in normal work activities of all ministry staff and there should be budgets to support the key events etc. Relying on DP support is not sustainable for such a core function. This should be the long term strategy incorporated in the

planning goals. In the short term it will be important that there is continuity of support to ensure no dislocation

Indicator 2 Extent to which referral system is strengthened in Nyanza and target districts

Before committing to further roll out of motor cycle ambulances it will be desirable to take into account the lessons learnt and, in addition, it would seem sensible to undertake a short comparative study looking at where they are being used successfully in Kenya to identify lessons which might improve appropriate utilisation.

Indicator 3 Extent to which the inventory system is operational at Provincial and District level

Without both provincial and district ownership exercises like the introduction of inventories has little potential sustainability and time invested in both establishment and ongoing limited term supervision is unlikely to be capitalised on.

Indicator 4. Extent to which the RH data management is functioning in Nyanza and target districts)

Planning is only as good as the data on which it is based. Whilst HMIS is recognised to have improved, further strengthening will be necessary for the investment in planning processes to be fully realised. Such efforts at strengthening the HMIS should be focused on specific tasks, with articulated goals and timelines which can then be monitored over time. A focus on the quality, breadth and use of data collected at health facilities also merits increased attention.

Output 3 Delivery of KEPH significantly strengthened in selected districts in Nyanza province especially to address poor women and infant health needs

Indicator 1 Population based Caesarian Section rate for target districts

As mentioned above targeted efforts are needed to improve the collection, analysis and review of HMIS data, including the capture of data on caesarean delivery from the public and, if possible, private sectors. It is also recommended that qualitative interviews be conducted to explore the barriers women face in accessing caesarean delivery and that results of such interviews be shared with Community Units to encourage local problem-solving. To note, data from Nyanza Province in the 2008 Kenya DHS showed that among women who opted to deliver at home, 45% of them did so because of long distances and transport issues. Cost was reported by only 17% of women. Given the potentially life-saving nature of caesarean delivery for the woman and fetus, it would be important to know if these are the same barriers for caesarean delivery, or if other or additional issues need to be addressed. In any case, interventions to assist the poorest women to access life-saving care for herself or her fetus should figure in any broad-based program to decrease maternal mortality and morbidity.

Indicator 2 Training in EOC and LSS in Nyanza province

Given the pool of trainers developed by EHS, efforts should be made to make sure that these individuals are called upon for future training efforts. In addition, interventions for day-to-day supportive supervision addressing issues of provider/patient interaction should also be explored, particularly given current low institutional delivery rates and broad community mobilisation for skilled care at birth.

Indicator 3 % of EHS targeted facilities that have increased number of EOC signal functions

It is recommended that Province-wide discussions be held to review the best series of maternal/perinatal indicators for routine collection at the health facility level and (separately) for the HMIS. It is also recommended at least at the health facility level, that consideration be given to collection of a broader series of the WHO Process Indicators for EOC, including the indicators of use of EOC services and health outcomes (met need for EOC and direct obstetric and intrapartum/early neonatal

case fatality rates, respectively). Collection of additional data, however, is only justified if it is accompanied by a commitment to data quality and data use.

Indicator 4 Extent to which quality of care has been institutionalised in all target districts

It is recommended that the training/ orientation provided to Quality Improvement committees be reviewed before being rolled out further to ensure that there is greater focus on improvement to the quality of clinical care and staff attitudes as well as enhancing the patient experience.

Output 4 Increased Community Level demand for KEPH especially for poor women in selected districts in Nyanza province

Indicator 1 Number of Community midwifes trained in EOC in target districts

A final recommendation regarding continuation of efforts to train and support Community Midwives should not be drawn until conclusions from the Value for Money assessment are available. The ultimate decision should be based on that quantitative assessment in conjunction with the qualitative assessment presented here. The level of investment required to train and support Community Midwives would be small relative to many of the activities undertaken by the EHS programme. However, the outcome, if measured by number of births attended, should always be expected to be small as well. The goal is not to encourage home-based births, but to provide pregnant women who would otherwise not opt for a health facility-based birth, with a medically skilled attendant.

Indicator 2 Number of functioning community units established

Given the increasing but still low rates of skilled attendance at birth and caesarean section, it is our conclusion that demand-side interventions must be pursued even if hard data supporting their effectiveness are scant. It seems more likely that community-based demand-side interventions will encourage service use than dropping these activities and hoping that women will come. The construction and upgrading of maternities and operating theatres, supply of equipment, clinical training investments compared against the number of deliveries per day managed at these facilities in EHS supported districts suggest that “if you build it, they won’t necessarily come”, or at least not in large numbers and not right way.

There has been a degree of dropout of CHWs already and it is suggested that some recognition of their work will be needed in future if their establishment is to be capitalised on.

Indicator 3 Number of CUs with functioning community referral system for SBA

Given that quantitative data reflecting actual use of referral services are scant, conclusions regarding the continuation of activities to support referral (community to facility and facility to higher level facilities) will need to rely to a great extent on qualitative data. A referral system is not optional in a setting with such a high percentage of home-based births. Therefore, it is recommended that increased attention be paid to basic record-keeping at all levels of the referral chain to permit better monitoring in the future. Specific recommendations regarding the motorcycle component of the referral activities are outlined above.

Indicator 4 Number of communities with established verbal autopsy

It is recommended that verbal autopsy committees be continually supported where they have been established and that this activity be rolled out broadly. Given the infrequent occurrence of a maternal death, this is not a heavy burden on the committees. This activity also supports the idea of maternal deaths being considered

a “notifiable” event even at the community-level, as is the expectation at the health facility level.

Output 5 DFID support to delivery of EHS programme effectively managed to promote MOPHS and MOMS ownership

Indicator 1 Number of project workplans and budgets approved by the Programme Steering Committee

As Kenya moves further towards harmonisation support programmes should not require separate Programme Steering committees. Whilst they continue to exist, there is a need for consistency of representation from the Ministry (ies) to ensure that the programme is held to account

Infrastructure, construction and renovations

The facilities built were all designed using programme funding. There is a strong argument to adopt a “national” design for health centres/ maternity wards etc which could be rolled out wherever infrastructure is being developed. This approach has been used in a number of countries for many years (including the “Best Buy” hospitals in the UK) and has resulted in lower costs. National designs could incorporate eco-friendly features and could be customised cosmetically (tiling/ paint colour etc)

The provision of equipment under EHS was based on ensuring all units had a certain agreed minimum but again did not appear to have used a national standard inventory. Room data sheets specifying both furniture, equipment and fittings are available both commercially and as a global good. It is recommended that the inventory exercise be used as an opportunity to develop standards for equipment and furniture, possibly using the templates developed under EHS.

It is recommended that a follow up survey on utilisation is undertaken to assess the accuracy of demand forecasting

Finance

There is a need for a small pool of flexible funding which can be utilised to facilitate urgent work and to “unblock” barriers to progress. This has been a feature of DFID funding which has been much appreciated.

If there is a continuing requirement of DFID for detailed financial projections and small tolerances on disbursement (which is almost certainly the case) then it will need to be reflected in a skill mix which has greater emphasis on financial management which will inevitably result in heavier overheads for any contractor managing programmes of this sort.

Gender

In order to assess gender impact in future initiatives, documentation of gender relating to the following would be valuable

- Community Health Workers recruited
- Community Extension Workers recruited
- Community midwives recruited
- Community Health committee members
- Quality Improvement committee Members

- Attendees at Verbal Autopsies

It would further be helpful to examine attrition rates of staff in the first three cadres above by gender.

It is suggested that gender be recorded in respect of staff recruitment and attendance at all training initiatives. Where professional staff registration is in place (e.g. nurses) it should be possible to ensure that participation reflects the gender makeup of the cohort.

Indicator 2 Extent to which lessons learned have been shared with MOPHS/MOMS

Identifying bottlenecks

Any future intervention to support the achievement of MDGs 4 and 5 should be subject to a “whole pathway” approach as part of national level AOP, to ensure that any bottlenecks in the pathway are addressed so that the investment can be fully realised.

Sustainability

The sustainability plan should be monitored monthly by EHS/ DFID/ MOMS/MOPHS until the end of the programme to provide early warning of areas where planned mitigation of risk cannot be delivered

Annex 3: Readiness to perform signal functions of Essential Obstetric Care at Baseline and Endline surveys; EHS-supported facilities

		SIGNAL FUNCTIONS FOR ESSENTIAL OBSTETRIC CARE								
		BEmOC FUNCTIONS							CEmOC FUNCTIONS	
		Antibiotics	Oxy-tocics	Anti-con-vuls	Man vacuum aspiration	Man removal placenta	Vacuum extraction	Resusci-tation	Blood trans-fusion	Caesarean section
BASELINE	**Homa Bay District Hospital**									
ENDLINE	**Homa Bay District Hospital**									
BASELINE	**Maguna Health Centre**								NA	NA
ENDLINE	**Maguna Health Centre**								NA	NA
BASELINE	**Ndiru Health Centre**								NA	NA
ENDLINE	**Ndiru Health Centre**								NA	NA
BASELINE	**Pala Health Centre**								NA	NA
ENDLINE	**Pala Health Centre**								NA	NA
BASELINE	**Kombewa District Hospital**									
ENDLINE	**Kombewa District Hospital**									
BASELINE	**Manyuanda Health Centre**								NA	NA
ENDLINE	**Manyuanda Health**								NA	NA

		SIGNAL FUNCTIONS FOR ESSENTIAL OBSTETRIC CARE								
		BEmOC FUNCTIONS							CEmOC FUNCTIONS	
		Antibiotics	Oxy-tocics	Anti-con-vuls	Man vacuum aspiration	Man removal placenta	Vacuum extraction	Resusci-tation	Blood trans-fusion	Caesarean section
	Centre									
BASELINE	**Kehancha District Hospital**									
ENDLINE	**Kehancha District Hospital**									
BASELINE	**Kekonga District Hospital**								NA	NA
ENDLINE	**Kekonga District Hospital**								NA	NA
BASELINE	**Isebania sub-District Hospital**								NA	NA
ENDLINE	**Isebania sub-District Hospital**								NA	NA
BASELINE	**Migori District Hospital**									
ENDLINE	**Migori District Hospital**									
BASELINE	**Karungu sub-District Hospital**								NA	NA
ENDLINE	**Karungu sub-District Hospital**								NA	NA
BASELINE	**Macalder sub-District Hosp**								NA	NA
ENDLINE	**Macalder sub-District Hosp**								NA	NA

		SIGNAL FUNCTIONS FOR ESSENTIAL OBSTETRIC CARE								
		BEmOC FUNCTIONS							CEmOC FUNCTIONS	
		Antibiotics	Oxy-tocics	Anti-con-vuls	Man vacuum aspiration	Man removal placenta	Vacuum extraction	Resusci-tation	Blood trans-fusion	Caesarean section
BASELINE	**Muhuru Health Centre**								NA	NA
ENDLINE	**Muhuru Health Centre**								NA	NA
BASELINE	**Rongo District Hospital**								-	-
ENDLINE	**Rongo District Hospital**								-	-
BASELINE	**Awendo sub-District Hospital**								NA	NA
ENDLINE	**Awendo sub-District Hospital**								NA	NA
BASELINE	**Siaya District Hospital**									
ENDLINE	**Siaya District Hospital**									
BASELINE	**Dienya Health Centre**								NA	NA
ENDLINE	**Dienya Health Centre**								NA	NA
BASELINE	**Kadenge Ratuoro HC**							**?**	NA	NA
ENDLINE	**Kadenge Ratuoro HC**								NA	NA
BASELINE	**Ligega Health Centre**								NA	NA
ENDLINE	**Ligega Health Centre**								NA	NA

		SIGNAL FUNCTIONS FOR ESSENTIAL OBSTETRIC CARE								
		BEmOC FUNCTIONS							CEmOC FUNCTIONS	
		Antibiotics	Oxy-tocics	Anti-con-vuls	Man vacuum aspiration	Man removal placenta	Vacuum extraction	Resusci-tation	Blood trans-fusion	Caesarean section
BASELINE	**Nyang'u Dispensary**								NA	NA
ENDLINE	**Nyang'u Dispensary**								NA	NA
BASELINE	**Rwambwa Health Centre**								NA	NA
ENDLINE	**Rwambwa Health Centre**								NA	NA
BASELINE	**Suba District Hospital**									
ENDLINE	**Suba District Hospital**									
BASELINE	**Mbita sub-District Hospital**									
ENDLINE	**Mbita sub-District Hospital**									
BASELINE	**Magunga Health Centre**								NA	NA
ENDLINE	**Magunga Health Centre**								NA	NA
BASELINE	**Sena Health Centre**								NA	NA
ENDLINE	**Sena Health Centre**								NA	NA

Annex 4: Persons Interviewed

DFID	
Aitken Ms Jean Marion	DFID
Daly Mr A	Regional Lead MNH DFID
EHS Staff	**EHS**
Dielemans Dr Paul	EHS
Odhiambo E	EHS Nurse-midwife – Homa Bay
Omondi RE	EHS Nurse- midwife, responsible for Community Strategy in Homa Bay
Oranga Mr Henry	EHS Finance Manager
Pendame Dr Richard	EHS Programme Manager
National Level MOMS	
Kiambati Dr	Director of Medical Services
	Chief Economist
	Head of Planning and Monitoring Department MOMS
Kuria Dr S	Acting Head of Reproductive Health
Mzoya Mr Munguti	Head of Policy and Planning MOMS
Ong'uti Mr E	Head of Policy Planning division MOMS
Wamae, Dr. Annah	Head , Dept of Family Health
National Level MOPHS	
Burow Ms. Fatima	Director Reproductive Health
Gathitu Mary	Program Officer, DRH
Kitetu Dr Ruth	Head of Planning Division MOPHS
Maina Dr. John	Commodities, DRH
Sharif Dr	Director of Public Health and Sanitation
Were Dr Samuel	Head of SWAP Secretariat
Development Partners	
Adiambo Berryl	JHPIEGO (Access, Uzima)
Bukusi Dr Elizabeth	Faces (USAID)
Erikson Sandra	TA /Secretariat, Development Partners in Health Kenya
Karamaji Dr Humphrey	WHO
Kidula Dr N	Reproductive Health Advisor JHPIEGO
Lavussa Dr J	WHO National Professional Officer, Family and Reproductive Health, Nairobi
Matterson Ms A-C	GIZ
Murakami Chie	JICA Project for Strengthening Management for health for Nyanza; Project Coordinator/ IEC Advisor, Kisumu
Odero Patricia	GIZ
Ojah Michael	JHPIEGO, Access Bondo, Nyanza District
Omogi Irene	GIZ Reproductive Health, Kisumu
Raburu Judith	UNICEF West Nyanza
Sanghvi, Dr Harshad	JHPIEGO, Baltimore, Maryland

Sugishita Dr Tomohiko	Chief Adviser JICA
Nyanza Provincial Level	
Bett Nora	Provincial Reproductive Health Coordinator, MOPHS, Kisumu
Gwoswar Clementine	Provincial Public Health Nurse
Jackson Dr Kioko	Provincial Director Public Health and Sanitation
Nge'tich Charles	PHO
Odhiambo M	Provincial Nursing Officer, MOMS, Kisumu
Ojwang Lusi Dr	Provincial Director Medical Services Medical
Okomo Dr Gordon	DMOH Njatike
Okoth Dr Peter	Provincial Disease Prevention and Control Officer
Omoto Dr Jackson	Gynaecologist Siaya District
Omondi RE	EHS Nurse- midwife, responsible for Community Strategy in Homa Bay
Ondite Dr Samuel	DMOH Siaya
Shiwalo Dr. Ibrahim	Responsible for all aspects of Community Strategy at the Provincial level
Homa Bay District	
Adur Charles O.	Chief – Health Centre Management Committee
Awuor Nancy Auma	Community Health Committee
Deya Amos	Assistant Chief; Community Health Committee
Gwalla Charles	Nursing Officer in Charge
Lynnette John	Deputy Nursing Officer in Charge
Kulei Nancy	Clinical Officer in Charge, Ndiru Health Centre
Juok Samuel	Chief; Health Centre Committee
Odongo Rosemary A	Community Health Committee
Ogutu Elizabeth	Chair Lady; Community Health Committee
Okoth Bontas	Motorcycle rider, Ndiru Health Centre
Otiato James	Reproductive Health Coordinator, Homa Bay District
Otieno Daniel	Treasurer; Community Health Committee
Otieno Jackim Onyango	Motorcycle rider, Ndiru Health Centre
Owur Rosebenta	Deputy Nursing Officer in Charge
Oyaro Peter	Community Health Committee
Migori District Level	
Chacha Isaac	Nursing Officer in charge MDH
Chanzu Mable	DDPHO
Lusi Joan	EHS MNH TO (Migori and Kuria)
Mogaka Josephine	District Nutrition Officer
Nydrera Eunice	Deputy Nursing Officer MDH
Obembo Charles	Clinical Officer

Odhiambo George	District EPI Co-ordinator
Odhiambo Peter	District Medical Laboratory Technician
Odongo Franc	Public Health Officer
Odwalo Phoebe	Nursing Officer Female Wards
Ogero Benard	HRIO MDH
Owino Dr Moses	DMO
Rocui Margaret	Nursing Officer PSC/ Chest Clinic
Samba Josephine	Nursing Officer Maternity
Kuria District	
Aggrey Anuso	Acting Nursing Officer,
Bongo Dr	DMO
Bwana Shadrack	Infrastructure Technical Officer EHS
Ouma Pamela	Reproductive Health Co-ordinator, Kuria East
Kurui Jonah	HAO
Migiro Charles	Health Administrator, Ishebania
Mokaya Teresina	Nursing Officer in charge Ishebania
Nchama Teresina	Reproductive Health Co-ordinator, Kuria West
Otiena Dr Jamea	Medical Superintendent
Otieno Obwanda	District Public Health Nurse
Rongo District Hospital	
Achienge Pamela	DHA
Mkigi George	Laboratory Co-ordinator
Ogwetke Vitalis	DPHN
Suba District	
Ajwala Mathews A.	District Public Health Officer, Mbita District Hospital
Akoko Chera Martin	Chairman Maternity Waiting Shelter
Amayou Kenn	Nurse midwife Magunga Health Centre
Auma Jane	Community Health Committee
Dileyo Samuel Wanjare	Chairman, Health Facility Committee
Edada Michael Ouma	Community Health Assistant - FACES
Gwalla Charles	Nursing Officer in Charge
Hussein Narra Nasimiyu	Clinical Officer in Charge
Kawaka Peter	Community Health Committee Chairperson – Samba
Kibai Dickson A	Community TBA/Community Health Worker
Lango Richard	Community Health Worker - PMTCT Promoter
Lynnette John	Deputy Nursing Officer in Charge
Magadi John	Community Health Worker – Community Unit rep
Mboya George	Community Health Assistant - FACES
Nalianya Dorgen	Nurse, Magunga Heath Centre
Nyachao Joel Opiyo	Committee member
Odhiambo Elizabeth	Community Health Worker
Okello Jane	Treasurer – responsible for running of MWH
Okerch Ongmus	MOPHS, Suba District

Oketch Lucy	Coordinator for Reproductive Health, Kenya EPI, Suba District
Okeyo Franco C	Secretary, MWH
Omolo Dr. Felix	Medical Superintendent; Mbita Hospital
Omondi Maxwell	Nurse, Magunga Health Centre
Omwanda Japheth A	Nursing Officer in Charge, Mbita Hospital
Ongeri Jactone	Community Health Worker – Community Unit rep
Ongete Christine A.	Reproductive Health Coordinator, Mbita
Onyango Alex	Community Health Worker - MTCT Promoter
Otier Grace	HIV Counselor - patient support Centre, Magunga
Ouko Samuel	Motorcycle Rider
Owino Dr. Omondi	District Medical Officer of Health;
Owour Roseberta	Deputy Nursing Officer in Charge
Soti Dr. David	Deputy Director of Health Promotion; Provincial ART Officer (and former DMO of Suba at the beginning of EHS)
Siaya District	
Rieko Benter	District Public Health Nurse, Siaya District
Omoto Dr Jackton	Medical Superintendent; OB/GYN; Siaya District Hospital

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