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MEASURE Evaluation PIMA NEWSLETTER

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http://www.cpc.unc.edu/measure/pima

Word from the Chief of Party

Dear Readers,

Welcome to the second issue of the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project quarterly newsletter.
Three years ago, MEval-PIMA project was started in Kenya. Over this period, we have worked closely with multiple stakeholders and partners, at the national and county level, to leverage resources and promote coherence and sharing of best practices. We are particularly happy with the partnerships that we have created in supporting malaria control efforts at the National Malaria Control Program and the county level, strengthening the metrics to support the national agenda to end preventable maternal and child death through the Reproductive and Maternal Health Services Unit, improving mortality surveillance through strengthening the vital statistics, contributing towards a functional referral system and strengthening the national health information system through the Community Health Services Unit.

Similar partnerships have been established at the county level to spearhead efforts to improve the capture and use of strategic information by the county health management teams. Clearly, these partnerships are the way to go.

In this issue of our newsletter, we provide key updates on the work arising out of the partnerships between MEval-PIMA project, the Ministry of Health and other partners during the last quarter at the national and sub-national levels. The activities focuses on strengthening health officials capacity and skills to spearhead performance monitoring, strategies aimed at improving data demand and use in decision making, and strategies that strengthen the organizational and technical capacity of the County Health Management Teams to plan and implement performance monitoring and quality improvement. You can also visit the MEval-PIMA website and the PIMA Community of Practice for engaging discussions and updates on useful resources in M&E.

Lastly, I would like to bring to your attention that Edward Kunyanga, who has been the Chief of Party for the MEval PIMA project since inception in 2012, left the project in January 2016. Edward is now based in the US, but will continue to provide senior level oversight for ICF International business interests in the region. We are proud of the achievements the MEval-PIMA project made under his leadership and we wish him well in his new role.

Abdinasir Amin
Chief of Party
MEASURE Evaluation PIMA

USAID FROM THE AMERICAN PEOPLE

KENYANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

MEASURE Evaluation PIMA

Training and Mentorship of Coders for Improved Civil Registration and Vital Statistics

National mortality statistics are critical for establishing national health program priorities, health planning and policy, and to inform allocation of health resources.

The World Health Organization's (WHO) International Classification of Diseases (ICD) is the global standard for certification and coding of morbidity and mortality data that are used to compile and analyze national statistics. In a bid to ensure uniform data capture, coding and analysis to enable comparison nationally and globally, Kenya adopted the 10th version of the International Classification of Diseases and Related Health Problems (ICD-10) introduced by WHO in 1993.

The ICD is designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Use of ICD standards allows uniform data capture, coding and analysis for comparison throughout the country and also globally.

Hospital morbidity and mortality data are an important component of the health information system. However, in Kenya, the lack of up-to-date, systemized training on certifying and coding deaths according to international standards has meant that deaths in the country's health facilities are, in most cases, not certified or coded per the required ICD standard. This presents an obstacle to obtaining complete and high quality cause-specific mortality information that could be used for planning.

To address the lack of capacity, the USAID-funded MEASURE Evaluation PIMA project, in collaboration with the Kenyan Ministry of Health's health information system (HIS) unit, participated in an international meeting in Dar es Salaam, Tanzania, to harmonize and institutionalize ICD in Kenya and to form a national mortality task force. PIMA also collaborated with the HIS unit in developing an international training and certification program (guidelines for implementation of cause of death certification and ICD curriculum guide) for ICD-10 mortality and morbidity coding, targeting clinicians as certifiers and health records and information officers as coders.

As part of this effort, MEval-PIMA, in collaboration with HIS, trained 224 health workers and civil registration officers (CROs) on ICD-10 certification and coding in several counties (Nakuru, Nairobi, Kirinyaga, Kakamega, Siaya and Mombasa). As part of post-training support, MEval-PIMA has facilitated three data review meetings in Siaya and Kakamega involving 24 sentinel facilities that were invited to share data and challenges they had faced after the training. Some of the challenges identified varied from low internet connectivity or the lack of it entirely, resistance from colleagues on proposed actions that could improve the quality of certification and coding, high turnover of staff due to transfers or student interns completing their learning at the facilities, difficulty in locating inpatient files, late reporting on DHIS 2 (the software platform for health data capture) and incomplete forms, among other challenges.

To address these challenges, MEval-PIMA, in collaboration with the Ministry of Health, has conducted mentorship visits and on-the-job-training at the facility level to review action plans, discuss and identify additional remedial actions, and enhance skills transfer. Mentorship visits to sentinel facilities have been carried out in Nairobi, Nakuru, Kakamega, Siaya and Kilifi. Plans are in place to conduct additional ICD-10 training in Murang'a, Migori and Kisumu and to continue provision of post-training support in all the target counties. It is expected that the training and follow-up support will improve the quality of data captured on DHIS 2 and improve the capacity of health workers at the county, subcounty and facility levels to undertake data cleaning processes and address gaps identified. It is also expected that counties will be able to generate mortality statistics for different reporting purposes. All this will inform availability of quality data to facilitate evidence-based planning at the county level.

In March 2015 in Kakamega, 14 Coders, 23 certifiers and three CROs were trained on ICD-10. Following the training, the county, in collaboration with MEval-PIMA, has held two data review meetings, each attended by 11 sentinel facilities, and has conducted two rounds of mentorship visits. Here is what one of them had to say:

Judith (in white) working with colleagues at Kakamega County General Hospital's records department to clean data on DHIS2

Judith Mirenja Manyalla – Health Records and Information Technologist, Kakamega County General Hospital
I was introduced to the international classification of diseases during a training using ICD-10 curriculum in December 2014. In follow-up activities, I have participated in the training of health care workers in Kakamega County, data review meetings and facility mentorship of coders supported by MEval-PIMA. In applying the knowledge I gained, I have observed several challenges to effective implementation. Lack of computers and access to the Internet have affected reporting into DHIS 2 for some facilities. There was some resistance from some medical officers and clinicians on changes required to improve quality of certification, coding and reporting. Over time, the certifiers appreciated the importance of proper certification of D1 forms (medical certificates for cause of death) and the coders recognized the importance of the proper assigning of codes. I have also learned how to use CoDEdit and ANACoD tools to clean data in DHIS 2 and prepare facility mortality reports. I am able to generate the top ten causes of death reported at the facility which can be used in decision making, compared with when cardiopulmonary arrest (CPA) was reported as the only condition leading to death. Continuous updates on ICD-10 are highly welcomed so as to improve our data capture and report generation.

The MEval-PIMA project works to strengthen health systems and improve the quality and use of data in Kenya for the sustainable delivery of quality health services. For more information on MEval PIMA's work in strengthening civil registration and vital statistics see:

- Baseline Assessment of National Civil Registration and Vital Statistics System here http://www.cpc.unc.edu/measure/pima/baseline-assessments/national-civil-registration-and-vital-statistics-system
- Fact Sheet – Strengthening Civil Registration and Vital Statistics M&E Systems here http://www.cpc.unc.edu/measure/pima/civil-registration-and-vital-statistics

Supporting Health Worker Mentorship to Strengthen HIV Care and Referrals services

For the last three years, USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) has supported Kenya's Ministry of Health (MOH) in strengthening the referral system to ensure that patients ultimately receive high-quality care that is accessible, affordable, equitable, and responsive to their needs for better health outcomes, as highlighted in the 2010 Kenyan constitution. Health care referrals are the means by which a patient arriving at a health facility can be sent for care to a specialist or to another facility to receive the treatment appropriate for his or her health issue.

The need to strengthen health care referrals was informed by a needs assessment undertaken in 2013 by MEval-PIMA, which highlighted several gaps in the health referral system. Some of the gaps included a weak capacity among health workers to manage and monitor performance of referral systems, inadequate referral infrastructure and financing, poor coordination among facilities, noncompliant referrals, and a lack of standardized tools used to communicate and document referrals.

The health worker mentorship is carried through facility visits that are designed to strengthen health worker capacity in managing and monitoring the referral system for HIV services, assess the performance of the referral systems for HIV services through collection and analysis of referral data,

- assess how the referral system collects, collates, and analyzes data on HIV services and
- promote the use of referral data for decision making at the facility level.

The visits are undertaken on a quarterly basis by mentors drawn from MEval-PIMA and the county health departments. Mentors include MEval-PIMA project staff, county HIV/AIDS and sexually transmitted infections coordinators. Others are the county health records and information officers, and staff from U.S. Government implementing partners.

During the visits, mentors and mentees review facility data on HIV referrals to identify gaps in the HIV referral and linkage to care processes. The reviews help in the development of action plans to address the gaps. MEval-PIMA is supporting mentorship visits in ten counties including Homa Bay, Kakamega, Kilifi, Kisumu, Machakos, Migori, Murang'a, Nairobi, Nakuru, and Siaya. In these counties, the mentorship has contributed to improved health worker capacity to document, manage, and assess data on HIV care referrals in targeted facilities and has enhanced the use of data in decision making at the facility level.
Strengthening the health referral system, has been identified by the Government of Kenya as a a priority investment for the national health sector as a whole.

PHOTO CREDITS: WILFRED KAZUNGU – COUNTY DEPARTMENT OF HEALTH KILIFI

Strengthening Partnerships in Health through County Health Stakeholder's Forums

The County Director of Health Dr. Bilal Mazoya addressing stakeholders during a Q&A session

The devolution of health services in Kenya to the 47 counties has created a situation where county departments of health are now responsible for delivery of health services to their constituents, hence the need to work in close collaboration with stakeholders to implement the health agenda of their respective counties.

USAID-funded MEASURE Evaluation PIMA project has been supporting the Kilifi County department of health to establish a health stakeholders' forum and to develop a coordination framework to guide its operations.

Stakeholder's forums are aimed at, strengthening coordination, enhance synergies amongst health actors, and mobilize partners' support to address critical health challenges in the county. The ultimate objective is to nurture a culture of evidence-based planning and decisions in the county health system. The stakeholder forums are held quarterly and are guided by terms of reference that spell out how the forums will be conducted and the roles of each actor in the forum.

In February 2016, MEval-PIMA worked with the Kilifi County Department of Health, the USAID-funded APHIA Plus project, KEMRI Kilifi, and other stakeholders to convene the second stakeholder forum as a follow up of the first forum held in November 2015. The forum drew its participants from institutions such as faith- and community-based organizations, civil society organizations, the private sector, and county departments, including the County Health Management Team led by the county executive committee member for health and the chief officer.

Institutionalization of the stakeholders' forum is in progress-a coordination framework has been established. The forum has a developed a sector-wide calendar of events and is now regularly scheduled in the county department of health calendar. This has created an environment for sharing information and facilitating linkages between partners working in similar health program areas, which has been facilitated by forming program-based thematic working groups to address health priority areas, including HIV and tuberculosis, maternal health, child health and nutrition, and environment and community health.

Through these thematic groups, partners identify opportunities for collaboration, enhance synergies, and eliminate duplication of activities where possible. In the long term, the milestones achieved through this forum are intended to strengthen coordination.

PHOTO CREDITS: WILFRED KAZUNGU – COUNTY DEPARTMENT OF HEALTH KILIFI

Eunice Mwanyalo from Kenya Association of Manufacturers Salt Sub-sector contributing to a discussion

Devolving the use of a Reproductive Maternal Newborn and Child Health Scorecard to the sub county level

Ending preventable child and maternal deaths remains a key priority for the Government of Kenya. Part of the strategies to end preventable child and maternal deaths include the use of data to track the level of investments and the outcomes along the reproductive maternal and newborn health continuum of care. An RMNCH scorecard, is one of the tools developed to support decision makers to track the magnitude of maternal and child deaths and the factors that contribute to them. The scorecard also help to improve service delivery, uptake, and accuracy in reporting data.

The Ministry of Health (MOH), through the Division of Health Informatics and Monitoring and Evaluation (DHIM&E), spearheaded the development of a RMNCH scorecard for Kenya. The result of this work is a quarterly scorecard comprising 27 national- and county-level indicators across six categories that span the care continuum. The six categories are (1) pregnancy and newborn care, (2) early childhood care, (3) late childhood care, (4) adulthood, (5) health systems, and (6) the community. The development of the RMNCH scorecard was supported through MEval PIMA project in collaboration with development partners in May 2014.

MEval-PIMA, supported the MOH family planning program managers, to conduct sensitization meetings at the sub county level targeting participants from all the sub counties in Migori The participants were oriented on the use of the RMNCH scorecard, DHIS 2 use and functions, data quality and management, reproductive health commodities management—especially family planning commodities—and contraceptive technology updates.

Participants found the scorecard to be a very useful tool for identifying performance gaps, and areas that require improvements. Mr. John Odira, Deputy County Health Records and Information Officer (DCHRIO), Migori County, for instance noted that"the scorecard training has helped to identify the gaps in performance coverage in the county, andinforms the subcounty on which indictors they need to take an action on, especially the indicators showing as low-performing". He went to note that" the scorecard informs planning and interventions required because both county and subcounty management teams and program officers are able to identify the indicators that need to be urgently addressed to improve the overall county indicator performance".

Mr. Odira promised to use the scorecard in setting county priorities based on the gaps highlighted in the scorecard, plan for support supervision to improve on the low-performing indicators, and improve on data quality.
The scorecard is generated using data in the DHIS 2,

"We can see from the scorecard results comparing Q4 of 2014 and Qs 1 and 2 of 2015 data, we are able to see how we are performing in each indicator and where we need candid improvement."

John Odira, Deputy County Health Records and Information Officer (DCHRIO), Migori County

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"(The scorecard) creates a trigger in the minds of the leaders of the county or subcounty on how they can reverse the trends of low-performing indicators. The scorecard is a very good innovation for the county, which can help us to improve on the indicators."

Beatrice Oloo, subcounty nursing officer, Awendo Subcounty, Migori County

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And in her interview, she said:
Oloo: The scorecard is the simplest management tool I have ever come across that has many benefits. It helps to track performance on the prioritized high-impact indicators in the subcounty and has the ability of comparison. Most indicators are relevant to a nurse from report generation, evaluation, to decision making, hence the scorecard is an important tool to me as a nurse manager.

I plan to orient other subcounty members on the importance of the scorecard and how to use it. I also hope to sensitize health care workers in the subcounty on the maternal and child indicators so as to improve performance and periodical review using this scorecard.

I have realized, using the scorecard, you can look at several indicators and narrow down to specific ones as per the Annual Work Plan. Most of the indicators in the scorecard are geared towards Vision 2030 and the Sustainable Development Goals.

Sustainable National Referral Systems Technical Working Group

An assessment of the health referral systems in Kenya in 2013 showed inadequate mechanisms to effectively coordinate and improve collaboration in referral systems management and a lack of key policy documents to guide referral systems implementation in Kenya. To respond to these gaps, USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) advocated formation of a Referral Systems Technical Working Group (TWG) to coordinate country referral activities and spearhead the development of key policy documents.

The TWG, formed in May 2014, has provided technical guidance and coordination in the implementation of the National Health Sector Referral Strategy and has helped develop key policy documents to guide referral implementation in Kenya. The TWG also plays a critical role in bringing together referral systems stakeholders and provides a platform to address key referral systems issues across board.

Since the TWG began, MEval-PIMA has been the key partner providing support. MEval-PIMA has now moved into year 4 of the project, which has shifted focus from strengthening the referral systems to supporting HIV referrals and linkages. As a result, support for the TWG has been transitioned to the Government of Kenya Ministry of Health (MOH) to ensure its sustainability and continuity. MEval-PIMA collaborated with the MOH National Referral and Ambulance Services Unit to develop a sustainability plan; however, in the past year, leadership in the unit has changed, and the TWG has met inconsistently. The TWG also lacks a formal work plan and meeting schedule for the year.

In response and in collaboration with MOH, MEval-PIMA supported a TWG meeting in January, when the new head of the Referral and Ambulance Services Unit was inducted into the TWG under the group's terms of reference. At the same time, the TWG developed a work plan, set up a meetings calendar, and agreed to lobby for financial commitment from member institutions to support scheduled activities.

The meeting achieved these key milestones: inducted new TWG members and reviewed their roles and responsibilities, set up an annual TWG work plan and meeting calendar, and formed four task forces to spearhead implementation of priorities outlined in the Referral and Ambulance Services Unit annual work plan. The World Health Organization committed to provide financial support for the quarterly TWG meetings, training for health workers in six counties, and development of referral systems standard operating procedures—all key milestones to ensure that the TWG functions will continue and that MOH will continue to provide a leadership role.

Further information on the MEval-PIMA organizational support is available here http://www.cpc.unc.edu/measure/resources/publications/fs-14-115/

Malaria Control Strengthened with Accurate, Timely Surveillance Data: Focus on Kisumu County

Kisumu County in the western region of Kenya has the highest rate of malaria in the country. In 2010, 38 percent of the county's population was infected with malaria, according to the Kenya Malaria Indicator Survey, 2010. An assessment of the county's capacity to address the high malaria burden showed that efforts were hampered by a lack of accurate, timely data to support the monitoring of malaria control efforts and inform decision making by the county health managers.

To improve malaria surveillance, the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project, with support from the U.S. President's Malaria Initiative (PMI), has been working with county health management teams in malaria-endemic counties in western Kenya to train healthcare workers on malaria surveillance.

The Kisumu county health management team selected 10 staff for a five-day train-the-trainer workshop on malaria surveillance held in March at Kisii University. The workshop trainers were provided by the National Malaria Control Program (NCMP) and MEval-PIMA. The 10 workshop trainers later trained 160 health workers from county public health facilities in the use of accurate, timely data in the national health information system platform, District Health Information System 2 (DHIS 2). With this information, the workers learned how to generate nine core World Health Organization (WHO)-recommended malaria surveillance graphs that the NMCP uses to track progress in malaria control.

The training has resulted in substantial improvements in the quality of data reported and reporting rates from health facilities. An example of the improved reported data is decline in the total suspected malaria cases which has decreased from 34,310 in April 2015, to 30,438 at the end of December 2015. These result indicate that there is a true decline in malaria cases, probably due to effective malaria control intervention.

Packaging malaria surveillance data effectively helps the national malaria control program, counties, stakeholders, and donors monitor the performance of malaria indicators and identify gaps and areas for support, integration, and coordination among many malaria partners to help Kenya meet the vision of having a malaria-free generation.

The MEval-PIMA project supported the development of a quarterly county malaria bulletin to showcase the increased capacity of the county health management team to use malaria and other health data effectively. This bulletin has helped demonstrate the team's outstanding performance and encouraged development of action points for program improvement during routine data review meetings.

Several county managers have commented on the bulletin, as shown in the text boxes.

"Kisumu County Health Department has been working closely with the Measure Evaluation PIMA Project in improving malaria surveillance. This partnership has ensured regular analysis, interpretation and dissemination of data, and consequently, using data for decision making has been embraced."

Dr. Dickens Onyango, Kisumu County Director of Health

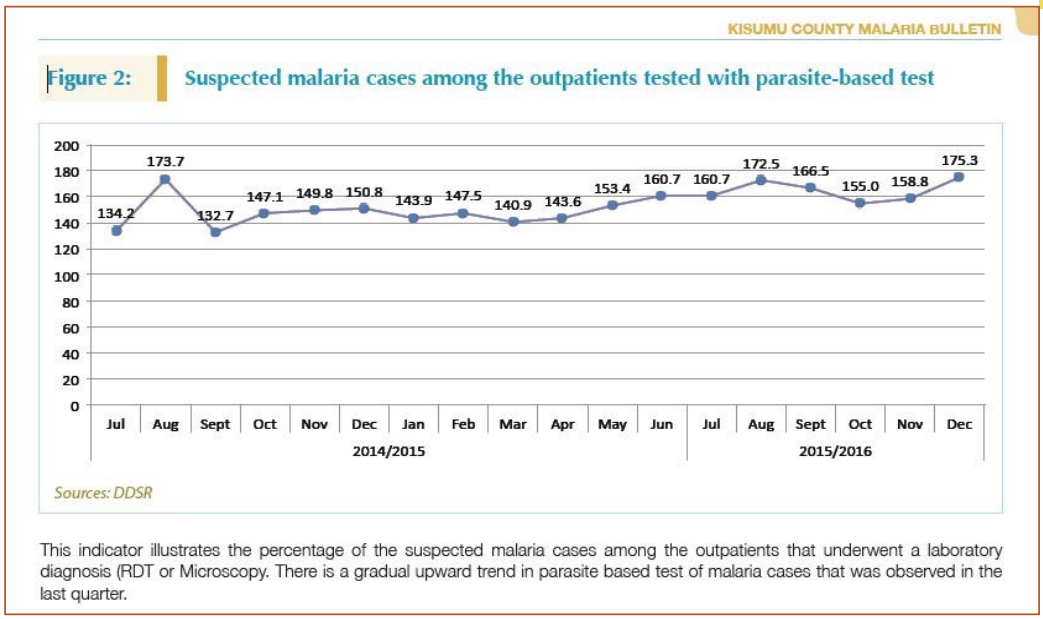
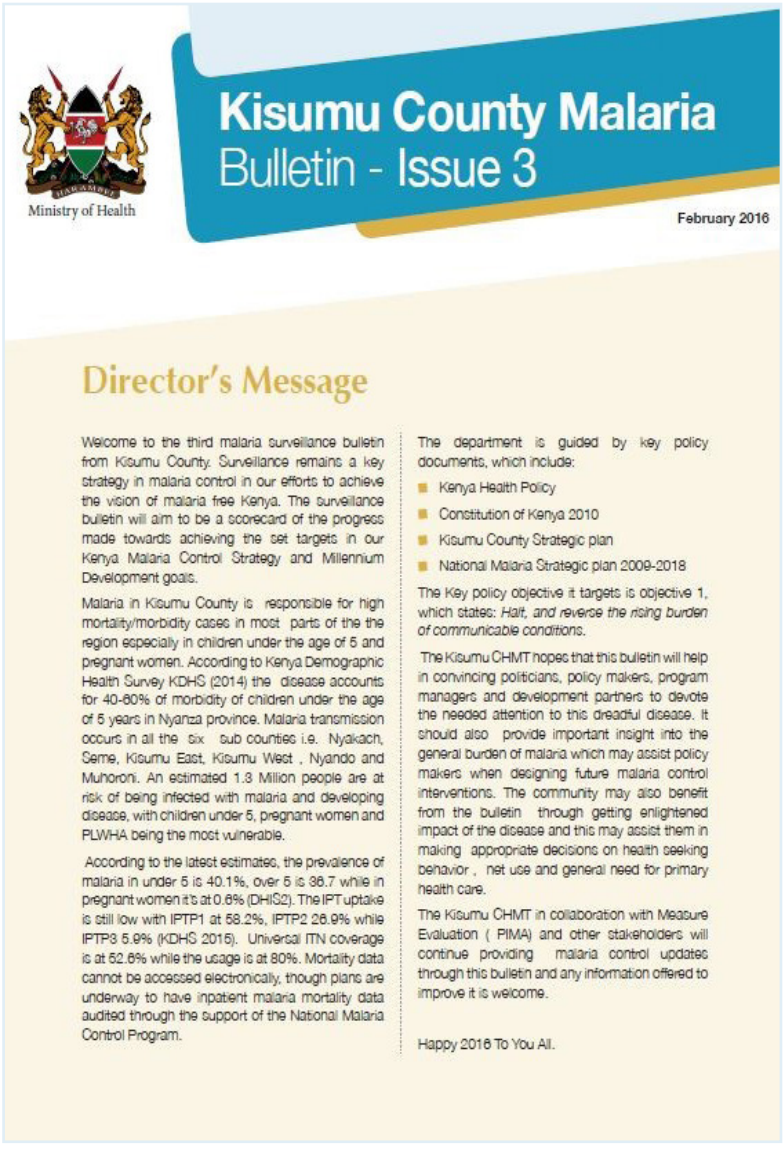


Figure 1 shows a graph from the Kisumu county malaria bulletin indicating an increase in suspected malaria cases diagnosed using a parasite-based test.


Ministry of Health

Kisumu County Malaria Bulletin - Issue 3

February 2016

Director's Message

Welcome to the third malaria surveillance bulletin from Kisumu County. Surveillance remains a key strategy in malaria control in our efforts to achieve the vision of malaria free Kenya. The surveillance bulletin will aim to be a scorecard of the progress made towards achieving the set targets in our Kenya Malaria Control Strategy and Millennium Development goals.

Malaria in Kisumu County is responsible for high mortality/morbidity cases in most parts of the the region especially in children under the age of 5 and pregnant women. According to Kenya Demographic Health Survey KDHS (2014) the disease accounts for 40-60% of morbidity of children under the age of 5 years in Nyanza province. Malaria transmission occurs in all the six sub counties i.e. Nyakach, Seme, Kisumu East, Kisumu West , Nyando and Muhoroni. An estimated 1.3 Million people are at risk of being infected with malaria and developing disease, with children under 5, pregnant women and PLWHA being the most vulnerable.

According to the latest estimates, the prevalence of malaria in under 5 is 40.1%, over 5 is 38.7 while in pregnant women it's at 0.6% (DHIS2). The IPT uptake is still low with IPTP1 at 58.2%, IPTP2 26.9% while IPTP3 5.9% (KDHS 2015). Universal ITN coverage is at 52.6% while the usage is at 80%. Mortality data cannot be accessed electronically, though plans are underway to have inpatient malaria mortality data audited through the support of the National Malaria Control Program.

The department is guided by key policy documents, which include:

- Kenya Health Policy
- Constitution of Kenya 2010
- Kisumu County Strategic plan
- National Malaria Strategic plan 2009-2018

The Key policy objective it targets is objective 1, which states: *Halt, and reverse the rising burden of communicable conditions.*

The Kisumu CHMT hopes that this bulletin will help in convincing politicians, policy makers, program managers and development partners to devote the needed attention to this dreadful disease. It should also provide important insight into the general burden of malaria which may assist policy makers when designing future malaria control interventions. The community may also benefit from the bulletin through getting enlightened impact of the disease and this may assist them in making appropriate decisions on health seeking behavior , net use and general need for primary health care.

The Kisumu CHMT in collaboration with Measure Evaluation (PIMA) and other stakeholders will continue providing malaria control updates through this bulletin and any information offered to improve it is welcome.

Happy 2016 To You All.

Figure 2. A snapshot of the front page of the Kisumu county malaria bulletin issue 3

PHOTO CREDITS (YVONNE OTIENO/MEVAL-PIMA)

Participants at the data review meeting in Embu

Three-phase Support Package Encourages Data Use by Subcounty Health Teams

Kenya's family planning program has recorded notable gains in the last five years, as demonstrated by the Kenya Demographic and Health Survey (KDHS) 2014. Key achievements include an upward trend in contraceptive prevalence among all women, from 46 percent in 2009 to 58 percent in 2014, and a decline in the unmet need for family planning among currently married women, from 26 percent in 2009 to 18 percent in 2014.

Management of routine health information data reporting on family planning commodities and services through the public health sector also showed improvements in the same period, with the mainstreaming of the DHIS 2 software platform contributing to improved data reporting. However, gaps remain, especially following the 2013 devolution to county health management teams (CHMTs) for health care delivery. The Kenya Ministry of Health reproductive and maternal health services unit (RMHSU) requested financial support from the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) Project to address the gaps.

In response, MEval-PIMA partnered with RMHSU and other USAID-funded projects to develop a three-phase package of support for subcounty health management teams and CHMTs. In the first phase, September 2014 to March 2015, the effort oriented 268 health workers from 47 counties on use of family planning data for decision making. In phase 2, April 2015 to September 2015, the effort oriented 88 CHMTs. And in the third phase, October 2015 to March 2016, the effort oriented 131 subcounty staff. The trained teams are expected to be champions of improved reproductive, maternal, newborn, and child health and family planning data quality, and have developed an action plan for quarterly follow-up meetings.

Dr. Jonah Maina, the programme manager for RHMSU, explained the importance of ensuring timeliness, quality, and routine use of data for program management. "Reporting is not enough; the health departments have to work on improving the quality of data," he said. His closing remarks reiterated that data improvement is a continuous process.

To ensure sustainability and to follow up on the trainings held last year, MEval-PIMA has been supporting follow-up data review meetings with subcounty health management teams to improve use of quality data for decision making for services and programs.
In February, 2016, Muranga County held a data review meeting with support from RHMSU and MEval–PIMA. During the meeting, subcounties presented data on their performance on reproductive and child health services and family planning commodity management indicators. Dr. Maina clarified data indicators and each subcounty developed an action plan to address areas for improvement, including better data gathering if needed.

Dr.George Kariuki, Ministry of Health, Muranga North

I oversee three subcounties— Kangema, Kiharu, and Mathioya. This week we have been meeting to review data on reproductive and neonatal maternal health. Reviewing the data helps us know whether we are on track in terms of targets and also helps us measure our performance, compared with other regions and against the country data. From the review, we have seen our gaps and are developing work plans to help achieve our goals. In terms of some indicators, we have seen uptake of family planning methods is at 68 percent, but our target is above 80 percent. We want to minimize that gap as much as possible. We plan to do this through support supervision and data quality analysis and give feedback to the person in charge of the facility.

Dr. Juliana Muthoni Mbuthia, Medial Officer of Health, Muranga South

I oversee all the health activities and programmers in the four subcounties—Gatanga, Kandara, Murganga, and South Kigumo. This week we are here to review our reproductive, maternal, newborn, and child health data. This is important because it gives us a chance to examine and interact with our data and evaluate how far we are from achieving our goals. County personnel present included the public health nurse, health records officer, and the subcounty pharmacist. Together, we were able to analyze the situation of the subcounty, present it for critique, and find the gaps and possible solutions.
Some of the general gaps that were seen were in the quality of data collection and presentation. There seemed to be issues with understanding indicators. Across the board, we are not doing too well on family planning updates and, specifically, what emerged is the limited use of post-natal registers and gaps in commodity management. Some of the solutions we have proposed include regular supportive supervision, continuous mentorship, and regular data quality analysis. We thought we were doing very well and that we had we had high uptake, but now we know we should not ignore family planning data. This was relevant because from here, we already know what we want to do to get where we should be.

Are Health Facilities Ready to Provide Emergency Obstetric and Newborn Care?

PHOTO CREDITS: YVONNE OTIENO

"My greatest Joy is seeing a mother safely delivering her baby and happily feeding the baby. For me nursing is a calling and not just another job."

Everlyne Kasyoka, Nurse in charge of Marternity ward in Muthule

Most deaths of newborns and their mothers in Kenya are preventable, often stemming from causes as simple as high blood pressure and infection. Proper care and equipment could save an estimated 30 percent to 45 percent of newborn deaths and 25 percent to 62 percent of intrapartum stillbirths every year. An estimated 74 percent of maternal deaths could be averted if all women had access to the interventions for preventing or treating pregnancy and birth complications, in particular access to emergency obstetric care. Emergency obstetric and newborn care gives health workers skills, life-saving medicines, and equipment to manage the leading causes of maternal and newborn death.

The Kenyan Ministry of Health is working closely with county governments and other partners to expand the coverage of emergency obstetric and newborn care (EmONC) to all health facilities nationwide. Two levels of care are recognized under this approach: (1) basic (administration of parenteral antibiotics, uterotonic drugs, and anticonvulsants; manual removal of placenta, removal of retained products of conception, assisted vaginal delivery, and newborn resuscitation) and (2) comprehensive (all seven basic functions plus Caesarean section and safe blood transfusion). Primary-level facilities are required to provide all seven basic EmONC (BEmONC) signal functions; hospitals must provide comprehensive EmONC (CEmONC) signal functions.

In July 2013, in partnership with the U.S. Agency for International Development (USAID), the Ministry of Health embarked on a program to expand EmONC services to 15 counties in the country's 10 major regions. The program began with assessments of the needs of selected facilities in 14 counties. These surveys were conducted to identify the specific changes needed to expand services and to provide baseline data for monitoring and evaluation—to be able to tell what works. In 2014, county teams, with support from USAID-funded service-delivery projects, explored the EmONC needs, focusing on the 13 Kenyan counties with the highest maternal and neonatal mortality rates. The research teams studied the preparedness of 376 health facilities (278 health centers and dispensaries and 98 hospitals) to provide emergency obstetric and newborn care. From July 2014 to August 2014, they collected data in selected sites on the number of EmONC-trained health workers and the availability of equipment and medicines required to provide key services.

USAID projects involved in this work are: APHIAplus Kamili, APHIAplus Nuru Ya Bonde, APHIAplus Nyanza/Western, APHIAplus Imarisha, APHIAplus Nairobi/Coast, the Maternal and Child Survival Project (MSCP) and AMPATH plus. MEASURE Evaluation PIMA, a USAID-funded project focused on data for health decision making, then analyzed the research findings and disseminated them to county teams. Those teams then developed action plans. They found that about a third of the hospitals had all the supplies required to provide these functions—such as oxytocin, a drug used to control bleeding during obstetric emergencies—but that health worker staffs were often inadequate. For example, the number of health workers in the maternity and newborn departments who had received EmONC training in the 12 months preceding the survey was low, ranging between 10 percent and 30 percent in most counties. Further, guidelines on quality emergency obstetric and neonatal care practices were available in most hospitals but absent in many health centers and dispensaries.

"The majority of these health centers and dispensaries lack essential equipment and the commodities required to provide this type of emergency services to pregnant women and newborn infants," said Amin Abdinasir, who leads MEASURE Evaluation PIMA. "The government is committed to ensuring universal access to high-quality maternal and newborn care in health facilities across the country. The findings of the EmONC assessment have been used to develop county and facility action plans. Having the data to determine areas of greatest need will help us focus efforts to improve health services."

In response to the gaps noted in these 13 counties, USAID has provided training for health workers over the last two years to enhance respectful care in antenatal and maternity services, and has procured medical equipment valued at over US$1.5 million for the 47 counties to support maternity services. Some of the equipment is being used by health workers during delivery and in the newborn units to keep babies warm and enable resuscitation of babies who may develop breathing problems after birth. In addition, USAID has financed the renovation of maternity wards and newborn care units, providing a modern, spacious and baby-friendly environment.

What are the causes of maternal mortality?

Women die as a result of complications during and following pregnancy and childbirth, most of which develop during pregnancy and most of which are preventable or treatable. Other complications may exist before pregnancy but are worsened during pregnancy, especially if not managed as part of the woman's care. The major complications that account for nearly 75 percent of all maternal deaths are:

- severe bleeding (chiefly after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- unsafe abortion

The remainder are caused by or associated with diseases such as malaria and AIDS during pregnancy.

Reprinted from: World Health Organization. 2015. Maternal mortality: Fact sheet N°348. Geneva: World Health Organization.
Available at http://www.who.int/mediacentre/factsheets/fs348/en/

For more information

Ending preventable child and maternal deaths is one of USAID's global health priorities. The agency has made substantial investments to achieve this goal, including supporting the delivery of a core package of high-quality reproductive maternal, newborn, and child health interventions that provide a continuum of care to mothers, newborns, and children. Through projects such as MEASURE Evaluation PIMA, USAID also supports the Ministry of Health and county governments to monitor trends and maternal newborn and child health outcomes and to strengthen use of data at the national and county levels.
Read more at: http://www.cpc.unc.edu/measure/pima
To download a copy of the EmONC assessment report, see: http://www.cpc.unc.edu/measure/resources/publications/tr-16-123

Working Towards the Sustainability of the Child Protection Information Management System

The launch of the Kenya National Plan of Action 2015 for enhanced child protection led to both legislation and institutional structures to address diverse child protection challenges. One of the challenges experienced in child protection systems was a disjointed information system, with significant data on child protection services kept in manual files. The USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project has been supporting the development of a comprehensive and integrated information system that will routinely collect and facilitate analysis and use of child protection data for planning and decision making. The user-friendly Child Protection Information Management System (CPIMS) is expected to address the diverse information needs of various stakeholders in the children's sector in Kenya. The data is used for decision making, resource mobilization, programme planning, and prioritization of interventions

To cushion the process of developing this database from the risks highlighted above, MEval-PIMA worked with DCS, UNICEF, PLAN International, and other partners to develop a sustainability plan for CPIMS. During that process, MEval-PIMA worked with a team appointed by the Director for Children's Services to develop a first draft, which was validated by the CPIMS Technical Working Group (TWG) meeting in August 2015, followed by the endorsement of the TWG steering committee in September. These broad proposals are now being applied to guide engagement around CPIMS strengthening.

Some notable actions taken since the development of the plan include:

- The DCS has dedicated an internal task team to lead the process.
- As a demonstration of ownership and the need for sustainability, two new staff members were posted to the Information and communications technology (ICT) unit in DCS to support efforts to design a sector-wide system that will incorporate information on all aspects of child protection.
- A technical staff member from MEval-PIMA is co-located in the department for sustained mentorship and skills transfer to the DCS team so that the system is not dependent on partners upon completion.
- A mentorship plan for the ICT unit was developed and endorsed and is being rolled out by MEval-PIMA staff.
- Additional partners have been enlisted to support different components of CPIMS implementation and roll-out.
- The Office of the Director of Finance and Administration at DCS has identified itself as the primary champion for this task and has allocated full-time staff to support its realization.

This sustainability plan empowers both DCS and stakeholders to address potential constraints to effective stakeholder participation, engagement, support and ownership of the initiative and its final outcome. Notably, DCS has been able to maintain stakeholder interest and has dedicated staff to work with MEval-PIMA team to develop and implement a critical database for the children's sector.

The development of the sustainability plan for the Department of Children's Services is part of MEval-PIMA's customized technical assistance in organizational development.

For more information on PIMAs work on organizational development see http://www.cpc.unc.edu/measure/resources/publications/fs-14-115/

For more on PIMAs support to development of the CPIMS see http://www.cpc.unc.edu/measure/pima/meval-pima-news/developing-a-child-protection-information-management-system-in-kenya

PHOTO: NOLTE LOURENS/SHUTTERSTOCK/FREEPIK

MEval-PIMA's support to improving children protection data at the county and national levels

The regular use of reliable information from a well-designed child protection information management system (CPIMS) is important for ensuring and sustaining improvements in child protection. Using reliable information from CPIMS over time aids in improving child protection outcomes, tackling disparities, enhancing efficiency and fostering child protection programming.

More than 25 years ago, the world made a promise to children: that we would do everything in our power to protect and promote their rights to survive and thrive, to learn and grow, to make their voices heard and to reach their full potential (UN Convention on the Rights of the Child, 1990). Since 2000, the Millennium Development Goals (MDGs) have helped drive tremendous progress among children. The MDGs proved how much can be achieved by galvanizing global efforts around concrete, common goals. In spite of the overall gains and while some gaps have narrowed, others have persisted and in some cases widened – even within "countries reporting national gains (UNICEF, Progress of Children 2015). Kenya's Department of Children's Services is developing a system that can provide quality data for evidence-based decisionmaking to narrow these gaps.

In Kenya, child protection data in most of the counties is incomplete and is even missing in the annual national caseload. According to the 2014/15 caseload summary data, 60% of the counties did not submit their quarterly data as per the stipulated guidelines.

According to the 2014/15 caseload summary, the caseload prevalence rate ranges from 50 to560 cases per 10,000 children across the 47 counties in Kenya. If Kenya does not have an adequate child protection system, measurement of progress in child protection and children's rights will prevail and overall inequity among the children due to skewed programming an element that the UNCRC address.

The figure ig below shows the counties with a caseload prevalence of over 100 reported cases per 10,000 children in Kenya.

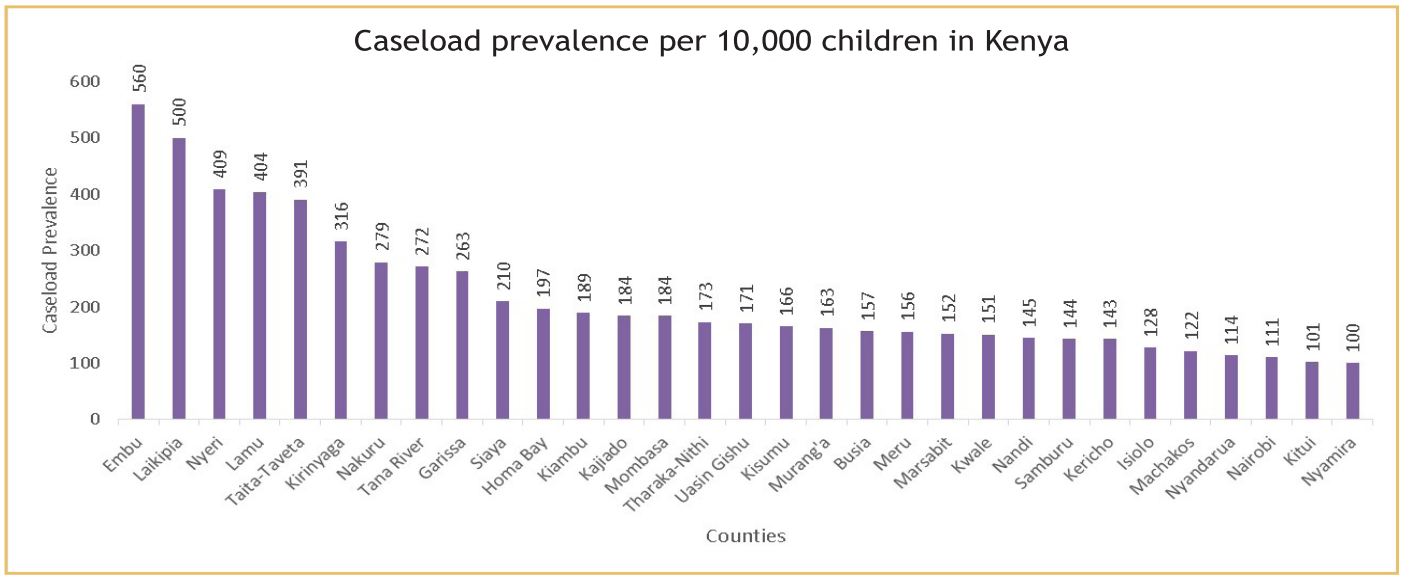
The USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project is supporting the Government of Kenya to build sustainable monitoring and evaluation (M&E) capacity to use evidence-based decisionmaking to improve the effectiveness of the Kenyan child protection system. MEval-PIMA is supporting to the Department of Children's Services (DCS) to enhance its capacity to collect and report child protection information and increase utilization of the same data among all stakeholders. Unavailable quality child protection data will lead to disparities in programming and will not allow stakeholders to track progress in the children's sector. During a recent M&E capacity assessment workshop, Mr. Ahmed Yusuf, the county coordinator of Nakuru County, who has served for over 30 years in DCS, acknowledged the efforts that have been put in place to have child protection data available at the click of a button., He urged the data office at headquarters to go to the field offices and provide in-depth sensitization training on the reviewed tools and guidelines. Such an endeavor will ensure that team members apply the same standards when filling in the case record sheet and when transmitting the data.

In collaboration with DCS,, MEval-PIMA has embarked on a mentorship program for all the DCs sites where it is currently working to improve the quality of data through sensitization about standardized data collection and reporting tools and guidelines that were reviewed and shared with the field team in August 2015. The process aims to improve data flow and adherence to the DCS reporting structures among all the actors in the system. The overall aim is to strengthen the paper-based system before the actual roll-out of the electronic system (CPIMS).

The first sensitization forum meeting was held for Nairobi County in Feb 2016 and will be replicated in other counties in the subsequent months.

Mr. Ahmed Yusuf, the county coordinator of Nakuru County during Nauru Children's Parliament Workshop 2015

MEASURE Evaluation PIMA (MEval-PIMA) is supporting the Department of Children Services (DCS), based within the Ministry of Labour, Social Security and Services. MEval-PIMA supports expanding the functionality of the Child Protection Information Management System (CPIMS) and the OVC Longitudinal Management Information System (OLMIS) while building the capacity of relevant stakeholders to use these systems to monitor and evaluate their programs, and use the data to make programmatic and policy decisions to improve child protection outcomes.



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