MEASURE Evaluation PIMA

Feb - June 2015 - Quarterly

NEWSLETTER

INSIDE

Welcome from the Project Director

Edward Kunyanga
Project Director
MEASURE Evaluation PIMA

Dear Readers,

It is now about two years since the launch of the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) program in Kenya. Since its inception, we have worked collaboratively with the Government of Kenya, especially the Ministry of Health, to strengthen health systems and to improve the quality and use of data in the country for the sustainable delivery of quality services under the devolved governance system.

Nationally, we continue to work with multiple key stakeholders and partners, especially the Malaria Control Program, the Reproductive and Maternal Health Services Unit, the Community Health Strategy Unit and the Disease Surveillance and Response Unit. We also work with the Ministry of Interior, the Ministry of Labour, Social Security and Services, with a specific focus on the Civil Registration and Vital Statistics Department and the Department of Children Services. At the sub-national level, we work directly with county and sub-county government units and the various county assemblies and health focal points.

In this first issue of our newsletter, we present a snapshot of some of the interventions implemented at the national and sub-national levels. These have included building monitoring and evaluation (M&E) capacity for systematic improvement in data collection and use to inform policymaking, to strengthen organizational and institutional capacities to monitor and evaluate health programs and services, and to provide technical assistance to decision makers in applying M&E results for more effective and sustainable health programming.

This issue specifically highlights efforts in malaria control through malaria surveillance training, the role of partnerships and improved strategic information to scale up emergency obstetric and newborn care, and how the interrogation of data influenced free birth registration in Garissa

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

"90% of the world's data has been created in the last two years. The ultimate question is really what insight and value can we draw from that data?"
CIO Goldman Sachs-George Lee

USAID FROM THE AMERICAN PEOPLE

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County. We also reflect back on the first Annual Health Congress held earlier in the year. In the past few months, we have engaged stakeholders in child safety and protection in the development of a Child Protection Information Management System, and have also seen the launch of a Garissa County M&E plan. The newsletter has stories detailing all these events.

These are just a few of the stories documented in the newsletter and we hope you will enjoy them. 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.

Happy Reading,

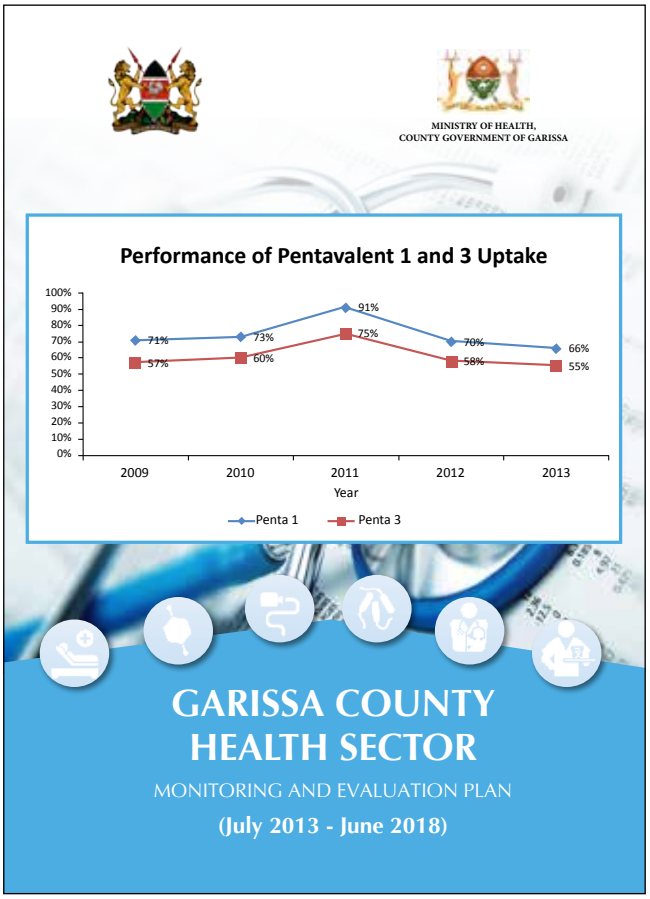
Edward Kunyanga
Project Director
MEASURE Evaluation PIMA

In the past few months as a programme we have engaged stakeholders in child safety and protection in the development of a Child Protection Information Management System and have also seen the launch of a Garissa County Monitoring and Evaluation plan.

Garissa County Launch Health Sector Monitoring and Evaluation Plan

In April, Garissa County launched its County *Health Sector Monitoring and Evaluation Plan*, making it the first of 47 Kenyan counties to do so.

The plan is intended to monitor progress towards the implementation of the county's health sector strategic plan, and support efficiency in the delivery of health care services.



Speaking during the launch of the document, Abdullahi Hussein, the Garissa County Deputy Governor, noted that the county was committed to improving access to health services by implementing the activities contained in the strategic plan. He added that "the health M&E plan for Garissa County, 2013-18, will serve as an important guide for monitoring the implementation and evaluation of Garissa County Health Strategic Plan 2014-2015."

Dr. Farah Amin, the Garissa County Director for Health, who shared an overview of the M&E plan, said the county government was committed to fund the cost of plan implementation in forthcoming county budgets.

"According to the county's performance monitoring, health is the best-performing sector and we have allocated 21% of the county budget for the financial year (2015/2016) to the sector," Dr. Amin said.

The M&E plan was developed by the Garissa County Ministry of Health, with financial and technical support from the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project. Other partners involved in the plan's development included APHIAplus, IMARISHA, UNICEF and CARE International.

The MEval-PIMA project is currently supporting five other counties to develop M&E plans as part of its support to strengthen the capacity of the national Ministry of Health to identify and respond to information needs at the national and sub-national levels.

The launch was attended by other county officials involved in the development of the plan, including the chief executive officer of the county referral hospital, a member of the county health committee, the county assembly speaker, and representatives from sub-county health management.

Access more information about the Garissa M&E plan online on http://www.cpc.unc.edu/measure/pima/brochures-and-resources/brochure-garissa-county

Partnerships and improved strategic information scales up emergency obstetric and newborn care in Kenya

According to the World Health Organization, 800 women around the world die every day from pregnancy- or childbirth-related complications. 99% of those who die live in the developing world. While most complications develop during pregnancy, others can exist before pregnancy and be exacerbated by it. Major complications accounting for nearly 75% of all maternal deaths are:

- Severe bleeding, mostly after childbirth;
- Infections, usually after childbirth; and
- High blood pressure during pregnancy (i.e. pre-eclampsia).

Source: www.who.int/mediacentre/factsheets/fs348/en/

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

A mother and her child at a clinic in Kisumu County, Kenya.

With a maternal mortality ratio (MMR) of 488 deaths per 100,000 live births,[1] and as part of its efforts to achieve Millennium Development Goal 5, Kenya is committed to reducing its MMR to 147 deaths per 100,000 live births by 2015.[2]

The challenge is considerable. A 2009 survey on access to essential medicines in Kenya cited numerous barriers to the provision of emergency obstetric and newborn care (EmONC), including patient-related factors, as well as access, human resources, policy and infrastructure factors.[3] Some patient-related barriers included low utilization of antenatal care and skilled deliveries and poor knowledge, attitudes and practices. Additionally, even though the majority of Kenyans access care through public sector primary health facilities (e.g. dispensaries and health centers), which constitute 75% of the 4,433 public health facilities, almost a quarter of women (21%) felt it was not necessary to deliver in a hospital setting.

Moreover, only three percent of health facilities have the capacity to provide emergency obstetric care to address pregnancy-related complications, and access to essential services remains a serious challenge for most Kenyan women.[4]

In July 2013, USAID implementing partners (APHIAPLUS, AMPATHPLUS, MCHIP and MEASURE Evaluation PIMA [MEval-PIMA] and County Health Management Teams [CMHTs] embarked on an initiative to scale up EmONC services to an initial 15 counties with high rates of maternal mortality, with varying results. Availability of quality data on EmONC is required to design interventions to address maternal and newborn complications at childbirth. EmONC is an integrated strategy aiming to equip health workers with skills, life-saving medicines, and equipment to manage the leading causes of maternal and newborn death.

A review of the first phase of the initiative was conducted in April 2014, with important lessons learnt that informed the technical and monitoring and evaluation (M&E) approaches adopted in the second phase. Overall, the key recommendations made for the success of the scale-up included a need for closer collaboration among partners, standardization of the support package offered to facilities, and standardization of the M&E tools, including the assessment and monitoring guidelines.

The revised approach led to a re-selection of target counties, a re-focus of the scope of support, and inclusion of the CHMTs in the decision-making processes. Implementing partners worked in consultation with USAID in providing guidelines and training on EmONC, as well as redistributing equipment. The M&E for the scale-up changed significantly, with MEval-PIMA taking the lead role in coordinating the review of assessment and monitoring tools and mechanisms to improve data quality, and training of partners and CHMT focal persons on assessment methods, tools, data analysis, interpretation of Excel-based dashboards, and data use for action planning.

Unlike the first phase, in which data analysis was limited by significant levels of missing data (Figure 1on page 4), the second phase involved the design and standardization of data tools, resolving the challenge of inadequate data capture, consolidation, and analysis – which made it possible to compare data across facilities and counties.

MEval-PIMA provides hands-on support for analysis and use of the dashboards, while facility-specific profiles provide evidence to focus activities from facility to county level (Figure 2 on page 4).

Dr. Ruth Jahonga from USAID/ APHIAPLUS KAMILI, a USAID-funded project that supports scale-up in health facilities of the former Central and Eastern provinces of Kenya, explained the importance of EmONC.

Figure 1: Changes in data quality between phase 1 and phase 2 for which MEval-PIMA provided support

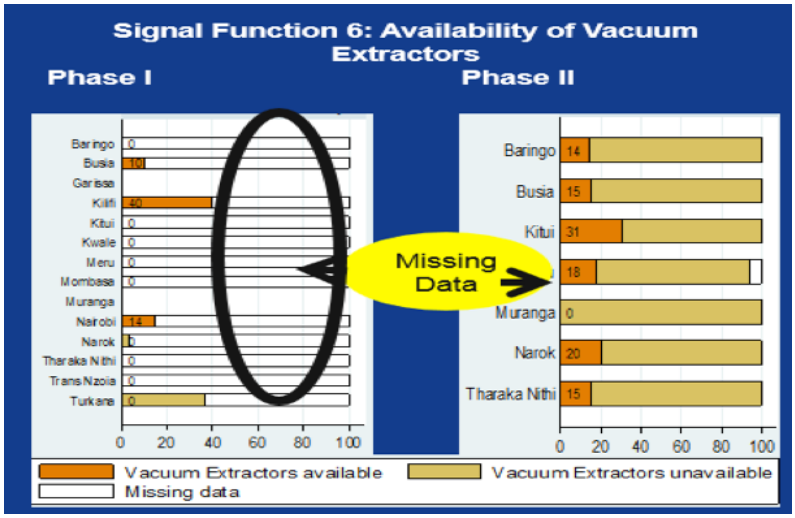
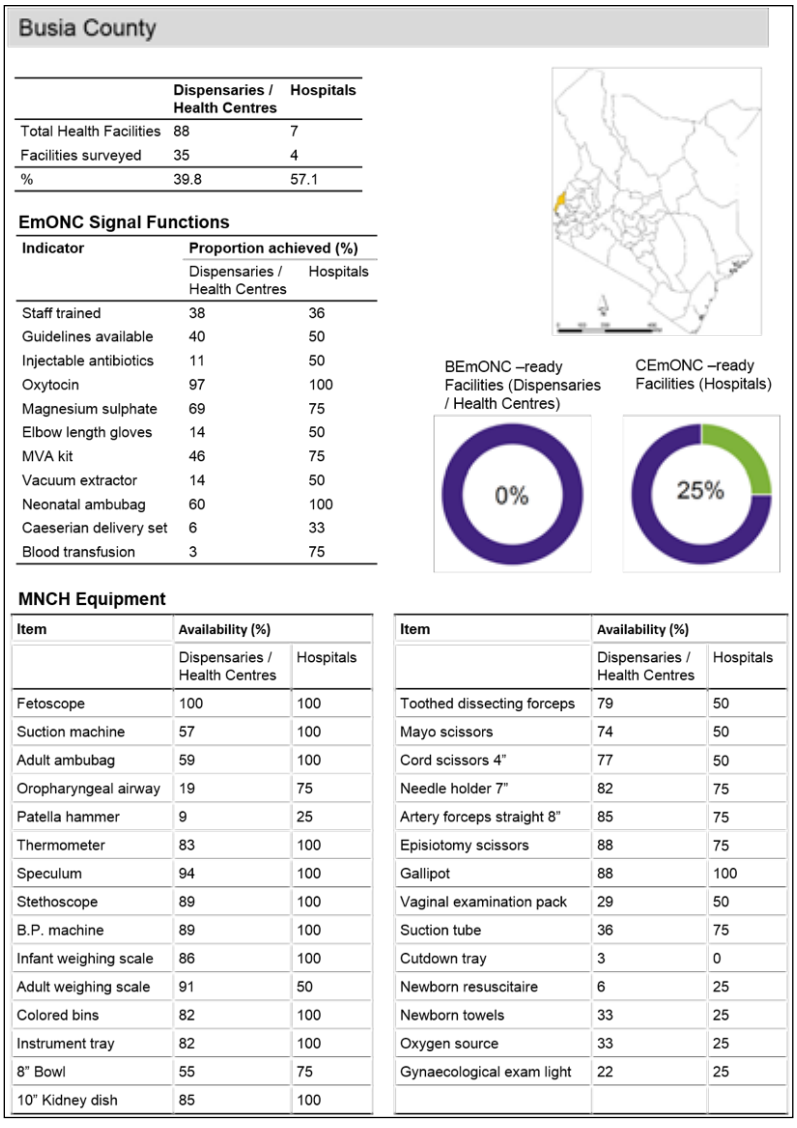


Figure 2: A sample county EmONC 2014 profile



Busia County

	Dispensaries / Health Centres	Hospitals
Total Health Facilities	88	7
Facilities surveyed	35	4
%	39.8	57.1

EmONC Signal Functions

Indicator	Proportion achieved (%)	
	Dispensaries / Health Centres	Hospitals
Staff trained	38	36
Guidelines available	40	50
Injectable antibiotics	11	50
Oxytocin	97	100
Magnesium sulphate	69	75
Elbow length gloves	14	50
MVA kit	46	75
Vacuum extractor	14	50
Neonatal ambubag	60	100
Caeserian delivery set	6	33
Blood transfusion	3	75

BEmONC –ready Facilities (Dispensaries / Health Centres)

0%

CEmONC –ready Facilities (Hospitals)

25%

MNCH Equipment

Item	Availability (%)	
	Dispensaries / Health Centres	Hospitals
Fetoscope	100	100
Suction machine	57	100
Adult ambubag	59	100
Oropharyngeal airway	19	75
Patella hammer	9	25
Thermometer	83	100
Speculum	94	100
Stethoscope	89	100
B.P. machine	89	100
Infant weighing scale	86	100
Adult weighing scale	91	50
Colored bins	82	100
Instrument tray	82	100
8" Bowl	55	75
10" Kidney dish	85	100

Item	Availability (%)	
	Dispensaries / Health Centres	Hospitals
Toothed dissecting forceps	79	50
Mayo scissors	74	50
Cord scissors 4"	77	50
Needle holder 7"	82	75
Artery forceps straight 8"	85	75
Episiotomy scissors	88	75
Gallipot	88	100
Vaginal examination pack	29	50
Suction tube	36	75
Cutdown tray	3	0
Newborn resuscitaire	6	25
Newborn towels	33	25
Oxygen source	33	25
Gynaecological exam light	22	25

"It is a strong advocacy package that can influence decision making and resource mobilization. For example, using the package, we tracked some facilities that were supplied with vacuum-assisted delivery equipment that they weren't using. We learnt that staff lacked confidence in using the equipment. To build that confidence, it was recommended to have staff visit and work alongside a mentor in a facility that was using the package. Without the tool we wouldn't have identified this gap."

The new tool has also led to increased county ownership of the findings, as demonstrated by CHMTs' active involvement in data management and data use for action planning. This level of ownership has been realized by critically involving the CHMTs throughout the process in the spirit of true partnership.

References

1. Kenya National Bureau of Statistics and ICF Macro. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro, 2010.
2. Ministry of Health. *Health Sector Strategic Plan. Transforming Health: Accelerating attainment of Universal Health Coverage: The Kenya Health Sector Strategic Plan, July 2013 – June 2017*. Nairobi: Ministry of Health, 2013.
3. Ministry of Health. *Access to Essential Medicines in Kenya: A Health Facility Survey*. Nairobi: Ministry of Health, 2009.
4. Ministry of Health. *Kenya Service Availability and Readiness Assessment Mapping, 2013*. Nairobi: Ministry of Health, 2014.

Useful resources

Ministry of Health. *National Reproductive Health Strategy 2009 – 2015*. Nairobi: Ministry of Health, 2009.

World Health Organization, UNFPA, UNICEF and Mailman School of Public Health. *Averting Maternal Death and Disability: Monitoring emergency obstetric care; a Handbook*. Geneva: World Health Organization, 2009.

Making a Difference in Malaria Control through Surveillance

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

Faith Anne Akinyi watches over her daughter, Gill Adhiambo (19 months old), who is receiving treatment for malaria at Kombewa County Hospital. Gill is one the many children who benefit from facilities having trained health workers.

In Kenya, both the national malaria strategy and the government's *Kenya Vision 2030: First Medium-Term Plan* highlight the need to combat malaria, in part through stronger surveillance of the disease and monitoring and evaluation (M&E) systems to track key indicators of disease prevalence.

In support of the government's efforts, MEASURE Evaluation-PIMA (MEval-PIMA), funded by USAID/PMI, developed a comprehensive malaria surveillance training package and a roll-out plan for malaria surveillance in the country. To date, MEval-PIMA has supported 40 Training-of-Trainers (ToTs) and the training of 649 health workers in four malaria-endemic counties (Migori, Homabay, Kisumu, and Kakamega) since March 2015.

Timely recording, analysis, interpretation and sharing of data, as well as the testing, treatment, and tracking of malaria, are among the skills that participants learn during the training sessions.

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

Mr. Moses Otieno, a participant in MEval-PIMA's malaria surveillance training, refers to his records from the malaria register, which is completed every month and submitted to the Health Records Officer, who subsequently submits the information to the web-based District Health Information System.

"The training was quite relevant," says Mr. Collins Oluoch, a pharmacist from Kombewa County Hospital in Seme Sub-County, Kisumu, who participated in one of the sessions. "I also learnt how to analyze data and interpret the trends. This is very helpful in detecting whether malaria is endemic in an area.

This being the rainy season, we expect to receive more patients, especially in the evenings. We usually have 10 to 20 patients diagnosed with malaria hospitalized daily between April and June," adds Mr. Oluoch.

Those numbers are down from five years ago. To illustrate the trend, Mr. Moses Otieno, a lab technologist and also a beneficiary of the training, showed his records that demonstrate the reduction of numbers.

"In July 2010 we had about 2,200 positive malaria tests, with 718 being children under the age of five. One year later, we had 1,700 positive malaria tests, with 301 being children under five. Today, we have 758 positive malaria tests," says Mr. Otieno.

The Ministry of Health corroborates the reduction of malaria cases. During national World Malaria Day celebrations, Mr. James Macharia, Kenya's Cabinet Secretary for Health, reported "Kenya is seeing the fruits of our efforts in malaria control."

"It is hoped this kind of investment in malaria surveillance training of health workers, together with other key interventions – including public education on the uptake of interventions, distribution of nets, procurement of commodities, and diagnostic kits – will help Kenya meet its vision of having a malaria-free generation," says Mr. Edward Kunyanga, Project Director for MEval-PIMA.

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

Children being tested for Malaria at Kombewa County Hospital, Kisumu, Kenya

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

MEval-PIMA's malaria surveillance training "really emphasized the need to follow the guidelines," says Mr. Collins Oluoch. "Whereas before we would give Artemisinin Combination Therapy to everybody, now we only give it to people who have been confirmed positive through testing."

More information

MEval-PIMA is a five-year project to support the Government of Kenya to build sustainable M&E capacity to use evidence-based decisions to improve the effectiveness of the Kenyan health system. For more on MEval-PIMA support to the national malaria control program in Kenya, visit: http://www.cpc.unc.edu/measure/pima/malaria.

Resources of Referral Strategy and Guidelines

Geoffrey Lairumbi, Dr. Abdinasir Amin, Edward Kunyanga from MEASURE Evaluation PIMA with Prof. Fred H.K. Segor (the then Permanent Secretary, Ministry of Health), Dr. Custodia Mandhlate (WHO Kenya Country Representative) and Dr. John Odondi (the then Head of Directorate of Clinical Services, Ministry of Health) at the launch of the Referral Strategy documents.

MEASURE Evaluation PIMA (MEval-PIMA), in collaboration with the Kenya Ministry of Health (MOH), USAID and World Health Organization, launched the Kenya Health Sector Referral Strategy and the Referral Implementation Guidelines.

The documents serve as a foundation for the country's health system and are intended to yield continuity in health care provision and to forge stronger links between various levels of care, including hospitals. The strategy provides a framework that guides functional referral system building. The implementation guidelines inform health workers of their roles and responsibilities in the referral system.

"We are working with the MOH and other key stakeholders to create a harmonized system," said MEval-PIMA's Project Director, Edward Kunyanga.

MEval-PIMA will support the Ministry of Health's efforts to strengthen the referral system by identifying and using quality data for everyday decision making. These efforts should result in a well-functioning referral system that provides patients with improved health care, thereby increasing access and equity, and ultimately improving health outcomes in the country.

Find more information on http://www.cpc.unc.edu/measure/pima/referral-systems

Interrogation of Data influences Free Birth Registration in Garissa County

Birth registration is essential for public health as it allows authorities to estimate the size and scope of epidemics. Governments rely on a robust civil registration system to know where to distribute resources that will most effectively overcome disease and provide health services to those who need them most. According to the World Health Organization, a country should have registration of births and deaths coverage above 80% for its data to be considered complete and reliable.

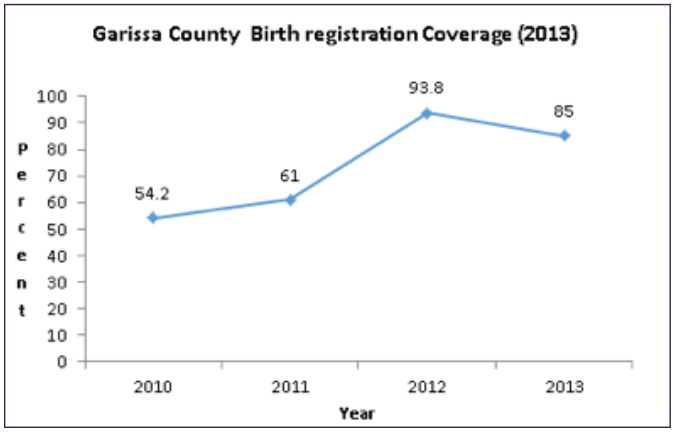
In Kenya, where the USAID-funded MEASURE Evaluation PIMA (MEval-PIMA) project works closely with the national government's Civil Registration Services (CRS) agency to compile annual vital statistics reports, the coverage rate is 58% for births – putting it well below the international standard. This low coverage hampers population forecasting, which impacts planning for investments in health, geographic coverage, and other programs.

In 2014, while developing the country's annual report for the preceding year, a team from CRS, the Ministry of Health (MOH), the Kenya National Bureau of Statistics, Catholic Relief Services, Pathfinder International, the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF) and the Office of the Garissa County Commissioner, detected unusually high birth registration in the county and inconsistencies in birth registration coverage i.e. the birth registration coverage rate in 2012 was 94% compared to the previous two years when it was 61% and 54% (Figure 1). These discrepancies resulted in a decision to explore the past data records to identify the causes of the anomalies.

MEval-PIMA convened partners to analyze the data. During the data review meeting, two main data issues were detected: It was noted that the rate of registration was unusually high, and the high registration rates were due to inclusion of the refugee population into the total births registered; however after data cleaning and analysis, the births registered from the Kenyan citizens was 29.7. This is a low registration compared to the national birth registration of 58.4%.

According to Dr. Eric Ochieng, the Medical Health Officer of Fafi Sub-county, the cost of registration and the long distances to the Civil Registration Office (CRO) contributed to low birth registration.

Figure 1: Garissa County Birth registration Coverage (2013)



"It takes about a day to travel from a health facility to the CRO. It takes time to process the certificate and often one is required to seek accommodation for the night. This is expensive to the community and deters them from seeking a birth registration," said Dr. Ochieng.

To address the challenge of data quality and the high cost of birth registration, including travelling long distances to register births, collaborative action planning meetings were held with various stakeholders, led by the County Health Management Team and CRS. A key recommendation from the team was to report birth registration for refugees and the local Kenyan population separately. MEval-PIMA was assigned to support two sub-counties (Fafi and Garissa) with the objectives of: 1) training local register agents and placing them within local health institutions, 2) providing data collection tools, and 3) engaging facility health officers to register births through Maternal Child Health (MCH) strategy initiative.

The determination to have an impact led to an agreement with Garissa Hospital to provide free birth certificates to all families who use their services.

"The issuing of free birth certificates at the facility meant that the community wouldn't have to travel long distances to get both registration certificates. This led to a notable increase in the number of birth registrations. Between June 2014 and January 2015 we had 172 registered births, a number that was difficult to achieve before the training," explained Dr. Ochieng.

Additionally, the Health Records Information Officer received free access to the hospital's administrative resources to process birth certificates. The new free birth registration service will also be promoted via local radio stations and in public markets.

By bringing together agencies that often work to interrogate data, identify gaps and craft innovative solutions based on the local context, MEval-PIMA was able to help address the fundamental barriers to birth registration.

Promoting Data Use to Manage a Transitioning Health Sector in Kenya

Constitutionally, national and county governments in Kenya are responsible for providing quality, affordable health care for all, and must do so in a responsive, transparent manner. Following the devolution of governance, county health departments have recently assumed more visible roles in health service provision at a time of complex administrative transition, compounded by resource constraints, and high citizen expectations.

Barbara Hughes - "It was refreshing to see participants attending a skills building session on data as early as 7:00 in the morning," says Barbara Hughes, Director of the Office of Population and Health at USAID.

Early this year, the Ministry of Health (MOH), working with county departments of health and development partners, convened the country's first National Health and Leadership Congress under the theme of "Transforming Healthcare in a Devolved System through Effective Leadership, Management and Governance." The meeting aimed to review progress, to identify best practices and implementation constraints, and to agree on steps to address constraints in health service delivery at national and county levels.

MEASURE Evaluation PIMA (MEval-PIMA), a project funded by USAID to strengthen monitoring and evaluation (M&E) capacities in the health sector, provided extensive support to the establishment of the conference agenda. This included emphasizing the primacy of data as a critical ingredient to support result-driven health sector reforms, the importance of conducting effective performance reviews, and the need to make critical policy choices to address emerging health challenges.

MEval-PIMA also supported the preparation of technical presentations in plenary and parallel sessions, and held a skills building session covering data use.

Reflecting on the congress, Edward Kunyanga, MEval-PIMA's Project Director, offered that the congress played an important role in highlighting the important linkages between financial and political accountability, strategic decision making and data use.

"Accountability requires data. With devolution of health services, the need for the use of data to make judgement calls on how much money is required at the county level is all the more critical," said Mr. Kunyanga.

"Transforming healthcare in a devolved system will work if everyone feels accountable. Accountability should not be limited to the government. The private sector, non-governmental organizations and the community also need to be responsible with the resources allocated. Accountability is mutual," he added.

At the end of the five-day deliberations on a wide range of issues and perspectives, a consensus was generated that included:

- The congress was concerned that only 20 of 47 counties were able to provide complete data for consolidation and review. Consequently, the meeting emphasized the need to invest comprehensively to strengthen the culture of evidence-based planning and decision making at all levels of the health system.
- Weak performance reviews in the counties were preceded by the non-existence, or poor quality, of annual health work planning processes. The lack of data-driven work planning with poor quality data has the potential to weaken the health sector's reform momentum, to result in the duplication of resources and effort, to misdirect funding to non-core areas, and to lead to overall sectoral under-performance. It also leads to weak implementation, leadership, and governance systems affecting national and global targets, such as improved maternal and child programs and meeting demand for family planning services.
- Inadequate resources allocated to health generally, and specifically to M&E, means that this function is left to unpredictable donor funding.

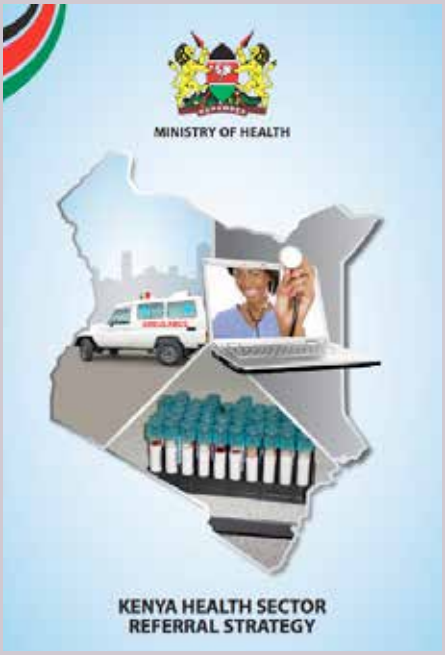
In light of these and other issues shared at the congress, MEval-PIMA supported the development of a congress communiqué highlighting the joint commitment by all actors to address the following M&E-related challenges:

- Provide stewardship in sector planning and strengthening of data management and M&E;
- Disseminate the M&E framework at county and national levels;
- Develop clear sector guidelines for M&E institutionalization;
- Assist counties to set up M&E units;
- Develop and generate a consensus on a sector-wide health research agenda;
- Facilitate annual sector review stakeholder meetings;
- Provide a framework for translation of research findings into policy;
- Develop and implement a health information policy;
- Allocate funds for health information systems (HIS); and
- Integrate program information systems (e.g. malaria, HIV, TB) into a centralized HIS.

These commitments were adopted by the health sector stakeholders. MEval-PIMA later supported the MOH M&E Unit to consolidate and translate the commitments into actionable activities that are now being tracked by the inter-governmental forum on health services.

Profile Story on Referral Systems - Interview with Dr Caroline Gitonga

What is a referral system? A referral system is a mechanism that enables a patient's health needs to be comprehensively managed using resources beyond those available at the location where they access care, be it in a community unit, a dispensary, a health center, or a higher level health facility.



What is the importance of a referral system? The key importance of a referral system is that it ensures that all citizens have access to the highest possible standard of health, irrespective of where they access care in the health system. A well-functioning referral system promotes linkages across the different levels of care in the public and private sector, therefore ensuring that there is continuity of care for each client.

What is the structure of the referral system in Kenya? The referral system in Kenya links six different levels of care.

What are the six levels of care in the Kenyan health system? The first level comprises community health services, which lie at the foundation of the health service delivery system. The second level provides primary care services and forms the interface between the community and the rest of the health system. The third level provides primary care services but with additional services, such as basic inpatient services, including deliveries, and includes other facilities, such as nursing homes and maternity centers. The fourth level forms the first level of hospitals and provides both inpatient and outpatient services. The fifth level offers a broad spectrum of specialized curative services, and together with level four, forms the county referral hospitals. The final level comprises tertiary level hospitals whose services are highly specialized.

What is the Kenya National Referral Health Strategy? This is the official document that will guide the strengthening process and the implementation of the referral system across all levels of care in Kenya. The document is guided by the Millennium Development Goals and the Kenya Health Policy (2012 – 2030).

What is the scope of the Referral Strategy in Kenya? The Referral Strategy deals with the management of four key movements. The first is the client movement, which is the key importance of a referral system in that it ensures that all citizens have access to the highest possible standard of health, irrespective of where they access care in the health system. It is the movement of the actual patient who is seeking an appropriate level of care in which his or her health needs are best addressed. The second is the expertise movement, which involves the system of rotation and facilitation of health care providers so that they are able to reach patients in need of care, and especially in instances where it may be more efficient and cost-effective. The third is the specimen movement, which involves the movement of a sample, such as urine or blood, usually for investigative purposes. The fourth movement is the client parameters movement, which is an indirect referral involving the movement of the patient's information for supportive diagnosis to higher levels of the system. The development in the information technology sector directly facilitates the latter form of referral.

What are the advantages of an effective referral system? By creating a comprehensive, harmonized, effective referral system, the government can ensure that care is provided at the minimum possible cost, whilst promoting universal coverage for all citizens, safeguarding continuity of care across different levels of care, and ensuring efficient collaboration and coordination amongst health facilities at both the national and county levels.

What are the Health Sector Referral Guidelines? The referral guidelines are formal advisory statements to guide health workers on the management of referral processes, including referral communication, documentation, and coordination. The referral guidelines also outline the roles and responsibilities of the various stakeholders in the referral system.

Why are the Health Sector Referral Guidelines important? Previously, the lack of a formal guiding document on how referral should be conducted had created a number of challenges for the health care structure in Kenya. These systematic challenges included inappropriate referral practices, poor communication of referrals, and poor relationships among providers, among other challenges that caused delays in the delivery of quality health care to patients.

Who is responsible for making the referral system a success?

All key stakeholders in the health industry have to play their parts in order to establish a well-functioning referral system. These stakeholders include the Ministry of Health at both the national and county levels, both private and public health facilities across the various levels, health providers, and patients.

Dr Caroline Gitonga is Technical Specialist Referral Systems at MEASURE Evaluation PIMA.

Ending Child Marriage: Using data to protect the young

Efforts to end child marriage in Africa are the focus of this year's observance of the Day of the African Child, on June 16. In Kenya, despite legislation prohibiting marriage before the age of 18, the practice under "customary" law – marriages according to customs of communities of one or both parties – and Islamic law sets no minimum age. Many young girls, especially in rural areas, are given in marriage by their parents in exchange for livestock or goods or because they are seen as an economic burden. A recent study showed 43% of girls were married before age 18 and just under 12% of boys.[1]

Photo by Jack Hazerjian, MEASURE Evaluation

As the Government of Kenya seeks to combat these early marriages, it needs reliable data to inform policies and pinpoint districts where more resources are needed for programs to safeguard children from early marriage – programs such as improved access to education, health information, and child protection services.

MEASURE Evaluation PIMA (MEval-PIMA) is currently working to address this data challenge in the Kenyan child rights and welfare sector, working with the country's Department of Children Services (DCS). Kenya's child protection system promotes the well-being of children through the prevention of violence, abuse, exploitation, and neglect, and by ensuring prompt and coordinated action in response to such events. Data necessary for the Child Protection Information Management System (CPIMS) helps guide national-level allocation of resources, as well as the planning and targeting of education and health interventions, among others.

But challenges remain, including:

- A non-functioning digital database;
- Absence of a system that integrates all child protection activities;
- Inferior data quality, data processing, and analysis for decision making;
- Limited national coverage to enable access for all stakeholders.

MEval-PIMA is focusing on the CPIMS, seeking to improve its functionality while building the capacity of stakeholders to use the system to monitor their programs and evaluate their resulting data for improved programmatic and policy decisions. The project intends to roll out the CPIMS system to 10 counties, which requires systems and stakeholder assessments, system upgrades, user training, and strengthening of stakeholder coordination forums to share data and build on best practices and practical experience.

Instituting a comprehensive, functional child protection system in Kenya that captures child marriage data and, especially, identifies geographic hotspots where it is occurring, will provide accurate, valid information for meaningful action.

The Day of the African Child commemorates protests made by thousands of black South African school children on the streets of Soweto nearly 40 years ago. Kenya is honoring those children this year in its efforts to establish a coordinated data system to help reduce the incidence of child marriage in Kenya and ultimately protect its children, especially its young girls.

Kenya's child protection system promotes the well-being of children through the prevention of violence, abuse, exploitation, and neglect, and by ensuring prompt and coordinated action in response to such events.

For more information visit http://www.cpc.unc.edu/measure/pima/child-health-and-safety.

References

1. Plan International. *Because I am a Girl – Kenya country report 2012: Study of the factors influencing girls' access, retention and completion of primary and secondary school education.* Nairobi, Kenya: Plan International, 2012.

Developing a Child Protection Information Management System in Kenya

National governments are legally obliged to ensure children's rights – including the right to health, education, family life, play and recreation, an adequate standard of living, and protection from abuse and harm – through enactment of relevant laws and provision of services. In Kenya, the Department of Children Services (DCS) is charged with these tasks.

The successful implementation of child protection and social welfare services is dependent upon the availability and use of relevant data. This data should provide information on the magnitude of, and any trends evident in, child protection issues, as well as the impact of programs and interventions. Currently, however, Kenya does not have a functional national child protection information management system (CPIMS) capable of providing accurate and timely information on key child welfare concerns.

This deficit seriously hampers the work of the various actors in the sector. An inadequate CPIMS impedes measurement of any progress in child rights and welfare, providing minimal evidence to inform and guide the allocation of resources. For example, every year, the Kenya National Bureau of Statistics publishes its Economic Survey report, presenting the country's socio-economic highlights in the previous five years. It also provides important information for planning and budgeting, monitoring, and policy formulation processes in the country. However, for the last three years, data on child protection has been omitted from the report due to lack of reliable data. This has significant repercussions for child protection programming in Kenya.

Since 2007, the DCS, in collaboration with its key stakeholders, has attempted to develop a functional CPIMS. Currently MEASURE Evaluation PIMA (MEval-PIMA) is working with the

A participant at the National Stakeholders Forum held in Nakuru in April 2015

It is hoped that the development of the CPIMS will result in the generation of data that can contribute to the improved availability and use of quality child protection information at national and sub-national levels

DCS to support the development of a robust CPIMS. This work is intended to provide the country with a national child protection database that not only meets stakeholders' user needs for case management and reporting, but also generates timely and accurate data for evidence-based programing and decision making in the children's sector.

The main objectives of the phase 2 development are to: ensure the capacity of the CPIMS to capture diverse information needs and provide comprehensive data on the child protection system; enhance data collection, quality and security; and increase the number of counties utilizing the CPIMS for the collection and reporting of child protection activities and data on orphans and vulnerable children.

In the last seven months, the CPIMS Technical Working Group – that includes relevant line ministries, departments and agencies, UNICEF, Goal Kenya, Plan International, Save the Children, Cooperazione e Sviluppo Onlus, Comitato Europeo per la Formazione e Agricoltura, and MEval-PIMA, among others – have defined the development roadmap in a consolidated, costed work plan. Among the planned activities are a CPIMS stakeholder mapping exercise, an analysis of CPIMS users' needs, a review of the DCS's business processes, and various capacity assessments, including ICT and M&E strengthening, and system upgrades, among others.

Preliminary findings from those planned and already completed activities include the need to: a) strengthen the CPIMS data flow and reporting structures in the DCS; b) strengthen the paper-based reporting system; c) develop a hybrid system for case management and data aggregation; d) address internet connectivity challenges; e) simplify the amount of data to be captured; and f) develop a sustainability plan for the work that includes building the capacity of staff, involving the ICT unit of the lead ministry in the design and rollout of the system, providing technical and financial support for operations and maintenance, improving system utility, and involving more stakeholders, such as county governments.

It is hoped that the development of the CPIMS will result in the generation of data that can contribute to the improved availability and use of quality child protection information at national and sub-national levels. Most importantly, it will help build sustainable monitoring and evaluation capacity for Kenyan Child Officers using evidence-based decision making to improve the effectiveness of the country's children's sector.

References

1. African Committee of Experts on the Rights and Welfare of the Child. The African Charter on the Rights and Welfare of the Child, 2015. OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999.

Strengthening Malaria Control Efforts through Surveillance Training in Kenya

More than 570 health workers from four Kenyan counties are now trained in the malaria surveillance system, thanks to a model "Training of Trainers" (TOT) and subsequent workshops, conducted with support from MEASURE Evaluation PIMA (MEval-PIMA), and funded by USAID.

The April workshops are part of an effort to improve malaria surveillance systems in the country – a need identified by the National Malaria Control Program (NMCP). Those trained are health workers from high-prevalence malaria endemic areas in western Kenya (Migori, Homa Bay, Kisumu, and Kakamega counties).

The training included fundamental concepts and practical approaches used in malaria surveillance, based on the World Health Organization guidelines adopted for Kenya. Participants learned an overview of disease surveillance; case identification, confirmation, and reporting; surveillance data management; core surveillance data graphs; and entomological surveillance.

Below in pictures are some of the highlights of the training and comments from participants in attendance. (All photos by MEval-PIMA).

Participants taking a pretest during the malaria surveillance training. Training of health staff in malaria surveillance usually includes a pre- and post-test exercise. Results of the testing are presented to participants at the end of the training.

Lillian Dayo, Kisumu County Malaria Coordinator, prepares to perform a malaria rapid diagnostic test (RDT) on Paul Ogutu, Disease Surveillance Coordinator from Chulaimbo, during a MEval-PIMA-supported malaria surveillance training.

In order to ensure the implementation of the diagnosis-based treatment policy, the Ministry of Health, with the support of development partners, procured and distributed 14.7 million diagnostic test kits to peripheral health facilities. More than 1,500 laboratory staff were trained on malaria laboratory diagnostics and quality assurance. This has increased access to diagnostic services, and all those presenting with symptoms are tested. Positive cases are provided with effective medicines.

Rose Kombewa, Deputy Hospital Matron, Kombewa District Hospital, Seme

"The training was important because reporting has been an issue. Not many people know the correct tools to use," Ms. Kombewa says. "A number of people have also been diagnosing malaria clinically, but we have learnt the best way for diagnosis is to test and confirm before treating. From this training, I will share with my colleagues the importance of not only having complete data but also submitting the data at the correct time. I have learnt that this is important for informing the right response or intervention at the right time."

Marolyne Adhiambo, Asat Beach Dispensary, Seme Sub County – Kisumu

"The training was very enlightening," Ms. Adhiambo said. "I learnt how to take responsibility in the use of data. All data needs to be timely and complete. I also learnt that it is best to treat malaria only if it is a confirmed case. Not all cases of fever are malaria. This training will help me monitor the trend in my work station and I will be talking to pregnant mothers to educate them on the appropriate use of Long Lasting Insecticide Treated Nets (LLITN's) for prevention of malaria infection."

Edith Nyosio, Nurse, Oseure Dispensary

"From the training, I learnt how to observe standards of practice and how to compile and complete my reports in time," Ms. Nyosio says. "The most interesting thing about the training for me was how to use graphs to analyze and present data. By analyzing my data and presenting it, I can interpret the trends and know whether I am getting more or fewer cases of malaria. This will enable me to put more effort in applying appropriate and effective interventions, for example, sensitizing the community on the use of Long Lasting Insecticide Treated Nets (LLITN's)."

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