



Partnership for Prevention and Treatment of Malaria (PPTM)

Malaria Communities Project
North Rift Valley - Kenya
Cooperative Agreement #GHN-A-00-09-00008-00
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Main Accomplishments:

During this first year implementing the Partnership for the Prevention and Treatment of Malaria (PPTM), HealthRight and project partners have made good progress on all of the activities as described in the approved annual work plan. While addressing the leading cause of morbidity among children under 5, the PPTM project activities have been well integrated into other HealthRight initiatives in the North Rift Valley, particularly the maternal and neonatal health project, making health programming in the districts more comprehensive, sustainable and effective. The accomplishments for 2010 are outlined below by objective.

After approval of the project proposal, HealthRight drafted a project work plan and then used the draft to bring together national and local stakeholders for input and revisions. The organizations and partners that were involved in that process include the Division of Malaria Control (DOMC), the five District Health Management Teams (DHMT), the Provincial Medical Office (PMO), JHPIEGO, Population Services International (PSI), USAID, and most of the 21 health facility management committees (HMFC). The meetings resulted in the submission of a revised work plan to the MCP office in May 2010. Although already approved, these revisions are discussed briefly in the **Program Changes/Adjustments** section below.

1. Objective 1: To build the capacity of communities, local organizations and CHV¹s to promote sustainable prevention and care-seeking behavior.

Working with Community-Based Organizations

In this first year, HealthRight worked with the District Administrative Offices and the DHMTs to identify local community-based organizations as potential partners to the PPTM project. The team used several criteria in the vetting process, ensuring that all project partners:

1. Must be registered with the social services.
2. Must be implementing health related activities.
3. Must be currently active.
4. Must be operating within the target sites for the MCP project.
5. Must demonstrate a capacity to sustain their work without funding from HealthRight.
6. Must have a bank account that is active.

Most of the active community-based organizations in the five districts have been implementing HIV projects with funding from the Constituency AIDS Coordinating Committees (CACC) which is a mechanism of channeling national HIV prevention money to local partners. Working as a partner to the PPTM project will allow these organizations to expand their health focus and integrate malaria into the HIV messaging. For the next two years, HealthRight will work with the following organizations to provide logistical resources, financial support and capacity building opportunities.

Table 1: Partner Community Based Organizations by District

District	Organization
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¹ Community health workers are now being called community health volunteers in Kenya. This is a change in title (but not in role) since the beginning of the PPTM project. For the purposes of this report, CHW and CHV are considered interchangeable.

West Pokot	Yangat
	Sikom
North Pokot	Nalemit
	Muslim Youth Development
Central Pokot	Yes Plus
	Kalas
Marakwet	Tumaini Support Group
	Sabon
Trans Nzoia	Community Action Network of Africa (CANAA)
	Jambo Women Group

During the past three months, HealthRight has been providing sensitization training about malaria to the community partners for integration into their existing messaging. All partners have been provided with training on malaria prevention and treatment basics.

In the next quarter, HealthRight will begin providing organizational trainings based on the priority needs for each organization. Priority needs will be determined through an organizational needs assessment. The first trainings will be obligatory financial management and budgeting training, prior to the disbursement of small sub-grants for social behavior change campaigns. Also, beginning next quarter, HealthRight will be providing Social Behavior Change training to partner CBOs to improve their capacity to implement more effective behavior change campaigns. The details of this activity are described in more detail under **Social Behavior Change Campaigning** below.

Working with Community Strategy Units:

The Kenya Ministry of Health has been slowly implementing the National Community Strategy to deliver health care services at the household level by working with communities to identify and train Community Health Volunteers (CHV) and Community Health Committees (CHC). HealthRight and USAID have been instrumental partners in establishing new community strategy units and supporting existing units in the North Rift region. The PPTM project will continue that positive trend by supporting 21 community units (1050 CHVs and 21 CHCs) with training about malaria and social behavior change methodologies, provision of job aids and meeting supplies, provision of non-financial incentives such as annual recognition awards and badges, compilation and reporting of community data, and transport assistance.

So far in the first year, HealthRight has collaborated with the DHMTs to identify all of the 21 target community strategy units. The PPTM project has been supporting the leader of each community unit, the community health extension worker (CHEW), to organize their CHV and CHC monthly coordination meetings, providing meeting supplies and refreshments, organizing pertinent informal trainings and photocopying the required data collection forms. The PPTM training support has been tailored in each district to meet the most important needs of the DHMT and community units. For example, in Trans Nzoia East, the DHMT identified four existing units which have already received basic CHV training to work on the PPTM project. The DHMT then requested that HealthRight also support them to organize the training and orientation needed to establish one new unit in their district.

Also in Year 1, HealthRight has been supporting the DHMTs to initiate the use of CHV referral forms. The referral forms had been drafted at the national level but had not yet been implemented in most of the PPTM project districts. CHVs in over half of the 21 partner community strategy units have been trained on the use of the referral forms including opportunities to practice their skills in their work. In addition, DHMTs lack the financial resources to print the CHV referral books which are carbon copied booklets; therefore, HealthRight has been providing photocopy versions of the forms during the monthly CHV coordination meetings to facilitate data collection. Finally, in the Pokot Districts where literacy rates among the CHVs is very low, HealthRight has been adapting the national CHV forms to include pictures of each required indicator. This low-literacy adaptation is on-going in the Pokot districts and, if successful, will be shared as a resource at the Provincial and National levels.

Marakwet District presents a particular challenge for the PPTM project because, prior to the start of the project, the district had not succeeded in establishing any functional community strategy units. This issue is described below in the **Constraints to Progress** section.

Social Behavior Change Campaigning:

The PPTM work plan for year one includes social behavior change training (SBC) for all community partners. HealthRight has been working with the Academy of Educational Development (AED) to provide a CCHANGE training using a curriculum adapted specifically for the project's context using existing baseline malaria data. The SBC trainings were to start at the end of Y1 and continue through Y2. However, the initial Master training for HealthRight Malaria Managers has been delayed due to some time constraints with AED. HealthRight anticipates that the training will be delivered to all participants in Y2 despite a few months of delay in their commencement. This partnership will provide the project staff with a good quality, well-tested SBC methodology and will result in cost savings in the training budget for the PPTM project.

In the first year, HealthRight Community Mobilizers have been organizing community education events to raise awareness throughout the five districts about the malaria prevention and treatment. The Mobilizers have been providing announcements, dramas and health discussions at community *barazas* which are meetings held by chiefs of each community each month. The team has also integrated malaria education into events organized by collaborating organizations such as mobile outreach clinics organized by health facilities to provide services in rural villages, and the Annual Tegla Loroupe Peace Race in Kapenguria. In the past nine months, 58 malaria events have been held and messages shared with 14,389 people. As the project matures, HealthRight will transition away from these activities and will support CBOs, CHCs and CHVs to organize their own SBC campaigns, which will be more sustainable.

Support for Indoor Residual Spraying:

Several of the partner DHMTs receive support from the national level for Indoor Residual Spraying prior to the onset of the rainy season. HealthRight assists with these efforts through the provision of transport of the teams when possible.

2. Objective 2: To build the capacity of 21 target facilities and five District Health Management Teams (DHMTs) to deliver appropriate prevention, diagnosis, and treatment services.

Provider Behavior Change:

In the work plan, the PPTM envisioned providing formal Malaria Case Management training to 42 providers throughout the five targeted districts. However, because JHPIEGO supported the Provincial DOMC malaria trainers to provide this training to health facility staff in several North Rift districts early in 2010, HealthRight worked with the trainers to identify the remaining gaps and support training for 42 health staff in the Pokot Districts instead. This was accomplished at the end of the first year.

To improve sustainability and effectiveness of training, HealthRight focuses efforts on continual mentoring in the 21 target facilities. Based in the District Hospitals where the need is greatest, the Malaria Managers work alongside facility staff several days each week to improve skills, answer questions and ensure that new policies are adhered to. Rural health centers and dispensaries are visited at least one day each month for these purposes. A total of 49 providers have received mentoring in the first year. The behavior change that the Malaria Managers promote is increased microscopy diagnosis, where possible, and appropriate treatment with ACT.

Annual Operations Planning:

In each of the five targeted districts, HealthRight works in partnership with the DHMTs on the planning, implementation and monitoring and evaluation of all projects. In an effort to increase the buy-in of the health staff and the sustainability of the project's impact, HealthRight sits as a partner in the operations planning process each year during with the HFMC or DHMT plan their activities, the required resources and budgetary needs. During the planning process, all HealthRight project activities and DHMT/HFMC responsibilities are added into the plan. This work plan provides an outline of the partnership for the next year and as projects are handed over, ensures that many of the activities continue. HealthRight also provides some financial support to the AOP meetings.

Health Systems Strengthening:

The PPTM project Malaria Managers serve an important role in each of their districts to help improve basic health systems including data management, drug supply chain and facilitative supervision.

In the first year, HealthRight has worked directly with the health information officers in each of the 21 partner facilities to monitor and verify data compilation to ensure accuracy and timeliness of reporting. In the last six months of year 1 during which data was being collected, 20 of the 21 health facilities were submitting their monthly data reports in a timely manner. In some cases, HealthRight assists in transporting the data to the district or provincial levels.

The Malaria Managers have also been involved in the monitoring of ACT supplies. They have built the capacity of the pharmacy staff to calculate consumption rates so that the facility can predict their needs more accurately for the next quarter, an activity which is essential with the new "pull" drug supply system that Kenya is attempting to implement. Also, when supplies or

medications are running low in one facility, because of the PPTM project monitoring, HealthRight is in a position to note these problems and to transport supplies from other sites where they are not needed as appropriate.

HealthRight assists the DHMT to conduct facilitative supervision to all of the facilities in their districts. DHMTs monitor the quality of services using MOH supervisory checklists. HealthRight serves as a member of the supervisory team and also assists with the planning and the transportation needs. Some partial financial support is also provided for this activity. By policy, facilitative supervision is supposed to happen every quarter; however, all facilities received at least one supervisory visit in Y1. HealthRight's logistical assistance overcomes one of the biggest barriers for health facilities and DHMTs to addressing all of these health systems problems.

3. *Objective 3: Strengthen systems to support long-lasting insecticide treated net (LLITN) distribution and use in the five districts to decrease malaria transmission, particularly for pregnant women and children under 5 years of age.*

HealthRight partnered with PSI to complete a distribution of 22,160 LLITNs in the three Pokot districts this year. PSI had completed distributions of the LLITNs in the two districts of Marakwet and Trans Nzoia East prior to the signing of the MOU. Distributions were slightly delayed while working through a memorandum of understanding with PSI which included the changes in distribution policies and in monitoring requirements. LLITN distributions are now scheduled to occur on a quarterly basis, driven by the distribution records at the health facilities. This change from an annual to a quarterly distribution schedule will decrease the risk of LLITN loss.

As an important part of the PSI partnership, the PPTM project has agreed to monitor the LLITN distribution and use at three levels: district hospital distribution to the rural health facilities; health facilities to the household level; ownership and use at the household level through the use of CHVs.

Several instances of discrepancies in LLITN distribution practices and records have been noted in the first year of implementation. For instance, in one hospital, staff were selling the PSI LLITNs to the target recipients rather than giving them for free. Other sites have withheld LLITNs from pregnant women until they have attended more than one ANC visit, in some cases waiting until the fourth visit, using the net as an incentive for good ANC attendance. There have also been a few cases of nets missing from stocks without appropriate documentation.

Next year, the PPTM project will be responsible for the distribution of approximately 88,640 LLITNs in the Pokot and Marakwet districts. HealthRight is working on agreement with PSI for the distributions in Trans Nzoia East, which had been done in 2010 prior to the signing of the MOU.

Table 2: Project Year 1 Accomplishments²

Project objectives	Indicators (current result)	Key Activities (from Y1 work plan)	Status of Activities (including outputs)	Comments
Build the capacity of community, local organizations and Community Health Workers to promote sustainable prevention and care seeking behavior.	Ten CBOs identified; 21 target community strategy units identified and formed	Community Mobilizers identify all active and willing local groups to partner on malaria activities (including CHCs)	Completed	MOUs to be signed in Y2; training for CBOs in Y2 work plan; subgrants provided in Y2
	100 CHVs trained 18 CHC members trained	HealthRight supports malaria training to all identified local partners and community health committees	Training for CHVs and CHCs commenced	Training to continue through year 2
	100 CHVs trained 18 CHC members trained 452 CHV referrals made	Training of CHVs to make appropriate and effective referrals for malaria treatment; the importance of early attendance at ANC and correct usage of ITNs	Training for CHVs and CHCs commenced;	Training to continue through year 2
		HealthRight to organize SBC training for all local partners including NGOs, CHCs and CHVs.	<i>Delayed</i>	Not done in year 1; master training scheduled in November 2010; All training completed in Y2
		HealthRight to work with the CHCs and all community partners on the development of the key malaria messages for community campaign	<i>Delayed</i>	Not done in year 1; awaiting SBC training
	800 CHVs monitoring LLITN ownership and usage during home	CHVs to monitor household net distribution and correct usage.	Good progress in Y1;	Marakwet CHVs identified but not yet monitoring LLITN usage

² Other routine monitoring data is provided in the ME section of this report.

	visits;			
Build the capacity of 21 target health facilities and five DHMTs in Marakwet, Trans Nzoia East, and North, Central and West Pokot districts to deliver appropriate prevention, diagnosis, and treatment services.	42 providers in Pokot Districts trained	Organize refresher malaria training for providers in ACT treatment at the targeted facilities	Formal malaria training completed	Providers in other districts already trained by DOMC
	5 malaria managers hired; 49 health facility staff received mentoring	Mentorship of trained health staff by HealthRight malaria managers	Ongoing; mentoring provided in all 21 facilities every month	
	5 malaria managers hired; 21 health staff trained on calculation of ACT consumption rates 2/21 facilities reporting ACT stock out in past 6 months	HealthRight Malaria Managers work with DHMT and health facilities to monitor malaria medications to ensure constant stock (ACT and SP)	Ongoing; ACT stocks monitored each month;	
	21 Health information officers mentored on calculating malaria thresholds	HealthRight Malaria Manager establishes malaria surveillance system in epidemic-prone areas	Ongoing	Began in Y1; Q4 in preparation for rainy season in Y2
		HealthRight Malaria Manager assists facilities with epidemic-preparedness planning	Ongoing	Began in Y1; Q4 in preparation for rainy season in Y2
Improve the system of mosquito net distribution in the five districts to decrease malaria transmission, particularly for pregnant women and	MOU signed with PSI in 2010	partner with PSI to ensure adequate supply of LLITNs for the five districts		
	22,160 LLITNs distributed in Y1; Q3	assist in transport and logistics of distribution of nets to local health facilities	Ongoing	Quarterly distributions to all 169 facilities in all five districts
	5 malaria managers reviewing LLITN	Monitor distribution of LLITNs to community	Started in Y1 Q3; Ongoing	Extensive monitoring and checking of distribution

children under 5 years of age.	distribution records each quarter	members, particularly pregnant women and children under 1 year of age, through community health volunteers and other outlets.		records being done as a part of the MOU with PSI
	800 CHVs collecting data during household visits about LLITN ownership and usage	work with CHVs to monitor appropriate use of LLITNs		

Constraints to Progress:

Slow MOH Rollout of the Community Strategy:

In Marakwet District, the MOH hasn't yet made any progress on the rollout of the national strategy and no community units have been established or trained. This presents a real challenge to the project. According to policy, each unit is to receive a two week CHV/CHC orientation that explains the roles and responsibilities of the positions as well as a brief overview of all health messages. The estimated cost to orient one new community unit is \$25,000. Given budgetary constraints, HealthRight has adapted the project activities in a number of ways in light of this constraint. In one location, HealthRight has partnered with the District Health Management Team to provide the 2-week orientation for 50 CHVs. HealthRight has worked with the community leaders in each of the five units to identify their prospective CHVs and CHC members. The HealthRight Project Director will work with the Marakwet DHMT to determine other resources that may be available for more complete training of these volunteers. Alternatively, the newly identified CHVs can start with the limited support that the project offers for monthly coordination meetings and informal capacity building, while awaiting additional funding to provide training in other more comprehensive health topics.

Staffing Levels and Staff Retention:

The North Rift Valley is a challenging place to live and work, suffering from insecurity, harsh climate, geographic isolation, and scant resources. These conditions make it difficult to hire and retain qualified health care workers. Staff turnover and low staffing levels are a threat to the sustainability of all programs in the region and will not be solved through this project. However, HealthRight has been working in these districts since 2005 to identify the best means of ensuring institutional memory remains despite frequent turnover of staff.

HealthRight's PPTM Project Director resigned suddenly in August 2010 for personal reasons. The organization was fortunate to have a veteran project director on staff who could fill the position quickly and easily in order to avoid any loss in project's momentum or progress. HealthRight received approval for this personnel change in September 2010.

Contradictory DMOC and RH Policies:

The specific policies that were discussed and found to be in conflict with the PPTM initial work plan are included here.

1. According to DOMC policy, Intermittent Preventive Treatment during pregnancy (IPTp) is not warranted during ANC in any of the HealthRight project locations. The DOMC recommends a confirmed lab diagnosis for malaria in any pregnant women presenting with symptoms before administering treatment. However, this policy is in contradiction to the Division of Reproductive Health which advocates for two doses of SP during pregnancy. The HealthRight Maternal and Neonatal Health project has been working for the past three years with the District Health Management Teams in the three Pokot Districts to implement this DRH policy and ensure that all pregnant women receive two doses of SP during each pregnancy.
2. Presumptive treatment for children <5 years of age is not warranted in the project districts. DOMC recommends confirmed diagnosis through microscopy for all patients presenting with symptoms regardless of age cohort. However, many of the project sites lack the microscopes necessary to confirm diagnosis.

SBC Training Delays:

As mentioned under Objective 2 above, the PPTM project is delayed by one quarter in the SBC training activities. This delay is due to the decision to partner with AED and the CCHANGE project to provide the Master Training to the Malaria Managers. This delay is not expected to result in a delay for the completion of the trainings however, which will be completed according to the work plan by the end of year 2.

Vehicle Procurement:

HealthRight has been in the process of procuring a vehicle for the PPTM project since the first quarter of implementation. That lengthy process has not yet been completed. In September, due to delays with the Kenya Revenue Authority, the vendor sold the vehicle to another customer, which will require HealthRight to start the process again from the beginning. Throughout year 1, HealthRight has been allocating vehicles from other projects to the PPTM to avoid unnecessary delays in project activities.

Program Changes/Adjustments:

The following changes to the to the PPTM work plan are required:

- Commencement of SBC training timeline pushed back by one quarter (see **Constraints to Progress**)
- Vehicle procurement pushed into year two (see **Constraints to Progress**)
- LLITN distributions being done on a quarterly basis rather than yearly (noted in previous quarterly report submissions and in work plan)

In addition, HealthRight had planned to work with one community strategy unit to pilot a Malaria Community Case Management project in one community. This plan was not accepted by the provincial and national levels of the MOH and was removed from the work plan in May 2010. If it is possible to reconsider implementing such a pilot project because of willingness on behalf of the MOH or a change in community strategy policy, the PPTM will do so.

HealthRight had planned to distribute 106,000 LLITNs annually through the PPTM. This number is likely to be reduced for several reasons. PSI has remained responsible for the distribution of LLITNs in Trans Nzoia East district. Also, quarterly distribution amounts are constantly revised based on the distribution records and needs at each health facility level. HealthRight predicts that the PPTM will be responsible for the distribution of 88,640 LLITNs in Y2.

Monitoring and Evaluation Activities:

Baseline Survey:

Although not a requirement of the MCP grant, HealthRight organized the collection of baseline malaria data using a household KPC survey in the 21 targeted units in which the CHVs will be active. This was done in order to measure progress at the end of the project period in these 21 communities. Using Lot Quality Assurance Sampling, 25 households were randomly selected from a list of all eligible households in the 21 units. HealthRight trained enumerators from among the 50 CHVs in those communities. The final survey tool was adapted from the USAID Rapid CATCH survey tool, focusing on the malaria indicators upon which the project will be

measured. The survey tool was translated into Kiswahili and Kipokot, and then back translated into English to ensure that the questions would be accurately communicated. Oversampling was done to ensure that an adequate number of responses were available in all of the communities and for all of the questions. HealthRight included questions on socioeconomic status as well, which were drawn from the Kenya Demographic and Health Survey, and which can be used to measure equity of the project’s impact across SES levels.

In general, the baseline survey showed that knowledge about malaria prevention is high in our 21 targeted communities with a total of 70% of respondents stating that use of a mosquito net can prevent malaria. However, 7% of respondents could not name any methods for preventing malaria.

Although 79% of the respondents knew that malaria was transmitted by mosquitoes, 23% felt that “being rained upon” was also a transmission method. A total of 52% and 67% of respondents in our 21 communities identified “fever” and “chills as symptoms of malaria. Only 2% of respondents stated that they did not know any symptoms of malaria while 22% thought that diarrhea was a symptom of malaria. LLITN ownership in the 21 target communities was shown to be 68%. LLITNs are most often slept under by children under 5 years at 75% followed by mothers at 63%.

The tables below provide data from some of the baseline indicators.

Table 3: Knowledge of Malaria transmission (multiple responses allowed)

Supervision Area	Transmission*					Total No. of respondents
	Mosquito Bite	Rained Upon	Eating maize /sugarcane/ mango	Other	Don't Know	
Amakuriat	92%	4%	4%		8%	25
Arror	60%	15%	10%	40%	5%	20
Chebiemit	86%	32%	5%	14%	5%	22
Chepareria	37%	52%	22%	7%	15%	27
Cherangani	68%	20%	8%	12%		25
Edebess	87%	26%		13%	4%	23
Kabichbich	96%	%			4%	23
Kacheliba	91%	32%	14%			22
Kacheliba M	96%	20%	8%	8%		25
Kacherop	52%	43%	26%	9%		23
Kapenguria	91%	17%	4%	4%	4%	23
Kapsara	100%	17%	9%			23
Kasowar	43%	24%	14%	29%	24%	21
Kolongolo	96%	19%				26
Konyao	100%	16%	8%			25

Lomut	100%	48%	22%			23
Ortum	87%	13%	9%			23
Serewo	67%	33%	11%			18
Sigor	100%	20%	16%			25
Suam	67%	24%	14%	14%	10%	21
Tot	38%	14%	33%	43%	5%	21
Total	384 (79%)	113 (23%)	54 (11%)	42 (9%)	19 (4%)	484

Table 4: Identification of Malaria Signs and Symptoms (multiple responses allowed)

Supervision Area	Signs and Symptoms									# of respondents
	Fever	Chills	Headache	Muscle ache	Tiredness	Nausea / Vomiting	Diarrhea	Other	Don't Know	
Amakuriat	60%	68%	56%	64%	44%	28%	20%	4%		25
Arror	50%	5%	50%	15%	35%	10%	5%	65%	5%	20
Chebiemit	59%	32%	45%	36%	50%	36%		18%	5%	22
Chepareria	11%	67%	63%	26%	30%	30%	19%	4%		27
Cherangani	38%	46%	67%	38%	46%	54%	46%	4%	4%	24
Edebess	50%	71%	33%	25%	42%	13%	4%	8%		24
Kabichbich	48%	91%	87%	100%	100%	100%	65%		4%	23
Kacheliba	91%	73%	36%	14%	23%	27%	9%	9%		22
Kacheliba M	64%	68%	76%	32%	40%	52%	16%	8%		25
Kacherop	48%	61%	61%	52%	39%	43%	13%	13%		23
Kapenguria	39%	57%	83%	30%	35%	26%	9%		9%	23
Kapsara	25%	79%	83%	29%	50%	42%	8%			24
Kasowar	57%	33%	48%	19%	29%	19%	24%	24%	10%	21
Kolongolo	73%	85%	81%	58%	54%	62%	12%	8%		26
Konyao	36%	88%	36%	32%	24%	28%	16%	4%		25
Lomut	74%	91%	96%	70%	74%	100%	48%	4%		23
Ortum	78%	96%	96%	78%	83%	87%				23
Serewo	81%	81%	75%	81%	81%	25%	19%			16
Sigor	76%	100%	100%	84%	68%	88%	84%			25
Suam	33%	71%	67%	43%	38%	29%	24%	19%		21
Tot	19%	29%	71%	29%	43%	24%	14%	52%		21
Total	253 (52%)	324 (67%)	325 (67%)	219 (45%)	234 (48%)	216 (45%)	106 (22%)	53 (11%)	8 (2%)	483

Table 5: Knowledge about malaria prevention methods (multiple responses allowed)

Supervision Area	Method of Prevention*					Total No. of respondents
	LLITN	Mosquito Repellents	Avoid Stagnating Water	Others	Don't Know	
Amakuriat	35%	22%	43%	%	9%	23
Arror	73%	7%	20%	33%	20%	15
Chebiemit	86%	32%	55%	18%	5%	22
Chepareria	67%	11%	33%	%	17%	18
Cherangani	40%	24%	12%	20%	4%	25
Edebes	82%	55%	18%	18%	9%	22
Kabichbich	63%	88%	54%	4%	8%	24
Kacheliba	77%	41%	45%	9%	%	22
Kacheliba M	84%	44%	40%	4%	8%	25
Kacherop	65%	22%	57%	22%	9%	23
Kapenguria	87%	26%	30%	4%	4%	23
Kapsara	96%	25%	38%	%	%	24
Kasowar	55%	15%	30%	20%	20%	20
Kolongolo	100%	42%	42%	23%	%	26
Konyao	64%	32%	48%	4%	%	25
Lomut	90%	57%	43%	14%	10%	21
Ortum	91%	14%	9%	5%	%	22
Serewo	67%	78%	67%	%	22%	18
Sigor	36%	84%	52%	%	%	25
Suam	55%	65%	25%	25%	5%	20
Tot	67%	17%	11%	28%	11%	18
Total	325 (70%)	179 (39%)	172 (37%)	53 (11%)	32 (7%)	461

Table 6: LLITN Ownership

S.No.	Supervision Area	Availability of Nets at Household		Total
		Yes	No	
1	Amakuriat	80%	20%	25 (100%)
2	Arror	83%	17%	24 (100%)
3	Chebiemit	70%	30%	23 (100%)
4	Chepareria	67%	33%	27 (100%)
5	Cherangani	64%	36%	25 (100%)
6	Endebes	75%	25%	24 (100%)

7	Kabichbich	48%	52%	23 (100%)
8	Kacheliba	80%	20%	25 (100%)
9	Kacheliba M	68%	32%	25(100%)
10	Kapcherop	32%	68%	25 (100%)
11	Kapenguria	39%	61%	23 (100%)
12	Kapsara	79%	21%	24 (100%)
13	Kapsowar	61%	39%	23 (100%)
14	Kolongolo	80%	20%	25 (100%)
15	Konyao	83%	17%	24 (100%)
16	Lomut	61%	39%	23 (100%)
17	Ortum	86%	14%	21 (100%)
18	Serewo	78%	22%	23 (100%)
19	Sigor	100%		25 (100%)
20	Suam	45%	55%	20 (100%)
21	TOT	48%	52%	23 (100%)
Total		341 (68%)	159 (32%)	500 (100%)

Table 7: LLITN Usage

S.No.	Supervision Area	Slept Under Net*				Total No. of respondents
		Youngest Child (0-59m)	Mother	No One	Other	
1	Amakuriat	81%	57%	5%		21
2	Arror	60%	60%	35%	15%	20
3	Chebiemit	59%	53%	41%	29%	17
4	Chepareria	89%	94%	6%		18
5	Cherangani	71%	65%	6%		17
6	Edebess	81%	100%			16
7	Kabichbich	89%	67%	11%		9
8	Kacheliba	90%	60%	5%	5%	20
9	Kacheliba M	78%	61%		17%	18
10	Kacherop	25%	13%	75%		8
11	Kapenguria	33%	78%	11%		9
12	Kapsara	78%	67%		28%	18
13	Kasowar	36%	36%	57%	7%	14
14	Kolongolo	70%	65%	10%	10%	20
15	Konyao	95%	38%		5%	21
16	Lomut	92%	77%	8%		13

17	Ortum	94%	100%			18
18	Serewo	77%	62%	8%		13
19	Sigor	92%	32%	8%		25
20	Suam	60%	80%	30%	30%	10
21	Tot	45%	55%	45%	9%	11
Number of Respondents		251 (75%)	210 (63%)	48 (14%)	25 (7%)	336

Table 8: Presence of fever in children under 5 in the past two weeks

S.No.	Supervision Area	Fever in the last two weeks			Total
		Yes	No	Don't Know	
1	Amakuriat	96%	4%		25 (100%)
2	Arror	74%	26%		23 (100%)
3	Chebiemit	65%	35%		23 (100%)
4	Chepareria	70%	30%		27 (100%)
5	Cherangani	58%	42%		24 (100%)
6	Endebes	10%	90%		21 (100%)
7	Kabichbich	77%	23%		22 (100%)
8	Kacheliba	88%	13%		24 (100%)
9	Kacheliba M	80%	20%		25 (100%)
10	Kapcherop	84%	16%		25 (100%)
11	Kapenguria	73%	27%		22 (100%)
12	Kapsara	96%	4%		23 (100%)
13	Kapsowar	68%	27%	5%	22 (100%)
14	Kolongolo	88%	8%	4%	26 (100%)
15	Konyao	92%	8%		25 (100%)
16	Lomut	39%	61%		23 (100%)
17	Ortum	80%	20%		20 (100%)
18	Serewo	75%	25%		20 (100%)
19	Sigor	90%	10%		21 (100%)
20	Suam	73%	23%	5%	22 (100%)
21	Tot	65%	35%		23 (100%)
Total		359 (74%)	124 (25%)	3 (1%)	486 (100%)

Table 9: Care seeking for fever in children under 5³

Supervision Area	First Source of Treatment / Advice					Total
	Public Facility	Private Facility	Traditional Healers	CHWs	Others	
Amakuriat	33%	46%	4%		17%	24
Arror	57%	43%				14
Chebiemit	77%	15%		8%		13
Chepareria	59%	6%	12%	24%		17
Cherangani	50%	42%			8%	12
Endebes	100%					1
Kabichbich	69%	15%		8%	8%	13
Kacheliba	60%	25%		15%		20
Kacheliba M	79%	5%	11%	5%		19
Kapcherop	95%	5%				20
Kapenguria	67%	20%			13%	15
Kapsara	76%	12%	6%	6%		17
Kapsowar	36%	50%	7%		7%	14
Kolongolo	9%	22%		43%	26%	23
Konyao	77%		5%	18%		22
Lomut	56%	11%	22%	11%		9
Ortum	75%	19%		6%		16
Serewo	71%			29%		14
Sigor	95%	5%				19
Suam	75%	8%		8%	8%	12
TOT	50%	42%			8%	12
	205 (63%)	62 (19%)	10 (3%)	32 (10%)	17 (5%)	326 (100%)

Additional Survey Data:

In July 2010, HealthRight's USAID Child Survival and Health Grant project, entitled the Partnership for Maternal and Neonatal Health (PMNH), underwent a final evaluation in the three Pokot Districts. The final evaluation included a KPC survey adapted from the USAID Rapid CATCH Survey Tool and included data on all maternal and neonatal health standard indicators. The survey, therefore, also contained data about LLITN ownership and usage among pregnant women and children under five, important maternal and neonatal health indicators.

The PPTM project is being implemented in five districts, three of which were also implementing the PMNH project mentioned above. Therefore, HealthRight can use the LLITN data for these

³ Individual results for each community unit are only significant in units where 19 or more surveys were completed.

districts as a baseline for the PPTM project and can compare this data with the KPC information collected at the end of the project. In the Pokot districts, LLITN ownership was estimated at 67% of households. For LLITN usage, only 58% of children under 1 year slept under an LLITN the previous night while only 10% of their mothers did. These statistics are lower than the averages of the 21 targeted communities surveyed in the PPTM baseline.

Routine Monitoring Data:

The HealthRight MCP team has developed a routine monitoring matrix which is compiled and reviewed each month to track progress and guide implementation. The matrix and data collection tools were prepared in the first two quarters of the project so that routine data monitoring began in April 2010. Below is a list of the priority indicators that the project tracks along with results for the past six months. In addition to this list, HealthRight tracks numerous process indicators which document community and facility training, DHMT supportive supervision, drug supply monitoring, and facility HIS reporting rates.

Table 10: Sample PPTM Routine Monitoring Data (April – September 2010)

Indicator	Value	Means of Verification	Comments/Status
Total malaria tests	40,074	Standard health facility data	
Total new malaria positives	2,048	Standard health facility data	Only includes those confirmed by microscopy
Total treated for malaria with ACT	75,763	Standard health facility data	
Percent of new confirmed malaria cases	41% (average)	Calculated by HealthRight (Cases confirmed by microscope / clinical cases + confirmed cases)	Target to increase
Total number of referrals by CHWs	452	Standard CHW Community-Based Health Information system data	Increasing trend as CHWs are identified and trained
Number of malaria community educational events organized	58	Collected by CHEW, partners and HealthRight staff	Represent only those organized by HealthRight currently
Number of Participants in community events	14,389	Collected by CHEW, partners and HealthRight staff	
Percentage of CHWs in monthly meeting.	51% (average)	Collected by CHEW – standard CBHIS indicator	Increasing trend as CHWs are identified and trained
Percentage of CHCs in the monthly meeting	54% (average)	Collected by CHEW – standard CBHIS indicator	Used to measure functionality of CHCs
Number of home visits by CHWs	6,442 (4 months of data)	Collected by CHEW – standard CBHIS indicator	Increasing trend as CHWs are identified and trained
Number of ITNs distributed to households	11,605	Standard health facility data	In partner facilities only

Households with at least one LLITN	Incomplete data		
Pregnant women sleeping under LLITNs last night	Incomplete data		
Children under 5 under LLITN last night	Incomplete data		

“Total new malaria positives” is an indicator to track the number of cases that are confirmed using microscopy. Currently, not all targeted facilities have microscopes to confirm cases, which is one reason that this indicator is significantly lower than the “total treated for malaria with ACT”. However, the PPTM project intends to procure some microscopes for placement in priority facilities. In this way, the PPTM will increase the percentage of malaria cases that can be confirmed each month. In addition, the PPTM will work to reduce the discrepancy between the number of confirmed malaria cases and the number of people treated.

HealthRight Community Mobilizers have been very active organizing malaria educational events in the nine months. However, with the identification of the project partners, these events will increasingly be organized by local community-based organizations, community health volunteers and other project partners.

The project is tracking LLITN usage for pregnant women and children under five routinely as a total number rather than a percentage. CHVs collect raw data during their household visits and report it during their monthly coordination meetings with the CHEW. The information is compiled and provided to HealthRight each month. The MCP indicators for “% of pregnant women and children under five sleeping under an LLITN on the previous night” will also be collected at the end of the project period using a household survey as a part of the final evaluation.

Additional Data Collected for PSI

As a partner to Population Services International, HealthRight has agreed to provide some vital LLITN monitoring data to them on a quarterly basis. These indicators include:

District Level:

1. HealthRight Malaria Managers will check the accuracy of the LLITN distribution records from rural health facilities by cross checking them with the monthly ANC reports.
2. HealthRight Malaria Managers will assist the DHMT to calculate existing LLITN stock each quarter so that stocks can be verified during the distribution.

Facility Level:

3. HealthRight Malaria Managers in each district will verify the facility records in collaboration with the DHMT malaria focal point during the quarterly distributions.

Household Level:

4. The MOH Community Health Extension Workers (CHEWs) in each facility will use facility distribution records to conduct monitoring to 5% of the recipient households on a quarterly basis.

5. 1,050 CHVs trained by HealthRight will document the ownership of LLITNs at the household level during their home visits.

Technical Assistance:

USAID and MCHIP provided the PPTM project and HealthRight staff with technical assistance in the finalization of the malaria baseline KPC survey tool and the LQAS sampling frame.

In the next year, the PPTM project will benefit from a USAID-funded collaboration with AED's CCHANGE project for the delivery of social behavior change master training for staff. In year 1, the CCHANGE project staff have dedicated time to adapting their training curriculum to meet the needs of the PPTM project. In addition, they have provided technical assistance in the development of the training plan and timeline.

PMI Team Collaboration:

The PPTM Kenya team has been collaborating with the USAID PMI focal point in all aspects of the project, from planning to implementation. Dr. Wachira assisted in the revision of the PPTM work plan. He was invited to stakeholders' meetings and participated in national level meetings with the DOMC. This collaboration has been particularly useful in communications with the DOMC.

MCP Story:

As this is the first year of implementation, HealthRight has not written a story that illustrates the success of the project to date. It is expected that those will be available before the end of the project. However, below is a personal story from a CHV about how the PPTM project has changed his life. A second story can be provided at a later date, if one is not sufficient.

Being a Community Health Volunteer (photo not currently available)

Thomas is a 27 year old man married to one wife and a father to three children. He hails from Karon village in Chepareria Division of West Pokot. Thomas attended school up to form three (High School) but then dropped out of school due to lack of school fees. In his quest for education, he had a vision of becoming a doctor and coming back to serve the local community. This dream was shattered when his father died and all his family's cattle were taken during an attack from neighboring Karamajong cattle rustlers.

Being the first born in a family of four, Tommy had to drop out of school and take up the position of the farther at the age of 19. All hopes were dashed and the blue sky offered no solace. The only option that was left for Tommy was to pool up some extra funds and start some farming for subsistence. In the farm he grew maize, planted a few fruit trees and onions. Tommy and the mother toiled in the farm, braved the scorching heat, tended the dry stony ground and prayed to God to bless the work of their hands.

The younger siblings continued going to school since school fees were not required in the lower primary. As the farming picked momentum, more labor force was needed. Tommy toyed with the idea of marrying a wife, but this could not be realized immediately as he had no cattle for paying the bridal price. They had to work hard and Tommy had to subsidize by taking odd jobs in the market place or working for others on their farms. Finally, his efforts were rewarded and

he was able to raise the bride price. At the age of 23 he married the apple of his eye, Cherop, who has since rewarded Tommy with three lovely boys. Tommy hopes that one of his boys will become a doctor.

Tommy's dreams came to realization when his community selected him to be a CHV. He feels that through this volunteer health work he is going to make a difference in people's lives. Since then, he has received basic health trainings that have now enabled him to give health messages, identify danger signs and to be able to advise women and the community to seek health care services. He works closely with the households, the men, leaders and the entire community to accept facility services and he provides key health messages.

Tommy continues with farming and also volunteers his time as a CHV. One major challenge is that the needs of the community is demanding and sometimes takes some of his farming time, however he feels fulfilled as he is doing the work that he loves to do. He adds—'if only I had a bicycle, I would shorten the time I spend moving from one house to the other'.

MCP Photos:



LLITN distribution 2010 (photo taken by HealthRight staff)



2010 (photo taken by Hellen Chemtai, HealthRight staff)



A community drama group spreads health messages in the communities. (photo taken by Augustine Kakoku, HealthRight staff)



Local Pokot dance group spreading health messages in the communities. (photo taken by Jennifer Olson, HealthRight staff)

CHV and CHC orientation training (photo taken by Bendy Kipchoge, HealthRight staff)

